Robert Dumond, Just Detention International
Testimony before the U.S. Review Panel on Prison Rape
Supplemental testimony

a. In your written testimony (p. 6), you cited research that predators may target vulnerable inmates by nonverbal cues suggesting ease of victimization. Please elaborate.

The target selection process is a complex calculus that includes the cost-benefit ratio, likelihood of success, and other characteristics. One likely characteristic is the presence of nonverbal cues. Research on perceived vulnerability as manifested by body language was conducted in 1981. The researchers videotaped people walking down a high-crime block in New York City over a three-day period. They then showed these tapes to fifty-three prisoners who had been convicted of violent assault and asked them to identify who would make an "easy target." Prisoner participants made their selections within seven seconds. The selections were remarkably consistent among all the inmates participating.

Selection in this study was not dependent on race, age, size, or gender. Some large men were selected while some small, slight women were passed over. The prisoners themselves could not always articulate their reasons for identifying someone as an "easy target." Subsequent video analysis, however, provided a description of common factors:

- *Stride* (targets had exaggerated stride—short or long—e.g., shuffling, not lifting feet);
- *Rate* (targets walked differently—either too slow or too fast, seen as nervousness/fear);
- *Fluidity* (targets tended to have awkward body movements);
- *Wholeness* (targets' arms and body movement were not "centered"); and
- *Posture and gaze* (targets had slumped posture and downward gaze).

In short, vulnerable individuals emitted nonverbal cues that indicated ease of victimization, which has been confirmed by several additional studies.

Interestingly, these characteristics may be observed in the behavior and physical appearance of individuals with specific disabilities and under the influence of psychotropic medication. Therefore, nonverbal cues may contribute to the increased vulnerability of individuals who have disabilities and/or are on certain medications.

It is important to note that these factors were identified in a non-custodial setting. It is not clear that these cues have the same impact in custodial settings. However, it is reasonable to theorize that targets are identified in custodial settings, at least partially, though nonverbal cues.

b. In your written testimony (p. 7), you noted that the Bureau of Justice Statistics' survey indicates that inmates with a history of sexual abuse experience a high rate of sexual victimization by other inmates. You wrote, "While this problem plagues both male and female inmates, the exceptionally high rates of previous instances of sexual abuse among women mean that it may have a disproportionate effect on female inmates." Please explain how having a history of sexual abuse is significantly different for male and female inmates.

Although it has been recognized that many incarcerated men have had trauma histories, there appear to be differences between these prior experiences among incarcerated men and women. Many incarcerated men have had physical victimization in childhood, but the rate of sexual victimization appears to be far lower among men then among women, and then men have been abused, the abuse generally has not extended into adulthood.

On the other hand, the evidence is overwhelming that women in custody appear to have had disproportionate long-term exposure to three inter-related issues – trauma histories, substance abuse, and mental health issues. These experiences tend to have begun in childhood, continued into adulthood, and had a devastating and debilitating effect on their growth and development, and on their pathway to incarceration.

For instance, incarcerated women have substantially higher rates of PTSD, at a statistically significant rate, than women in the community. PTSD in female prisoners is two to three times higher than in the general population and women, in general, appear to be more vulnerable to PTSD. In contrast, the rate of reported PTSD in incarcerated men is far lower.

As a direct result of their trauma histories, incarcerated women appear to have different pathways to incarceration than men. Additionally, such long term, repeated, on-going trauma often contributes to Complex Posttraumatic Stress Disorder (C-PTSD, also known as multiple interrelated post traumatic stress disorder), in which the psychological injury is the result of protracted exposure to prolonged social and/or interpersonal trauma. This disorder results in helplessness, deformations of identity and sense of self, and the lack or loss of control.

c. In your written testimony (p. 8) you noted, "To meet the unique personal needs and situational and contextual issues facing women, corrections agencies have begun developing much-needed gender responsive and trauma-informed treatments and programs focusing especially on the well-being of female inmates." (Citations omitted.) Could you explain in more detail what an effective "gender responsive" treatment program is for female inmates?

"Gender responsive" means creating an environment through site-selection, staff selection, program development, content, and materials that reflects an understanding of the realities of women's lives and addresses the issues of participants. Gender responsive approaches are multidimensional and are based on theoretical perspectives that acknowledge women's pathways into the criminal justice system.

These approaches address social (e.g., poverty, race, class, and gender inequality) and cultural factors, as well as therapeutic interventions. Gender responsive interventions address issues such as abuse, violence, family relationships, substance abuse, and co-occurring disorders. They provide a strength-based approach to treatment and skill building.

The emphasis is on self-sufficiency. Because women's pathways to crime are different from men's, the overwhelming experience of trauma has contributed to substantive dysfunction, substance abuse, mental health issues, and has compromised their ability to successfully reintegrate back into the community. To be effective, corrections treatment programs and

services must be developed in three broad areas: (1) breaking the cycle of destructive behavior; (2) developing and maintaining healthy relationships, and (3) building meaningful life skills.

Corrections agencies should employ classification and assessment tools that are tailored for female prisoners and should use a gender-informed security re-classification scale. Corrections programs and services should focus on addressing substance abuse issues; managing and dealing with trauma histories; improving relationships between women and their children; and increasing women's safety.

d. In your written testimony, you included an appendix (app. 1) that describes four phases of an effective model for responding effectively to prison rape: (1) Intervention, (2) Data Collection and Analysis, (3) Interdiction and Prosecution, and (4) Intervention. Please provide more details on the fourth phase, Intervention. What is the significance of this final phase?

Intervention includes all of the strategies which must be employed to respond to incidents of sexual violence. Comprehensive services must be initiated as soon as possible after the event and must address immediate, short-term, and long-term issues (as identified in Appendix I). To be successful, interventions must be sustained throughout the prisoner's incarceration experience and include appropriate referrals to community services upon release.

Mental health practitioners in corrections settings should become familiar with RTS and PTSD, but also with current, sound, evidence-based interventions with demonstrated effectiveness. The goal of all treatment should be to "do no harm." Therefore, the treatment that is provided should be trauma-informed, gender specific, culturally sensitive, and of sufficient duration to ensure adequate impact on victims. Systematic reviews of therapeutic interventions have validated the effectiveness of several approaches, including: Trauma Focused Cognitive-Behavioral Therapies (TFCBT), Eye Movement Desensitization and Reprocessing (EMDR), and SSRI Pharmacotherapy.

(a) **Crisis Services** include:

- Ensuring safety for victim
- Separating victim from perpetrator
- Providing necessary medical care and forensic evaluation
- Evaluating suicide risk
- Negotiating psychological assistance and on-going mental health care
- Initiating classification review and develop safe, short-term placement options

(b) **Short-Term Treatment** includes:

- Providing on-going medical follow-up treatment
- Providing follow-up on HIV/AIDS, STD, and other disease testing/treatment
- Continuing close mental health supervision
- Continuing mental health assessment of suicidality, depression, and mental status
- Always ensuring victim safety and security

(c) **Long-Term Strategies** include:

- Continue monitoring of medical issues, including STD evaluation and HIV/AIDS testing every 6 months for up to 18 months post assault
- Empowering victim to not place self at risk
- Continuing mental health intervention, including on-going counseling and support, with attention to PTSD symptomology, mental status, sexual identity, and coping skill responses
- Providing on-going, scheduled monitoring and assessment of victim
- Supporting victim through prosecution
- Ensuring continuity of care as well as consistency and availability of medical and mental health treatment as prisoner moves through incarceration
- Making appropriate follow-up referrals upon transition to the community

<u>References</u>:

Austin, J., & Hardyman, P. L. (2004). *Objective prison classification: A guide for correctional agencies* (Accession Number 019319). Washington, DC: National Institute of Corrections

Blanchette, K. & Brown, S. (2007*). The assessment and treatment of women offenders: An integrative perspective*. Wiley Series in Forensic Clinical Psychology. New York: John Wiley & Sons.

Blanchette, K. & Taylor, K. (2005). *Development and field-test of a gender-informed security reclassification scale for women offenders*. Ottawa, Ontario: Correctional Service of Canada, Research Branch.

Blanchette, K., Vergrugge, P., Wichmann, C. (2002*). The Custody Rating Scale, initial security level placement and women offenders.* Ottawa, Ontario: Correctional Service of Canada, Research Branch.

Bloom, B., & Covington, S. (2000). *Gendered justice: Programming for women in correctional settings.* Paper presented to the American Society of Criminology, San Francisco.

Bloom, B., Owen, B., & Covington, S. (2005). *Gender Responsive Strategies for Women Offenders: A summary of research, practice, and guiding principles for women offenders*. May 2005, NIC Accession Number 020418. Washington, D.C.: National Institute of Corrections.

Browne, A. & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin*, 99: 66 – 77.

Browne, A., Miller, B., & Maguin, E. (1999). Prevalence and severity of lifetime physical and sexual victimization among incarcerated women. *International Journal of Law and Psychiatry*, 22(3-4): 301-322.

Dumond, R.W. & Dumond, D.A. (2010). Managing prison sexual violence: A guide to effective victim services. In English, K, Heil, P. & Dumond, R.W., National Institute of Justice [NIJ] Final Report of the Colorado Department of Public Safety, Division of Criminal Justice. Denver, CO: Colorado Department of Public Safety, Division of Criminal Justice, Office of Research & Statistics, Appendix D: 261 - 286.

Grayson, B., & Stein, M. I. (1981). Attracting assault: Victims' nonverbal cues. *Journal of Communication, 31*, 68–75.

Gunns, R. E., Johnston, L., & Hudson, S. M. (2002). Victim selection and kinematics: A point-light investigation of vulnerability to attack. *Journal of Nonverbal Behavior*, *26*(3), 129–158.

Harlow, C. *Prior Abuses Reported by Inmates and Probationers (Publication No. NCJ 172879)*; U.S. Department of Justice, Bureau of Justice Statistics: Washington, DC, USA, 1999.

Herman, J.L. (1997). *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror*. New York: Basic Books. ISBN 978-0-465-08730-3.
Herman, J. L. (1992). "Complex PTSD: A syndrome in survivors of prolonged and repeated trauma". *Journal of Traumatic Stress* **5** (3): 377–391.

James, D. J., & Glaze, L. E. (2006, September). *Mental health problems of prison and jail inmates.* (NCJ 213600) [Bureau of Justice Statistics Special Report]. Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Lewis, C.F. (2005). Female offenders in correctional settings. In C.L. Scott and J.B. Gerbasi, (Eds.). *Handbook of correctional mental health*. Washington, D.C.: American Psychiatric Publishing, Inc., Chapter 8, pp. 155 – 185.

Lewis, C.F. (2003). Prevalence of psychiatric diagnoses in HIV positive incarcerated women. Paper presented at the annual meeting of the American Psychiatric Association, San Francisco, CA, May 17 – 22, 2003.

Miller-Perrin, C.; Perrin, R. *Child Maltreatment: An Introduction*; Sage Publications: Thousand Oaks, CA, USA, 2007.

Sakaguchi, K., & Hasegawa, T. (2006). Person perception through gait information and target choice for sexual advances: Comparison of likely targets in experiments and real life. *Journal of Nonverbal Behavior, 30*(2), 63–85.

Singer, M.I. Bussey, J., Sony, L.Y. et al., (1995). The psychosocial issues of women serving time in jail. *Social Work*, 40: 103 – 113.

Stavrianos, C.; Stavrianou, P.; Vasiliadis, L.; Karamouzi, A.; Mihailidou, D.; Mihail, G. Emotional maltreatment of children. (2011). *Social Sciences, 6*, 441–446.

Teplin, L. A. (1990). The prevalence of severe mental disorders among male urban jail detainees: Comparison with the Epidemiological Catchment Area Program. *American Journal of Public Health*, *80*, 663–669.

Teplin, L. A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health, 84*, 290–293.

Van Voorhis, P. (2004). *Classification of women offenders: Gender-responsive approach to risk/needs assessment*. NIC Accession Number 028816. Cincinnati, OH: National Institute of Corrections.

Veysey, B. M., & Bichler-Robertson, G. (2002). Prevalence estimates of psychiatric disorders in correctional settings. In *The health status of soon to be released inmates: A report to Congress, Vol. 2.* Chicago: National Commission on Correctional Health Care.

Wolff, N. & Shi, J. (2012)._*International Journal of Environmental Research and Public Health, 9*, 1908-1926.

Wolff, N.; Shi, J.; Siegel, J. (2009). Patterns of victimization among male and female inmates: Evidence of an enduring legacy. *Violence Vict., 24*, 469–484.

Zlotnick, C. (1997). Posttraumatic stress disorder (PTSD), PTSD comorbidity, and childhood abuse among incarcerated women. *Journal of Nervous and Mental Disorder*, *185*, 761–763.