

Introduction and Module 1: Detecting and Assessing Signs of Sexual Abuse

Dr. Jaye Anno

On behalf of the National Convention on Correctional Healthcare I want to welcome you to the specialized training for medical and mental health professionals on PREA requirements.

As many of you may know, all correctional staff in any type of correctional facility are required to have training on PREA but medical and mental health professionals are required to have specialized training. This training has been developed under the auspices of the National Commission on Correctional Health Care and the panel that is here with me are part out the content experts who have developed the training.

I am Doctor Jaye Anno. I'm a correctional health care administrator. My husband and I were the co-founders of the National Commission on Correctional Health Care. I will be serving as the moderator for this particular session.

Also with me is Karla Vierthaler. She is with the Pennsylvania Coalition Against Rape and she is the outreach coordinator for PCAR.

Then we have Kim Day. She's with the International Association of Forensic Nurses. She is a registered nurse and she is double board-certified in the care of adult, adolescent, and pediatric sexual assault patients.

Next we have Jayne Russell. Jayne is a correctional mental health worker who currently is a health care consultant.

And then we have Robert Dumond. He is the mental health program manager for the sixth circuit district court in Concord, New Hampshire.

I want to introduce a couple of other people who are important to this process.

We have Dr. Gibson sitting back here. He is the Vice President of Operations for the National Commission and is really the go-to person who has been the umbrella contact for the development of this specialized training.

And we also are happy to have with us Ms. Peg Ritchie. Peggy is the senior program analyst with PREA Resource Center. Uh, Peggy, you have a couple comments you want to make?

Peg Ritchie

Dr. Anno, Dr. Gibson, panelists- Welcome. Good morning everyone.

I spent many, many years in the field and worked in the Arizona system.

[I] worked in the Ohio system, I just spent five years working with the California Department of Corrections and I served at the National Institute of Corrections for many years, which Doctor Anno was a consultant [for] medical mental health workshops that we did for many, many years and has done a lot of consulting.

So I want to welcome you from the PREA Resource Center as well. There are a few handouts on the front table. If you do not get a copy, jot down your name and your email address and I'll be happy to send it to you. It has events, upcoming events sponsored by the PREA Resource Center, of which we have numerous partners, including the National Commission, Just Detention International, and ACA, APPA, the Moss Group, etcetera are partners that work with us.

We have special presentations such as this that we help co-sponsor. Doctor Gibson is working with us on the curriculum where we're going to start training auditors for PREA in June. We have webinars that are on our website, we have technical assistance both targeted which includes: policy reviews, staff training, human resource, victim services, et cetera... and we're doing regional workshops around the country on many of these topics- investigator training, including saying nurses are part of that.

We're working on a training for trainers for investigators because they have to have specialized training as well. And we have different types of demonstration sites and projects that are going on, and Colorado being one of them. So many thanks, welcome, have a great morning and look forward to hearing from you.

Dr. Anno

Thank you, Peg.

We also want to acknowledge the help from Just Detention International, Linda McFarlane, who's the Deputy Executive Director and especially Christine Kregg, who has worked very closely with us in the development of these materials.

So I just want to give you a little bit of a history of PREA. The Prison Rape Elimination Act was passed by Congress in 2003. The standards, however, weren't released until last May. The DOJ expects its representatives to begin auditing facilities as early as August of this year. Note, however, that as of this point we do not yet have published compliance indicators or auditing tools but Ms. Ritchie has indicated that they're going to be training people starting in June, so we anticipate that those will be available shortly.

Why are you here? Well, obviously because Congress said that this training is mandated for all correctional staff. But, that said, it is also the right thing to do.

There was a Bureau of Justice statistic that found, that was published in 2008 that found that sexual abuse in correctional facilities was a hidden epidemic. Data

collected from correctional administrators in 2008 showed only 7,444 recorded allegations of sexual victimization. In contrast, sex victimization reported by former prisoners in 2008 found 9.6% reported one or more incidents during their last incarceration. With an estimated population of 1.2 million incarcerated in state prisons in 2008, this would yield almost 120,000 incidents of sexual victimization. This is over fifteen times more than the number reported by correctional administrators that same year.

There are actually four different sets of standards- one step for adult prisons and jails, another one for lockups, another one for community confinement facilities, and the fourth one for juvenile facilities. There are some differences in the requirements depending on the type of facility. For the most part, we'll be concentrating on those standards for adult prisons and jails. Where there is an item we are discussing or requirement where it differs in one of the other sets, we'll try to point that out as well.

All right, definitions:

For confined individuals if you're in an adult prisoner jail, the standard/PREA standards referred to you as an inmate. If you're a detainee then that means you are in a lockup, and people who are confined in juvenile or community facilities are referred to as residents.

What are the prohibited acts under PREA?

Well, sexual abuse and that is specifically defined as: any contact between the penis and vulva or the penis and the anus, any contact between the mouth and the penis, vulva, or anus, any penetration of the anal or genital openings, any other intentional touching of the genitalia, anus, groin, breast, inner thigh, or buttocks of another person.

Voyeurism is also prohibited. Voyeurism by a staff member, contractor, or volunteer is defined as: an invasion of privacy of an inmate unrelated to official duties.

And finally, sexual harassment is prohibited and that is defined as: repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature, whether by staff or another inmate.

Under staff, the PREA standards distinguish between employees, volunteers, and contractors. All of them would be considered to be under the umbrella of staff.

And then we have Health Care personnel and PREA standards talk about qualified medical practitioners and qualified mental health practitioners, but what they mean by qualified medical practitioner and qualified mental health practitioner is: an individual who has received specialized training under PREA, such as the training that you are receiving today.

And then there is the definition of the findings. A substantiated allegation means: it was investigated and determined that sexual abuse occurred. An unfounded allegation means: it was investigated and determined that sexual abuse did not occur. And then finally, an unsubstantiated allegation means: it was investigated but it could not be determined whether sexual abuse took place.

I would like to introduce Karla who will be giving our first module on detecting and assessing signs of sexual abuse. Karla?

Karla

Good morning, everyone. My name is Karla Vierthaler and I am the Outreach Coordinator at the Pennsylvania Coalition Against Rape and I will be representing the victim advocacy point of view today.

The sexual violence movement is about forty years old... excuse me, ANTI-sexual violence movement. We began in the early seventies with a group of individuals who had survived sexual violence in their lives and wanted to help other survivors. Small groups of individuals who wanted to provide services began in their homes. They started hotlines, 24 hour hotlines where victims could call for assistance. They started providing group counseling and individual counseling for survivors to find support with other survivors because they knew what kind of support was needed. And that movement has certainly professionalized over the last forty years but we still are in essence focused on empowering survivors and providing services, most of which are free and completely confidential.

Now I work at the coalition level and we support Pennsylvania's Rape Crisis Centers. Every state has a coalition and they also support those Rape Crisis Centers. Now, not every county will have a Rape Crisis Center but every state has a Coalition. So I encourage you, if you have not already, to reach out to the closest rape crisis center to you as PREA encourages and, if not, if you can't find services there, do reach out to your state coalition. We are certainly working in Pennsylvania with county jails, with our local rape crisis centers to help support those, also with our Department of Corrections and also many different juvenile detention facilities.

Okay so I do wanna say, as I shared earlier, I am coming from the advocacy perspective. I am not a mental health practitioner, I'm not a neurologist, but I am used to and my job is to train on the victim experience and victim behavior so that is the perspective I'm coming from today. I will certainly be sharing with you things that you all probably know better than I do but these are tools that we use to share where we're coming from with victims to help you all understand where victims are coming from after surviving sexual violence, either in the acute phase or long term.

So these are our objectives for my presentation- module one.

- We are going to examine sexual abuse in prisons and how it is to find in PREA. Jaye already did that but I'm going to show you some nuances and talk a little bit about the definition of consent.
- We are going to learn how to detect signs and symptoms of both acute and prior sexual abuse.
- We are going to summarize the short and long-term effects of trauma on the brain.
- We are going to describe considerations for the development of intake screening tool requirements, as in PREA and recognize the health care provider's role in the screening process.

So I'm going to share with you a video from Just Detention International. They are our advocacy arm on the national level, actually international level, and they work directly with survivors who are incarcerated. And so this is the story of three survivors that they have worked with and I want to thank JDI for allowing us to use this and for helping us inform this presentation.

VIDEO PLAYS

A woman speaks

Being transgender was not easy at that time. I became homeless, I lost my job, and because I had no means to survive, I had to resort to the "street economy." Because of that, I was arrested and while I was waiting for my arraignment, I was locked up in the county jail. I was coerced into having sex against my will with another inmate. And during that time I was exposed to HIV.

A man speaks

It's almost unbelievable that it escalated to the point where it did but I remember, you know, being arrested for being publicly drunk and being terrified, 'cause I was in jail and I had to let them know that, you know, I was gay and different because they go after the weak, the weakest links and I was the target.

It just became very, um, a very terrifying ordeal. As I tried to stick up for myself, one of the officers made a threat against me and said that he was going to come get me later on... and I told on him. I remember telling his supervisor the threat that this officer just made on me and he said, "Mr. Mendoza, you are in L.A county jail. You are in one of the safest facilities around, you have nothing to fear." And um, boy was he wrong.

Everybody's pod was shut except my pod. And I remember it seemed eerily quiet and then as I'm looking around I see all the guards just like dispersing, just leaving. And my pod is still open. And I'm wondering what's going on and from the corner of my eye I see the gentleman, the officer that threatened me earlier coming towards my cage, coming towards me. And I was frantically trying to shut it, I started screaming and yelling... to no avail, nobody came to my rescue. And he just came in there and manhandled me and stripped me butt naked and sexually assaulted me.

A young man speaks

I first went in to Juvenile hall when I was 12 years old. Staff ridiculed me, other inmates ridiculed me, gang members... I was forced to oral copulate. Gang members, bloods and crips, in the shower areas. Staff often knew what was happening and they turned the other way, because staff did not like kids my age that were different.

VIDEO ENDS

Karla

So that was a difficult video to watch for sure. Certainly we want to thank those survivors for sharing their stories. I'm going to talk about victim response a little bit later on in the presentation but the reason we wanted to start with the video is because we want to show, we want to allow survivors to speak for themselves. That's the essence of why we're here today.

Yes, we certainly need to follow PREA standards, but the reason we want to do that is so that we can prevent this from happening to other inmates and also to learn how to best treat them when these situations do occur, so thank you for your attention.

Okay. Jaye had shared this statistics, statistic, with you earlier. Again, this is from the National Prison Rape Statistics Program. It is the survey of former inmates. These surveys were collected by individuals who are on parole supervision in over forty states and there were over 18,000 videos done by former inmates. And they were done in a private room where individuals were interacting with a computer and there was both an audio and [written] survey on the computer so we really, they really tried to maximize confidentiality and minimize literacy issues with this Survey... so just to give you a little bit of background there.

And they did find that 9.8% of former inmates reported sexual abuse while in incarceration. Another thing they did find was that about 5.4% of those who reported sexual victimization were abused by other inmates and then 5.3% were abused by staff; so it is about half and half reporting- half were abused by other inmates, half were abused by staff. And I think there is a large misconception that most of the abuse that happens in prisons is inmate-on-inmate abuse and that is just not the case.

And finally, this survey also found that 31% of inmates who reported abuse were abused three or more times while incarcerated and we're going to talk about the effects of repeat victimization on the brain and on the psyche and how individuals respond.

Okay, so again, Jaye talked about some definitions related to PREA but I wanted to talk about consent because the definitions clearly talk about if the victim does not consent. This is inmate-on-inmate abuse, it talks specifically about the lack of

consent (and consent in correctional facilities can be a little bit murky) and we define consent as: voluntary cooperation and the exercise of free will. Consent is much more than saying yes to something because certainly coercion exists. Consent cannot be granted through force, threat or force or coercion... and the definition of coercion includes: applying pressure that is emotional or psychological nature, trickery, applied threats, blackmail, promises, privileges... Some examples can be: demanding repayment for debt, staff promising privileges, or providing contraband, or threatening to interfere with visits, or any kind of work assignments, things like that... and certainly protective pairing is also, plays into coercion.

So really in these examples, sometimes people may "consent"/say yes to interaction, but coercion is happening there and that would still be considered sexual abuse under PREA. So we also wanted to point out when it comes to sexual abuse when staff is involved, it can be with or without consent- so even if it is a consensual relationship it would be considered sexual abuse because the power dynamics are very different between an inmate and staff.

And also this comes into play with sexual harassment when it's inmate-on-inmate it is repeat and unwelcome and when it is involved with staff it's just repeated comments or gestures of the sexual nature. Doesn't matter if they're welcome.

And I did want to point out also certainly we all know in incarceration, there can be consensual sexual relationships between inmates. It is not allowed but it certainly happens- and those relationships are not covered under PREA. What comes into play under PREA is when there is not consent there.

Okay, so we know that this is happening certainly in incarceration- who are targeted?

What we know from JDI and several several studies (this is a quote from JDI's website), "the two leading risk factors of prison sexual abuse: one is being identified as lesbian/gay/bisexual/transgender and the other is being previously sexually abused. So those are the two main risk factors in numerous studies.

We're gonna talk about a little bit about why previous sexual victimization makes a person a target for additional sexual abuse but I want to briefly go over this definition of LGBTQI. I'm probably sharing information you already know, but I hope you don't mind me repeating this quickly.

The definition of transgender: It's often used as an umbrella term to encompass of wide range of people whose gender identity or expression (so how they choose to express their gender) does not match the category society has put them into. So it has nothing to do with sexuality, it has to do with gender expression.

Next, intersex also comes up, sometimes questioningly. This also has nothing to do with sexuality. It is a general term used for a variety of conditions in which a person is born with the reproductive or sexual anatomy that doesn't fit the typical definitions of male or female or whose chromosomal structure is other than just XX or XY.

And then finally, queer is a term that is used again in another umbrella term for people who do not conform to norms around gender or sexuality. So, again, we're using the term "umbrella terms" a lot.

Identity is very individualized but these are just some rough definitions to give you an idea of how people may identify in institutions. So certainly people who are younger are often targeted, minors who were charged as adults tend to be targeted, people with disabilities, and this includes a wide range of disabilities. It includes people who may have a mental health diagnoses or mental health issues, it can include people with developmental or intellectual disabilities and that occurs on a wide spectrum- could be in the autism spectrum, could be any form of mental retardation, IQ related disabilities and certainly people with physical disabilities, someone who may use a wheelchair or cane to move around, any sort of sensory disability, an individual who might be deaf... all of those are included and all of those individuals have been shown to be targeted more for sexual victimization within incarceration. People who are biracial or multi-racial and certainly people who have been victims of previous sexual abuse.

And again, we're going to certainly go into what happens when an individual has become a victim, some changes that may occur in the brain that may make a person more vulnerable to sexual victimization in the future. And the other thing we want to point out is that this list is not very different in the general population

I certainly do training to all types of audiences and we know that in the general population people with disabilities are targeted for sexual abuse very widely. Children are targeted. We know that one in four girls and one in six boys will become victims of sexual abuse before the age of 18. It's a huge, large number of the population. We know that women with developmental disabilities- 82% will be victims of sexual abuse in their lifetime. Half of that number, so 40%, will be victimized ten or more times in their lifetime.

And sexual abuse- we don't have great statistics. It is the most underreported violent crime according to the FBI and we know it is also very highly private crime. People don't like to talk about it.

So what we have are varied statistics but these are things that we do know and what we try to focus on is- why are people being victimized? Why are these groups being targeted? Because perpetrators don't want to get caught. They want to... they want to choose a victim who will... who is unlikely to be believed if they come forward, who's not very credible in some cases. They want to get away with sexually abusing

somebody and not get caught. And we see that these are the individuals in prisons who are less likely to be believed and not as credible, unfortunately.

Just another statistic for you. The first one on the left is again going back to that former prison survey that 1-in-3 gay and bisexual men were sexually abused while in custody and then another study done in California state prisons. 59% of transgender inmates reported sexual abuse compared to 4% of other inmates. So we know that these groups are being... certainly being targeted.

Okay, one of the things our groups expressed when we were kind of coming up with this curriculum- obviously we're all coming from different perspectives, different fields- and one of the things that came up was, "well, why wouldn't the person report? If this was happening to them in a prisoner jail or any kind of incarcerated facility, why would they not report?"

Again, from the former prisoner survey- and people were allowed to choose more than one response- number one reason is that they did not want anybody to know. And I will tell you, this is what we hear all the time in the general population. "I just want to pretend like this didn't happen to me." They feel ashamed or embarrassed. They are afraid of the perpetrator, afraid of retaliation, afraid of... they thought staff would not investigate, and then finally being afraid of being punished by staff. So these are all certainly real reasons why people would not report.

I want to share a couple more statistics [for] you. Again, same survey. 37% of victims of inmate-on-inmate sexual victimization said they reported at least one incident to facility staff. 37% did report inmate-on-inmate abuse and I would like to point out that that is a higher percentage than in the general population. Again, according to FBI crime statistics 23% roughly, changes every year... 23% of victims of sexual abuse report that to law enforcement. So again, the majority does not report for reasons that are very similar to why former inmates did not report. Unfortunately, reporting to medical or mental health was less common, only 14% of survivors reported to you all... so just important to recognize that.

And then finally 5.8% of victims of staff sexual misconduct reported abuse to other staff, so that's compared to 37% who'd experienced inmate on inmate abuse. So... and we know that it's happening at equal rates, so that's just another kind of important thing to take note of.

Ok, now we're going to talk about physical indicators and potential responses to sexual abuse. As I had shared earlier, this is a huge part of my job, talking about signs and symptoms of sexual abuse and I've certainly done this with state mental health hospitals and parents and people in nursing homes and personal care homes and police officers, wide ranges of audiences and oftentimes, and rightfully so, people want me to give them a list, a checklist so they can know what signs and symptoms there are so they can know if sexual abuse is happening in people's lives. And I'm sure you all know that I cannot share that list with you. There is no list. Certainly every survivor responds differently. It's difficult to track physical

responses or physical signs and symptoms as Kim is going to talk about today with you a little bit more, so these are just some potential signs and symptoms and responses that could be indicators of sexual abuse or something else that's going on with individuals... so I just want to share that disclaimer with you.

Okay so some physical indicators: certainly sexually transmitted infections and/or diseases, unexplained pregnancies (pretty obvious there), stomach or abdominal pain, oftentimes abuse will sort of manifest itself as a physical pain generally around the stomach area, any anal, penile, vaginal discharge, bleeding, pain, difficulty in walking or sitting, and any unexplained injury. So those are some physical indicators, not a great list, as you saw...

Some potential responses to victimization... more emotional... and what you might see in prisons... and this is sort of what you would think you would see. These are responses to trauma, these are known psychological responses to trauma that people will share: acting out, anger, anxiety, depression, suicidal thoughts, numbness, disbelief, difficulty concentrating- all of these are very common. They could be a response to incarceration as well, 'cause we know that that will also have effects.

But we know that a crisis interrupts a survivor's ability to manage life and certainly in correctional facilities that's really not allowed. You have places to be, you have things to do at certain times, you don't have the time to disengage, to numb out, to have difficulty with daily routines. Daily routines are what you need to be doing in a facility. So oftentimes, people will, quote, "act out" at difficult uh... sort of engaging risk-taking behavior, which puts them in a dangerous situation. They certainly can get in trouble, there are ramifications for acting out, but oftentimes we see this happening because there is no other way to kind of express what's going on with the response to the traumatic situation.

Okay. So some impacts on the incarceration- how is it a little bit different? Those were with general population, certainly, so impact of incarceration on survivors- and I think we covered a lot of this- retaliation is a huge one that is an additional fear, ongoing contact with perpetrators can be a huge issue if a person does not report. They may put themselves in a situation, [rather] they may be in a situation where they have no choice but to interact with their perpetrator or perpetrators or individuals they know know the perpetrator and know what happened- terrifying situation. They know that there is an increased likelihood of re-victimization either from becoming labeled as a victim or, in that retaliation piece, there is a real threat of punishment or isolation. Often times if a person reports sexual victimization they are isolated to keep them safe which can be further traumatizing on the individual.

There is certainly a limited access to services. We know that PREA is really trying to push access to sexual victimization advocacy services but, you know, if you come forward and ask for services, you are identifying yourself as a perpetrator or, excuse me, as a victim... so that's limited and, you know, we're talking about little control

over our bodies and environments. I could go to a rape crisis center of free will but if I was in an incarcerated situation, I don't have those choices; I don't have those options.

Certainly you can't make phone calls. We do have a 24-hour hotlines at rape crisis centers but they may not be on my call list and if I put them on my call list, I could be identifying myself as a victim.

I do want to talk briefly about this little control over body or environment. What we know from doing this work for forty-plus years in the advocacy movement is that empowerment, giving survivors choices and control over some things that happen in their lives after a victimization, is hugely important to helping a person heal. And that is... that cannot happen a lot of times in an incarceration.

We're going to talk about, Bob's going to talk about reporting. If I choose to go forward right now and go to the hospital, I can choose whether or not I talk to police, I can choose whether or not my information is shared about what happened to me. A person who is incarcerated does not have those choices to share, so that is a huge difference of survivors and the impact of incarceration.

So, some potential long-term responses. Primarily what I want to talk about here is Post-Traumatic Stress Disorder. Certainly not all individuals will meet the diagnosis of Post-Traumatic Stress Disorder after experiencing sexual victimization but a lot of the characteristics will come forward. Now again, I am not a therapist, but these are... I'm going to share with you the characteristics of Post-Traumatic Stress Disorder, which I'm sure you already know but these really summarize the long-term effects an individual may come forward with.

So for... according to be diagnosed with Post-Traumatic Stress Disorder, there there are six criteria. One is that you need to have experienced or witnessed a traumatic event, which is the stresser. Two: you need to have intrusive recollection, meaning you are remembering, feeling like you're re-living, dreaming about the traumatic event on a regular basis, repeatedly. Third is there is an avoidant or numbing phase, meaning you're avoiding the people, places, and things associated with what happened to you, associated with the traumatic event. Now think about this in an incarcerated situation. If you were sexually abused in a prison, it's not very easy to avoid people, places, and things associated with that event. The fourth is hyper arousal. These are persistent symptoms of having difficulty sleeping, irritability or outbursts of anger, difficulty concentrating, hyper vigilance, and an exaggerated startle response, meaning, again, hyper arousal. You are ready. You are on edge. And we're going to talk about that response a little bit later when we talk about the neurobiology of trauma in the next couple slides- what our brain is saying after we've experienced these traumatic events- and then when we are either dealing with the trauma response or ongoing threats to our safety. And then the fifth criteria is: these responses need to be happening for one month or more. And then finally,

the disturbance causes a clinically significant distress or impairment and social, occupational, or other important areas of functioning.

So those are the six criteria for Post-Traumatic Stress Disorder and we know that this is very common in victims of sexual assault and I'll share a statistic with that in the next slide. I do want to share that I'm sure many of you know that the DMS is going to come out with a new version, sixth version, fifth version, excuse me in May of this year and the one thing that is changing in the diagnosis of PTSD is that it will no longer be considered an anxiety disorder but it will be considered a trauma and stressor-related disorder.

This is huge. This is recognizing the effects of trauma and stress on the mind and body. And that that the DMS is recognizing it is huge and I think this really will... this signifies the importance of what we're talking about today, which is the effects of trauma on the mind and body, which is so important, obviously, to the work that you are doing in facilities.

So just some statistics: Victims of sexual abuse are (and this is from the World Report on Violence and Health from the World Health Organization which... this study was done on a global level in 2002) and we know that victims of sexual abuse are: three times more likely to suffer from depression, six times more likely to suffer from post-traumatic stress disorder, thirteen times more likely to abuse alcohol, twenty six times more likely to abuse drugs, and four times more likely to contemplate suicide. And I'm sure you all are well aware that the individuals that you were working with who are incarcerated have these higher rates as well (than the general population.) These are the people that you're working with, so part of what we wanted to share today is yes, it's important to recognize victimization when it's occurring but it's also important to recognize that many of the people that you're working with already have been victims of sexual abuse sometime in their lives and may be displaying the signs and symptoms but not identifying the trauma that they've experienced in their lives.

So again, we're going to talk, as I had said, about how trauma changes the brain. Again, I am not a neurologist, I am going to share with you some research but we found this is a very effective way to share why victim behavior is what it is because, I'll be honest, it's very confusing. People may not remember what happened to them and you think "Oh my God, how could they not remember this person's face or what they were wearing? Why would you not want to identify your perpetrator?" and this really helps explain kind of what happens on a very basic level to individuals in this traumatic experience.

So, there is a traumatic event that occurs and what happens in the brain is there is a human stress response and these hormones are released and they are to help us respond to trauma, to respond to this life-threatening event. And there's two points I want to share with you about what happens automatically, and all of these things are automatically, this is our mammalian response to what is happening to us. We

don't get to make choices. There's a threat to life, our brain sends sends a signal to our body. We don't get to think about "Oh, well, what do I want to do here? Should I fight back? What should I do?" No. Our body tells us what it's going to do. And we're very familiar with the two- with fighting or fleeing in response to traumatic information. But there is another response that has been well documented in mammals and humans, which is freezing, which we don't talk a lot about.

Freezing- it's actually called, excuse me, tonic immobility. Our body literally freezes and/or plays dead in the traumatic incident so we can't move. We are literally temporarily paralyzed, and our brain has told our body to do this. And when we release materials to you all, we will have the scientific research that's been done on tonic immobility but it's very fascinating. 'Cause oftentimes we'll hear from victims of sexual assault in the community, certainly in police interviews and they'll say, "Why didn't you fight back?" Especially with men, male victims of sexual violence, there's this feeling of "Why didn't you fight back?" or "Why didn't you run and get away?" and they say, "I don't know. I just froze." And oftentimes victims will report "I didn't... I didn't... I don't know why I did that..." and they're very frustrated with their own bodies for not doing those things. And what we're learning is that that is the brain is telling the body to do so. We don't know why people choose, or why the body freezes instead of fighting back and/or fleeing, but we know that it's happening. So this is just one thing we wanted to share with you all because you may hear this from individuals that you're working with who have experienced sexual abuse and they may be very frustrated as to why this happened, why their body responded that way, and so we wanted to share that piece with you.

The other piece that we wanted to share with you is that stress hormones interfere with the way that we are able to store memory. So what we'll hear from victims all the time is... let's say someone was abused, uh, assaulted by a stranger in an alley. They may not remember what that person's face looked like, even if they were right here (*She waves her hand in front of her face*), but they will remember the cologne they had on or the brand of shoe that they had on and the accent color and that's very strange and certainly frustrating for police who want to solve the case. They say "I can't get anything out of this individual. They remember weird things." And that, those are the effects of the stress hormones on the brain. It interferes with the ability to store memories, it interferes with the way that we are able to remember. And oftentimes survivors will report, "Oh Gosh, I had a flashback of something." That's the brain slowly releasing information as it becomes safer to do so.

And I think the point of all of this is that our brains are going back to how we were when we were mammals living on, I mean, this is very primal responses that doesn't make logical sense and how we process and deal with things now, but they will come into play when you're working with survivors, so we wanted to share those pieces.

What we know it happens and this is both in the immediate response and then when we start talking about the trauma response when either a person experiences

ongoing threats or when a person is experiencing Post-Traumatic Stress Disorder and the trauma is continuing to live on in their brains.

We know that there is an emotional stimuli that's either a real threat or that psychological threat and instead of going up to our human brain, the part of our brain, the cerebral cortex, the part of our brain that plans, and reasons, and thinks things out, that part is skipped with the trauma response. We completely skip that part and we go straight to the amygdala, the mammalian response. We start responding without logic and in that hyper vigilant way that we had talked about earlier. And so that reason piece may not make sense to all of us when we're witnessing it- "Well why is this person acting out and getting themselves in trouble and having things taken away from them, privileges...?" You know they may be putting many things at risk if they're in the community corrections and they've been granted privileges, all of these things come into play. "Why are they making these choices that aren't logical all of a sudden?" That is what is happening here. They are acting as mammals, as hyper vigilant mammals.

This is just showing it in a different way, this chronic hyper arousal both increased continuous threats, so that that fear of retaliation... or, if it's ongoing abuse that's occurring, certainly in protective pairing we know that that happens a lot. That chronic hyper arousal has an effect on the brain or it could be the person is experiencing Post-Traumatic Stress Disorder and when we looked at that definition, so many things come to play in incarcerated situations. You can't change your people, places, and things. You may not be able to separate yourself from contact with the perpetrator. So there's always these fears, these threats that this may occur again and what happens is the brain kind of hard wires itself to respond quickly. You are ready to respond to trauma. The brain is ready to respond to trauma. So what you see is the inability to calm down, a lot of anxiety, difficulty sleeping, irritability, impulsions, people acting without... all of these things come into play and we talked about that.

And one final slide for you. This is a picture of an MRI and this was research done by Doctor Bremer who is a Professor of Psychology Radiology at Emory and he has studied individuals with Post-Traumatic Stress Disorder and what he found was that the size of the hippocampus is affected by Post-Traumatic Stress Disorder. So the brain, literally, is not as big. What happens in the hippocampus is that it has the ability to regenerate neurons as functioning, so it continuously grows. And what happens when a person has Post-Traumatic Stress Disorder? Stress interferes with that regeneration and literally the brain shrinks, the hippocampus shrinks, this brain with PTSD has an 8% reduction in the size of the hippocampus. So it's interesting to think about that and learn about that and learn more about the brain. I hope you found it interesting as well.

All right, now we're going to talk about assessment and screening requirements in the PREA standards and your role there. There is a screening requirement for the risk of victimization and abusiveness when a person enters a facility. This needs to

be done within seventy-two hours of the person's arrival to a facility and this is required to be done by a "objective screening instrument." Now there is no standard screening tool. Facilities are encouraged to create their own and certainly I think when those start to be created in different facilities across the country some of those examples will be at the PREA Resource Center but we don't have something to give you right now- but we know that that tool needs to be objective and then we also know that there are specific things that need to be included in the tool.

So what needs to be included? Whether the inmate has a mental, physical, or developmental disability, the age of the inmate, the physical build of the inmate, whether the inmate has previously been incarcerated, whether the inmate's criminal history is exclusively non-violent, whether the inmate has prior convictions for sexual offenses against an adult or child. Now I'll ask you question: do you think that if a person has a prior conviction for sex offenses, do you think they are more or less likely to become victimized when incarcerated?

She waits for the audience to respond. More likely, yep. So it's interesting that these are the standards that were created by PREA knowing what the risk factors are for individuals. Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming, whether the inmate has previously experienced sexual victimization... interesting here- the inmate's own perception of vulnerability, so the standards also recognize that choice is important here as well. Does the person perceive themselves to be vulnerable? Would they like to have more protection or be placed in a different place than a person who has a higher risk of becoming a perpetrator? And whether the inmate is detained solely for civil immigration purposes. So all of these things need to be part of the screening tool.

Now I do have some notes of differences- this is in prisons and jails. The youth screening is slightly different different. It takes into account developmental stages of adolescence. It also has some different wording. For example, there is the fifth standards, [which] deals with the emotional and cognitive development of individuals in juvenile detention facilities. And then finally, any other specific information about individual residents that may indicate a heightened need for supervision. So there's one where people can identify any... any perceived risks that may not be in this list.

Finally, community confinement facility standards are also slightly different, with fewer items and a focus on conviction history. So just to point out those differences.

And we want to make note of a couple things on this list. As you can see, these are pretty personal questions- asking about a person's previous victimization, asking about their their sexual identity or gender identity... pretty personal- any prior convictions- all of these things are sensitive questions so we do encourage you to take that into consideration when asking these questions, when doing this

screening. We encourage you all to do it if possible but we know that that's not possible in every case.

So if you all could have a hand in a role in training individuals who will be doing the screening, that would be also great. And I think that's really the keys that we wanted to share there.

Okay- use of screening information. So this comes into play when you are determining, or when it is determined where a person will be housed, where they will sleep, where they will work, their education, their program assignments... and the overall goal, as you probably know, is to keeping those who are high-risk of being victimized apart from those who are at high risk of being abusive. And it really should inform every aspect of how a person is incarcerated and the decisions that are made there.

And this is a standard reserved for lockups: The agency shall make individual determinations about how to ensure the safety of each inmate. This standard talks specifically about transgender and intersex inmates and how to house them, and how to determine what should happen with these individuals. We know that the standards say that it should be determined on a case-by-case basis. They also say that the individual's own views should be taken into account- where they want to be placed, how they want to be placed, how they feel most safe. Transgender or intersex individuals should have the opportunity to shower separately from other inmates and also there should not be dedicated facilities, units, or wings solely to individuals based on their sexual identity or status... so just to share that information.

All right, protective custody- and this applies only to prisons and jails. It is reserved in the lock-up juvenile and community confinement standards and basically what it says is that if a person, a person who is at risk, at high risk for sexual victimization, they should not be placed in an involuntary segregated housing unless an assessment of all available alternatives have been made and there's nowhere else for an individual to go. Basically it's saying because a person is at high risk, they should not be punished and oftentimes involuntary segregation is a punishment. The other piece of that is if a facility cannot conduct an assessment immediately (within that 72 hours), they can be housed there for 24 hours before the assessment is done.

Finally, very close to the end here, we wanted to talk about screening. We do... there is a requirement that if a person is indicated to have been a victim of prior sexual victimization or has previously perpetrated sexual abuse, that mental health or medical staff follow up with the individual within fourteen days of the intake screening. Now we do know that in jails it is only for individuals who have experienced prior sexual victimization. So that obviously, directly influences you all and makes a difference in your job. And finally, just a little piece around confidentiality and reporting requirements (and Bob is certainly going to talk a bit

more about this) but we just wanted to note that basically even though there is a reporting requirement of sexual abuse that happens during incarceration, that is still considered... it should only be shared when necessary.

And then finally, when we're talking about prior victimization that did not happen during incarceration, that is also considered confidential information and again Bob's going to talk more about that.

And that wraps it up for my piece on detection and assessment and now I'm going to hand it over to Kim Day to talk to you more about the forensic exam. Thank you for your interaction and your attention.

Note: This transcript has been edited to remove extraneous material.