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CORRECTIONAL GROUP TREATMENT FOR VICTIMS OF SEXUAL ASSAULT

BY

Todd Derbyshire

B.A., University of New Hampshire, 2002

THESIS

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ABSTRACT

CORRECTIONAL GROUP TREATMENT FOR VICTIMS OF SEXUAL ASSAULT

by

Todd Derbyshire

University of New Hampshire, May 2009

There is a lack of research regarding therapeutic treatment for inmates who suffer from suicidal ideation after being sexually victimized. This paper reviews the existing research on sexual assault in prisons and the various impacts an event can lead to including suicidal ideation. A model is proposed in using reality therapy to introduce a new perspective in treatment for inmates that suffer suicidal ideation from being sexually victimized.

Many psychological theories are suggested when working with the sexually victimized population. The uniqueness of the correctional population emphasizes the strengths of reality therapy. In reality therapy the individual is limited only to their own insight in realizing what he or she is able to do in their situation. This insight in an otherwise debilitating setting can have therapeutic

breakthroughs where other theories fall short. Implications for treatment and suggestions for future research are discussed.

CHAPTER I

INTRODUCTION

A clinician always holds the responsibility of assessing a client's thoughts of suicidal ideation. A clinician must assess clients more frequently about his or her suicidal ideation at the local county jail or state prison. The World Health Organization, as cited in *Suicide and Mental Association International* (2004), states that inmates serving sentences are three times more at risk for suicide than individuals living in the community. Similarly, Hayes (2005) states that suicide ranks as the third leading cause of death in prisons, behind natural causes and AIDS, which illustrates the severity of the issue.

Correctional systems across the country have examined and identified many factors that can put an inmate at higher risk from suicide. An inmate is at his or her highest risk in the first 24 hours of being in the prison (Hayes, 2005). During this period the inmate might be going through drug and alcohol withdrawal along with the shock of the dramatic change in his or her environment (Hayes, 2005). Mental health clinicians in the corrections

system have developed a list of suicidal signs and symptoms which can indicate the possibility of that individual committing suicide (Hayes, 2005). The list includes depression, expressions of strong guilt and/or shame over their offense, talk about suicide, under the influence of drugs or alcohol, severe agitation and aggressiveness, etc. (Hayes, 2005). One possible predictor that is not on the list that some experts in corrections believe should be is whether the inmate has experienced any acts of sexual assault. In looking at the research connecting sexual assault victims and treatment in the correctional setting there are very few findings. Therefore, the aim of this investigation was to develop a group model for treating individuals that experience suicidal ideation from sexually traumatic events of sexual assault.

Purpose of this Investigation

The central purpose of this investigation is the construction of a group model relating to the treatment for those individuals in a correctional setting suffering from suicidal ideation as a response to sexual assault events. Although there has been a great amount of research done on the recovery process for victims of sexual assault, there is very little to no research on this population in the unique setting of the corrections institution. Although

victims of sexual assault can develop similar symptoms due to the event, the altered way of living in a prison can greatly affect those symptoms even more. A concern when developing a model for treatment in a correctional setting is how to make the treatment not only effective for the current life of the client but also when the individual transitions back to the community. The challenge is that these individuals need treatment that is more than just time spent behind bars, where after a prolonged amount of time they are released back into the community without the supports to deal with their mental disorders in an adequate way.

Development of a group model will be based upon the existing literature on sexual assault victim group treatment in the correctional setting and then expanded to general models of group treatment for sexual assault victims. A group model of treatment will be proposed over individual treatment for the benefits of the client finding a support system and reducing social isolation. Also the hope for this model is that it is more time and cost efficient for mental health workers and correctional teams.

Background and Rationale

Hayes (2005) states, "Suicide attempts are sometimes a response to rape, particularly among prisoners, who feel

vulnerable to continuing abuse" (p. 36). However, he asserts that, unfortunately, there is not enough data about the relationship, if any, between sexual assault and suicide to fully comment on this issue (Hayes, 2005). Hayes (2005) states, "According to the National Institutes of Corrections, the impact of sexual assaults may cause an increased risk of suicide or suicide attempts, post-traumatic stress disorder or rape trauma syndrome, heighten pre-existing psychiatric disorders, etc." (p. 37).

Robert W. Dumond, a licensed clinical mental health counselor, in an interview with Hayes, agreed that the effects of sexual assault during incarceration have been shown to be very traumatic and debilitating. He asserts that male victims are more often physically assaulted during attacks, and male victims may be labeled "punks" and forced to endure years of sexual slavery (Hayes, 2005). Over one third of female rape victims in prison were shown in one study to develop post-traumatic stress disorder at some point in their lives (Dumond & Dumond, 2002). That being said, there is not much research in the field that indicates that inmates are receiving adequate treatment for their symptoms as a result of events of sexual assault that have occurred in their lives.

There are many reasons why research is lacking when there is a discussion about sexual assault in the corrections system. One reason this topic is under-researched is that prison administrators often deny access to the researchers when the results show unacceptable findings (Ibrahim, 1974; French, 1979). Another reason is that researchers in previous generations did not understand why inmates engaged in homosexual activity (Cotton & Groth, 1982). Also many individuals in society believed for a substantial amount of time in the past that sexual assault went hand in hand with prison sentences. These assertions underscore the importance for research on sexual assault in correctional settings and the institutional response to those assaults.

Recently, there have been a few published studies that address the subject of sexual assault in the correctional setting. One study was conducted by Struckman-Johnson, Struckman-Johnson, Rucker, Bumby, and Donaldson (1996), which set out to find the actual occurrence rate of sexual assaults in prisons. In a more recent study by Wolff, Blitz, and Shi (2007) it was found that sexual victimization occurred for males at a rate of 10.3% while females reported being sexually victimized at 24.5%. The earlier study is important in identifying the scope of the

sexual assault occurrences in the correctional system as it eludes to identifying possible barriers for future research in this field of study.

Another more recent study was conducted by Morgan and Hawton (2004) on juveniles in Europe between 16 to 18 years old from a juvenile detention center. The researchers examined how life events and psychological characteristics correlated with deliberate self-harm. In this study, deliberate self-harm was defined as overt attempts of an individual that harm that individual. This study found that, although this population is younger, there is a correlation between sexual assault and suicidal ideation. These participants progressed beyond ideation to deliberate self-harm. These studies indicate that there is a connection between sexual abuse and suicidal ideation in the inmate population in the correctional setting.

Definition of Terms and Concepts

Sexual Assault

Sexual assault is defined as any physical contact between two or more people in which one or more person is unwilling. This can include the use of hands, mouth, penis, or anus of a person by force, or the threat of force, intended either for sexual gratification or sexual intimidation of the other.

Suicidal Ideation

Suicidal ideation refers to any thought of not wanting to be alive, ranging to a specific plan of taking one's life (Reynolds, 1987).

Basic Assumptions

The premise of this investigation is based upon the work of others. The most successful studies done on this topic were self-reported studies by prisoners who retained their anonymity. Sexual assault has been absent in research associated with suicidal ideation, but more research needs to be done to conclude what is the best method of treatment for these individuals. This investigation will provide a best practice model of treatment for the treatment of prisoners with suicidal ideation.

Summary

Research on the topic of sexual assault experienced in prisons and suicidal ideation has been lacking. Recently, this trend has been reversed as the stigma of sexual assault in prisons has dissipated and society has grown more intolerant of sexual assault to inmates occurring in prisons. The results of this investigation contribute to the limited research on prisoners who have experienced sexual assault and have suicidal ideation. Conclusions

drawn from this investigation can lead to a comprehensive best practice group model for inmates who suffer suicidal ideation and are survivors of sexual assault.

CHAPTER II

REVIEW OF THE LITERATURE

Treatment for inmates who are victims of sexual assault is a highly under-researched subject. Given the lack of data from which to draw on this topic, it is important to look at how sexual assault is treated in the correctional system.

One of the symptoms a victim of sexual assault experiences after a traumatic sexual event is the feeling of losing one's identity. This feeling of lost identity can lead to an increased feeling of suicidal ideation, an area that has had a great deal of research and will help to form an understanding of how to develop a comprehensive model of treatment for inmates who are victims of sexual assault. It is because of this anxiety and isolation that a group model, which is likely to discourage isolation and reduce social anxiety over time, will be proposed over an individual model of treatment.

Suicide and suicidal ideation have been heavily researched in the corrections system. Researchers have looked at suicide thoroughly and have tried to devise ways in which professionals can identify predictors for suicide

(Hayes, 2005; Patterson, Dohn, Bird, & Patterson, 1983; Campbell, 2004; Juhnke, 1994). An example of how researchers have tried to identify suicidal signs and symptoms specific to the correctional system is found in the research conducted by Hayes (2005). In his research, Hayes suggests that, in addition to the common signs of suicide (i.e., depression, under the influence of alcohol or drugs, etc.), specific signs which relate to the correctional system such as expressions of strong guilt or shame over their offense can be used as predictors of suicidal symptoms (Hayes, 2005).

One scale of suicidal predictors, called the SAD PERSONS Scale, identifies a list of traits that indicate a higher tendency for that person to be at risk for suicide. The scale includes risk factors related to the traits of sex, age, depression, previous attempts, ethanol abuse, rational thought loss, social support lacking, organized plan, no spouse, access to lethal means, and sickness (Patterson, et. al, 1983). Research indicates that males are more likely to be successful in their attempts, while females will make more attempts. Age is a possible predictor of suicide when a client is under the age of 19 years or older than 45. Evidence of depression also indicates that the client might be at a higher risk for

suicide. An individual that had a previous attempt of suicide would lead to a higher score on the scale. Ethanol and drug abuse also clouds decision making and puts an individual at higher risk for suicide. Rational thought loss is another risk factor that, understandably, will lead an individual to a higher risk of suicide. The inability to access social supports is another factor that can increase an individual's risk. A major key to assessing individuals' suicidal thoughts is if they have a plan for killing themselves. Individuals who have a plan indicate that their thoughts have advanced further than innocent thoughts about escaping an undesirable situation. A client who does not have a significant other is also at a higher risk for suicide. Finally, a client is at a higher risk if he or she has a medical or psychological illness (Patterson et al., 1983). Campbell (2004) suggested adding the predictor of availability of lethal means to the scale, making the acronym now SAD PERSONAS. A client who has the availability of a gun is at a much higher risk than a client who has access to a butter knife.

These predictors are still used today for rapid psychological assessments of clients when they are suffering from suicidal thoughts. Juhnke (1994) says that the SAD PERSONS scale in the hands of competent clinicians

provides these professionals with a tool to enhance their ability to evaluate suicide risk and make appropriate clinical interventions. Mental health clinicians use this list of predictors for suicide in agencies, schools, and even prisons. However, is every therapeutic situation the same? For example, is the client population of an agency the same as that of a state prison? It is a rhetorical question indeed, but the question points to the credibility of such a blanket assessment of predictors for suicide.

Lindsay Hayes (2005) states that suicide is the third leading cause of death in U.S. prisons, behind natural causes and AIDS. Interestingly, suicides in jails have been on the decline for the past few decades. From personal experience, the distinguishable difference between jail and prison is the length of stay in the correctional institution. Overall, an inmate will stay at a jail if he or she is serving a sentence of less than one year. Any sentence that is given to an individual that extends past one year means that he or she will go to prison. Another main difference between the types of institutions is the amount of security between the two facilities. A prison is more likely to have the inmates highly supervised and monitored. An inmate at the jail will have fewer

restrictions than at the prison level and more services available for them to access.

In 1983 there was an average of 129 suicides per 100,000 prisoners. This is in contrast with an average of 47 suicides per 100,000 in 2002 (U.S. Department of Justice, 2005b). Overall, jail suicides are down by 64 percent since 1983 (U.S. Department of Justice, 2005b). Violent offenders committed suicide three times more than those who were non-violent offenders (U.S. Dept of Justice, 2005b).

There are numerous factors that can put an inmate at higher risk for suicide. One factor previously mentioned in elevating an inmate's risk in experiencing suicidal ideation is the first 24 hours they experience in prison. Some other common factors that elevate the risk for an inmate in experiencing suicidal ideation are depression, giving away valuables, and numerous others. Not listed or missing from the list is prison sexual abuse.

Sexual Assault and Suicidal Behavior

Sexual abuse has been loosely associated with suicide in various fields of research. However, there has yet to be a study that draws a relationship between the two. In one particular study, researchers found that childhood sexual abuse was a predictor for poor outcomes after

parasuicide (Soderberg, Kullgren, & Renberg, 2004). Hayes (2005) stated that, "Suicide attempts are sometimes a response to rape, particularly among prisoners, who feel vulnerable to continuing abuse" (p. 36). However, he goes on to say that there is insufficient data about the relationship, if any, between sexual assault/rape and suicide to fully comment on this issue (Hayes, 2005). One study concluded that at least a quarter of men in correctional facilities say they have been pressured for sex (Kupers, 1999). The federal bureau of prisons also estimates that between nine to twenty percent of male prisoners become victims of sexual assault during their prison terms (Kupers, 1999). The National Institutes of Corrections believes sexual assaults may lead to an "increased risk of suicide or suicide attempts, post-traumatic stress disorder or rape trauma syndrome, and heighten pre-existing psychiatric disorders" (Hayes, 2005, p. 37). The effects of sexual assault, as previously mentioned, during incarceration have been shown to be very traumatic and debilitating. Often the victim of prison rape will experience anxiety, distress, and can possibly develop a psychological disorder in the future. It is clear from research that there is a developing issue

occurring in the correctional systems involving a prisoner's physical and mental health.

The Dilemma of Sexual Assault in Prisons

Despite the research that has been presented on the prevalence of sexual assault in prisons, it still is likely to be vastly underreported. Once a rape or sexual act occurs, the victim is stuck in a moral dilemma. For instance, the victim would like to report the incident to his or her correctional officer, and be protected from the sexual predator. In doing so, however, the victim may be risking his or her life since by telling on the sexual predator, he or she is being labeled a snitch (Kupers, 1999). When labeled a snitch, the perpetrator will often try to kill the victim personally or will hire someone to kill the victim for them (Kuper, 1999).

The overwhelming sense of fear of this violence is often enough to keep an individual silent about their trauma. In fact, in order to avoid further physical abuse he or she may engage in further consensual sexual acts (Kupers, 1999). These victims, although willing to engage in these activities, are still being coerced into sexual acts as they are trying to gain some special treatment. Whether it is a small trinket or bodily protection, the sexual act becomes less and less malicious and becomes

almost a way in which one has to operate in order to survive the prison life (Kuper, 1999). Landis (2005) suggests why rape occurs in prisons: "Rape is a crime of violence and of sex, but it is also a crime of hierarchies. The rapist uses his or her power over the raped" (p. 1). In essence, Landis is stating that sexual assault in prison is a way for an individual to assert his or her authority over another individual. By asserting one's self over another he or she is telling the individual that he or she, the asserter, is more powerful than the victim.

This type of lifestyle in a prison can take a toll on an individual's well being. As a male victim, one may question his gender after being sexually assaulted. The process of a male prisoner being objectified as a female is called being "turned out" (Kupers, 1999). Individuals who appear to be more vulnerable to sexual assault are: younger, inexperienced, physically small or weak, inmates with a mental illness or disability, middle class, not gang-affiliated, known to be homosexual or overly effeminate, convicted of sexual crimes, etc. (Dumond & Dumond, 2000). A vivid picture of a male inmate is portrayed going through the turning out process: "The inmate rape victim, the 'punk' is no longer a man in the eyes of the toughs; he has been turned into a woman; he is

at the very bottom of the heap" (p. 141). Kupers suggests that this phenomenon of questioning one's gender in male sexual encounters goes back to the schoolyard. After a physical or verbal exchange has occurred, often there is a winner or loser where the winner will denounce the loser as a girl or a pansy (Kupers, 1999).

Women inmates suffer and deal with their sexual assault differently from their male counterparts. Sexual assault for a woman is often part of that woman's past, whether she has been physically or sexually abused as a child or been a victim of assault, domestic violence, or rape as an adult (Kupers, 1999). Also, in the case where the woman is sexually assaulted by a male, whether it was another inmate or prison guard, and becomes pregnant, the psychological scars can be immense. Once it becomes known to the staff that the inmate is pregnant, she can be under constant pressure to give up the name of the sexual predator (Kupers, 1999). Again, keeping the truth hidden is protecting oneself in not being labeled a "snitch."

The American Civil Liberties Union (2001) exposed an incident of a female prisoner reporting a sexual assault incident to staff at the prison who was later beaten, sodomized, and raped by three men who were made aware of her reporting (¶ 5). Correctional staff will often

pressure the female victim not to carry the baby to term, and constantly harass the woman to have an abortion (Kupers, 1999). The process of going through an abortion is a moral struggle that is experienced by any individual encountering that decision, and can mentally haunt that individual for the rest of her life. These are long term mental consequences for female inmates after being sexually assaulted in prison.

Awareness of Sexual Assault

The field of research on sexual assault in the corrections setting has not been extensive. Part of the reason for the lack of research in the field is the lack of demand for research on the topic. If there is no public outcry for research then there is no money for researchers to study this topic. Although it is the year 2009, the amount of research done in this field compared to other similar topics in mental health is clearly lacking. Attitudes have been changing, and over the past decade research has started to address sexual assault in the prison population.

The issue of sexual assault in prisons, and its linkage to the psychological distress of those victims, is not a new topic in American society. The Supreme Court has heard and discussed the topic of inmates being coerced into

performing sexual acts. In the Supreme Court case of Farmer v. Brennan, the court recognized the dire situation in the correctional system, and ruled that prison officials had a duty to protect felons from unnecessary risks of sexual assault (Farmer v. Brennan, 1994). The plaintiff of the case, Dee Farmer, stated that the correctional officers at the prison acted with deliberate indifference in his requests for assistance to escape the sexual abuse he was experiencing (Farmer, v. Brennan, 1994). That being said, there is not much in the field that links sexual assault in an inmate's duration in prison as a predictor of suicide.

One of the reasons for the paucity of research on sexual coercion in the correctional system is a lack of awareness about this issue (Struckman-Johnson et al., 1996). Due to the fact that sexual assault in prisons happens in a controlled environment, information made available to the public by the government is less than for other research topics. It has been reported in previous research that those trying to gain information on the subject have met resistance from prison administrators (French, 1979; Ibrahim, 1974). The problems that these researchers faced in the late 1970s still exist in today's society, as evidenced in the Morgan and Hawton study (2004)

where prison administrators stepped in and shut down the study.

Another reason for minimal research in the field is due to the lack of understanding of why an inmate engages in homosexual activity (Cotton & Groth, 1982). When a researcher does not understand the intentions of the subject, in this case an inmate, it convolutes the research. When an inmate engages in continuous sexual activity and a researcher does not explore it and instead categorizes it as consensual homosexual behavior, it is potentially erroneous and a grave injustice to that victim (Struckman-Johnson et al., 1996).

Finally, lack of information on prison rape may be due to the public viewing it as not horrific (Struckman-Johnson et al., 1996). In a poll taken by the Boston Globe, 50 percent of 400 registered voters had the perception that prison rape is acceptable and is part of the payment for their misconduct in society (Sennott, 1994). It is clear that due to society's outlook on the issue of sexual assault in prisons the funding for research on the issue was lacking. If a society deems certain research a person may want to study as irrelevant, then he or she will not continue to conduct research in that area. Also, there will likely be no funding or grants awarded for people

pursuing research in this area. It is reasonable to conclude that the general attitude of society can greatly impact the amount of research on a specific topic. With all these factors combined, it is clear that there are hurdles in researching the topic of sexual assault in the prison population.

Recent Studies

In recent history there have been a few studies that have looked at the issue of sexual assault within the prison population. One study, conducted by Struckman-Johnson et al. (1996), set out to find accurate occurrence rates of sexual assaults in prisons. Other research goals were to document the dynamics of sexually coercive incidents, to assess inmates' emotional reactions to sexual coercion and gauge if they had or had not reported the incident, and to compare opinions regarding how to prevent sexual coercion in prison between staff and inmates. The researchers collected their data using anonymous surveys instead of personal interviews. These surveys were sent by mail back to the researchers to ensure confidentiality. The prison consisted of 1,801 inmates; 1,708 men and 93 women, of whom 486 men and 42 women responded to the questionnaire. The staff consisted of 714 individuals, of which 264 returned a survey. The survey they used was

taken from Soreason, Stein, Siegal, Godling, and Burnam's (1987) strategy of assessing general information about overall coercion experience and specific information about one incident. Specific aspects were defined by responses to associated questions and scores were rated on a seven point Likert scale. A reminder was sent to all inmates and staff members one week after issuing the surveys. The return rates were approximately 30 percent for the inmates and 39 percent for the staff (Struckman-Johnson et al., 1996). The results of this study found that 19 percent of the inmates had been pressured or forced to have sexual contact in prison, while the staff estimate was approximately 15 percent (Struckman-Johnson et al., 1996). There was an additional one percent who had encountered sexual assault in prison, but was able to fend off their attackers and prevent the act from happening (Struckman-Johnson et al., 1996).

This study was groundbreaking in how it elicited the data it was able to gather. For the first time, this field of research was able to gain some insight into how pervasive sexual assault is in the prison system. Also, the researchers were able to specify tactics that the perpetrator used to manipulate the victim into performing sexual acts. It cannot be underestimated that the success

of this study hinged on the use of an informal questionnaire to gain anonymous perceptions from the inmates. The findings of this study are intriguing and are important to address when forming a group for survivors of sexual assault in the correctional setting. One of the findings that could apply to the formation of the model is that there is a great deal of confidentiality needed for individuals to feel comfortable in discussing this subject. Another important factor is that it is questionable whether correctional staffs are aware of the prevalence of the problem. These are important aspects to address when forming a model of treatment for victims of sexual assault who have to live in a situation where these are the norms of society.

Another study that looked at suicidal behavior in juvenile offenders was conducted by Morgan and Hawton (2004). In this study the researchers sampled 150 participants who ranged from 16 to 18 years of age from a juvenile detention center. Their methodology used an adaptation of the Child and Adolescent, Self Harm in Europe (CASE) study. The CASE study is a collaborative effort across numerous European countries that gains information on instances of self-harm from hospitals to anonymous reports (European Commission Daphne Programme, 1998). The

purpose of this study was to identify life events and psychological characteristics that correlate with deliberate self-harm and suicidal ideation in this population (Morgan & Hawton, 2004). Results of the study showed that 15.6 percent reported an act of deliberate self-harm, and 26.6 percent reported past suicidal ideation (Morgan & Hawton, 2004). The researchers also found that sexual abuse was significantly associated with deliberate self-harm (Morgan & Hawton, 2004). This study is critical to the proposed model, as it supports a correlation between sexual abuse and acts of deliberate self-harm in an institutionalized setting. The ability to identify this link between self-harm and sexual abuse further indicates how serious and dire the situation can be for inmates.

Models of Treatment

There is a body of research on the treatment for victims of sexual assault. However, research on how to treat victims of sexual assault who are inmates in a prison is marginal at best. This poses a unique dilemma for the individual who has been sexually assaulted as the environment is singular to any other environment for therapy. There are many factors that make this population unique which can range from the ability to live with the stranger that may have sexually assaulted the individual,

lack of privacy, and a lack of freedom amongst other defining characteristics. It is clear that a model of treatment for inmates who are victims of sexual assault is necessary and can be adopted by existing proven therapeutic models of treatment, but needs to take into account the aforementioned factors to be effective.

One model of treatment that has been effective in treating victims of sexual assault is the Cognitive Processing Therapy (CPT) approach. The model proposes that data about a traumatic event is stored in the brain in what is called "fear networks" (Resick & Schnicke, 1992). A fear network is composed of memories of traumatic stimuli and responses along with their meanings (Resick & Schnicke, 1992). It is the objective of the fear network to stimulate avoidance behavior in the survivor of sexual assault to prevent any future threat (Resick & Schnicke, 1992). Researchers have found that these fear networks that are developed by survivors of sexual assault create a mental filter that readily seeks the attention of any perceived threat and blocks out any evidence that is found to be contrary. This seems to lead the individual into experiencing the symptomology of Post Traumatic Stress Disorder (PTSD) (Resick & Schnicke, 1992). CPT is able to address the treatment needs for sexual assault survivors

usng several components. The first component of CPT is education (Resick & Schnicke, 1992). In CPT it is essential to educate the clients about their symptoms and the approach that is going to be used (Resick & Schnicke, 1992). Another component of CPT is exposure. In exposing the clients to images and accounts that will elicit the activation of their fear networks, it allows for the survivors to process their emotions and become desensitized to the stimuli (Resick & Schnicke, 1992). The last component of CPT is cognitive therapy which helps clients recognize and challenge maladaptive thinking patterns and how to handle distressing emotions (Resick & Schnicke, 1992).

Treatment in a sexual assault victim group in CPT runs the course of twelve weekly sessions that last for approximately an hour and a half each (Resick & Schnicke, 1992). In these sessions it is the goal of the group to help members adjust their stuck points in five areas: safety, trust, power and control, esteem, and intimacy (Resick & Schnicke, 1992). Research has shown that CPT is effective in treating PTSD and depression in limited studies. In one study, a group CPT approach to sexual assault victim treatment lowered the existence of depression in a client by 57%, and by the end of the same

group none of the members met the criteria for PTSD (Resick & Schnicke, 1992). The CPT approach based upon the research of Resick & Schnicke alludes to an effective approach for treatment of sexual assault victims. However, for the purposes of having a group of inmates being involved in a CPT group, it is evident that the results might not be as successful. During a CPT group members are fixated at trying to help other members adjust their stuck points and alleviate their distress in areas of safety, trust, power and control, esteem, and intimacy. These areas are severely warped when living in a confined environment such as a prison. Many of the elements of the CPT approach are stripped from an inmate on the first day they arrive at the prison. Therefore, it is much the norm to feel a lack of the above mentioned aspects that are discussed in the CPT model without ever having to be sexually assaulted. That being said, the CPT model appears to be an effective model of treatment for victims of sexual assault but not appropriate for those who are housed in a correctional setting.

Another model of treatment for rape victims and the earliest form of treatment that recognized the symptoms of sexual assault as a temporary crisis is the crisis intervention model (Sutherland & Scherl, 1970). According

to Holmes and St. Lawrence (as cited in McArthur, 1990), the focus of the crisis intervention model is to give information, support, and empathy to the victim. An inherent advantage of crisis intervention, as suggested by Forman, is that an integrated approach spread out through the various disciplines can provide a short-term, inexpensive treatment for the victim of sexual assault (as cited in McArthur, 1990). Kilpatrick, Resick, and Veronen assert that although this approach is inexpensive and integrated, symptoms of fear, anxiety, and depression were present long after the crisis period ended (as cited in McArthur, 1990). Even though crisis intervention seems imperative for an individual to stabilize him or herself after being a victim of sexual assault, it alone is not enough to heal all the damage of the event.

Another model of treatment for victims of sexual assault is peer support groups. There are times when the support of friends and family may not be enough or might be lacking where the support gained from a peer support group can help regulate and normalize the victims' feelings (McArthur, 1990). According to Coates and Winston ( ), by joining a peer support group a victim of sexual assault decreases isolation, loneliness, and experiences a reduction in depressive symptoms. Yalom indicates, (in

McArthur, 1990) "that consensual validation from others in similar situations helps group members build the ego strength necessary to work through the trauma." Validation from others in a group setting normalizes the traumatic experience and allows individuals to open up more and discuss their past experiences. Cryer and Beutler (as cited in McArthur, 1990) reveal that rape victims often want to talk to other rape victims in hopes of alleviating some of the isolation they feel. The model of peer support groups is unique as the focus is on more of the experience than it is the education. With that said, group dynamics in a peer support group can be very instrumental in the prognosis of an individual's treatment in a peer support group. Not all peer support groups are created equal and what needs to be cautioned in a pure peer support group are the individual members who can become dominant over the rest of the group.

The group identity is integral in this model and vulnerable to change as each member contributes one way or another to this group identity. In a peer support group, change can cause individuals to shut down and not participate or feel that they have the ability to express themselves. Within the peer support group model it is essential for each individual to feel that he or she has

the ability to express him or herself in order to make therapeutic progress. Therefore, if a group member becomes suddenly absent or if a new group member is added, it distorts the group identity and changes the roles of the members in the group to something new. Peer support groups can be very effective for victims of sexual assault as they are able to become aware that there are other individuals who have experienced the trauma that they have in the past. This newfound awareness that the model advocates removes the client from isolation and puts the individual in a position where he or she can begin to challenge his or her own maladaptive perceptions that have most likely created an increase in anxious and depressive symptoms in his or her life. Even though it is clear that first-hand experience is powerful in this situation, the mental challenging that any psychotherapy model provides is still essential.

Summary

Overall, research on the topic of sexual assault in the correctional system is lacking. As documented by recent research, there are tremendous hurdles that have barred research in this field from occurring. Recently, due to a change in the viewpoint of public opinion and the political change that came from the Farmer v. Brennan

decision (1994), more research has been conducted. In spite of this new research, development for models of treatment for inmates who are victims of sexual assault is non-existent. Models of treatment for victims of sexual assault have been developed using various theories but none of the proposed models appear to be appropriate in a setting such as a prison. Consequently, the purpose of this thesis is to propose a conceptual model of group treatment for inmates who are victims of sexual assault based on the reality therapy approach.

CHAPTER III

DEVELOPMENT OF THE MODEL

Components of the Model

Treatment for victims of sexual assault in prisons involves many unique characteristics that need to be accounted for when developing a therapeutic model. One of the defining characteristics of the prison setting is the restrictions that are placed on an inmate. Many of the freedoms that individuals enjoy every day outside of the prison, such as hobbies and spending time with their families, are restricted in a prison setting. The choices for prisoner's activities are always predetermined, which leaves the prisoners often lacking in the fulfillment of their desires. Inmates also have a lack of privacy and self-intimacy. It is important to consider the lack of privacy and self-intimacy into any correctional therapeutic model as these freedoms are stripped away from individuals when they enter the correctional facility.

Another factor that should be generally acknowledged is that the prison setting is an artificial environment. As an artificial environment, individuals can develop behaviors that suit them to help adjust to that particular

environment. However, upon entering society, the individual will cast those behaviors away and adopt new behaviors to handle the stress of society. In acknowledging these important defining characteristics of the prison setting, a model can be developed to treat victims of sexual assault in prisons.

Current Policies

In order to understand how current mental health professionals help inmates who suffer from sexual assault, it is important to look at the current policies. The Prison Rape Enforcement Act Plan is composed of five elements: staff training, inmate education, victim services, response and investigation practice, and inmate monitoring components (Dumond, 2002). Staff training will be done every other year to have correctional staff learn inmate rights, hotline procedures, warning signs of victimization and predatory behavior, maintaining confidentiality, among other topics (Dumond, 2002). Also, upon arrival, inmate education informs inmates with written information about sexual misconduct and violence, including how to seek services if needed (Dumond, 2002). Current victim services are conducted by the sexual assault response team (SART) (Dumond, 2002). It is the objective of the SART team to contact the inmate within 24 hours after

reporting the incident and provide the client with the services needed (Dumond, 2002). A member of SART assesses the inmate, develops and maintains a treatment plan, and determines the need for long-term treatment (Dumond, 2002). Members of SART range from mental health staff, health services staff, Chaplin, and an appointed correctional staff member to be the sexual assault liaison (Dumond, 2002).

In reviewing the policies of the Oregon correctional system that Dumond was reviewing at the time, it appears at first glance that the policies are heavily weighed in the crisis intervention model. A concern that appears to be unaddressed in providing services is what types of services are available to the inmate. Expanding upon this idea involves the question of what the inmate has to undergo in order to obtain these services. It can be very detrimental to the inmate if he or she either has to leave the correctional facility to attain proper treatment or wait to complete his or her sentence. In having the inmate outsourced to a mental health agency the inmate would have a social stigma as he or she would be able to experience personal freedoms that the rest of the inmates would not have. Delaying treatment to the completion of his or her sentence and making a referral to a proper agency seems to

jeopardize and minimize the inmate's distress. After reviewing the policies that have been laid out in Dumond's review of correctional policies on sexual assault, it appears that the practices fall short of being adequate and there is an urgent need for best practices to be adopted.

Reality Therapy

The development of reality therapy was founded by William Glasser which states that an individual's behavior is aimed at the fulfillment of physiological and psychological needs (McArthur, 1990). These psychological needs include the need for survival, love and belonging, power, freedom, and fun (Glasser, 2000). In reality therapy there are two different identities: the success identity and failure identity (McArthur, 1990). Individuals who have a success identity have a great sense of community with themselves and others, and perform activities that are worthwhile to them and are able to receive and give proper recognition and respect (McArthur, 1990). Failure identity is the polar opposite of success identity. Those individuals who align themselves with having a failure identity do not have a great sense of community and do not perform activities that are worthwhile to themselves or others (McArthur, 1990). Also these

individuals are unable to receive recognition or respect from others or themselves (McArthur, 1990).

Kaltenbach and Gazda (as cited in McArthur, 1990), argue that these individuals experience a higher level of pain through emotional disturbances, behavior problems, disturbances of thought, or sickness. For example, an emotional disturbance can often take the form of depression; behavioral problems can include but are not limited to an individual's using drugs or being promiscuous; individuals who experience disturbances of thought can experience delusions or obsessions; and sickness refers to aches and pains an individual might feel (McArthur, 1990). It is essential in reality therapy to have the client realize that his or her needs are not being met along with a pause in striving for one's wants. In this case the failure identity sets in and the familiar terms of depression and diagnoses come to form.

WDEP Model

Similar to other models of therapy, there are four steps in the WDEP model which help clients evaluate their decision-making process. The "W" in the WDEP stands for Want (Justice, 2003). In this particular step it is vital for the client to be able to express his or her commitment to change. Wubbolding (as cited in Justice, 2003) founder

of the WDEP model, notes that there are different levels of commitment from not wanting to do anything to being completely committed to accomplishing the task. The "D" in the model stands for direction and doing which entails that the client describe the situation and related details (Justice, 2003). Evaluation is the "E" in the model where the client assesses whether or not the current direction is working for what they want in this particular situation (Justice, 2003). Lastly, the "P" stands for planning where the client plans tangible goals that can be reached to accomplish their wants (Justice, 2003). In planning the SMART method, which represents Specific, Measurable, Attainable, Realistic, and Tangible, should be used in creating goals. This four-step process, which is the blueprint of reality therapy, simplifies overwhelming life situations for individuals. What was once unattainable or unfathomable now can be reached by stripping away the emotion behind it. Due to this unique characteristic, this theory has the capability of being applied to populations that otherwise struggle or cannot be reached. One of those populations is the inmates in the correctional systems who have been victims of sexual assault.

The Model Proposed

Members of the group will be selected and screened by the mental health staff on site at the facility. Individuals screened into the group will be individuals who are victims of sexual assault who have an increase in depression and anxious symptoms. Individuals who will be screened out include those who have not experienced sexual assault, do not report an increase in anxiety or depression, or are actively experiencing suicidal ideation. Optimum group membership should range between ten to twelve members since membership over twelve members can lead to a decentralized group identity and the establishment of cliques. The timeframe of the group should last through twelve weekly sessions which last an hour and a half each. These are the guidelines of the reality therapy group.

The role of the group facilitator in the group is to be a model for being responsible (McArthur, 1990). During the group, the facilitator is responsible for being involved with each inmate, keeping the focus on the here and now, helping clients define what they want, and making value judgments when necessary (McArthur, 1990). Also the group facilitator is responsible for rewarding the successes of inmates in their therapy and to make sure no criticism or excuses are accepted. Overall, the objective

of the group facilitator is to provide the framework of the model, much like an educator, and step in when necessary. In this case, the facilitator is removed from being the all-mighty powerful mystic that the inmate must rely upon for help but rather an individual who empowers the inmate to believe in him or herself.

The group's weekly sessions are broken up into three different segments in the therapeutic process: Evaluation, Planning, and Working it out. At the beginning of the first group in week one, rules and guidelines are explained to the members by the group facilitator. Also at this point a brief explanation is given on reality therapy and the WDEP model. During the first week it is suggested that the group perform group bonding activities to solidify the solidarity of the group. This should be done for several reasons. One of the reasons for performing group activities is that the group's success is going to be contingent on the relationships the members of the group have with one another and the ability to trust one another. Because inmates in this group have had their ability to trust shattered, these issues must be addressed in the beginning stage of the group in order to move on to the latter stages of the group. Over time the inmates will be able to learn that the group is a safe place, find

commonality with other members in the group who have had similar experiences of sexual assault, and befriend individuals for the first time in a long time. These are the goals of the first week.

In week two of the group the facilitator will ask the group members what they want in life. At this moment the role of the facilitator will be to make sure that no war stories are told and that the group members are staying within the reality therapy model. Further, group members will be asked what they are doing to accomplish that want. At the end of the second week's session the facilitator will ask the members of the group to evaluate their current actions in accomplishing their desired want and to write down their want, what they are doing, and their evaluation of what they are doing in a journal that will be provided by the group facilitator. Once the group members are able to evaluate the current directions of their wants, they then move on to the next phase of the group process.

Group sessions during weeks four through six are referred to as the Planning Phase. In the planning phase the group members are planning out their means to attain their wants. Often the group members will work out their plans with each other or seek the aid of their peers through peer support. Also, it is important to note that

individuals may often have to make several plans before finding one that is successful. The role of the facilitator is to make sure that the members of the group make goals at which they can be successful, as well as to remove all criticism from the members of the group (McArthur, 1990). The completion of the planning phase concludes with the development of a plan.

The last stage of the group, which encompasses week's 7 to 12 and can actually run past the duration of treatment is the working through phase. In this phase of treatment individuals work on the plans that they set out to accomplish. As time passes, group members begin to learn more about the reality therapy model and are able to practice the model outside of the session. Also as they begin to practice the model outside of the session, group members will begin to struggle with their wants as well. At this point group members will work on the fulfillment of their wants and seek the counsel of their peers if they begin to fall short. During this time an individual may begin to develop new wants, realizing that new heights can be attained. Ultimately, the inmate progresses to a state of realization that all goals are attainable as long as the individual has the will to want to put the effort into attaining it.

Implications for Treatment

A reality therapy group model is essential for inmates who have suffered the victimization of sexual assault. Reality therapy has this ability to address the problems of inmates who suffer from sexual assault experience. The prison setting creates difficult and unique problems in treatment that other theories fail to address. Many theories such as cognitive behavioral therapy or existential therapy emphasize increasing an individual's personal freedom. Although these theories are successful, they fail to accommodate the needs of the clients in a correctional setting. Reality therapy allows the client to be able to see all possible options to a given situation instead of working from a limited set of known solutions. By increasing the client's awareness of his or her choices in handling a situation and understanding the ramifications of those choices, the client can gain insight on how to solve the problematic situation. This theory breaks from other theories by departing from stressing the client's previous reinforcing behaviors or how they may feel about the situation. Instead, the theory becomes more simplified and practical for the client and can be applied to any given situation without much difficulty. For this reason

an introduction of a group therapy model involving reality therapy for inmates who suffer from sexual abuse would be beneficial for those inmates.

CHAPTER IV

SUGGESTIONS FOR FUTURE RESEARCH

Deepening the Current Knowledge

One of the reasons for the proposal of this group model is the fact that there is not a best practices approach for inmates who suffer from the traumatic experiences associated with sexual assault. In fact, there is very little research to indicate that there is a collaborative approach at all. This is disconcerting for a population that experiences a great number of sexual assaults. A main factor that might play into the reason such interventions do not exist in the prison setting is the perspective that prisons take in viewing such an event. While reviewing the literature, it is clear that cases of sexual assault are dealt with by using crisis management techniques. The implication of such techniques implies the usage of the medical model of treatment. Although effective in the immediate moment for the inmate in the short term, the medical model fails to provide services for the inmate in the long term. The inmate is therefore exposed to exacerbated levels of anxious and depressive symptoms leading to the higher risk of developing a stress

disorder. The lack of a formalized treatment model to address the presented concerns supports the suggested idea to further research in this field through surveys, clinical observations, and a collaborative effort in the mental health community.

Existing Research

The existing group models of treatment for inmates who experience traumatic events such as sexual assault are not universally conformed or well known. Little can be gathered from the research on current mental health options for an inmate who experiences trauma from such a psychologically damaging event. There are a variety of factors that have led to such negligence. One such reason is that it is often difficult for a researcher to gain access to prison inmates and then publish the results of the research because correctional staff will not give permission to publish the results (French, 1979; Ibrahim, 1974). Another reason group models for treatment of inmates who suffer from sexual assault have been under-researched is the fact that for many generations researchers could not understand why inmates engaged in homosexual activities (Cotton & Groth, 1982). This includes the survey results that were published in the *Boston Globe*, that 50 percent of those surveyed believed

that prison rape went hand and hand with an inmate's sentence (Sennott, 1994). In looking at the results of the survey it is clear that society has turned a blind eye to those individuals behind bars. Where many other populations are studied rigorously, the demand for an inmate's rights for best practices of treatment went by silently until the passage in 2003 of the Prison Rape Elimination Act in 2003. However, to this day the focus of the Act is still on prevention and persecution of those who commit acts of sexual assault on others. Presently there is still no outcry for assistance for inmates who are victims of sexual assault.

Furthering the Knowledge

Given that group treatment models for inmates who suffer from sexual assault experiences are nonexistent, plenty of questions are left that need to be answered. A variable to look at that would increase the knowledge base is the inmate's ability to work in groups. A percentage of inmates are unable to work well in group settings. To expect that a group setting will help an inmate and not consider such characteristics as personality disorders would be flawed. Therefore, an assessment of an individual's ability to perform well in a group setting for inmates found to be suffering from a traumatic sexual

assault will be necessary to substantiate a support group model, such as reality therapy. Furthermore, it is suggested that such a model of group therapy be implemented and then through self-report surveys measure the results against the effectiveness of individual counseling. If positive results yield for the group therapy approach, it would mark the beginning of a breakthrough for correctional mental health treatment because often the mental health units within the corrections institutions are strained and understaffed. Given the current economic crisis of 2009, and if research can show that a group approach is equally effective in comparison to an individual approach, a group therapy approach would also be economically affordable for not only the prison but the taxpayer.

Conclusion

Research shows that there is little to no development of group models for inmates who suffer from events of sexual assault. Given the numerous barriers that have prevented researchers from investigating this area, the field is vastly under-researched due to misconceptions, a lack of access to prison inmates, and the barrier to publishing the results. Recently, the government has taken action in the form of the Prison Rape Elimination Act in establishing a serious stand against prison sexual

assaults. It is important to mark this as not a final solution and the act alone by Congress does not remedy the situation in full. A focus should be spent on how to treat the individual who suffered from the traumatic event, and develop a best practices policy for treatment.

Upon the implementation of the suggested model of group treatment for individuals who suffer from sexual assault, an opportunity arises for further exploration. One area of potential study is being able to identify which type of sexual assault is more troubling for an individual, sexual assault that occurred in the prison or outside of the prison as the individual is serving his or her sentence. It could be that both are equally distressing, but as a mental health clinician the results from such a study would be invaluable. Also a study that indicates the effectiveness of group treatment for inmates who do not have a diagnosis that would impact their social functioning within a group compared to a control group would be beneficial for the correctional setting. Such a study and its results would better define the unique characteristics of the prison setting and would be better able to identify the appropriateness of group treatment in a correctional setting. Lastly, it would be beneficial to run a study that compared the effectiveness of treatment comparing the

effectiveness of individual and group treatment approaches to the prison population for the symptoms of suicidal ideation. These are some of the many areas of research which would greatly enhance the understanding of correctional counseling, and also the therapeutic treatment of inmates in prisons.

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