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James Radford

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REMOVING THE STIGMA OF PRISON RAPE AND SEXUAL ASSAULT: THE FIRST STEP TO PROVIDING HIV TREATMENT TO PRISONERS

James Radford*

Introduction

Since the AIDS pandemic began, there have been significant changes in treatment, perceptions and epidemiological data. Although it clearly is a virus that affects everyone, it has made some significant shifts in the populations that it is most directly affecting. Probably the most significant change has been in regards to a life living with the virus. Living with AIDS is no longer viewed as a death sentence—at least in the United States and other countries which have relatively fair and equitable access to treatment. AIDS has morphed into something of a chronic illness—still formidable but yet possible to manage (perhaps akin to diabetes). However, the challenges still facing someone living with HIV are significant. The costs of the medications are prohibitive and the side effects can be significant. In addition, there is still considerable stigma surrounding the virus. With HIV, unlike almost any other health condition, there seems to be an element of a puritanical “well, you deserved this.” Now, imagine having to deal with HIV and all of its issues in prison. All of the difficulties and stigma are compounded, to say the least.

About a year and a half ago, I worked as a criminal defense attorney for Legal Aid Society in New York City. During my tenure at Legal Aid, I defended parolees at administrative hearings. The Parole division was a unique assignment in that, unlike at the criminal court, all client meetings were held at Riker’s Island Jail, or on rarer occasions, at another facility such as the federal jail or a mental health facility. A parolee could be facing charges that were legal (new felony or misdemeanor charges), fact-based (such as failure to report to your parole officer or a violation of curfew) or a mixture of both. Although the hearing was administrative in nature, the parolee, who had been released to the streets, faced a return, either to finish out his sentence (the worst case scenario) or to serve some allotted time that was based on a categorical determination.¹ Although parolees are not given “additional” time on their sentence, the time they are given could be substantial if the parolees still had a great amount of their sentence remaining. If the parolee had been given life sentence the risk of a lengthy imprisonment was substantial, to say the least.² Further compounding the sense of frustration is the fact that judges overhearing the cases were actually employees of the New York State Board of Parole. Despite the fact that the parole judges were supposed to be “independent,” the judges were under a great deal of pressure to administer sentences that would reflect a “tough on crime” attitude. Indeed, it was not unheard of for judges to be disciplined by the New York State parole board for decisions that were “too liberal.” Often this “too liberal” approach involved placing too many individuals in substance abuse or mental health treatment instead of a sentence of time.

Just as in criminal court, attorneys pick up new clients through one or two arraignment shifts a week. Although the

number of clients an attorney represented at arraignments could vary, an attorney would generally receive somewhere between six to ten new clients every arraignment shift. Similar to criminal court as well, a great many pled out, although some were placed in the aforementioned treatment facilities. Others went on to an administrative hearing where they had the opportunity to call witnesses, testify on the stand, and mount a vigorous and zealous defense. This was often an uphill battle, as many had to overcome the general rule of parole, which seemed to be “guilty until proven innocent.”

Client meetings were held in an interview room which consisted of five cubicle-type areas containing a seat on each side and bars in between. These were not private, as they were open on both sides to other inmates and attorneys. Most clients were very open about what they discussed with their attorneys. However, there were two subjects that were often whispered or written down: sex offenses and the nature of the client’s HIV status. As we shall see, both of these issues, themselves already stigmatizing to the inmates, intertwine with an even greater stigma of having been sexually assaulted or raped in prison, and make identification and treatment of HIV extremely challenging.

In order to have a greater discussion of the issues, it is important to develop an understanding of how stigma works. Only after then can we begin to imagine the difficulties faced when discussing the public implications of HIV testing, prevention strategies and HIV/AIDS treatment in an incarcerated setting, and the effects that this stigma will have on those issues.

The Concept of Stigma

There are a number of different ways to conceptualize stigma. Some believe that stigmatization occurs when a “particular trait of a person was understood by both the stigmatized person and others in a social group to ‘spoil’ the identity of the possessor.”³ Others disagree. One author, Erving Goffman, who heavily influenced the concept of stigma, argued the thesis that stigma should be defined in social terms—that it was not simply the characteristic or trait, but the shared understanding between the possessor of the trait (in this case, HIV positive or victim of sexual assault) and the “normal” that makes possession of the trait damaging.⁴ Lawrence Gostin, co-director of the Georgetown/Johns Hopkins Program on Law and Public Health, describes Goffman’s theory as follows:

Stigma has been understood as a social relation between a stigmatized and a “normal” person, based on the shared belief that some part of the stigmatized person’s identity is, as Erving Goffman put it, “spoiled.” A person who feels stigmatized shares others’ negative view of his condition to some degree.⁵

This concept of being spoiled is particularly relevant to incarcerated settings, since an individual who feels stigmatized may not have any outlets where he could discuss these feelings. In addition, because jail is a twenty-four hour experience, it only stands to reason that inmates would be unable to escape the general population's negative view of any stigmatizing mark. The dynamics of placing a stigmatizing mark on an individual is described in the following passage:

It is the dramatic essence of the stigmatizing process that a label marking the deviant status is applied, and this marking process typically has devastating consequences for emotions, thoughts, and behavior. Many words have been applied to the resulting status of the deviant person. He or she is flawed, blemished, discredited, spoiled, or stigmatized.⁶

The concept of marking in stigma, mentioned above, is esoteric in nature and difficult to quantify because:

The mark may or may not be physical: it may be embedded in behavior...or group membership. It may also be possible to conceal it. The mark is potentially discrediting and commonly becomes so when it is linked through attributional processes to causal dispositions, and these dispositions are seen as deviant.⁷

In addition, in my experience there are a number of factors that may affect the perception of stigma, most notably:

- Concealability—Is the condition hidden or obvious? To what extent is visibility controllable?
- Course—What pattern of change over time is usually shown by the condition? What is its ultimate outcome?
- Disruptiveness—Does it block or hamper interaction or communication?
- Aesthetic qualities—To what extent does the mark make the possessor repellent, ugly, or upsetting?
- Origin—Under what circumstances did the condition originate? Was anyone responsible for it and what was he trying to do?
- Peril—What kind of danger is posed by the mark and how imminent or serious is it?

It is important to note that stigmatization occurs on two separate, but inter-related levels. First, stigmatization generates at the societal level. The characteristics of societal stigmatization are defined in the following formulation:

In our conceptualization, stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link

labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed into distinct categories so as to accomplish some degree of separation of “us” from “them.” In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. Thus we apply the term stigma when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold.⁸

The second level when stigmatization occurs is to the individual. In the case of sexually assaulted or HIV positive inmates, this process first begins when they are sexually assaulted, are coerced into a sexual relationship, or both.⁹ This is when the individual first encounters the public's views of his situation (i.e., being a victim of sexual assault) or suffering from an illness, or the “orthodox” view of the stigma, which is made up of four beliefs...that the public is ignorant about the disease, intolerant in its attitudes toward those who have it, prone to discriminatory practices against them, and therefore responsible for most of the problems associated with disease identity.¹⁰ In other words, the individual

begins to personalize the stigma and incorporate all of their own experiences with the stigmatized condition into their view of their own condition. Because he holds to the four tenets listed above, he is unlikely to seek medical or mental health assistance.

At this point, the individual has the choice to accept or reject the orthodox view of his condition. He may choose to accept the orthodox view as factually true at face value, or “accept the reality and force” of the society's view.¹¹ This choice has important implications:

Accepting the stigma predisposes people to hide their condition and attempt to pass, in the class response described by [Erving] Goffman. The management of stigma becomes a major preoccupation, playing out through often elaborate strategies of concealment and the avoidance of occasions on which the secret could be uncovered. People who reject the stigma, by contrast, tend to adopt resistance strategies . . .¹²

Concealing a stigma would seem to reduce the chances that harm would come to an individual due to his status; however, it is unclear how successful an inmate would be at keeping the information a secret from the general population. Whether he chooses to report the rape will hinge greatly on which strategy he adopts. However, individuals who choose to conceal their stigma suffer the “daily harms of the chronic hid-

den distress.”¹³ Thus, it seems that inmates suffer more than just the initial harm of the condition or illness. They also suffer the harm or the threat of discrimination or other reprisals due to this condition, and physical, emotional and psychological harm due to the concealment of this condition.

A Stigma's Effects

Upon being sexually assaulted or coerced an inmate has a number of immediate physical concerns to which he must attend. In an ideal situation, this would involve seeking medical treatment as soon as possible. However, he may not seek medical attention because of the stigma of being sexually assaulted, knowing that seeking medical treatment will likely result in a “report” of the rape. It is possible, because of the shame and stigma of the assault, the inmate may “treat” himself and fail to make any report of the assault. This refusal to come forward may expose the inmate to a number of short and long-term health risks.

In the short-term, the inmate will not receive any medical care for any injuries nor will he be referred to the appropriate mental health professional. In addition, any possible evidence that could be used to prosecute the sexual assault will not be preserved.¹⁴ In the long-term, failure to report a sexual assault could expose the inmate to repeated assaults, either by the same or different perpetrator or perpetrators. Once an inmate has been sexually assaulted, he is viewed by the general prison population as having been “turned out” and faces increased chances of being assaulted by the same or different perpetrators.¹⁵ The general population views him through a stigmatized lens—he has lost his manhood or masculinity.

Medical Concerns

Unless the perpetrator used a condom, both he and the victim are at risk of contracting any sexually transmitted disease (“STD”) that the other may have, with the recipient of the anal sex being at far greater risk. Unfortunately, my experiences with most prisons and jails do not provide their inmates with condoms. The reasons for this seems specious at best - they maintain that either (1) the inmates in their jail or prison do not engage in consensual sex or (2) passing out condoms or other means of protection will only encourage sexual behavior in the jail or prison.¹⁶ Although it is highly unlikely that somebody would use a condom during a sexual assault, it is important to have them available to inmates for obvious reasons, as they are extremely effective in limiting the spread of HIV and to a lesser extent, other sexually transmitted diseases. Having condoms available for all inmates would reduce the rates of HIV positive inmates dramatically. Furthermore, despite the protests of the Department of Corrections, there is a great deal of consensual sex that occurs in prison. Making condoms available is not an implicit approval of that fact any more than needle exchange programs are an endorsement of

heroin use. It simply adheres to the main tenet in harm reduction, which is to meet people where they are. Allowing inmates to have access to condoms and other safe sex material would merely promote safety and reduce the rates of STD and HIV infection.

Statistics

The most recent reports on HIV in the prison system are helpful, yet somewhat misleading. However, they are instructive in illustrating the minimum number of those affected with HIV and AIDS residing in the federal and state justice systems. In 2004, 1.8% of the prison population was HIV-infected.¹⁷ When broken down, a gender disparity is evident.

At the end of 2004, 2.6% of incarcerated women were HIV positive, in contrast to only 1.8% of men.¹⁸

In 2005, little changed in regards to the numbers. The percentage of infected inmates in the general population dropped slightly, with only 1.7% of the incarcerated population having HIV.¹⁹ Again, a disparity existed with regards to gender; 1.7% of the men were HIV positive, in contrast to 2.35 of women.²⁰ As one can see, there was little change in the overall percentages.²¹

However, in 2004, only twenty states required testing at admission or while in prison.²² Forty-eight states test inmates if they “have HIV-related symptoms or if the inmates request a test.”²³ If an inmate was involved in a situation where he could have been exposed to HIV, the number dropped slightly, with only forty-one states and the Federal system testing inmates for HIV.²⁴ Most tellingly, only eighteen states and the Federal system test all incoming inmates²⁵ and only three test inmates at the time of release.²⁶

Aside from the stigma of being sexually assaulted in jail, there are a number of gaps in the federal testing system that give rise to a many public health questions. First, thirty-two states fail to test an inmate upon arrival, thus eliminating an opportunity for a baseline. This is not only unsafe, as it fails to identify HIV positive individuals, but it is also a missed opportunity for providing care. Unfortunately, for many individuals, the prison setting is the inmate’s only chance for a health intervention to occur.²⁷ Furthermore, testing only “high-risk” groups or only when an inmate makes a request is foolhardy at best. Almost any individual in incarceration is “high-risk.” Despite the willful ignorance and disavowal of the prison system of the prevalence of consensual sex in jail and prison, a great deal of consensual sex happens without the protection of condoms. These ostrich-like policies of “if I cannot see it, it is not happening” or alternatively, “if we pass out safe sex materials, such as condoms, we are encouraging it” is dangerous and conducive to the spread of HIV and other sexually transmitted diseases.²⁸

Rape and Transmission of HIV

Further compounding the situation is the stigma of

being raped (or in a sexually coercive relationship). The rape itself stigmatizes the individual who is now in fear of yet another stigmatizing marker, an HIV diagnosis. Obviously, should the victim come forward, he would receive a drug regimen that inhibits the spread of HIV as well as tested for other STDs.²⁹ The inmate can receive treatment even if he fails to identify the perpetrator or perpetrators. However, should he come forward with the identity of who assaulted him, the opportunity exists not only for prosecution of the crime, but to test the perpetrator(s) as well.

Obviously, many will not come forward because of the stigma of being raped as well as to avoid being identified as a “snitch.” This is why routine testing is essential. Furthermore, it is highly possible that an individual will come forward and blame the injuries on some other altercation. If there is any suspicion of sexual assault, an HIV test should be administered. Relying on the inmate to report a traumatic and stigmatizing event is not enough.

Recommendations and Conclusions

People often assume that testing is cost-prohibitive and must be done by a medical professional. Neither assumption is true – test such as OraSure and Oraquick make for cheap, quick and easy testing and allow someone without medical training to administer the procedure. Secondly, by testing individuals frequently throughout their stay in the prison, the medical staff may pick up HIV infections that testers missed at the time of admission, assuming that testing occurs. It is very possible that an individual, upon admission, would test negative but actually be HIV positive if it is too early in the infection for a test to register positive. Again, regular testing is the key. Even an inmate that comes forward with a sexual assault would have to be tested again, since the initial test could occur in the window period.

There are obvious reasons why the jail or prison facility would want to identify an individual who was HIV positive, both at entry and after a sexual assault. Indeed, I would argue that inmates should be routinely tested at medical exams. This would not only serve a public health purpose but allow the medical staff to have confidential and frank discussions with the inmate about sexual health.³⁰ It would allow for the medical staff to have an honest conversation about risk factors, both within the prison or jail and upon release. It is not uncommon for people who are high-risk to avoid testing completely—they just “do not want to know.” Furthermore, it allows the inmate to receive appropriate treatment within the facility and to be referred to similar treatment upon release. With HIV treatment, the maxim “the earlier the better” applies. For example, one New York procedure requires inmates to report back that they were receiving care and the proper medications,³¹ but it was not uncommon for an individual who was on parole to be locked up and then switched to a medicinal regimen that he had already failed on, simply

because an alternative study was unavailable at the jail. Thus, it stands to reason that the individual would stand to gain the most from being informed of the infection as early as possible.

This will allow for them to consider appropriate treatment options.

The prison system must strive to identify HIV at inception in order to gain headway in the treatment and prevention of the disease. By taking steps to remove the stigma from prison rape and sexual assault, more victims will step forward and report, enabling the prisons to clearly see the HIV problems presented before them and to affirmatively deal with the disease. The prisons, however, must make policy changes in order to usher in a more fundamental understanding of prison rape. A victim of rape or sexual assault should never have to hide his victimization from authority and fail to receive diagnosis and treatment of HIV, regardless of whether he is behind bars or living among society.

¹ For example, if the parolees underlying offense was a drug offense, they were considered a Category 2 defendant. Under NY statutory law, for their first two violations, a category 2 defendant would receive a mandatory sentence to a boot-camp styled drug treatment program that lasted for 90 days upon arrival (meaning the total time incarcerated, with time spent waiting for a hearing and then time spent being moved to the boot camp, could last from 4-6 months). Upon their third sentence, the parolee was now considered a Category 4 and would receive jail time of anywhere from 4 to 12 months (or the remainder of their sentence up to 12 months).

² It shouldn't be assumed that someone who had three years to life was a violent offender. I worked in New York State, where the extremely harsh Rockefeller drug laws continue to wreak havoc on individuals' lives and make a mockery of the state judicial system. It is true that a crime such as murder could place someone on parole for life; however some drug offenses could also garner lifetime parole. I once defended a twenty-one year old junior at NYU who received three years to life for selling fifty ecstasy tablets. His rap sheet contained no violent offenses.

³ Scott Burris, *Disease Stigma in U.S. Public Health Law*, 30 J.L. MED. & ETHICS 179, 179 (2002).

⁴ See ERVING GOFFMAN, *STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY* (1963).

⁵ Lawrence O. Gostin et al., *The Law and The Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 92 (1999) (citations omitted).

⁶ Alex Geisinger, *Nothing but Fear Itself: A Social-Psychological Model of Stigma Harm And Its Legal Implications*, 76 NEB. L. REV. 452, 476 (1997) (quoting EDWARD E. JONES ET AL., *SOCIAL STIGMA: THE PSYCHOLOGY OF MARKED RELATIONSHIPS*, 4-7 (1984)).

⁷ *Id.*

⁸ Burris, *supra* note 3, at 180-81 (citing Bruce G. Link and Jo C Phelan, *On Stigma and its Public Health Implications*. Paper presented at Stigma and Global Health: Developing a Research Agenda, a conference convened by the Fogarty International Center of the National Institutes of Health, Bethesda, Maryland, Sept. 5-7, 2001).

⁹ Since we are discussing stigma, there are stigmas both to sexual assault and to HIV, so it certainly stands to reason that to be sexually assaulted and to be HIV positive would expose an individual to dual instances of stigma. For the purpose of this beginning discussion, however, I am referring to the stigma of being raped.

¹⁰ Burris, *supra* note 3, at 181.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ This is assuming that the prison or jail staff takes appropriate action. Unfortunately, this is not always the case.

¹⁵ Steven D. Pinkerton, Carol L. Galletly, & David W. Seal, *Model-Based Estimates of HIV Acquisition Due to Prison Rape*, 87 THE PRISON J. 295, 297 (2007).

¹⁶ This knowledge was gained through my firsthand experience as a Legal Aid attorney.

¹⁷ LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS BULLETIN: HIV IN PRISONS, 2004, at 1 (2006), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/hivp04.pdf> [hereinafter MARUSCHAK, HIV IN PRISONS, 2004].

¹⁸ *Id.*

¹⁹ LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS BULLETIN: HIV IN PRISONS, 2005, at 1 (2007), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/hivp05.pdf> [hereinafter MARUSCHAK, HIV IN PRISONS, 2005].

²⁰ *Id.*

²¹ It's interesting and instructive, however, to read the numbers a different way. Taking the numbers at face value, there are a total of 22,480 HIV-infected prisoners and 5,620 confirmed AIDS-infected prisoners. The state-federal split is dramatic, with 20,888 residing in the state system, while only 1,592 reside in the federal system. Women make up a smaller portion of the total (though they have a higher percentage) with only 2,036 cases total. *Id.* When using the percentages, the numbers sound much smaller (it's all a matter of framing). When looking at the total number of HIV positive individuals and realizing that there is no sexual protection available in the prisons, the potential for an epidemic is obvious.

²² MARUSCHAK, HIV IN PRISONS, 2004, *supra* note 19, at 5.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.* at 6.

²⁶ *Id.* at 5.

²⁷ Prior to law school, I ran a street outreach program in Rhode Island. Although the program passed out condoms

and such to any individual we encountered, the primary focus was on intravenous drug users, homeless and sex workers with a special focus on youth. Obviously, there was a great deal of overlap between those three groups. Because of a lack of inpatient beds throughout the state, for many individuals the best chance for detoxification is prison.

²⁸ STDs and HIV go hand in hand. On one hand, unlike HIV, some individuals will show symptoms for some STDs, such as chlamydia or gonorrhea. This is likely to send them to the infirmary. However, a great percentage of men and a larger percentage of women do not have any primary symptoms whatsoever. What this does is twofold. First, the individual does not receive treatment for the STD. In the case of the aforementioned bacterial infections, this is a one-time treatment. Secondly, undiagnosed STDs manifest in the body and expose it to HIV, either through lesions or open sores or the general breakdown of the immune system.

²⁹ It is important that this is administered within the first seventy-two hours, as the closer in time to the incident that medical staff administers medication, the better the chances for successful treatment.

³⁰ Assuming of course, that only the people who needed to know had knowledge that an inmate was HIV positive. That does not include guards. The only people who "need to know" would be the inmate and the appropriate medical staff. All others should use universal precautions. This would alleviate the inmate's fears that the stigmatizing condition would be revealed and lead to isolation, discrimination, bodily harm or death.

³¹ Of course, I have no way of knowing if this was the case nor should this comment be taken as an endorsement of New York procedures. However, I did make it a point of asking about their health care.

** James Radford earned his Juris Doctorate from Northeastern University School of Law. After obtaining his law degree, he worked as a staff attorney for the Legal Aid society where he represented individuals who violated their parole at administrative hearings. Mr. Radford was also responsible for negotiating plea bargains, advocating for alternatives to incarceration, conducting investigations into pending violation charges and preparing for and conducting hearings. As Harm Reduction Coordinator for AIDS Care Ocean State, Mr. Radford designed and implemented a new needle exchange program in Rhode Island. He worked with the state Department of Health to affect legislative change regarding harm reduction issues and developed innovative education and preventative oriented street outreach program for high-risk youth. Mr. Radford also worked cooperatively with local city and state governments on advocacy issues for at risk adolescents and designed, implemented and taught street outreach curriculum to over 60 youth workers.*