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SEXUAL ASSAULTS OF PATIENTS IN PSYCHIATRIC HOSPITALS: OPPORTUNITY STRUCTURES AND NORMAL ORDER

A Dissertation

by

Judith L. Musick

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University of California, San Francisco
December 1983
For E.G and J.S.
Acknowledgments

The study upon which this dissertation is based is the work of many hands and minds. The list of project staff, University of California faculty, NIMH staff, consultants and personal friends who have contributed time, ideas, and conviction about the importance of the work is a long one, demonstrating once again that it is the "collective conversation" which propels both academic and feminist enterprise.

In particular, I want to acknowledge the forebearance of my son, Justin, who has been the child of a graduate student for virtually his entire life, and who, like many youngsters of his generation, has been caught in the maelstrom of a mother's desires to achieve. For women of my generation, the need to contribute, and to mother are not compatible, absent the supports which we hope will one day enable others to tend to children and work without the neglect of either. For now, Justin has my thanks for his interest, his encouragement, and his understanding.

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Finally, I want to thank the women who were interviewed in this study. Without their willingness to speak out, sexual abuse in mental institutions would have remained a hidden problem.

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ABSTRACT

This ethnographic study of sexual assaults in psychiatric facilities is based on the retrospective accounts of twenty-six formerly institutionalized women. The accounts were generated from intensive semi-structured interviews and analyzed using formal content analysis techniques. The purpose of the research was to (1) develop an understanding of the special properties of institutional sexual assaults; (2) identify institutional features and practices associated with the incidence of mental hospital assaults; and (3) develop concepts and hypotheses to direct future research in this area.

The study describes patterns of institutional assault, in terms of assault characteristics, assailants' status, and situational features of the assault. The assailants' status is identified as the key feature of institutionally-situated assaults. The author hypothesizes that staff assaults against patients are more numerous than assaults committed by other patients, tend to involve multiple acts over a period of time, are less likely to be resisted and reported by victims, and are virtually undetected. It was found that aspects of normal institutional social organization create an "opportunity structure" for rape, and mediate against the detection and prevention of sexual abuse of patients.

Several features of institutional social organization associated with the incidence of sexual assault are discussed, including: (1) factors which create specific opportunities for assailants, such as poor supervision of incapacitated and restrained patients and poor
security of isolated areas; (2) practices which promote the vulnerability of patients and reduce their ability to resist, such as treatment-related incapacity, circumstances and practices which promote dependency of patients on staff, negative staff attitudes toward patients leading to objectification of patients by staff, promoting social distance between staff and patients, and compelling staff to discredit patients' assault complaints; (3) staffing and placement practices which fail to exclude and control abusers within the setting, including negligent hiring and dismissal practices, gender-integration of wards and patient-care, and poor supervision of male staff and patients regarding sexual behavior; (4) organizational factors which inhibit the detection and prevention of sexual abuse, such as the absence of proactive prevention activities and inadequate methods of handling patient complaints of sexual abuse; and (5) structural features which reduce the likelihood of criminal sanctions against assailants, such as informal dismissal practices of staff-assailants and the failure of civil authorities to treat patient complaints as legitimate criminal complaints.
Chapter One

Introduction

This ethnography of sexual assaults in psychiatric facilities is based on the retrospective accounts\(^1\) of formerly institutionalized women. The ethnography is part a collaborative socio-legal research effort which began almost four years ago when I met Camille LeGrand, a local attorney with considerable experience in litigating civil suits for victims of sexual assaults, an emergent area of tort law. She was representing four women who had been raped while patients at a local county hospital. The litigation was in "discovery" at the time our collaboration began. LeGrand attorney was interviewing witnesses and seeking experts to help support the plaintiffs' claims of negligence and damage. She invited me to observe two of her predeposition interviews and she explained the facts of the case(s) as she knew them.

According to the plaintiffs' accounts, two of the four women had been raped during the night shift by psychiatric technicians; the other two had been raped by a penal code patient on separate nights. Two of the women

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\(^1\) Accounts are linguistic devices by which individuals interpret events. Mills (1940) has suggested that through "vocabularies of motive," people interpret and negotiate problematic conduct acts. Scott and Lyman (1968) use the concept of "accounts" to refer to excuses and justifications which people use to limit their culpability for deviant acts. Scully and Marolla (1982: 3) describe "accounts" as "socially approved vocabularies that neutralize an act or its consequences and always a manifestation of an underlying identity negotiation."
had been in seclusion and restraints\textsuperscript{2} when they were raped by the patient-assailant who had been transferred to the locked psychiatric facility from the county jail. According to the District Attorney's account, the patient-rapist had been allowed by the attendant-in-charge to roam around the unit during the night shift. His only restraint within the unit was provided by the shackles he wore around his feet. On at least two separate occasions he entered the rooms of the female patients and raped them. The District Attorney believed that the patient-rapist was able to assault these women not merely because the night shift staff had been negligent in supervising the unit, particularly the penal code patients, but because the attendant had actually set up the assaults and allowed the patient-assailant access to the women in some sort of clandestine exchange — perhaps for peace and quiet on the ward or as part of a drug trade. The D.A. did not have sufficient evidence to bring charges against the attendant. The D.A. further speculated that the hospital's administration suspected (after the fact) the complicity of the entire night shift staff in these (and possibly in other) sexual assaults, but were unable to dismiss any of the staff because they couldn't prove their theories.\textsuperscript{3}

The fact that rapes would occur under circumstances of such vulnerability prompted each of us to pursue further the issue of sexual safety in psychiatric hospitals. We jointly applied for and eventually received funding

\textsuperscript{2}The plaintiffs claimed that they had been in "four-point" restraints at the times of the assaults, which is a violation of California statute. In "four-point" restraint, each of the patients limbs is strapped to corners of the bed, putting the person in a "spread eagle" position.

\textsuperscript{3}According to a women who called us soon after she had been released from that particular hospital unit, she had been threatened during her two nights there by an attendant who said that he would "let men have [her]."
from the National Center for the Prevention and Control of Rape of the National Institute of Mental Health to carry out the investigation upon which the present analysis rests.

**Literature Review**

At the time we proposed our study we were aware of no systematic studies in the rape, mental health or sociological literature, which specifically addressed the sexual assault of confined mental patients. In searching the literatures of relevant disciplines (social science, psychology, and mental health), I found no research which focused on the specific problem of sexual assault in psychiatric facilities. However the general literature which considers the social etiology of extrainstitutional rape provides useful concepts and theoretical propositions which may be applied to understanding the social processes within institutions which make sexual assaults possible (probable).

Experts in the field trace the causes of rape to: a predisposing impulse on the part of the would-be rapist; situational factors which facilitate the aggressive behavior; and the availability of a vulnerable target (cf. Goldstein, 1975; Finkelhor, 1981; Becker and Abel, 1978); and, more generally, to social relationships and social organization which promote and support male violence towards women (c.f. Sanday, 1981; Russell, 1975; Griffin, 1979). David Finkelhor presents a four factor model of the preconditions of child sexual abuse, which is helpful in identifying some of the social causes and conditions associated with rape, in general, and the sexual abuse of institutionalized mentally disabled adults, in particular. Finkelhor's model, which was employed by Russell (1982b) to organize her comprehensive review of rape etiology
theories, includes the following elements: factors creating a predisposition or desire to rape; factors reducing internal inhibitions against acting out this desire; factors reducing social inhibitions against acting out this desire; and factors reducing the potential victim's ability to resist or avoid the rape.

According to Russell (1982b), the assailant's predisposing desire to commit an act of sexual violence may be attributed to biology (Brownmiller, 1975; Symons, 1979), psychopathology, which is sometimes the result of childhood sexual trauma (Groth, 1979), male sex role socialization which promotes a fusion of sex and aggression or violence (Finkelhor, 1981; Russell, 1975); and/or exposure to media which encourages sexual violence (Malamuth and Check, 1981). The factors which reduce the assailant's internal inhibitions against acting out the desire to sexually molest the child include: alcohol, stress, frustration with marital/sexual relationships, and, perhaps most importantly, socialization to cultural values which tolerates or encourages (or fails to inhibit) adult males' sexual interest in children (Finkelhor). The scholarly treatment of rape in general has also addressed the relationship of cultural values and the prevalence of rape. These include such cultural values as viewing female sexuality (sexuality per se) as a commodity (Clarke and Lewis, 1977) and a long list of social myths which support rape behavior, for example, "It is impossible to rape an unwilling woman." So deep are the values and beliefs that support rape that many rapists fail to see themselves as rapists (cf. Scully and Marolla, 1982) or they use these social attitudes which support rape to excuse their behavior after the fact (cf. Burt, 1978).

Feminist scholars concerned with the social etiology of rape, such as Brownmiller (1975), Russell (1975) and Barry (1979), have argued that rape is the logical consequence of misogyny and a means whereby women are
controlled within patriarchy. As is clear from the cross cultural work of Peggy Reeves Sanday (1981), rape is not an inevitable fact of male nature. There are many cultures where it is virtually unknown. Sanday, analyzing a cross cultural sample of 156 societies, found what she determined was reliable rape information on 95 societies. Almost half (47 percent) of these were "rape free" — that is rape was absent or rare. In rape free societies, like the Ashanti, women are respected and influential members of the community and a female deity is believed to be the creator of life. Rape free societies are also characterized by an harmonious and nonexploitive relationship with nature. On the other hand, rape prone societies are characterized by a high toleration of violence, encourage men and boys to be aggressive and competitive, and limit women from taking active roles in public decisions and religion. Women and their work are demeaned and a male deity is seen as the creator of life. The work of these scholars clearly shows that the etiology of rape lies in social organization, within the fabric of the "normal" social relations of a given social unit.

The last two factors described by Finkelhor are most germane to the present discussion, as they are focused on specific social conditions associated with the crime. Finkelhor's third precondition for the intrafamilial sexual abuse of children is the presence of (social) factors which reduce the social inhibitions against acting out rape desires. These include a mother (protector) who is sick, absent or powerless, a domineering father, crowding or sleeping together, opportunities for the assailant to be alone with the child, and social and geographical isolation of the family. The final precondition of child sexual abuse Finkelhor describes are those factors which reduce the ability and likelihood of the child to resist: emotional deprivation,
social isolation, familiar assailant (nonstranger), the child's special fondness
for the adult, the child's vulnerability to the incentives offered by the adult,
the child's helplessness and powerlessness, the child's ignorance of what is
happening, the child's sexual repression and sexual curiosity, and the
assailant's coercion against the will of the child.

The phenomenon of sexual abuse of mental patients has been discussed
(albeit briefly) in other sources, including the classic study, *Women and
Madness*, (Chesler, 1972), and newspaper accounts of particular incidents and
scandals. Psychologist Chesler found that

> in general psychiatric wards and state hospitals . . .
> physical and sexual violence . . . are routinely enforced
> . . . (R)ape of the patients by the staff (is) . . . not
> unknown (35-36).

Chesler cites six separate incidents of rape and other sexual abuse (by the
professional and lay staff and male inmates) which received newspaper
coverage between 1968 and 1970. In her interviews with twenty-four women
who were formally institutionalized she found that "many . . . were sexually
propositioned or molested in mental asylums" (1972: 170). One interviewee
reported that

> there was a girl who was raped by the attendant but
> the nurse went to speak to him and it was hushed up.
> A doctor tried to rape me during a gynecological
> examination and I was afraid to complain, afraid they'd
> say I was lying or crazy and give me shock treatments
> (1972: 170).

Chesler's work is an important contribution to feminism and the
psychology of women literature. It did not address the kinds of institutional
dynamics which are the focus of the present study. Chesler did not emphasize
sexual assault. Her discussion of sexual abuses within psychiatric hospitals
was, rather, intended to further document the systematic oppression of women
by and through psychiatry.

We found no research which addressed the traumatic sequelae of rape for the chronically mentally ill or how hospital staff generally responded to the problem of sexual abuse within their working environment. We were unable to find, by contacting the State Assembly and public mental health agencies, any systematic investigation or study within California which addressed the problem of sexual abuse within the state's own psychiatric facilities. More importantly, we were unable to find a single institution which systematically collects and analyzes the sexual assault complaints of its patients.

What we were able to find regarding the problem of sexual abuse within psychiatric hospitals, besides the discussion of institutional abuse within Chesler's work, were two essays written by psychiatrists. Both articles used limited case examples. The first (Deutscher, et al., 1976) focused on the problems of hospital administration and crisis management in the face of accusations of sexual assault by patients. The second (Stone, 1975) emphasized the problem of establishing a high and consistent standard of ethics for physicians regarding sexual involvements with patients. Neither article spoke of sexual assaults in terms of "rape," and neither article sufficiently addressed the problem of controlling and preventing violent crimes against patients within institutions.

**Perspective**

The integrating concept of our joint socio-legal approach is that of
environmental safety relative to sexual assault. In using the term "environment," I mean to convey both the physical and social features which make a particular social setting a distinguishable social system. In this case, I am referring to psychiatric hospitals and facilities.

The central organizing question has not been, as many people have asked, "How much of a problem is sexual assault in psychiatric hospitals?" but rather, "What kind of a problem is it in these special environments and how do those in charge of the environments handle the problem of sexual assault?" Without established systems that make safe reporting possible for people who have been victims of a crime (especially where the perpetrator is also the "caretaker") and which thereby allow the continuous collection and analysis of aggregate assault data, neither I, nor anyone else, can answer the questions regarding the frequency with which sexual assaults in mental hospitals occur. I can, however, explore the question "What constitutes a safe environment relative to sexual assault?" This question forces a focus on what conditions and active social processes make a place safe, what environmental factors are associated with breaches in that safety, what deters and prevents rape, and how the environment reorganizes itself in the aftermath of a sexual assault.

Using the concept of a "safe environment, we have been able to integrate legal and empirical perspectives. LeGrand has focused her component of the study (the legal analysis) on the constitutional rights of institutionalized persons, the duty of care of hospitals to provide safety relative to sexual assault, and theories of negligence by which hospitals may be held accountable for sexual assaults of patients. I chose to investigate the empirical side of the issue, to interview former patients who had been
sexually assaulted and to interview psychiatric staff (as well as former patients) about institutional practices which contribute to incidents of sexual abuse and assault. Together we have identified a list of "safe environment factors" associated with the prevention and rectification\(^4\) of sexual assaults as expressed in the state statutes and administrative regulations and in actual institutional practice. Some of these factors will be presented and discussed in the concluding chapter.

There is an extensive body of case law, including the recent Supreme Court decision in *Younghberg v. Romeo*,\(^5\) that supports the principle that hospitals must provide a safe environment for their patients. Presumably, this principle applies to sexual safety as it does to other aspects of physical and emotional well-being. However, a recent civil suit demonstrates\(^6\) how problematic it is to define a hospital's duty of care relative to sexual safety, because there is no community standard to apply to hospitals — no collective definition of what constitutes safety standards relative to sexual assault (unlike, for example, safety standards relative to fire). Moreover, the exact duties and work of hospital administrators and staff in this regard are difficult to define in the absence of their acknowledgment that sexual violence against patients occurs in hospitals. Such "safety work"\(^7\) on the part

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\(^4\)I am using the term "rectification" to refer to those processes undertaken by participants in the environment, principally staff and administrators, to repair (or make whole) the environment in the aftermath of a sexual assault allegation. The rectification process may or may not include parallel processes: counselling of the patient-victim, legal sanctioning of the hospital, criminal investigation and prosecution of the offender.


\(^6\) *Tolbert v. Louisiana*, 370 So. 2d 166 (La. App. 1979).

\(^7\) I have applied the term "safety work" used by Fagerhaugh and Strauss (1983) to those intentional and anticipatory efforts staff and patients undertake to avoid and limit patient exposure to harm.
of staff is further hampered by the absence of understanding among staff regarding the relationship of such assaults to the social conditions and context within which they occur.

My purpose in approaching sexual assault as an environmentally situated phenomenon is not to argue that environments "cause" rape. Rape is, after all, carried out by "rapists," not environments. Environments may, however, influence the probability that such violence will occur. There are at least three separate factors associated with an occurrence of rape: an acted upon impulse on the part of the rapist, an opportunity for the rapist to carry out the rape, and the perception by the rapist that there is minimal risk of being caught and/or punished. The latter two features in the etiology of rape arise from and are shaped by environmental processes. Environmental features may provide an "opportunity structure" for rape as well as enable or impede a victim in identifying the act. Environmental features influence whether the assailant is apprehended and punished. The social environment shapes both the prevention of rape and the rectification processes that follow from its occurrence. Later, I will discuss the specific environmental (i.e., institutional) features which we have found contribute to the occurrence of sexual assault, and the responses of inmate-victims and staff when assaults occur.

The overall orientation of my empirical approach is that of symbolic interactionism, as described by Blumer (1969) in his discussion of situational definitions as the genesis of joint action. The salience of the definition of the situation is strikingly clear in the case of rape — in the intended victim's immediate apprehension of the meaning of the act, the ways rapists disavow the deviance of their actions, and in the ways participants in the
social aftermath of sexual assaults (or accusations of assault) assign victim credibility and take (or fail to take) steps to rectify the situation (i.e., to bring things back to some semblance of order).

Institutional life, and therefore, the social acts of which it is comprised, are the result of joint actions. What "is" is the result of what people do and what they do is the result of how they define the situation in which they are called upon to act (1969: 19).

How is environmental safety relative to sexual assault created by the actors within a psychiatric facility? If people act on the basis of how they define a situation (sexual safety within the institutional setting), we can postulate that those settings which are seen as (or assumed to be) safe will generate few, if any, joint actions explicitly intended to make them safe. Our data show that such complex joint actions (the development and implementation of hospital policy and unit protocols) intended to make an environment "safe" (proactive prevention work) are reserved for responding to highly visible losses of safety and conditions which have come to the attention of external authorities (i.e., regulatory agencies, courts, the criminal justice system). And yet, as our data also show, sexual abuses of every kind happen (and at least half are reported to staff) in (probably) every hospital.

What accounts for the absence of collective and proactive prevention work by staff of psychiatric hospitals? Do they not act because they simply don't see sexual assaults occurring? Do they not act because the abuses that occur are not defined as acts which require extraordinary remedial actions? Do facility staff not act in a collective and proactive way to prevent rapes because there is no structural support for such action, or because there exist
countervailing definitions which motivate other actions? I will only partially address these questions in my analysis of patient-victim accounts. What is clear, however, is that ward level staff do not define the situation of patients, via a via their vulnerability to sexual assault, as critical. They do not, as a rule, see the hospital as a place where rape is a big problem (and, indeed, it may not be, when compared with other places or other problems on the ward). Sexual assault is not a topic which is regularly or adequately discussed by hospital staff (anymore than it is discussed by people who work in other kinds of social environments). However, the problem of managing and controlling presumably consensual sexual behavior is discussed, as is the problem of the personal safety of staff from patients.

Women patients, on the other hand, may be highly cognizant of the threats to personal safety posed by being locked up. Some may even have come to see psychiatric hospitals as places where they "have to expect" some level of sexual abuse (as one psychiatrist reputedly told a woman patient who was complaining of being continually sexually accosted). To the degree that they are exposed to sexually abusive and assaultive behavior, patients may be far more likely than staff to form collective definitions which emphasize the risk of being sexually assaulted within psychiatric environments. Yet, patients are not usually able or allowed to form effective collective action during their confinement. They rely (and are forced to rely) instead upon the actions of staff (and other advocates) to protect them. Yet, as I believe is very often the case, the "protectors" don't see the danger and, as a result, the situation remains in the control of those who would exploit and manipulate "opportunities" to injure and abuse vulnerable people.

This dissertation is a descriptive exploratory inquiry into a new area of
rape research which focuses on the retrospective accounts of former patients who were sexually victimized during psychiatric hospitalizations. It is important for the reader to understand that this is an analysis of accounts of sexual assaults, not of sexual assaults per se. The difference between the two must not be confused. Because a study of sexual assault cannot be based on direct observation, it must, by definition, derive from some form of verbal accounting of the assault — either directly from the victim of the assault, or indirectly from someone else. The accounts provided by victim-respondents are attempts retrospectively to describe experiences, interpret, in this case, highly problematic and stigmatizing conduct/acts, and negotiate identities.

I do not fully treat or incorporate here all aspects of the larger study of which this thesis is a part. I do not, for example, include an analysis of staff accounts of known incidents, or their explanations of institutional policies and practices which would limit and control such abuses. What I do focus on are the properties of sexual assaults against mental patients in institutional settings which are described in their accounts. I also analyze, again from the perspective of the victimized patient, the social aftermath of assaults within the facility, particularly reporting and other forms of safety work in which the patient engages.

Defining Sexual Assault

Throughout this discussion, the acts with which I am primarily concerned include the class of unwanted sexual acts (from the point of view of the person on whom the act is committed), which involve physical touching. These acts, representing a continuum of experience and definition, may be correctly
or incorrectly labeled by victims (or observers) as rape, sexual assault, sexual abuse, sexual molestation, sexual misconduct, exploitive sexual behavior or "inappropriate" sexual behavior, a term popular within psychiatric facilities. I will use the terms sexual assault and sexual abuse to describe the behavior with which I am concerned. I have adopted this usage in order to focus attention on the more assaultive and less definitionally problematic sexual encounters which occur in facilities. In choosing between the terms rape and sexual assault/abuse, I use the latter for two reasons. First, rape is a legal term for which there is no standard definition applicable in all fifty states. Second, sexual assault (or sexual abuse) may be applied to a variety of serious nonconsensual sexual acts; its connotation is broader than just those acts involving penile penetration. These more inclusive terms better fit the experiences described by the women I have interviewed.

Sexual assaults have social trajectories, including the sub-acts which lead up to and follow from the sexual acts themselves. Before the assault(s) begins, the assailant may engage in a number of social interactions with the victim which set up the assault, influence the definition of the situation which the victim holds (or will hold), and reduce the possibility that he will be caught and punished. Clinicians who treat incest victims and incest

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8While my focus has been on accounts of sexual assaults, (presumably) "false" accusations of sexual assault (particularly when they are against staff members) also have significant impact on staff and the hospital environment. Presumably false accusations, according to staff we have interviewed, happen "all the time" and have a serious demoralizing effect on the staff. Staff claims that they work "in a climate of accusations," whether true or not, are a deterrent to preventing sexual abuse and taking patient complaints seriously.
perpetrators refer to this as the "grooming" stage.⁹ Similar preparatory processes occur in the sexual victimization of hospitalized mental patients.

There are also post-assault stages, aspects, or sub-acts, some of which may take place over an extended period of time. The social aftermath of sexual assault depends on how the victim defines the assault, her available choices of action, and the probable (as she calculates them) consequences of these choices. If she chooses to resist and/or report, she may be involved in a multidimensional process of establishing the credibility of her account and negotiating (with staff or others) what action she wants taken and particularly what she wants to happen to herself. She may immediately be discounted and need to develop strategies by which to protect herself from the assailant himself, and/or to minimize the harm caused by staff reactions to the report. If she chooses not to report she may find herself enslaved in a situation of ongoing abuse.¹⁰

The actors' emergent definitions of the assault during its entire trajectory affect how it is acted upon by all the salient actors, and the emergence of its collective definition. It is the unfolding of events and interactions within the entire trajectory that is at the heart of what Weis

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⁹This concept, used by clinicians at the Seattle, Washington Sexual Assault Center, was discussed during a workshop entitled "Treatment of the Incest Family," presented by Cathryne Schmitz, M.S.W., at the annual conference of the National Coalition Against Sexual Assault, August 1982. During the grooming phase, the incestuous father, according to Schmitz, typically manipulates the social relationships of the family members in order to increase the child's dependency upon him as well as reduce the probability that the child will disclose the incest. For example, he attempts to create distance and distrust between the child and the mother. He also restricts the child's friendships and forbids dating. Judith Hermann's (1981) research on father-daughter incest focuses on some of these dynamics.

¹⁰Barry (1979) defines sexual slavery as a situation of sexual abuse in which a person, no matter how they got into it, cannot get out.
and Borges (1973:72) describe as the process of "victimization."

Both the term and concept of victimization refer to societal processes that before, during, and after the event simultaneously render the victim defenseless and even partially responsible for it. Victimization includes the preparation of the victim for the crime, his or her experience during the crime, and the treatment or responses he or she will encounter as part of the aftermath of the crime.

**Sexual Assault Within Treatment Environments**

Sexual assault represents, within a context of risks associated with being mentally ill and/or being treated for mental illness, an illegitimate and, as I will argue, not entirely unanticipated risk of hospitalization. Although psychiatric patients are exposed to presumably "legitimate risks" of treatment, I believe they are also exposed to illegitimate risks deriving from being in an institutional environment. By the concept "illegitimate risk" I do not include those risks arising from clinical treatment, but rather, those which may be attributed to some failure in the maintenance or supervision of the social environment. Some illegitimate risks are anticipated by staff and administration. For example, staff openly acknowledge and work to reduce the risk of injury or death from fire. They also develop methods of assessing and monitoring patients they feel pose a risk of suicide. Patients are exposed to the risks of physical and emotional injury by other persons living or working in the facility. Patients may physically injure themselves, or be injured by other patients or staff. These sorts of injuries are anticipated by staff and are part of the acknowledged histories of most facilities. Although "they shouldn't happen," they are seen as sometimes "unavoidable" consequences of
mental illness, institutionalization and of managing persons who are mentally ill and sometimes violent. Staff have told us that they see it as their "duty to anticipate and prevent these sorts of problems."

Staff anticipate and openly discuss the potential of injury (including sexual assault) to patients and to themselves from other patients. They are less cognizant of and open about injuries caused to patients by staff. They are, if we may judge by recent writings in mental health journals, more concerned with the physical safety of staff relative to patient violence, particularly since the advent of patients rights legislation and key judicial decisions, which limit the "containment" strategies of staff to the least possible force and restraint (cf. Scott and Whitehead, 1981; Armstrong, 1979). Scott and Whitehead, who argue for an administrative (rather than clinical) approach to the management of violence within the hospital, expressed concern only with the consequences of violence upon staff and the facility budget. They did not address, even superficially, the problem of patient-to-patient violence nor the problem of staff-to-patient violence (abuse).

We can hypothesize that staff acknowledgment decreases when the injury/harm is that of sexual assault and the offender is a member of the staff. These represent risks which are so illegitimate within the context of a hospital that they are largely unanticipated in the form of collective safety work. This lack of awareness regarding the sexual abuse of patients, particularly by staff, is the result of at least two features of sexual assault:
a) it is a felonious act and therefore carried out in secrecy\textsuperscript{11}; and, b) it is an illegitimate risk within a designated treatment environment, which is supposed to provide safety and to "cause no harm." Sexual assault is not supposed to happen and when it does, it is hidden from full disclosure and collective accounting by a variety of organizational conditions and workgroup processes. In addition, individual and collective consciousness of sexual assaults is prevented by institutions' lack of competence in handling such complaints.

\textit{Prevention and Response to Assaults}

This study is limited to assaults which reportedly occurred within inpatient psychiatric units or facilities, including long-term state hospitals, psychiatric units of county and private general hospitals, private psychiatric facilities, and psychiatric units of Veteran's Administration hospitals. There are some salient differences among these hospitals regarding how they may organize (or fail to organize) prevention and rectification work. For example, public hospitals are more subject to public regulation than private hospitals. Private hospitals, unless they receive public monies, are not as subject to administrative regulation regarding the protection of patients' constitutional rights as are publicly run facilities.

\textsuperscript{11}Exceptions to strict secrecy of course exist. Gang rapes are less secret than single assailant assaults. As the case I initially presented demonstrates, sometimes assaults occur within an abusive scene created through the active participation and complicity of whole shift staffs. These are, however, "group secrets" and the complicit parties attempt to prevent disclosure to outsiders.
In spite of these differences, psychiatric facilities share certain features which make them different from the "outside" in how to construe and respond to rape, sexual abuse and assault, violence and sex. Within a psychiatric facility, patient-victims have a reduced capacity to resist and defend themselves against assault. This not merely because they are personally less able to defend themselves, but also because the organization of their care restricts them and makes them vulnerable to assault. As we have discovered in the course of this research, patient-victims are further restricted by the institutional environment and their caretakers from access to effective criminal investigation and prosecution, as well as to competent rape victim support services.

A psychiatric institution has physical and social properties which make it special, which may be implicated in the incidence of sexual assaults, and which influence the means by which these assaults are remedied. For example, long term psychiatric institutions (i.e., state hospitals) are physically separated from the larger community. They are often located in rural areas (or formerly rural areas) and are characterized by locked doors, back wards, and, sometimes, by high walls and/or gates. What happens within them is not usually visible or of real concern to members of the "outside" community. Psychiatric facilities, and what happens in them, are usually a case of "out of sight, out of mind." The general public is not concerned with what happens with the chronically mentally ill — except that they not be bothered by them.

Psychiatric facilities are paternalistic and hierarchically organized environments where staff have significant control in deciding what is "good" for patients and what will be done in response to their complaints. Many are,
as Goffman (1961) describes, "total institutions" in which "all aspects of life . . . [including, we will assume, sex and sexual violence] . . . are conducted in the same place and under the same single authority" which is, for the most part, bureaucratically organized (1961: 6). They are also insulated from other critical institutions and arenas of social action. Most important, from the perspective of preventing and controlling sexual abuse, they are insulated from the criminal justice system, as well as those agencies and groups which represent the anti-rape movement and victim support services.

As I was repeatedly told during a visit to one state hospital, it is extremely difficult for administrators to engage the attention of local police departments in the investigation of "inside" criminal complaints. Police had, on occasion, adopted a "hands off" attitude which, according to those we spoke to, left facility personnel feeling that they had the full responsibility for handling all but the most severe crimes and incidents. Rape complaints by mental patients would often not be considered a "legitimate" complaint for police investigation, perhaps because police did not view the victims as "reliable" complainants.12 Local police there, as in other localities we have studied, often defer, at least in part, to the judgment of mental health professionals in how they should proceed regarding a rape complaint. However, mental health professionals are themselves seldom prepared to handle the multifaceted responsibility of investigating and responding to a rape complaint, identifying abusers, providing support to victims, and developing joint actions which would more thoroughly protect patients from

12 According to Rose and Randall (1982), police investigators determine the legitimacy of a rape complaint largely on the basis of the credibility of the complainant as well as their perception of her willingness (and capacity) to go through the entire investigation and prosecution process.
future abuse.

**Actors in the Situation**

Just as we speak of the act and its context, so must we speak of the actors, their social relations and participation in the commission and/or social aftermath of sexual assaults. The relationships between the two major classes of actors in the situation, patients and staff, are characterized by hierarchical authority, extreme social distance and the absence of shared situational definitions. Each class has a role relative to creating safety within the context and each occupies particular locations along continua of vulnerability, responsibility, and power. Individual patients must depend on staff to provide for their safety; they have little personal recourse to provide for their own safety or remedy a breach in safety without the consent and active participation of staff. Furthermore, providing patient safety is a legitimate role of staff. Staff have the exclusive responsibility for taking care of patients and for maintaining control over the environment in which patients are confined. However, because of countervailing social processes — ones upon which staff depend to maintain the social distance many see as necessary for controlling patients — few staff know of (or accredit) patient accounts of sexual abuse and few are, therefore, able to offer patients the very safety it is their exclusive responsibility to provide.

When speaking of sexual assaults within psychiatric hospitals, new roles and relationships for the relevant actors emerge. These are partially reflected in the new "labels" they take on. A patient who is assaulted becomes a
"victim" or, when not believed, "sexually preoccupied," a "troublemaker" or "manipulator." Patients and staff who commit assaults become defined by a label which marks their assailant status (rapist, abuser, sociopath, etc.).

How patients who have been sexually assaulted in the hospital behave and are treated by staff is shaped by the fact that they are simultaneously victims and patients. Their status as inmates (and the situational powerlessness that derives from that status), as well as their mental condition at the time of their confinement significantly contribute to their vulnerability to sexual assault and abuse. They may be seen by rapists as "unbelievable" and "easy marks." The fact that mental patients are seen as "out of it" by rapists as well as nonrapists contributes to their being viewed as "legitimate" victims who will pose little or no threat. One psychiatric nurse we talked to described witnessing a sexual assault by one patient upon another. Although she stopped the assault, she did not construe the act as "rape" because (to paraphrase) "the patient was so out of it she couldn't have experienced it as a rape."

Beyond the fact that as mental patients they (or what happens to them) may not "count," patient-victims have the additional problem of being discredited persons. Those who have been successfully "institutionalized" may have little confidence that they will be believed, a trait shared by many other victims of sexual assault. Therefore, they may either not report or rescind a report that is challenged. When patients do report, hospital staff have the problem of "crediting" their account, of sorting out the "real"

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13 Weis and Borges describe the "legitimate" or "safe" victim as the victim "who will not be dangerous to the rapist, since she is unable to relate her experience to others or to effectively direct blame and accusation against the person who raped her" (1973:72).
reports from those which may be delusional, "expressions of anger at the accused," or in some other way "false."

We know the least about the assailant, although we can sometimes infer from the victim or staff description of the individual assault how it is the assailant managed to conduct the assault and minimize the risk of detection and punishment. What we can discern from an analysis of the accounts of former patients as well as facility staff is that the patient-assailant is much more visible than the staff-assailant. The assaults committed by patient- and staff-assailants also differ in terms of how they are defined and reacted to by patient-victims, how they are conducted by the assailant, and in their impact on the facility when they are discovered. Assaults committed by staff members are by far the most disruptive to the institution. If all sexual assaults represent an illegitimate and unanticipated risk within the institution or facility, those committed by staff are the most illegitimate and, therefore they cannot be anticipated or acknowledged, except after the fact.

The third class of situational actors with whom I am concerned is individuals who may witness or become party to the resolution and aftermath of the assault, or accusation of assault. This latter group includes institutional and, under some conditions, extramural actors. Institutional participants include staff, administration, and sometimes other patients. Extrainstitutional participants may include the patient-victim's outside affiliations — family, friends, or personal therapist, as well as representatives of other institutions and organizations, most notably the criminal justice system, mental health administrative and regulatory agencies, patients rights and/or rape-victim support services and, in some cases, other psychiatric facilities.
Sometimes institutional actors become agents relative to the a) resolution of the patient-victims complaint; or, b) rectification of the institutional environment and relationships (reconstituting normal order). Staff members who receive patient allegations of sexual assault, or become directly involved in response to allegations, take on an active role relative to a) the ongoing process of victimization, b) the prevention of other sexual assaults, and c) the rectification of harm caused to the environment and its members by the assailant, the fact of the assault, and the allegation. Extrainstitutional actors may also sometimes become agents for the patient, attempting to influence the institution in its post-assault reactions.

In some ways the members of the institutional setting function as an "audience" during the social aftermath of the assault. They do not usually see the assault (it is, after all clandestine, "backstage" behavior). Nor are they collectively and explicitly organized in their reaction to the report of the assault. They witness the aftermath as individuals and develop their collective reaction in the process of accrediting the account. Individual members may or may not become actively engaged in the rectification processes which result from reports but they most certainly observe at least part of such "performances." In addition, their (assumed) range of reactions may provide that "screen" against which both rapist and victim calculate their choices.

Organization of the Dissertation

This treatment of institutional sexual assaults is primarily descriptive. It is an ethnography of sexual violence within mental hospitals. The description
upon which the discovery of the relationships between the setting and the assaults rests is from the viewpoint of the patient-victim. Through the perspective provided by their accounts of the assaults and the social aftermath of the assaults, we can view not only the manipulations and behavior of assailants, but we can also see elements of institutional life which contribute to the commission of assaults and mitigate against their detection and prevention.

After describing the sample of accounts used in creating this ethnography, I will describe the patterns of institutional assaults and the conditions under which they occurred. I will present the differences between between peer (patient-patient) assaults and assaults by staff, and discuss the differential impact of each on the victim, her reactions, and the conduct of the assault. In describing the assaults, I will introduce the concept of an "opportunity structure of rape." This concept will be developed throughout the dissertation. It refers to those institutionally specific processes which the rapist is able to predict, and which he exploits and manipulates in order to commit undetected and uncontrolled assaults.

I will then analyze patient accounts of the social aftermath of assaults paying particularly close attention to two lines of patient actions which constitute a form of safety work: strategies of disclosure, which involve telling staff and reporting to police; and less social strategies, strategies of silence, which involve active tactics of avoidance, escape, and association. The reactions of hospital staff and others who did and did not choose to act as agents for reporting patients will also be examined.

The final substantive chapter consists of a full discussion of the opportunity structure of rape that is created and maintained within the
"normal order" of psychiatric facilities. Rape is a crime of opportunity. The major thesis of this work is that institutional life and the social discrediting of mental patients contribute to an organized structuring of such "opportunities." This research also touches on several theoretical issues of importance to sociologically oriented symbolic interactionists and some will be discussed in the concluding chapter of this dissertation. Special methodological problems I encountered will be presented in an addendum.
Chapter Two

The Assault Sample: Creating a Field of Inquiry

Introduction

While it may be no surprise that sexual assaults occur in mental hospitals, as they occur everywhere else, the absence of data and discussion in the literature is mirrored by the widespread lack of acknowledgment and discussion within the arenas that represent psychiatric hospital interests. There are no statistics generated by institutions or their regulatory agencies concerning the number of assaults reported to hospital personnel and to outside civil authorities. Psychiatric institutions appear to have been virtually untouched by the anti-rape movement. And even within groups of former patients and mental patient's rights groups, the issue of sexual vulnerability has yet to be isolated, identified and addressed. To date, no one has recognized the special needs of psychiatric inpatients, or demonstrated interest or capacity in developing rape prevention and intervention strategies for institutionalized persons. All the standard origins of reform and protest are still silent. In short, the sexual abuse of psychiatric patients is still invisible to all but those most affected — victimized patients.

The inattention of the public, mental health professionals and hospital administrators has resulted in (and from) a lack of systematic descriptions of institutionally-situated assault allegations. This absence of clear description inhibits the formation of situational definitions that would foster collective
prevention work: that "rapes" happen in hospitals, that treatment environments can be "unsafe" relative to sexual assault, that sexual assaults in facilities have special features which can be detected, etc. In order to foster the development of such collective definitions, upon which rape prevention work depends, we must establish the social reality of the problem over and against its overwhelming "facticity" as a nonproblem.

The same invisibility of the problem, which inhibits collective discovery and prevention, also presented major problems in formulating and conducting this research, at least in terms of interviewing institutional staff and administrators. With no preexisting aggregate institutional assault data, there were few "neutral" beginning points of reference and agreement between researcher and institutional staff upon which a more theoretically-oriented inquiry could be based. In order to develop an understanding of the dynamics of sexual assault per se, and more specifically, assaults on mental health patients, I chose first to gather and analyze the accounts of former patients who were assaulted. Such exploratory and preliminary investigation into the phenomenon not only provides a point of reference for further research but will, presumably, encourage and support preventive efforts among administrators and staff of mental health facilities.

My field of inquiry consists entirely of retrospective verbal accounts by women, who as patients in psychiatric facilities, were in some way sexually assaulted. Their accounts describe the assault themselves as well as the circumstances that surrounded the assaults. Their accounts also describe what they did after the assaults and their views of how staff reacted to the reports and the patients who reported. I have analyzed these accounts as one might examine each layer of an archeological dig, microscopically examining
those aspects of the accounts which treat the assault itself, discovering and marking those elements which reveal the relationship between the act and its context.

As stated earlier, environments do not commit rape or other sexually abusive acts. Men do. And when men rape, they presumably take into account the setting in which their assaults occur, that is, they manipulate the setting in order to carry out their clandestine acts while, at the same time, minimizing the risk that they will be caught and punished. What are those elements of the institutional setting that are manipulated by the assailant? In order to discover the relationship between the act and its social and environmental context, our interviewers conducted extensive interviews with approximately seventy-five respondents — former patients and institutional personnel. During the interview period, we increasingly refined and structured our interview schedules in order to direct our subjects to the kinds of detailed description we wanted. Although the accounts we collected are theoretically varied, this is more the result of chance than of any form of purposeful sampling. This chapter describes the account sample in terms of some of the theoretically significant dimensions.
The Subject Sample

My study of sexual assault in psychiatric institutions includes the accounts of staff as well as patients, but this dissertation is primarily an analysis of victim accounts. Although full understanding of institutionally-situated assaults requires an analysis of staff accounts, only the participants in the assaults themselves, the victims and assailants, can provide us with complete information concerning the assaults, and the circumstances within which they occurred and were defined. Staff members, unless they have witnessed or discovered an assault, know little about it; rather they know about the report of it. While the assault victims experienced first-hand actions and interactions, the staff, at best, experienced the impact of the communication of the assault.

Although three of the accounts included here were derived exclusively from content analysis of documents associated with five lawsuits, the majority of the accounts were derived from interviews\(^1\) with a sample of twenty-three women who had been sexually assaulted or abused while hospitalized in psychiatric facilities. The subjects were recruited by means of public newspaper advertising and appeals circulated through cooperating mental health facilities, mental patient advocacy networks, self-help groups, and sexual trauma services. Former patients were asked to contact the researchers if they had experienced "any form of sexual assault or unwanted

\(^1\)Subjects were asked to provide an open-ended account of the assault and the circumstances surrounding it. Interviewers then asked specific questions from a structured interview guide. Most subjects were interviewed in person although a few were interviewed by telephone.
sexual touching while hospitalized in a psychiatric institution, hospital or ward."

Age, Race, and Chronicity

The subjects ranged in age from twelve to fifty-three years old at the time they were assaulted. Almost one-fourth of the assault incidents involved patients who were children or adolescents. The majority of the subjects are white (twenty-two). We also interviewed one black woman and three hispanic women. Approximately one-half of the women we interviewed were chronically mentally ill at the time of the interview.² Approximately one-third of the women were taking psychotropic medications at the time they were interviewed and more were, by their own description, mentally disabled. Four of the women we considered chronically mentally ill were living in residential treatment facilities at the time they were interviewed. The rest were living by themselves, with their families or friends.

At least one-third of the women in our patient-victim sample are not now, or were they chronically mentally ill at the time they were assaulted. Instead, they were situationally depressed and/or suicidal, and sought asylum within the mental health system. Others were hospitalized because of alcohol abuse. The remainder were hospitalized a single time as children or adolescents, with such nonchronic problems as "adolescent rebellion" or

²We have attempted to apply the operational definition of chronicity definition of Goldman, et al. (1981) which focuses on: 1) severity of diagnosis (predominately the psychotic disorders, including affective illnesses); 2) disability (operationally defined by the receipt of disability payments such as Social Security Insurance (SSI) or the subjects' evaluation of themselves as "disabled"; and, 3) duration of hospitalization of one year or more, or frequent hospitalizations during one year amounting to ninety days or more.
running away from abusive homes. Most have managed to avoid further confinement within the mental health system and, we assume, are not likely to be institutionalized again.

**Mental Disability at Time of Assault**

Except for the methodological issues raised by interviewing subjects defined by themselves and/or others as mentally ill, it is more significant to concern ourselves with the mental condition of subjects at the time the assaults occurred. By rough measure (the number and length of hospitalizations, as well as severity of diagnosis), approximately half of our subjects were chronically mentally ill at the time they were assaulted. In terms of severity of diagnosis (that is, the definition of their mental condition as provided by the admitting psychiatrist), Table I describes how our sample was distributed.

### TABLE I

**DIAGNOSIS AT TIME OF HOSPITALIZATION**

<table>
<thead>
<tr>
<th>Specific Diagnosis</th>
<th>Diagnostic Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Cognitive Disorders</td>
<td>16</td>
<td>44.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>Affective Disorders</td>
<td>4</td>
<td>11.1%</td>
</tr>
<tr>
<td>Manic-Depression</td>
<td>Alcoholism</td>
<td>1</td>
<td>2.8%</td>
</tr>
<tr>
<td>Borderline</td>
<td>Missing Data</td>
<td>2</td>
<td>5.6%</td>
</tr>
<tr>
<td>Alcoholism</td>
<td></td>
<td>1</td>
<td>2.8%</td>
</tr>
<tr>
<td>Pt. didn't know</td>
<td></td>
<td>6</td>
<td>16.7%</td>
</tr>
<tr>
<td>Missing Data</td>
<td></td>
<td>6</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>36</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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3 This distribution is based on an analysis of assault sets (described below) and therefore the total frequency is the number of sets (36) rather than subjects (26).
In order to get an idea of how subjects defined their own mental disability at the time of the assault, we asked three questions: What was the precipitating problem that led to hospitalization? What was their state of mind at the time the assault occurred? and How able were they to communicate at the time of the assault? The answers to these questions helped us, in part, to distinguish between the various degrees of mental impairment and chronicity — to identify those who were most able to resist, report, and sustain the credible identity necessary to encourage staff to act on their reports and those who were not. Our subjects' explanations of why they were hospitalized were based in more than one lexicon. Some clearly described their problems in psychiatric terms: as a cognitive disorder (hallucinations and hearing voices), as depression, as "acting out." Others attributed their hospitalization to the action and power of others, for instance, because they had run away from home or their family couldn't deal with them at home. Table II shows the distribution of our sample in terms of the subjects' definition of why they were hospitalized.
Women in our sample of patient-victims were also asked to describe their state of mind at the time of the assault. Most of them were either significantly depressed and/or passive at the time of the assault (36.1%), or mentally confused, hallucinating, or "out of it" (33.3%). In addition, one woman was unconscious, another asleep, and a third was drunk at the time of the assault. Four of the women described themselves as neither mentally impaired nor passive at the time of the assault. Thus, the majority of our sample included women who were, by virtue of their mental condition at the time the assault set began, reduced in their ability to resist their assailants effectively. Or, as may be particularly the case with significantly depressed patients, they were easy targets for aggressive patients and manipulative staff-assailants.

We also asked respondents to describe their communication skills and capacities at the time of the assault, in order to differentiate among the subjects based on their capacities and probabilities of reporting. This is a

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4This distribution is based on an analysis of assault sets (described below) and therefore, the total frequency is the number of sets (36), rather than the number of subjects (26).
significant variable for at least two reasons. First, the noncommunicators may be at special risk of being assaulted because they can be counted on by the assailant not to report. Second, those who are verbal but speak only "word salad\textsuperscript{5}\" present special conditions when they do report an assault. Their disclosures are likely to be highly coded or disorganized. The majority (twenty) of women described themselves as \textbf{capable} of clear communication, although many chose not to report. Eleven women were verbally impaired or mute at the time of the assault. One woman, whose account was derived from analysis of legal documents, did not speak English.

\textbf{Histories of Institutionalization}

Another way in which our sample varies is in terms of respondents' institutional careers. Between them, the respondents have been hospitalized a total of more than 255 times. Some have spent several years at a time in a single institution. One woman, hospitalized at age sixteen in 1936, spent eighteen years in one state hospital. At least half are part of that population of the mentally disabled who are continually in and out of psychiatric hospitals. One woman for example, has been hospitalized by her estimate at least fifty times in the last ten years. Others have been hospitalized once or twice, and for relatively short periods of time. The historical span of institutional careers represented in this sample goes back as far as 1936. If

\textsuperscript{5}This term refers to jumbled, nonsensical, highly coded, and/or unfocussed verbal content, which is characteristic of the speech of some mentally disabled and psychotropically medicated persons.
we date the beginning of the Patient's Rights Movement at 1974 or 1975,\textsuperscript{6} approximately one-third of our sample was first institutionalized prior to the patient's rights era. We can trace the beginnings of anti-rape and rape victim support services to the mid-1970s also.

**Prior Victimization**

One last salient dimension regarding characteristics of this sample of sexual assault victims is their history of victimization. In recent years researchers have found increasing evidence of the relationship between childhood sexual and physical abuse and subsequent institutionalization (cf. Carmen et al., 1983). Our sample of former mental patients supports these findings. Forty-six percent of our sample was sexually abused as children and thirty percent was physically abused. Seven women (27\%) were raped as adults, at least once before the hospital assault. While prior sexual and physical victimization is clearly important to a clinically-oriented understanding of the traumatic impact of sexual assault on the mentally disabled, these histories are also important in understanding the responses these women had to being victimized in the hospital.\textsuperscript{7}

\textsuperscript{6} It is difficult to "date" a movement. I have chosen 1975-76 as the beginning of significant and broad based efforts for recipients' rights, as it was in those years that NIMH began funding developmental projects in that area, some of the more innovative programs and coalitions were formed (cf. Schmidt, 1977), and several states established statewide advocacy programs (Coye, 1977; VanNess and Perlin, 1977).

\textsuperscript{7} People learn so-called "victim" behavior (helplessness, for example) from the experiences of being victimized. Such behavior may make them exceptionally vulnerable to the actions and manipulations of assailants.
The Assault Sample

Incidents and Sets

Again, my analysis is based on the accounts of twenty-six women who, while confined in psychiatric hospitals, were sexually assaulted on at least one occasion. These twenty-six women reported and described to us eighty separate incidents of sexual assault ("unwanted sexual acts that involved physical touching"). It is clear from these figures that some women we interviewed were assaulted one time, others were assaulted more than once, sometimes multiple times by the same assailant. In order to distinguish between single assaults (one occurrence involving the same assailant, or, in one case, a "gang" assault by a number of assailants) and multiple separate assaults committed by the same assailant, I have analyzed assaults both individually, as incidents, and in terms of what I call sets.

The majority of subjects (twenty) was assaulted once by the same assailant (a single incident); fewer (sixteen) were assaulted more than once by the same assailant (multiple incident "sets"). Significant features of the assaults sometimes changed over the course of a "set." For example, the

---

8 Some described sexual encounters which they did not define as assault, but rather, as consensual. One woman described a consensual sexual liaison with a psychiatric technician and another woman described how a janitor paid her to perform fellatio on him "every day [she] was there" (she was a patient there for six months). Although these last two incidents are significant in terms of understanding the broader issue of sexual safety within treatment environments, the subjects did not consider them assaults. The accounts were not included in the assault data base, the former, because the subject didn't define it as assault, and the latter, because the total number of separate incidents (conservatively estimated as eighty) and the circumstances under which it occurred made it a unique case.
nature of the sexual act committed by the assailant could change, as could the location or duration of each assault. Only the identity and identifying characteristics of the patient, the assailant, and the facility in which the assault occurred necessarily remained constant. Absence of change in situational features from one incident within a set to the next provides evidence of an opportunity structure under the control of the assailant, to the extent that he is manipulating a constant set of environmental factors. The use of the concept of "set" to encompass all sexual incidents involving the same assailant is intended to capture the emergent definitional as well as strategic properties of sexual assaults. For example, if the patient did not resist during the initial assaultive encounter, the assailant would be likely to define to himself (and, if caught, to others) her response as "consensual." Furthermore, the victim may come to see herself as "consenting," or at least complicit in the act.

A "set" refers to assaults committed by the same assailant on the same victim and within the same period of confinement. Twenty sets included a single assault incident. Sixteen included multiple assaults carried out over a period of time. The period of time may be as short as several hours. For example, Alice was assaulted six times during three or four hours of a single night shift. The assailant, a psychiatric technician, entered her room on six separate occasions, each time committing another unwanted sexual act against her. The assault set with the longest duration occurred over a three year period and involved four separate sexual assaults by a staff physician.

\[^9\] In order to facilitate readability, I refer to respondents using pseudonyms. I also coin pseudonyms for the facilities mentioned in quoted passages from interviews.
Those aspects of assault sets that are subject to change from one incident to the next are presented in terms of their distinct "incident" properties. These mutable assault features include the nature of the sexual act: the patient's definition of the act; the time, duration and location of the incident; the assailant's approach and demeanor; the patient's mental condition and circumstances at the time of the assault; the reactions of the victim during the assault and immediately afterward; and the victim's circumstances at the time of the assault. Those aspects which are relatively fixed are presented for the set as a whole. These include the personal characteristics of the victim and the assailant and the type of facility in which the assaults occurred. Because post-assault reactions are constructed over the duration of the set, they are also described for the set as a whole.

My sample of assault accounts includes eighty separate assault incidents and a total of thirty-six sets. Of the eighty incidents, twenty occurred within single incident sets and sixty occurred within sixteen multiple incident sets ranging from two to ten separate incidents per set.

**Assailant Characteristics**

Assaults were committed by both patient-assailants and by staff-assailants. Eleven of the thirty-six assault sets were committed by patient-assailants and twenty-five were committed by members of the staff. The staff-assailants included men from every strata of hospital organization, except hospital administration. Table VI in the next chapter shows the distribution of assailant status (per set).
As I will demonstrate in my discussion of the assaults and their social aftermath, the status of the assailant significantly conditions the character of the assault, its meaning for the victim, how staff respond if it is reported, and, indeed, the degree to which sexual assaults (or false accusations) are seen by staff as an anticipated or expected risk of hospitalization. According to staff we have interviewed, patient-to-patient assaults are more frequent than assaults perpetrated by staff. Assaults by members of the staff were generally described by institutional personnel we interviewed as either nonexistent or as infrequent occurrences. These staff subjects described intrapatient violence and abusive sexual behavior as far more frequent than staff-to-patient abuse, as indeed, an unavoidable consequence of housing mentally unstable persons, some of whom are excessively aggressive or violent. Because very few assaults are reported to them, staff have no real way of knowing whether assaults by patients or assaults by staff are more frequent. What is clear, however, is that patient-to-patient assaults are more visible than assaults committed by staff members. Assaults committed by patients are also much less problematic for staff to detect and prevent, partly because they often take place publicly. Peer-perpetrated sexual overtures and acts, when they are assaultive (i.e., unwanted), may be more clearly seen as such by patient-victims than similar acts committed by staff because the dependency and power differences which characterize the patient-staff relationship may obscure clear definition by the victim. Peer-perpetrated assaults are also more expected and recognized risks of institutionalization according to staff. As such, they are more likely to be reported and are more easily handled by staff and administration.
Nature of the Sexual Acts Committed

Our original research design called for a narrow focus on rape, rather than the range of behavior that constitutes sexual assault and abuse. Soon after we began our study, however, we expanded our focus to include the widest possible range of sexual acts. We also included in the sample of assaults many acts which do not conform to the "popular" definition of rape as a violent act and, instead, defined assault as "any unwanted sexual touching." Our respondents provided us with a wide range of accounts in terms of types of sexual acts as well as manners in which the assaults were conducted. Table III shows the frequencies of sexual acts included in the accounts.

<table>
<thead>
<tr>
<th>Sexual Acts by Incident</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercourse</td>
<td>37</td>
<td>46.3%</td>
</tr>
<tr>
<td>Digital Penetration</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Fellatio</td>
<td>5</td>
<td>6.3%</td>
</tr>
<tr>
<td>Masturbation</td>
<td>5</td>
<td>6.3%</td>
</tr>
<tr>
<td>Fondling (direct)</td>
<td>5</td>
<td>6.3%</td>
</tr>
<tr>
<td>Fondling (over clothing)</td>
<td>17</td>
<td>21.3%</td>
</tr>
<tr>
<td>Frottage (over clothing)</td>
<td>6</td>
<td>7.5%</td>
</tr>
<tr>
<td>Kissing</td>
<td>3</td>
<td>3.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Vaginal intercourse comprised the largest single category of unwanted sexual acts committed (a count of 37 incidents or 46 percent of the total). Other serious sexual assaults accounted for eleven separate incidents. Twenty-two of the assaults involved fondlings, some of which were the first step of an escalating assault series by the same assailant. In one case, the nature of the sexual act(s) committed against the patient is unknown because she was unconscious during most of an apparent "gang" assault.
The Question of Rape

Just how many of these assaults could be legally considered "rape" depends on how rape is defined and who is doing the defining. Some of the assaults we were told of definitely were not acts of rape, according to legal definitions, but other types of sexual assault. In the strictest sense, "rape" is a legal term which, in California, refers to acts of heterosexual intercourse which are exercised without the consent of the victim. 10 California law recognizes and defines other sexual assaults as criminal conduct. These include sodomy ("sexual contact between the penis of one person and the anus of another person" - Sec. 286); oral copulation ("the act of copulating the mouth of one person with the sexual organ or anus of another" - Sec. 288a); anal or genital penetration by a foreign object (foreign object includes any part of the body except a sexual organ). California law also specifies the crime of "sexual battery" which includes "touching (the skin) of an intimate body part of another person," against that person's will, "for the purpose of sexual arousal, gratification, or abuse" (Sec.243.4). Sexual battery includes such acts as masturbation and directly fondling the breasts, genitals, groin, and/or buttocks. Sexual acts which do not involve directly touching of a person's skin are covered by simple assault and battery laws, for example, fondling a person over her/his clothes and "dry humping," an act of frottage when the person is fully clothed.

10California penal code (Sec. 263). Consent is defined by California Law as "positive cooperation in act or attitude pursuant to an exercise of free will. The person must act freely and voluntarily and have knowledge of the nature of the act or transaction involved" (Sec. 261.6).
The issue of consent is at the heart of defining when a sexual act is criminal behavior. The circumstances which preclude consent are specified in the states' statutes. In California, these circumstances include the perpetrator's use of force or threat of bodily harm; the victim's inability to resist because of any intoxicating, narcotic, or anesthetic substance; and the victim's cooperation "because the perpetrator threatened to retaliate in the future against her or any other person, and there is a reasonable possibility that the perpetrator will execute that threat." Sexual intercourse and other sexual acts accomplished with a person incapable of giving consent because of "lunacy or some other unsoundness of mind" are considered rapes, or some other class of sexual assault, in California and most other states. In spite of the ambiguity and complexities regarding the issue of consent and the capacity to consent associated with some of these accounts, each of the sexual acts included in this study was (at the time of the interview) defined by the subject as "unwanted." All but eight incidents were clearly nonconsensual at the time they occurred.

According to the strict legal definition of California's penal code, the incidents reported by our subjects could be categorized as including: thirty-seven (perhaps thirty-eight) rapes, six other sexual assaults (five acts of oral copulation and one act of digital penetration), and ten acts of sexual battery (six acts of masturbation and four acts of fondling). Twenty-six of the sexual assaults reported to us would not be classified as sexual assaults (or batteries) under the strict criteria of California's penal code because they did not involve direct touching of the person's skin or because they simply aren't covered (i.e., kissing). Instead they could be classified as simple assaults or batteries.
Table IV below shows the distribution of sexual assaults covered in this analysis according to these legal categories. Included as acts committed with force or threat of bodily harm are all acts committed when the victim was in physical restraints. Included under the heading of drugged or intoxicated are incidents when the victim described herself as "heavily" medicated, unconscious (1) or drunk (1). Included within the category "mentally confused" are those incidents which occurred when the woman recounted that she was hallucinating, unstable, "out of it" and/or had recently undergone electroconvulsive therapy.

### TABLE IV
**TYPES OF ASSAULTS BY PENAL CODE CRITERIA**

<table>
<thead>
<tr>
<th>Act</th>
<th>Use of Force</th>
<th>Use of Drugged, Apparent Consent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Force</td>
<td>PostECT</td>
<td>Confused</td>
</tr>
<tr>
<td>Rape</td>
<td>6</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Other Sexual Assault</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Battery</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other Battery</td>
<td>5</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total** 17 (21%) 38 (48%) 21 (26%) 4 (5%) 80

This distribution demonstrates that the majority (69 percent) of the assaults were conducted under circumstances easily characterized as "forcible," either because of the direct use of force (21 percent) or because the victim was heavily drugged, confused due to electroconvulsive therapy, intoxicated, or unconscious (48 percent). Twenty-six percent of the assaults occurred when patients were passive or confused because of their mental
condition. In other words, more than half of the incidents reported to us could fit the legal definition of forcible rape even if the victims had not been mental patients, because there was a clear absence of consent by the victims and the use of force and/or physical injury (or the threat of physical injury) accompanied the acts.

Several of the assault accounts were more definitionally problematic. They were, at least in part, conducted under conditions which the assailants may have construed as consensual. In one example, the patient described herself as "going along with" the staff assailant's sexual demands, after she made a discounted complaint to other staff. In another, the patient "went out with" two different staff members, once after she was released to a half-way house and another time when she was taken out of the hospital on a pass. These examples of ambiguous assaults demonstrate a) how an assailant may construct a relationship between himself and his disabled victim which "legitimizes" his behavior and has the potential of misshaping the meaning of the act for the victim and, b) the power of institutional personnel, whether assailants or other staff to whom patients make verbal complaints, to misname the acts "for" the victims thereby creating "victims without redress."
The Facilities — The Loci of Patients' Accounts

Facility Characteristics

This assault sample involves twenty-three separate psychiatric facilities in ten different states. Some hospitals were mentioned just once and six hospitals were the site of two or more assault sets. In spite of widespread lore, myth, and informal opinion that public hospitals are for some reason or another "worse" than private hospitals, the sample was evenly divided among both types of facilities. State hospitals, probably because they are places where people are confined for longer periods of time, accounted for the largest number of assault sets (sixteen). However, there is little difference in the distribution of separate incidents among hospital types. While the largest single number of incidents occurred in Veteran's Administration hospitals, the incidents were part of just three sets, all involving the same woman. Table V shows the distribution of incidents and sets by type of hospital.

Table V

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Sets</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>County Hospital Unit</td>
<td>8</td>
<td>22.2</td>
</tr>
<tr>
<td>Private Hospital Unit</td>
<td>6</td>
<td>16.7</td>
</tr>
<tr>
<td>Private Psych Hospital</td>
<td>8</td>
<td>22.2</td>
</tr>
<tr>
<td>State Hospital</td>
<td>10</td>
<td>27.8</td>
</tr>
<tr>
<td>V.A. Hospital</td>
<td>3</td>
<td>8.3</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
While the assault sample was nearly evenly distributed among hospital types, the sample was radically uneven in terms of one distinguishing physical feature of psychiatric facilities. The overwhelming majority of assaults, twenty-five of the thirty-six sets, occurred in locked units — insular environments which, by their very nature, constrain patients' mobility (ability to run or stay away from assailants) and, by tradition and active organizational processes (e.g., decentralization of authority and control), may inhibit outsider\textsuperscript{11} awareness of actual or potential mistreatment. Four assaults occurred within environments that were partially "secured" — open units within locked hospitals. Five occurred in hospitals that were completely open.

**Caveats and Limitations of Method**

In spite of my emphasis on the social and physical context of institutional sexual assaults, my study is not about hospitals per se. I have not yet had an opportunity to observe everyday psychiatric ward life and the ways in which staff deal with patients' complaints of various forms of abuse, or analogous situations or events. This represents a significant limitation on the generalizability of my findings, and on my ability to discover theoretically and interpret the sociological aftermath of rape and assault allegations. Part of the problem will be met with a full analysis of staff

\textsuperscript{11} By "outsider" I mean anyone who doesn't work on the unit itself, including other facility staff, administrators and social workers. Story after story by staff informants stresses the insider–outsider nature of psychiatric wards.
accounts, which is not included in the present work. However, we must await other research, which focuses on the handling of patient complaints within specific institutional environments, to understand more fully the social relationships and processes by which cycles of institutional abuse are maintained.

Particular hospitals are not the unit of analysis in this study, primarily because it was first necessary to establish a counterfacticity to the overwhelming lack of awareness of mental health administrators (those who ultimately provide researchers with access to hospitals) regarding the problem and prevalence of institutional sexual assault. It was important, as well, to demonstrate that the problem of sexual assault in psychiatric hospitals could be handled in a way that does not sensationalize the issue or "blame" hospitals. Beyond these political concerns, I was also concerned with mapping the broadest descriptive parameters of the problem and identifying the right questions to ask. It would not have been necessary to conduct observations in particular hospitals, even if a hospital has been willing to allow us full access to staff and patients, for the purpose of sampling their accounts of abuses and accusations. Thus, what follows is a special "ethnography," one which describes sexual violence and abuse within a type of environment, not from extensive field work but from creating and then analyzing a "field" of accounts.
Chapter Three

Patterns of Sexual Assault in Mental Hospitals

Introduction

In this chapter I present an analysis of victim assault accounts in terms of those dimensions which identify the institutional specificity of the assaults and the processes through which an "opportunity structure of rape"\(^1\) is created and manipulated, focusing on the assaults themselves and the specific patterns of institutional rape which emerge. I will discuss the following elements: status of the assailants, the nature of the sexual acts, temporal properties of the assaults, locations of the assaults, circumstances of the patient at the time of the assaults, assailants' approaches, and victims' immediate responses to the assaults.

The usefulness of analyzing this descriptive material lies, in part, in uncovering obscure and even obfuscated aspects of a previously invisible form of suffering. But analysis also, of necessity, reduces human experience to the smallest units of description and then reorganizes them in a scheme which only partially reflects the original individual context. The power and poignancy of each woman's account may be lost in this treatment. Indeed, looking at a full account of just one woman's experience, we could

\(^1\) I use the concept of an "opportunity structure" to refer to the organized processes and relations within the setting, which are consciously exploited by institutional assailants. This idea will be discussed throughout this thesis.
understand much of the phenomenon in question. By looking at the accounts of many women, on the other hand, I have found variation in the assaults and their sociological aftermaths. The analysis of variation illuminates the theoretical parameters of the problem and supports my objective: the development of a formal theory of institutionally situated sexual assaults. As a consequence of selecting certain unifying dimensions with which to organize my understanding and presentation of this collection of varied accounts, I recognize that the pathos of individual accounts which could have been retained were my format that of a selection of case studies, has been lost.

Assailant Status

The distinction between assaults committed by patients and those committed by staff is primary to this analysis, because of the differences in power each group exercises within an institution. Power differences of both kind and degree are expressed empirically in the way the assailants conduct the assaults. Post-assault victim reporting is also affected by assailant status. Sexual assaults committed by other patients present the patient-victim with fewer problems in defining the act and seeking redress. Sexual assaults committed by other patients more fully conform to staff and patient expectations of unavoidable risks associated with housing and caring for unstable people. Sexual assaults committed by members of the staff, especially ward caretakers or therapists, are presumed to be rare (according to hospital staff and administrators) and are unexpected. I will present data here which suggest that assaults by staff are not rare, but rather,
undetected, underreported, and, therefore, invisible risks of confinement in any psychiatric hospital.

The most frequently reported class of assailant in this study was ward level staff — orderlies, aides, psychiatric technicians and, in one case, a male nurse. These staffs, whom I refer to as "caretakers," have the most continuous contact with patients; they also represent the largest single group of psychiatric hospital personnel. For these reasons alone, we might anticipate that caretaker staff would be the most frequently named class of assailant. Table VI shows the distribution of assailant status and the number of incidents committed by each class.

| TABLE VI |
| STATUS OF ASSAILANTS |
| Number of Assailants | Number of Incidents |

<table>
<thead>
<tr>
<th>Ward Staff:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Aides</td>
<td>13</td>
<td>40</td>
</tr>
<tr>
<td>Nurse (male)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Orderlies</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Professional Staff:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Ancillary:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Janitors</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Guard</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>EEG Tech</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Patients</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Out-Patients</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Penal Code</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>36</td>
<td>80</td>
</tr>
</tbody>
</table>

The majority of assaults were committed by members of the staff. Seventeen, or 47.2 percent of the named assailants were ward level staff
members who accounted for 61 percent (or forty-nine) of all reported assaults and 65 percent (twenty-eight of forty-four) of the most serious sexual assaults (which involved intercourse and other acts of sexual penetration). Seven incidents (five sets) were committed by ancillary hospital staff with little or no responsibility for patient care. Three of the reported cases involved janitors, and one assault was committed, ironically enough, by the county sheriff's deputy assigned to provide security to the locked county facility. One assault was committed by an EEG technician when he was supposed to be conducting a prescribed test on the patient-victim. The assaults committed by ancillary staff demonstrate the range of risks to which patients are exposed, as well as the need for improved screening and supervision of this element of institutional staff. We have been told that some employees see sexual access to patients as a "fringe benefit" of employment.

In three cases the named assailant was a psychiatrist. Two of the cases involved young victims. In one case, the adolescent patient was fondled several times and forced to masturbate the doctor. The other case involved at least three rapes, conducted over a two-and-a-half year period, starting when the patient was twelve years old. The power of psychiatrists to sexually exploit patients is extraordinary, as they can construe assaults as consensual "seductions" which patients are not likely to report, especially when the psychiatrist-assailant's sexual "overtures" are accompanied by bribes.

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We have not yet heard of an instance where these issues are addressed formally in staff orientation and certainly not for ancillary staff such as janitors. I wonder what the impact would be of providing training to all staff on what behavior constitutes sexual assault and abuse, and the penalties for transgressions.
such as weekend passes and the promise of early release. In addition, psychiatrists have privacy enjoyed by very few others within psychiatric hospitals — space and time to construct the kind of seductive rapes which are seldom reported. As Brownmiller writes:

All rape is an exercise in power, but some rapists have an edge that is more than physical. They operate within an institutional setting that works to their advantage and in which a victim has little chance to redress her grievance. Rape in slavery and rape in wartime are two such examples. But rapists may also operate within an emotional setting or within a dependent relationship that provides a hierarchical, authoritarian structure of its own that weakens a victim's resistance, distorts her perspective and confounds her will (1975: 283).

In the psychiatric hospital setting, caretakers and therapists are those most able to "distort and confound" a patient's ability to resist sexual assaults. Caretaking staff members have delegated and legitimate authority within the hospital context, which allows them significant coercive power over patients — the power to do what they will over and against the will of the patient-victim. Staff also have the emotional power to compromise the victim's resistance, and indeed, misshape the meaning of social acts. Ward level staff have greater capacity than others in the institutional environment to control and manipulate the setting itself because they have the most intimate, daily knowledge of the special conditions which make patients particularly vulnerable. For example, they know when patients are chemically or physically restrained, disoriented, or secluded; which patients are least likely to be believed, most disliked by staff, and least likely to report or emerge from passivity, and who would be an "easy" target. Ward level staff also understand how the ward functions, who is on duty, and how fellow workers are likely to work and behave on any given day or shift. Ward level staff are, therefore, best able to set up and control situations whereby they
can exploit the vulnerability of patients with impunity. In particular, ward level staff have almost "free access" to patients during night shifts.

Patient-assailants account for eleven sets of sexual assault (a total of seventeen separate incidents). Although patients share the same physical access to vulnerable patient "targets" as caretaking staff, they are less able to manipulate the "opportunity structure" of assault. Patients are part of the "supervised" class of environmental participants, rather than the "supervisors." In cases where a patient violently raped another patient, we can see how staff is implicated, either because of inadequate supervision or, in the case of one assault, night staff apparently set up and allowed the rape of a female patient by a penal code patient. Less serious sexual assaults (fondlings) committed by patients were often observed and curtailed by staff, or else the targeted patient was able to resist effectively, without staff assistance.

**Type of Assault**

Table VII shows the frequency of each type of reported assault. Forced intercourse comprised the majority of the assaults. Notice our subjects reported thirty-six (thirty-seven, if we include the "unknown" incident) separate incidents of forced intercourse. Using the set perspective outlined in the previous chapter (grouping single acts committed against a patient by the same assailant), nineteen of the sets involved vaginal intercourse as the single (ten) or most serious (nine) sexual assault within the set. Other sexual assaults, involving physical penetration (oral copulation or digital penetration),
accounted for six separate incidents, and were the single or the most serious act within four sets. Thirty-nine of the incidents could be categorized as sexual battery; most of these involved the direct (explicitly sexual) touching of some part of the woman's body; none were at all ambiguous in intent. An isolated act of fondling, especially if it is over clothing, may be sufficiently ambiguous to disguise the assailant's intentions. A fondling may serve as a "test" of the way the woman is likely to resist, yell, or report, if the assault is escalated.

TABLE VII
TYPES OF ASSAULTS

<table>
<thead>
<tr>
<th>Incident</th>
<th>Incidents</th>
<th>Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercourse</td>
<td>37 (46.3%)</td>
<td>19 (52.8%)</td>
</tr>
<tr>
<td>Digital Penetration</td>
<td>1 (1.2%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>Fellatio</td>
<td>5 (6.3%)</td>
<td>3 (8.3%)</td>
</tr>
<tr>
<td>Masturbation/Assailant</td>
<td>4 (5.0%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>Masturbation/Victim</td>
<td>1 (1.2%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>Masturbation/Assailant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation/Victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation/Assailant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation/Assailant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation/Victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation/Victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fondling under clothing</td>
<td>5 (6.3%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>Fondling over clothing</td>
<td>17 (21.3%)</td>
<td>5 (13.9%)</td>
</tr>
<tr>
<td>Frottage</td>
<td>6 (7.5%)</td>
<td>2 (5.6%)</td>
</tr>
<tr>
<td>Kissing</td>
<td>3 (3.7%)</td>
<td>2 (5.6%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (1.2%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>Totals</td>
<td>80 (100.0%)</td>
<td>36 (100.0%)</td>
</tr>
</tbody>
</table>

Before the interviewing began, I had hypothesized that "lesser" assaultive acts would be the modal assault reported to us, because they expose the assailant to less risk of being caught in the act and less severe punishment, if reported. Fondling, for example, is more easily concealed than intercourse, and can be done so quickly that the victim herself has little time to define the situation as an assault and react accordingly. Forced masturbation and fellatio, although certainly serious assaults, may take less
time than assaults involving vaginal intercourse, require less physical space and, and do not, like intercourse, require that both victim and assailant be partially undressed. Furthermore, sexual fondling and acts of masturbation or frottage do not usually leave physical evidence to corroborate the victim's story. I had also assumed that assailants might reason that victims would be disinclined to complain about or formally report those abuses which do not fit commonplace definitions of "rape" and, therefore, commit non-intercourse assaults more frequently than acts involving intercourse.

Assailant Status and Type of Assault

It is possible that the surprisingly high number of assaults involving forced intercourse reported to us is an artifact of the research design because women are more likely to define as "sexual assault" those acts involving forced intercourse than unwanted sexual fondlings. Therefore, our advertisements for research subjects who had been "sexually assaulted or abused while a patient in a psychiatric facility" might have drawn a biased response. I am inclined, however, to consider these accounts potentially representative of institutional assaults committed by staff-assailants. The ward staffer can exercise great control over the situation. He can read the "opportunity structure of rape," determine how to minimize his risks, and carry out the acts of his choice. Analysis of the range of assaults committed by different types of assailants supports my point that staffers exercise sufficient power over the situation to allow them to get away with serious sexual assaults more easily than patient-assailants. Staff assaults (Table VIII)
consist primarily of intercourse and other serious sexual assaults, while assaults committed by patient-assailants do not include "intermediate" sexual acts such as fellatio and masturbation. Instead, patient-perpetrated assaults are either vaginal intercourse, in the extreme case, or much less severe assaults which were discovered by staff or effectively resisted by the patient-victim before they escalated by the patient-victim. The distribution of sexual assault acts within both populations of assailants suggests that staff-assailants will use patients to gratify a wide range of sexual impulses. Assaults committed by patients are far less diverse and seemingly less calculated, yet, our data show that assaults by patients are more likely to be forcible or violent because a) patient-assailants were violent to begin with (at least one patient-assailant in our sample of assaults was, according to the victim, a known rapist), and/or b) patient-assailants' repertoires of tactics are narrower than staff-assailants because they have less control over and within the setting.

### TABLE VIII
SEXUAL ACTS (SET) BY ASSAILANT STATUS

<table>
<thead>
<tr>
<th>Sexual Act</th>
<th>Staff</th>
<th>Patient</th>
<th>Set Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Intercourse</td>
<td>11</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Digital Penetration</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Fellatio</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Masturbation</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Fondling</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Frottage</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Kissing</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>25</td>
<td>11</td>
<td>36</td>
</tr>
</tbody>
</table>

One difference between staff and patient-assailants, which is even more significant than the types of assaults they committed, is the number of
more significant than the types of assaults they committed, is the number of assaults they committed against a single victim — what I refer to as the set size. As stated in Chapter II, sixty of the eighty separate incidents occurred within multiple assault sets (ranging from two to ten separate incidents). These are very unevenly distributed between patient and staff-assailants. Only 40 percent of patient-perpetrated assaults involved multiple incident sets, as compared to almost 85 percent of those assaults committed by staff. The multiple incident sets involving patient-assailants were committed by two men. One involved four incidents where the woman was accosted and "dry humped" on a stairwell until staff discovered and stopped the assailant. The other involved an outpatient who raped an inpatient while she was out on a pass on a date with him; he subsequently fondled her on two other visits to the facility.

The staff-assailants most frequently involved in multiple incident sets were ward-level caretakers. This makes sense considering their greater and more continuous access to patients. An abuser within the ranks of the caretaking staff is in the best position to calculate and manipulate successfully the opportunity structures of rape, thereby reducing the likelihood of detection and prolonging the duration of sexual abuse.

Temporal Dimension of the Assault

There are two aspects of assaults that involve time. One is when the assault occurred. The other is the duration of the assault, which includes the duration of individual incidents as well as the duration of the set as a
whole. Both temporal aspects are imbedded in the special ways time is organized in a hospital.

All hospitals organize the twenty-four hours of the day into three "shifts," time spans to which particular groups of people are assigned to work. This enduring feature of hospital organization means that the nonpatient composition of the setting completely changes every eight hours. During two of the shifts — evening and night — the number of professional personnel is reduced. The evening and night shifts, as well as shifts on weekends and holidays, are generally run by relatively small staffs whose obligations are mostly custodial. These understaffed shifts are also times when few outsiders (including family, friends, and few professional staff, such as therapists, social workers, and patient advocates) have access to the ward, and patients are most dependent on ward staff.

**TABLE IX**

ASSAULT FREQUENCIES BY SHIFT$^3$

<table>
<thead>
<tr>
<th></th>
<th>Incidents</th>
<th>Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weekdays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day shift</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>Evening shift</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Night shift</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Between shifts</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>68</td>
<td>30</td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>100.0%</td>
<td>99.9%</td>
</tr>
<tr>
<td><strong>Sets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day shift</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Night shift</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Between shifts</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>68</td>
<td>30</td>
</tr>
</tbody>
</table>

$^3$We were unable to determine the shifts when six sets occurred, which represent a total of thirteen incidents.
Fifty-four percent of all incidents (and at least 58 percent of the most serious assaults) occurred during undersupervised shifts. These evening, night, and weekend assault incidents were fairly evenly divided among assailants of different statuses. When considering the relationship between shift and occurrence of sexual assault incidents and not controlling for the way assaults are organized by assailants into sets, night shifts are not necessarily more dangerous than day shifts, nor weekends more dangerous than weekdays. Indeed, day shifts on weekdays accounted for the highest number of individual incidents on any one shift.

However, there is a strong relationship between shift and the likelihood of sexual assault when assaults are evaluated in set terms. Thus, when we control for differences among individual assailants, we find that undersupervised shifts (i.e., all shifts other than weekday day shifts) accounted for 68 percent of the assaults. If we also consider that staff were most often implicated in multiple incident sets, we can conclude that patients are much more likely to suffer multiple and longer-term sexual abuse during undersupervised shifts than during highly supervised day shifts.

There was some difference between day shifts and undersupervised shifts in terms of the seriousness of the assaults. Sixty percent of all incidents involving intercourse and other acts of penetration occurred during undersupervised shifts, and forty percent during weekday day shifts. Less serious acts were more evenly divided among shifts.

Assaults committed by other patients were much more likely to occur during undersupervised shifts than highly supervised day shifts. Eighty percent of all patient-perpetrated assaults, when analyzed in terms of sets, and sixty
percent of all individual incidents involving patient-assailants occurred during undersupervised shifts. Assaults committed by members of the staff were almost equally divided between highly supervised and undersupervised shifts.

The durational dimension of assaults is more clearly connected to the institutional context than the shift on which it occurred. Few incidents lasted more than fifteen minutes.\(^4\) This feature of the data suggests that patient supervision involving less than constant surveillance will not minimize the risk of sexual assault in facilities. It also demonstrates how easy it is for assailants to commit even the most serious assault within a short enough time frame to avoid detection and, in the case of staff-assailants, avoid being missed by other staff.

Three assaults lasted more than thirty minutes. These cases are so exceptional that I examined them individually in order to understand their special conditions. One assault, committed at night by a patient who locked himself in a single bedroom with another patient,\(^5\) lasted a little over thirty minutes. Two assaults lasted more than an hour. One of these took place off premises, when the patient, out on a pass and by prearrangement, met a psychiatric technician at a nearby motel. The second lasted a little over an hour. The assailant was an EEG technician and the patient-victim was brought to him for testing. He assaulted her during the exam and did not release her until the time her test normally would have ended.

\(^4\)Fifty-seven incidents (76 percent) lasted fifteen minutes or less. Fifteen incidents (20 percent) lasted an estimated fifteen to thirty minutes. The remaining three lasted one or two hours.

\(^5\)The door to the room was set so that it could be opened from the outside but, when closed, it was locked from the inside. The assailant entered the room and closed the door behind him. The victim was unable to escape and it was approximately half an hour before her pounding on the door brought the staff to investigate.
Duration of Multiple Incident Sets

An examination of multiple assault sets provides us with examples of two patterns of sexual abuse, which are specific to the institutional context: "shift" assaults (multiple incident assaults which take place entirely within a single shift) and longer term sexual exploitations, which take on the quality of a pseudoconsensual relationship. Four of the women we interviewed described shift assaults, all committed by staff members. Eleven women described long term "relational" abuse, ranging in duration from one week to three years.

Alice and Jan were both subjected to "shift" assaults. Alice was assaulted six separate times during a two to three hour period on a single night shift. Her assailant was the psychiatric technician assigned to do bed checks during the first half of the shift. Alice's assailant conducted his assault during a three hour period (his half of the duty). Each assault lasted no more than a few minutes. Neither the set nor any incident lasted long enough to generate suspicions on the part of the other staff. Alice, who had a poor reputation among staff (as a "troublemaker"), did not yell out or physically resist any of the incidents, and waited until the next shift to report the assault. She was afraid that telling would be misinterpreted by the other staff, and consequently, that she would be more vulnerable to the assailant and her release would be delayed. Instead she tried to unobtrusively

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6 From interviews with other ward staff of the same hospital, we learned that the two technicians assigned to the night shift routinely split the shift so that each can sleep for four hours. Needless to say, this informal practice is kept secret from administrators, and if a patient is injured (including sexually injured) during such a time, the hospital could easily be found negligent.
attract the attention of other staff (hoping they would discover the assault) with a series of noises (banging her foot against the bed screen, for example). She met each sexual act with silence and the assailant continued to escalate his assaults five times. If Alice had not reported the assaults the next day, the assailant might have continued to abuse her, perhaps thinking that since she did not tell him to stop, she didn't mind.

Jan's experience was very different from Alice's. The assault set lasted about thirty minutes, was conducted during a shift change when fewer staff were actively supervising patients, and consisted of two separate incidents. The first incident was "consensual" — she performed oral sex on a janitor, in exchange for his promise to bring her some marijuana. After that act, he asked her to meet him by the elevator on another floor, out of view of the ward staff. Then he took her to the basement, a locked area to which only staff had access, where he forced intercourse upon her.

Location of the Assault

Most of the assaults took place on the ward, either in the victim's bedroom or in a seclusion room. This is consistent with our finding that the largest single group of assailants is ward staff. The range of physical locations exploited by assailants reflects the institutional hierarchy, as it is

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7The units were themselves unlocked and patients could move between units and floors of the hospital. The hospital itself was locked so that patients could not leave without assistance.
expressed in "territory." Assailants use those physical spaces over which they exercise control. Ward staff assault patients in their bedrooms, seclusion rooms, treatment rooms and bathrooms (when they are charged with escorting patients there). Psychiatrists use their private offices (coded here as treatment rooms). Janitors use closets and basements. Patient-assailants assault other patients in their bedrooms and in those public areas to which they have access such as hallways and stairwells. Table X shows the distribution of locations used by each category of assailant.

TABLE X
ASSAILANT STATUS BY LOCATION OF ASSAULT

<table>
<thead>
<tr>
<th>Location</th>
<th>Patients</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedrooms</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Seclusion</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Bathroom</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Treatment</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Stairwell</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Tunnel</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Basement</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Closet</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other Inside</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Grounds</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Off Grounds</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>16</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>

Off-grounds assaults require special mention.8 In some cases, the woman was a patient and was assaulted (or sexually exploited) while out on a pass. Two women had been discharged. One assault, committed by an outpatient, was a "date" rape in which the assailant took the adolescent victim out on a

8These cases were included in the analysis because each was part of a multiple incident set, which either started or ended within the facility. Those incidents which may appear to have been consensual are included because they were defined as assault or abuse by the respondents.
pass to his apartment and raped her. The remainder were committed by caretaker staff (psychiatric technicians and orderlies), and involved three different patients.

In one case, the adolescent woman and a friend were out on day pass with a staff escort (a psychiatric technician assigned to the adolescent ward). The escort made a pass at the young woman. This "test" assault, consisting of touching the woman's buttocks while making suggestive remarks, was followed up several days later when the technician (escort) asked her if she wanted to go into her bedroom with him. Although the woman had tried to avoid him in the period between the two incidents, because she was "afraid it would happen," she went with him into her room where they had intercourse. The off-premises location of the initial assault was incidental to the incident which followed; the testing could have occurred as easily on the ward.

In another case, after the patient was released from the hospital, an orderly who had previously assaulted her in the hospital laundry room, came to her home and raped her.

One day, I answered the door and he was there. He was an orderly at Midtown Hospital. And I said well, what are you doing here? And he said he came to finish what he had started. . . . I remember it vividly because I always thought, "How could people be hired such as this?" And I even complained about him [regarding the prior assault]. And how can they get hold of your records? . . . I was raped. There was nobody home.

The final cases involving off-site assaults are more complex because the issue of consent is muddled. Each involved the same woman, Jane, who reported a total of four separate sexual encounters with two psychiatric technicians. The first, a set consisting of three incidents, started when Jane
was being put into a maximum security room. She was afraid to go into the room alone, and as the tech started to lock the door she embraced him. He "reciprocated" with sexual fondlings, including rubbing her clitoris. Later, after she was released to a halfway house, he picked her up twice and took her to places where he could have sex with her. According to Jane, there was no other activity or intimacy during these times to lend a relational quality to their association. Sometime later, during another hospitalization at the same facility, Jane was taken by another "tech" to a local motel for sex. It is not clear how he was able to take her off the unit.

The Circumstances of the Patient-Victim

The fifth dimension of the basic descriptive ground upon which my theoretical treatment of environmentally situated sexual assault rests is the victim's circumstances at the time of the assault. The accounts show that victim circumstances, including state of mind (level of function) at the time of the assault(s) as well as institutionally sanctioned sedation and restraints, strongly influence vulnerability to assault and exploitation, capacity to resist and report assaults, and credibility when assaults are reported.

Mental Condition

Most people are hospitalized because they are defined as a "danger to themselves" — because they are suicidal, self destructive, or unable to take care of themselves. Many are clearly vulnerable to exploitation because of their mental disability. Their basic mental incapacity may be a cognitive
disorder, such as schizophrenia or an affective disorder, such as acute depression, which is evidenced in extraordinary passivity. Nursing staff we have interviewed identify depressed women as extremely vulnerable to exploitation because of their mental disability. They are easy targets of aggressive male patients and difficult to protect without constant surveillance. As one former patient told me,

I had been there approximately forty-eight hours. I was very agitated, and emotionally and mentally ill. I didn't know what was real and what wasn't real. I remember pounding on walls, thinking that they would disappear, that this was all some kind of bizarre dream. And I had no reason to be afraid of anybody, or so I thought. I felt safe. I felt safe because I was in a dream. I literally was in another world. I was hearing voices. . . . And at one point in the evening, I happened to go into one of the patient's rooms. There were two other people there who were listening to music and dancing. And so I started dancing. I was really aware of them there. And I noticed Mike9 sitting on the bed drinking a bottle of wine. I didn't know his name then. And all I can recall is that he took me outside somehow down the main corridor, to the outer portion of the building, the outside area.

I think he saw an opportunity because of my vulnerability, my state of mind, helplessness. Because I was very confused the whole time I was in that place, I didn't even know to ask for the simplest needs. I felt totally lost, and alone.

Passive or confused patients are also taken advantage of by male staffers. Sandy was fondled by a male nurse each night he would take her blood pressure. She described her condition during that hospitalization:

9"Mike" was another patient. He had somehow managed to sneak in a bottle of wine, which suggests how closely patients were supervised during the evening shift in that particular hospital. The subject described how "Mike" followed her around for a few days after the assault and threatened to kill her when he found her with another male patient. He was transferred (or released) right after the subject reported him to the staff.
I was delusional at that time. I was not really coherent in a lot of ways. I was just experiencing flights of ideas and all kinds of delusional things that I remember.

... He would come and take my vital signs at night. And he would touch my breasts. I was wearing a gown. He would touch my breasts with the gown on. And I would always push his hand away. And he continued to do this over a period of two weeks.

... I told him I didn't think he should do that. And he said, he thought it was good for me. . . . I think I wondered if it was part of my therapy. I was very confused.

Patients who are sexually "promiscuous" or "preoccupied" are also extremely vulnerable to abuse and assault. Staff we have interviewed consider these patients most vulnerable to sexual abuse by male patients (the most visible and recognized form of sexual assaults within hospitals). They are "easy targets" because they are likely to cooperate, and because they may continually talk about sex, and "come on" to other patients, staff and others. These patients' reports of abuse may easily be dismissed. Furthermore, the sexual victimization of sexually "preoccupied" patients may be normalized in many hospital settings.

I recently received a phone call from a psychiatric social worker who was concerned because the administrator of the state hospital where he worked refused to establish an all-female unit. Staff there had requested such a unit, because they could not protect many women patients from being exploited by aggressive male patients. This hospital, like most long-term facilities, has many more male than female patients. The units of the hospital are sexually integrated, often at a 3:1 ratio, and male patients "continually hit on the women." The administrator had apparently told staff that he doesn't see a problem.
Treatment Incapacity

Perhaps the most horrifying element we have discovered in the pattern of institutional assault is that most of the victims were significantly restrained (either physically or chemically) and pacified at the time they were assaulted. Table XI shows those "special" circumstances (which are, rather, typical features of patient care in psychiatric facilities), which further disempowered already vulnerable women. At least sixty-seven of the eighty incidents occurred when the victims were incapacitated from drugs, electroconvulsive therapy, or physical restraints. The greatest number of individual incidents as well as multiple incident sets occurred when patients were heavily medicated.

TABLE XI

VICTIM CIRCUMSTANCES AT TIME OF ASSAULT

<table>
<thead>
<tr>
<th>Circumstances</th>
<th>Incidents</th>
<th>Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy Medication</td>
<td>29</td>
<td>13</td>
</tr>
<tr>
<td>Light Medication</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Restraints</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Seclusion</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Post-ECT</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Unconscious</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Drunk</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>None Mentioned</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>No data</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>80</td>
<td>36</td>
</tr>
</tbody>
</table>

Medication enhances passivity and makes physical resistance highly unlikely. Under heavy medication and or in the midst of receiving electroconvulsive therapy (ECT), the patient-victim may be unable to fully understand what is happening. The patient is unable to "name the act," and her ability to marshal the cognitive resources to make and sustain a report
directly after the assault is also compromised. Fifty-three of the assaults occurred when the patient was cognitively impaired by medications or from ECT. These included twenty-five acts of intercourse and, on the other end of the continuum of assaults, twenty acts of sexual battery.

In thirteen instances (seven of which were forcible rapes), the patient was in seclusion and/or restrained. She was not able to resist physically and her yelling went unheard or disregarded as "typical of what people do in such circumstances."

The Approach and Strategies of the Assailant

Assailants approached their victims in a variety of ways. Some acted in a "friendly," sexually aggressive way, as if they were engaging the women in consensual sexual relationships. Others threatened or attempted to bribe patients into being sexually cooperative. Some used extreme physical force. Most assailants physically imposed themselves upon entirely passive patients, in silence. The victims described, in addition to silent impositions (twenty-four), instances in which some degree of force was either threatened (thirteen) or used (eleven); six instances in which the assailant offered drugs, alcohol, food, or an early release if the woman would be sexually cooperative; and eight instances in which staff threatened victims with some institutionally specific punishment, such as seclusion, longer institutionalization or loss of privileges if they didn't cooperate. In seven instances, the woman was specifically warned by the assailant that telling anyone would do her no good because "no one will believe you." These
threats of disbelief were hardly necessary, since few of the women we talked to had prior confidence that they would be believed. Such threats, however, reinforced the discrediting of the self, which is such an essential part of the identity imposed upon mental patients.

Pauline Bart (1981) concluded from her study of rape avoidance that the object of the victim's fear significantly influences the mode of resistance she employs and, hence, the likelihood that she will successfully defend herself against rape. She found from interviewing women who had both been raped and avoided rape that "avoiders" reacted strongly against being raped and were not focused on the possibility of other injury. Nonavoiders were more afraid of the threat injury posed as a consequences of not cooperating. Like the women Bart interviewed, the institutionalized victims of sexual assault we interviewed acted according to the consequences they most feared. Yet unlike the avoiders and nonavoiders interviewed by Bart, our subjects were seldom faced with the use or threat of extreme physical violence. The threats used against them were more imbedded in their status as institutionalized mental patients.

I have identified three classes of threats that are commonly used against mental patient-victims. The first class of institutionally contextualized threats involve direct and indirect threats of prolonged or permanent institutionalization. This threat can only be directly employed by those institutional actors with the power to carry it out — psychiatrists, other therapists, and nursing staff whose evaluations of patients can have significant weight in "treatment decisions." An example is provided by Susan, who was institutionalized as a child, as a result of running away. When sexually fondled during the first assault incident, the psychiatrist-assailant
threatened to have her "locked up forever if she didn't cooperate." She "cooperated" and was raped three times after the initial assault.

Alice (a case mentioned earlier) was afraid that any active resistance to rape would be misinterpreted by the staff as "acting out," and thus, prolong her confinement on the locked ward. This fear, perhaps well-founded, as she had already earned a reputation for being "difficult" and sometimes physically "violent" (toward objects like windows and walls), prevented her from yelling out during any of the six assaults she experienced.

A second class of threats which is peculiar to institutional settings (and to intrafamilial sexual abuse) attacks the would-be victim's situationally fragile sense of self. Words like "no one will believe you [because you are crazy]" were used as assailant warnings in seven of the cases described to us and affected the woman's choice to resist or "cooperate" as well as her choice to report or keep silent. We can construe this class of threats as identity threats. The fear of not being believed was significant for some of the women in our study. Whether disbelief is a more potent injury to mental patient-victims than other rape victims who routinely experience themselves as credible, is a matter of speculation for the present. I think it is reasonable, however, to hypothesize that being actively disbelieved is likely to be less of a shock, but more of an injury, to persons who have been hospitalized as mental patients than to those who have not.

On the other hand, being disbelieved by staff, in response to reporting an experienced assault, could be a powerful contributor to an inmate's self-doubt and the mortification of self described by Goffman (1961). The reminder that they would not be believed effectively stopped some victims from reporting. The reminder that patients lack fully credible selves in the
institutional context is mixed with the spectre of prolonged (or permanent) hospitalization. Patients perceive little likelihood that they will be believed by staff instead fearing they will be viewed as unstable, delusional, or paranoid — all of which may result in augmentation of treatment and/or delayed release. An example is provided by the following account:

... I kept saying, "No!" And then I started going off. And he said "You're starting to get crazy, you're starting to get sick." [When he knew he could not gain her cooperation, he stopped and said] "Come on out and start acting like a regular" and he said things like "You know, you could be locked up for the rest of your life. I've seen your report and I know you are schizophrenic, paranoid. Nobody's going to ever believe you. So it would be best if you'd do like I say and not mention this." [He then pulled her out of the laundry room and called the staff. He told them she was getting out of control].

A third class of threats which may be used to gain the "cooperation" of would-be victims involves some kind of institutionally-meaningful punishment. Examples include being placed in physical restraints or into a seclusion room (or both), being "chemically restrained" with heavy tranquilizers, and being downgraded in the hierarchical structure of privileges conferred to "good patients" and thus, losing mobility privileges. Closely associated with this class of threats is the promise of rewards for cooperation, an effective approach for the assailant/abuser, as he not only secures sexual "gratification" but ostensibly redefines for himself the act as "prostitution," or at the least "consensual," and thus disavows the extreme deviance of his act. The victim's acceptance of payment, even though she may be mentally unable to understand the act or to positively choose to engage in sexual relations, may also influence how others define the act.

A recent New York case is a perfect example of this point. A mental
health worker took a young female schizophrenic patient into a hospital closet where he engaged in sexual intercourse with her. The incident was discovered. He claimed it was consensual because he had paid her ten dollars. The hospital suspended him without pay. However, subsequently, the labor arbitrator ruled that he should be reinstated because the intercourse was consensual (her acceptance of pay was considered consent), and "whatever physical abuse was involved was minimal." The New York Appellate Division overruled the arbitrator's decision, noting that "mental patients are incapable of giving consent in the context here presented" and that the assailant's act "constituted rape in the third degree" (New York Post, June 19, 1983: 14).

Within the context of a mental hospital, such payment, as well as other forms of bribery, are a form of coercion. Within the closed context of an institution, life can be extremely bleak and a clandestine system of rewards may be all that moderates the meanness. The fear that such rewards will be lost or never gained can be used by the assailant and construed by the patient-victim as a threat.

We can see how these classes of threats are grounded in the hospital milieu by the varied usage among different classes of institutional assailants. Patient-assailants are most likely to threaten victims with physical harm. This is because the forms of institutional threats discussed above are not available to them and because, presumably, they know that as mental patients, they are not likely to be punished in any greater degree by the criminal justice system than the mental health system. Janitors and orderlies, who cannot so easily make good a threat of permanent or prolonged confinement, threaten victims with the words "no one will believe you, — you are a mental patient." Assailants who are psychiatrists can threaten prolonged
institutionalization or unwanted treatment. Assailants who are on the nursing staff (i.e., psychiatric technicians) can threaten patients with restraints, seclusion, or with "chemical restraints." They merely have to substantiate claims that patients are "acting out" or delusional. Under some conditions, as in the case of a patient with a bad reputation and a very popular staff member, making good on these threats is easy.

Victim Resistance

The forms of resistance employed by patient-victims to deter an imminent sexual assault (and to avoid further assault attempts) are no different than those employed by other targets of sexual assault. Whether inside or outside of an institution, a woman may (theoretically, anyway) resist by screaming, physically fighting back, fleeing, trying to talk/bargain the assailant out of the assault, or "grossing out" the assailant by vomiting or committing some other upsetting act.10

The meaning and consequences of such actions are different for people within and without the institutional context, and therefore, certain strategies of resistance may predominate over others. For example, screaming may be viewed as a "normal" behavior for physically restrained patients. Yelling would not, therefore, necessarily attract the attention of others (depending on how usual such behavior is and the way it is routinely handled in the particular unit). A patient-victim who physically fights back could be depicted

10 Pauline Bart (1981) found that the most effective avoidance strategy for targets of extramural rape combines physical resistance, yelling, and running away. The least effective strategy relies on verbal bargaining.
to others by the assailant as "acting out"; physical resistance might allow the assailant to escape detection and subject the patient to institutionally sanctioned chemical or physical pacification. 11

The fear of misinterpretation or the futility of active resistance within the institutional environment accounts for some patients' choices not to resist. Yet, for some, active choice is clearly not the explanation for the absence of "obvious" resistance. Some patients may be unable to resist because of their mental condition at the time of the assault or because they are so heavily medicated. Others may simply be manifesting the consequences of "successful" female socialization, or patient "adjustment," or both. It is important to note that those who consciously fear the consequences of resisting do not fear so much the assailant as the ways staff (third parties) will react. This is a critical difference between institutional and "outside" extrafamilial sexual assaults.

Slightly more than half of the women we interviewed did not actively resist. 12 In fact, three sets were described by subjects as unwanted but "consensual." Fifteen sets occurred with no active resistance by the victims. One woman was unconscious, and the rest of the women described themselves

11 On the other hand, in order to be able to commit the assault without being detected, the clandestine institutional rapist must be able to control the situation. A patient who "goes off" (goes crazy) cannot easily be controlled if she and the assailant are in a semipublic place, such as a laundry room. In such an instance, the assailant may be stopped by the very craziness of the vulnerable victim. This is not, however, within the control of the patient and would, therefore not properly be considered a resistance "tactic."

12 In response to our asking them to describe how they reacted to the assault women described a range of reactions. In this analysis, I have included as resistance behavior verbal challenges, yelling and screaming, and any physical act which would signal nonconsent (such as pulling away from the assailant). An action need not have been forceful or effective to be included as physical resistance.
as unable or afraid to react. Explanation for the absence of resistance lies only partially in the condition and circumstances of the victim at the time of the assault. Women who were cognitively and physically impaired by heavy medications or ECT (50 percent) were slightly less likely to resist actively than women were not so impaired at the time of the assault (58.3 percent). Women, regardless of their mental condition at the time of the assault (depressed, hallucinating, confused, or in some other state), were as likely to resist as to react "passively." However, those who described themselves as "confused" (or otherwise cognitively disabled) were more likely to engage in sexual activities with assailants which they, at the time, defined as "consensual."

By far the most significant factor influencing the likelihood of active resistance or a more "passive" reaction was the status of the assailant. Patients far more often actively resisted patient- (peer-) assailants than staff-assailants. Approximately 73 percent of "peer" assaults (those committed by other patients) were resisted by the intended victim. Only a third of those committed by staff assailants were resisted. Table XII shows the distribution of resisting tactics by assailant status. The responses were analyzed in terms of assault sets (not individual incidents), which reduces the number of cases and limits the strength of any conclusions. However, the differences within each subset of assailants between resisters and nonresisters is dramatic and worthy of note.
TABLE XII
RESISTANCE TACTICS BY ASSAILANT STATUS

<table>
<thead>
<tr>
<th>Tactic</th>
<th>Assailant</th>
<th>Patient</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Resistance</td>
<td>3 27.3%</td>
<td>15 62.5%</td>
<td></td>
</tr>
<tr>
<td>Resistance</td>
<td>8 72.7%</td>
<td>9 37.5%</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11 100.1%</td>
<td>24 100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Women assaulted by staff members gave several reasons for not resisting (as well as not reporting) the assault. Some wanted the staff member to like them and feared resistance would cost them affection and support. Others described how futile they felt resistance would be, pointing to enormous differences in credibility between them and the assailant. They articulated not only the belief that resistance would be useless, but that it could result in misinterpretation and punishment by other staff. "What's the point?," asked one woman. "They could just put me down in a side room." Women also talked about the immobilizing impact of shattered expectations. ("How could he do that? My own doctor!")

Staff, whether they are psychiatrists with the power to commit, to treat, and to name the meaning of others' experiences, or ward level caretakers, with the power of the key, are authority figures. Institutionalized mental patients (who are at least situationally, if not emotionally, dependent on staff) are sometimes too awed and confused to understand a physical act as an assault, and too shocked and frightened to react. This is not especially surprising, but it helps to explain why staff assaults may not be so rare as they are invisible. A partially analogous situation is described by Burgess (1981: 1338-39). She interviewed sixteen women who had been sexually assaulted by the same gynecologist. The majority did not resist the
assaults that occurred while they were being examined. Twelve of the sixteen women left only after the physician stopped the examination. Of those who intervened, three asked the physician to stop and one sat up. Burgess reports that all experienced negative reactions, including feelings of powerlessness, immobilization, and confusion.

**Resistance Tactics and Consequences of Resistance**

From a theoretical perspective, resistance to assaults and other forms of victimization serves several functions. Resistance to an assailant's sexual overtures or behavior is one way a woman may succeed in avoiding further abuse. Obvious resistance also "marks" the nonconsensual meaning of the act to others — the assailant, as well as those who have an interpretive role in the investigations and support activities which follow some assaults. This is not to say that we define the act exclusively by the victim's behavior for this could result in blaming the victim. Rather, resistance is one of the ways assaults may become visible to nonvictimized members of the social group. Obvious signs that the victim has struggled have been shown to be a critical element for police investigators in determining that a "real" rape has occurred. Such evidence increases the victim's credibility and enhances the probability that police will pursue an investigation and apprehend the assailant (cf. Rose and Randall, 1982).

Resistance also has an identity function. By actively resisting, the intended victim "turns around" the full victimizing impact of the assailant's act. It allows the woman to distance herself from the imposed identity of
"victim" and, instead, more easily take on some other preferred identity such as "resister" or "avoider." We do not have enough data which theoretically samples this dimension, yet there is some evidence that those inmates who successfully resisted were those who did not fear the threats of the assailant. They did not fully accept a definition of themselves as noncredible persons without access to due process. In essence, they resisted the imposition and salience of a "mental patient" identity. By resisting the attack of their assailant, as well as by reporting afterwards, they also resisted the imposition of a handicapping identity.

**Conclusion**

Though limited in number and hardly generalizable, several theoretically significant points stand out in this analysis of victim accounts. First, as we would expect from the extreme power difference between patients and staff, assaults committed by staff exhibit different patterns than those committed by patients. Staff-perpetrated assaults are more prevalent in this sample, involve more serious sexual acts, and are more likely to continue over a period of time as multiple incident sets. As we examine the social aftermath of the assaults and the patient-victim's definitions of the situation, more differences between staff- and patient- perpetrated assaults will become

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13 Advocates for the rights of disabled persons make a distinction between disability and handicap. Disability refers to the objective physical (or mental) conditions which influence a person's ability to function. In its preferred usage, "handicap" (or "handicapping") refers to those social processes by which the disabled person is further limited in their social interactions. Handicapping refers to processes of social discrimination experienced by disabled persons.
clear. Second, time and location of the assault, even though both may be restricted and other staff are engaged in surveillance, can be controlled and manipulated by staff- and patient-assailants. (Again, staff-assailants are better able to control time and space than patient-assailants). Third, and perhaps most significant, patients are victimized when they are most vulnerable, that is, when they are cognitively impaired by medication and/or ECT or physically restricted. Patients who are passive and/or confused are more often assaulted by staff- than they are by patient-assailants.

These findings are evidence of the "opportunity structure" I have referred to throughout this work. Rapists act on the basis of the "opportunity" to rape. First, there is an accessible victim, as well as a way to conduct the act without being caught and punished. Second, elements of the assaults are patterned and organized. They are not random, accidental, or incidental to the context within which they occur. These elements (time, space, victim, circumstances of the victim) are manipulated by rapists in the course of planning and committing assaults. Both staff- and patient-assailants in the hospital setting, exploit the opportunity structure, but assaults by staff are more organized and reflective of the structural conditions (including sanctions) within which they occur than those committed by patients. Finally, apprehended staff-assailants may expect more severe treatment than patient-assailants (even though the most "severe" sanction imposed is rarely criminal prosecution).

The opportunity structure is a set of social processes which "from time to time may be dealt with as structures" (Schatzman and Strauss, 1973: 6). It is created by the staff rapist as he conducts his clandestine act, manipulating conditions inherent to the setting. Time and space, and the ways each is
normally and routinely managed within the institution, are used in order to evade discovery. More importantly, rapists exploit the disabilities of patients by choosing the most vulnerable and least credible victims. It is clear from the content of threats and warnings that rapists sometimes explicitly manipulate the social relations of the setting, taking advantage of (and sometimes exacerbating) social distance between patients and staff. Social distance between staff and patients hinges largely on the attribution of credibility. Staff rapists depend on the noncredibility of patients and on patients assuming a noncredible definition of self. Furthermore, staff rapists depend on the "natural" loyalties of co-workers to back them up and keep their acts invisible. The next chapter, which focuses on the social aftermath of assaults, will explore more fully how the discrediting of patients helps create the opportunity structure of rape.
Chapter Four
Definitions and the Problem of Action

Presumably a "definition of the situation" is almost always to be found, but those who are in the situation ordinarily do not create this definition, even though their society can often be said to do so; ordinarily all they do is to assess correctly what the situation ought to be for them and then act accordingly.

Introduction

Our definitions of a situation shape how we act in relation to the situation. As I will argue in this chapter, women's decisions to resist and report sexual assaults committed against them during hospitalizations depend, in large part, on how they define the situated act. Effectively resisting a sexual assault depends on when the patient understands the assailant's action to be a sexual assault (that is, both a sexual and assaultive act), as well as her perception of the consequences of resisting. The post-assault safety strategies patients choose to employ are also shaped by how they view their situation.

The assaulted patient may or may not be able to formulate and maintain her own definition of the situation, let alone convince unbelieving or normalizing others. If she persists in her definition of the situation over and against the counterdefinitions, discrediting attempts, severe challenges or
ignoring of others, she runs the risk of being further discredited as a "crank."

The women in our sample who successfully averted intended assaults were immediately able clearly to define the assailants' behavior as assaultive, and act on the basis of that definition by physically resisting and verbally challenging the assailant. The women who reported assaults to staff and/or other authorities not only defined the acts as assaults, but also defined them as deviant acts that "aren't supposed to happen here," and therefore, that should be reported (and prevented) and that staff would do something about. More importantly, they were not swayed from reporting by the fear that staff (or others to whom they could report) would define them as noncredible.

In this chapter I will describe how our sample of assault victims defined the assaults and how these definitions shifted over time. I will also discuss these patients' expectations of safety from the hospitals — the degree to which patients defined hospitals as safe places. Then I will look at our respondents' assumptions and perceptions about how staff (or others) should and/or would react to them if they accused someone, particularly a staff member, of rape or abuse, that is, whether patients anticipated staff or others would believe their accounts and define them as credible persons.

Situational definitions of sexual assaults refer to various dimensions: act, setting, expected staff responses, and self in the situation. These are active processes whereby social facts (and identity) become defined, both for the victim and other actors in the situation. Social life is not a blank canvas upon which emergent definitions simply appear. A collectively accepted label of rape requires considerable defining work, performed by a number of different actors principally individuals other than the victim (such as police
The process of collective defining starts with the patient-victims defining for herself what has happened, including the meaning of the act. If she clearly defines the act as rape and she attempts to make its occurrence a public and collective problem, then what happens to her may, under some conditions, become collectively defined as rape. Collective definitions give rise to collective actions following a rape complaint. But often this progression is short-circuited. For women socialized to be victims and patients socialized to be compliant and dependent, the ability to define an act as rape, to oneself and to others, may be thwarted at every turn. Preexisting "definitions" about the patient-victim and the social characteristics she represents, about rape and its likelihood of occurring in the hospital setting, and about the alleged assailant all influence the victim's course towards her ultimate definition as well as the course of the collective definition which emerges. Therefore, my analysis of the definitional dimensions of the assault will also consider some of the "counterdefining" processes that occur in response to victims' definitions/allegations of rape in mental hospitals. How counterdefinitions affect the victim's definition of the act and the collective definition which emerges, will also be explored.

Meaning of the Act

Defining the Act at the Time of Assault

Under what conditions is sexual behavior defined by the victim as an assault, as rape or attempted rape? In their research on women who resisted being raped, Bart and Schepple (1980) examined the definitions their sample
of subjects (women who had been raped and women who avoided rape) attached to the acts they experienced.

By the time a report of sexual assault makes it into the newspapers, onto the television or into the courtroom, the event has already been labelled. But the relation between specific acts of specific people out in the real world and the labels we associate with these acts are not always clear. Women in their daily experience encounter men constantly. And women are constantly interpreting the actions of these men as being friendly or hostile, well-intended or wicked, platonic or sexual. When do they begin to define the actions of men as constituting sexual assault?

. . . A great many women in our study indicated that they had a feeling "something was wrong" before the attacks occurred. . . . Often a woman would say that although she noticed the attacker before he made any specific move and although he made her uncomfortable, she dismissed her feelings as being overly "paranoid" or sensitive. There was a definite tendency for women in our study to give men the benefit of the doubt where there were no specific actions and even after an initial ambiguous step had been taken. This indicates that even though there might have been some clue that the situation was one of potential sexual assault, the ambiguity of the signs encouraged women to distrust their own feelings (4-5).

The women we interviewed who were able to avoid being raped were mostly quick to define the assailants' intentions and behavior as assault (rather than affection, unintentional or "part of his job"). Moreover, they were mentally and physically capable of resisting, and wished to avoid the assault more than they feared the consequences of resisting. Definitional clarity, as well as resistance based on such a definition, also influenced how our subjects felt and acted after the assault. Patients decided to report or not to report based on their multidimensional definitions of the situated act: how they defined the nature of the act (Did it count as an assault? Was it serious enough?); how they defined the act at the time it occurred, in terms of their own participation; how they defined the intentions of the assailant;
how they believed others (principally staff) defined them and the assailant, and would react to them if they reported; and whether they defined the ward/hospital as more or less safe in the aftermath of the assault, and more or less safe if they reported.

In relating their accounts, the subjects indicated how and when they first defined the act. Some were clear from the beginning that they had experienced a completed rape or attempted rape. A few subjects described their participation in the incidents as "somewhat consensual" (that is, they "agreed" to perform the acts requested by the assailant), although subsequently they came to see the "assailant's" behavior as abusive, exploitive, or coercive. A few women cooperated with the assailant, without any clear understanding of what was happening at the time. They agreed to perform (or simply performed) the acts the assailant wanted while in a "fog."

**Taxonomy of Nonconsent**

From the standpoint of the law, the issue of consent is the defining element of rape. Whether or not a victim consented distinguishes "criminal" behavior from an ordinary act. But how is "consent" determined? The principal determinant of consent, both in the law and popular definitions, is the *behavior* of the alleging victim and the alleged assailant. However, the issue of consent, as an act of will, may be empirically distinct from a victim's actions and reactions in relation to the assault and the assailant. And the relationship between consent and action is multileveled and complex.

It is clear from many discussions and testimonials of victims, clinicians, social scientists, and legal scholars, that the consensual properties of rape must be established based on evidence other than the absence of obvious
resistance of the victim. Emergent statutory reforms reflect a deeper understanding of the relationship between true consent and a victim's behavior during an assault. California's penal code, for example, defines consent in relation to sexual behavior, as "positive cooperation in act or attitude pursuant to an exercise of free will. The person must act freely and voluntarily and have knowledge of the nature of the act and the transaction involved" (emphasis added) (Sec. 261.6). There are also specific situations where resistance to a sexual assault is not possible, or unlikely to occur, for example, when the victim is a child, or a permanently or temporarily mentally disabled adult, who is unable to understand the meaning of the act and/or resist. Most states' criminal statutes recognize special classes of individuals that may easily be victimized and for which exceptions regarding consent must be made. Mentally ill and mentally retarded (developmentally disabled) persons are among those classes that have traditionally been covered by statutory rape provisions. In some states it is a special crime to rape or sexually assault a mentally disabled person. These laws reflect the distinction between behavior and consent.

The accounts of patient-victims also reflect the distinction between behavior and will. Based on patients' descriptions of sexual assaults, I have constructed a taxonomy of initial definitions of the events. This taxonomy represents variation on two axes: how consenting to the act(s) comprising the set the woman felt [consensual, nonconsensual, ambivalent, or was she too

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1Sexual intercourse committed against or with persons deemed incapable of giving legal consent is termed "statutory" rape. This term is generally associated with conditions quite different from those implied by the term "forcible rape" and as Loh (1981: 33) has concluded: "Neither the public nor the criminal justice system tends to regard this behavior as rape."
vague (out of touch) or nonsentient to understand what was happening or organize a "feeling"? and how she reacted (behaved) toward the assailant [actively resistant, passively responded, cooperated]. In my analysis of consent, I rely solely on the women's descriptions of how they felt about performing the acts and cooperating with the assailants. This is not how police or other investigators charged with determining the legitimacy of a rape complaint usually determine consent. For them, the word of the victim is seldom enough. Unless the assailant admits that he acted against the will of the victim, investigators look for "evidence" of resistance or cooperation based on characteristics of the victim and the situation, to determine nonconsent and "found" the complaint (cf. Rose and Randall, 1982).

### TABLE XIII

<table>
<thead>
<tr>
<th>TAXONOMY OF NONCONSENT</th>
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#### Behavioral Reaction to Assailant

<table>
<thead>
<tr>
<th>Feeling/Will</th>
<th>RESISTANT</th>
<th>PASSIVE</th>
<th>COOPERATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONCONSENTING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMBIVALENCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAGUE TO NONSENTIENT</td>
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</tbody>
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I have provided a theoretical matrix (Table XIII) to illustrate the possible combinations of will/feeling and behavior which may be expressed by the victim of a sexual assault/aggression. The matrix contains no data, in keeping with its illustrative function. It shows a total of nine cells although not all combinations are logically possible. The nonsentient (or highly
confused) victim, for example, can neither resist nor cooperate, but rather, by definition, will be passive during a sexual assault. However, the behavior of subjects who describe their feelings as nonconsensual or ambivalent, may manifest as either resistance, passivity, or apparent (meaning either feigned or partial) cooperation during a sexual assault/aggression. The taxonomy shows the possible variety of behavioral reactions when the victim feels nonconsenting. She may resist, be passive or cooperative. It also shows three forms of will/feeling which the victim may express: clear nonconsent, ambivalence, and circumstances where the victim is too mentally confused, frightened, or nonsentient to give or withhold consent. This taxonomy demonstrates the complex relationship between definitions and action by schematizing victims' actions/reactions as separate from their apparent consent.

The largest number of respondents defined themselves as "actively nonconsensual," that is, they didn't want to have sexual relations with the assailant and they actively resisted the assault. Several women described their reactions during the assaults in terms consistent with the category of "passive nonconsent" (they didn't want the sexual acts, but they acted passively). Alice, whose experience was recounted in Chapter Three, provides us with an example of passive nonconsent. She was so shocked and confused by the assailant during the initial assaults that she was completely passive in her reactions. She did not stop him nor respond to him sexually.

2 My taxonomy of definitions does not include "truly" consensual acts because our sample includes only accounts of unwanted acts. Actively-consensual sexual relations can and do occur between patients in psychiatric hospitals. It is also possible, from a legal perspective though not an ethical one, that consensual sexual behavior between a staff person and a patient may occur.
We have no clear examples of a situation where a victim defined her relation to the act as nonconsensual (at the time), yet acted in a cooperative manner. To cooperate by agreeing to meet him, not to tell, maybe even to act sexually responsive, in spite of feeling nonconsenting, is a strategic choice which a victim might make if she feared the consequences of not cooperating or conversely, if she perceived that she would gain something by cooperating. In several of the accounts of multiple incident sets, some victims passed through a stage of apparent strategic cooperation with the assailant (e.g., where bribes were offered and accepted in exchange for sexual acts). That we have no clear examples, however, may partly be a problem with our data. Not all interviews generated sufficient detail and description to identify changes in definitions during the various stages of the assault and its aftermath.

Several women had ambivalent feelings about participating in the sexual act(s). Those who initially defined themselves as ambivalent but ultimately declared themselves nonconsensual provide us with insights into the special vulnerability of mental patients to sexual exploitation. These cases permit us to speculate on how investigators would react if the assaults had been discovered. In some cases where the woman experienced feelings of ambivalence, she was, in one woman's words, "too out of it to care, to really know what was happening." The woman (described in Chapter Three) who grabbed onto and embraced the male attendant who was locking her up, described her participation as "kind of going along with it"; she liked the attention but was afraid to say no. An adolescent (also described in Chapter Three) who at age sixteen had been hospitalized for schizophrenia for over a year, was propositioned by a male psychiatric technician. She agreed to have
sex with him. He had first approached her about a week before, by making a couple of "passes" at her. She knew that he wanted to have sex with her and had tried to avoid him by staying in the day room, rather than being alone in her room during the day, where he could easily approach her. One day she encountered him in the hall on her way to her room and she recalled him saying,

"Hey, well, we'll have sex." And I said, "I don't know." So I finally said "Yes." And he had sex with me. And I felt real bad about it. But I didn't tell anybody about it for two months.

[Prior to assault] he seemed real nice and talked to me sometimes. He talked to my friends. I seemed to have liked him right away. I could go up to him and talk about anything I wanted to. Then after the sexual assault happened he didn't want to talk to me anymore. . . . I thought it would still be the same relationship we would have. I didn't feel good when I had sex with him. Because I knew it was wrong and I felt uncomfortable about it. But I did it because I wanted to make him happy.

In all cases included in this analysis, the victim's ambivalent feelings and cooperative behavior were a function of the assailant's status. Staff-assailants were more able than patient-assailants to persuade women to "go along" with their sexual demands, in spite of the victims' contrary feelings. Patient-assailants do not have the same situational power as ward caretakers and therapists to distort a victim's definition of the situation, or elicit cooperation/participation against a victim's will. This disparity suggests that it is not merely "mental incapacity" which makes patients vulnerable to sexual abuse, but also the social relations within the hospital setting which foster extreme dependency of patients on staff (perhaps particularly upon those staff who are friendly).
Several of the women we interviewed were extremely incapacitated at the time they were assaulted and completely unable to comprehend what was happening to them. One woman was unconscious during an apparent gang rape. Another respondent was in the midst of a course of electroshock treatments and, therefore, was unable to distinguish or clearly remember what happened. Neither woman could have consented. Both are victims of what an observer loosely termed "necrophilia." Whereas for some women giving or withholding "consent" is the critical element which defines the meaning of the act (as "sexual" rather than "assaultive"), for these women, just knowing whether or not sexual acts occurred was the critical definitional element.

Those victims most likely to report and be believed are those characterized in my taxonomy as nonconsenting and actively resisting, or those who can establish that they were assaulted while unable to resist (this latter category, however, includes a number of victims who would not likely be able to report at all). Those who experienced ambivalence are neither likely to report nor likely to view themselves as believable assault victims. Victims' post-assault safety strategies vary both according to self-defined consent and how victims view their behavior during the assault.

Changes in Definitions

Victims' definitions of their willingness to participate in the incidents changed from ambivalent or no definition to "assault" in twelve cases. Three definitions changed during the set itself, two changed sometime during the hospital stay and seven changed sometime between the time of assault and the time of the interview. For several women, these changes came in discernible stages. For Jill, an adolescent patient, during the months which
followed the assault, feelings of discomfort and knowledge that "it was bad" deepened. In the aftermath of telling the staff, she experienced both other patients' support for "blowing the whistle," as well as other patients' anger for "causing" the assailant, a popular young staffer with whom the teenage patients could identify, to be dismissed. Her feelings of "badness" about the incident continued to deepen. However, she didn't name what had happened a "sexual assault" until after she heard a presentation I gave to a self help/support group of which she is a member.

Factors Which Mediate Against the Labelling of Rape

Myths and Popular Misdefinitions

Joyce Williams (1978) has pointed out that the behavior which is most easily defined as rape constitutes a "popular definition" of rape: the assailant is a stranger and possesses a weapon, and the victim is injured. Other researchers have noted how this definition of "real" rape or "bad" rape is employed by police, as they investigate and credit a victim's complaint (Rose and Randall, 1982); by rapists, as they disavow their deviant acts (Scully and Marolla, 1982); by prosecutors, in determining which cases to charge (Loh, 1981); and by juries, as they evaluate the guilt or innocence of a defendant in a criminal proceeding (Bohmer, 1974; LeGrand, 1973). Unfortunately, many victims also employ these extreme criteria in defining what has happened to them, as well as in calculating how others will react.

However strong such views may be about what constitutes "real" rape, researchers and victim support counselors have found that a significant number of rapes and attempted rapes do not fit the stereotype of a violent
encounter between strangers. A significant percentage of all sexual assaults, like other acts of interpersonal violence, take place between persons who know each other (cf. Russell, 1982a, 1983; McDermott, 1979). We also know that attempted and completed rapes by nonstrangers are extremely underreported and, when reported, they are less frequently "founded" and charged by law enforcement personnel than attempted and completed rapes committed by strangers. Kanin's 1970 study of sexually aggressive behavior by college males showed that only 1 percent of the cases of completed or attempted "date" rapes uncovered by the study was reported to school or legal authorities.

The number of sexual assaults which involve violence (the use of a weapon, extreme force, and/or additional physical injury) may also be significantly lower than popular myth suggests. The National Crime Survey estimated that in approximately half of all the reported rapes the victim sustained additional injury. Because obvious physical injury "provides" the victim with corroborating evidence that she has been assaulted, we can

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3"Founding" is the process whereby police "decide whether the event related by the victim meets a reasonable standard of credibility, and, if so, whether the event constitutes a crime. When the police believe that an act has occurred that does fit the legal definition of a crime, a case is marked as founded as opposed to unfounded" (McCahill, et al., 1979: 103)

4 Analysis of the findings from The National Crime Survey of twenty-six cities showed that 20 percent of all rapes are committed by acquaintances (McDermott, 1979). The author of the analysis states that this is surely an underestimation of the actual number. She points out that a reverse record check in one city, San Jose, where interviewers surveyed known victims (persons had reported to police) showed that "only 54 percent of rapes committed by nonstrangers were reported to survey interviewers by known victims, compared with 84 percent of the rapes committed by strangers" (1979: 3).

5 In New York only rapes accompanied by other serious physical violence may require a "crime-related injury" report by a hospital or physician to a law enforcement agency" (LeGrand, 1983: 34)
assume that sexual assaults without additional injury are grossly underreported.

When the elements of an actual assault differ from these "popular" characteristics, it is more difficult for a victim to define the experience to herself as rape (Koss, 1983). In the absence of the various elements which constitute a "bad" rape, clearly marking for third party observers the absolute nonconsensual nature of the act and theoretically releasing the woman from feelings of shame or responsibility for the assault, it is difficult for the victim to define the act to others as rape. It is difficult for her to make an initial report and sustain the definition of the act as rape or attempted rape through the multiple retellings and challenges that occur in the typical police investigation. More than other adult victims of sexual assault, the patient-victim must establish that the act actually took place and is not a figment of her "delusional system." But once she has established that the act took place, because of her "special" condition under the law, fewer demands may be made on her to establish that she was nonconsenting. However, if the women we talked to are representative, many victims have difficulty convincing staff and subsequent investigators to take their charges seriously, especially if they aren't absolutely convinced of their own entitlement to inviolability, and the assaultive nature of the act.

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McCahill et al., in their study of cases of assault reported to the Philadelphia police, found that the reporting victim's psychiatric history significantly influenced the investigating officers decision to "unfound" the case. Complaints where the victim had a history of psychiatric "contact" were not likely to founded (1979: 119ff).
Discrediting the Complaint

The act is defined by the victim and those to whom she reports. A central feature of the process of investigating a rape complaint is determining the victim's credibility. Indeed, the victim's credibility is the primary basis on which police investigators found a rape case according to Rose and Randall (1982) and on which hospital (medical and nursing) staff treat victims and gather medical evidence of extrainstitutional sexual assaults (Lebourdais, 1976). However, the process of accrediting the victim often precedes, and therefore, prevents the collection of evidence necessary to corroborate her account. Clarke and Lewis (1977) analyzed the accounts of incidents reported to the Toronto police and discovered that a substantial number of the cases would have been founded, if police had not apparently considered the characteristics of the woman and the likelihood of conviction before their decision to press the case further.

The process of accrediting the assault victim may involve a significant number of actors if the assault becomes public. The person who was assaulted, the persons to whom she directly reports and by whom she is interviewed, and the persons who, while never speaking directly to her, engage in official and unofficial labelling acts. A mental patient, trying to have her rape complaint accredited, may begin with a "discredited" self; she may view herself as likely to be disbelieved. Like some of the women we talked to, she may have internalized the discredited status accorded her as an institutionalized person and regard herself as unbelievable. In addition, the formal process by which her complaint is "adjudicated" includes an extra level of accreditation — hospital staff. Although one woman we interviewed called
the police directly (her complaint was turned away), all other victims in our sample who reported assaults started by telling a member of the staff. How staff react may well influence a woman's view of what happened and what can be done. How staff react for her may determine how her complaint will be regarded by other staff and outside authorities. Before discussing the special institutional processes of accreditation by which a patient's account is defined as rape, I will provide some background on the processes of accreditation applied to noninstitutionalized rape victims.

The "special" need to establish the credibility of the rape victim arises out of the unique properties of the crime. According to Brownmiller (1975), rape is a crime for which evidentiary proof is often intangible. The "perpetration of an act of intercourse against a woman's will leaves no corpus delicti, leaves no recoverable physical goods, and may leave no sign of damage" (p. 413). Second, "rape is the only crime in which by law the victim is female and the offender is male" (p. 413). Because an act of rape may leave no tangible evidence, establishing its facticity is a matter of oath against oath, "the word of a woman against the word of a man" (p. 413). The way rape complaints are handled inside and outside of institutions, reflects these properties, and men's fears that they will be (falsely) accused.

What makes a victim credible to the police? LaFree (1980) discovered in his study of adjudicated rape cases in Indianapolis that police discriminate against victims on the basis of their prior behavior, age, and relationship to the offender. Rose and Randall found in their analysis of 610 victim complaints that police investigators' belief in the legitimacy of a complaint were affected, in large part, by how credible they though the victim was; whether they believed she had not consented; and by her personal
being believed) who reported promptly, were willing to undergo a physical examination, who evidenced visible emotional trauma (suggesting unwritten "rules" about how victims are supposed to act), and who were willing to cooperate with the investigators. They were more likely to believe a claim of nonconsent if the assailant was a stranger (a finding replicated in other studies), if the woman was subjected to force, and if she obviously resisted. If the victim's credibility was reduced due to her behavior, it could be partially "salvaged," according to Rose and Randall, if there was external verification provided by witnesses, or physical evidence, such as an obvious injury or torn clothing (p. 29).

The process of crediting and discrediting a victim's complaint on the basis of her behavior, relationship to the assailant, post-assault cooperation with authorities (usually male), and personal characteristics continues throughout the legal process. These factors strongly influence the discretionary decisions of prosecutors to charge (Loh, 1981) and judges' and juries' evaluations of the complaint and the complainant (cf. Bohmer, 1974; Feild and Beinen, 1980; LeGrand, 1973). From her experience as a practicing attorney, LeGrand asserts that within the judicial system, men are protected against convictions, "except when the complainant is a chaste, mentally healthy woman, who reports promptly and is willing to go through the horrors of a rape trial" (p. 938).
The Special Case of Mental Patient Rapes

All but five of the assaults reported to us were committed by persons with whom the victim was acquainted. The majority involved persons on whom the victim was directly dependent.7 These assaults share characteristics with other types of acquaintance rape; for instance, not only are few reported, but the victim is likely to be seen by investigators and others as in some way responsible for the act. It is most difficult to establish for third party observers, including police, judges, juries, friends, or family, to establish nonconsent in acquaintance assaults. Very few of the assaults we analyzed involved any significant force or violence. Only a couple resulted in obvious physical evidence of assault.

In addition to the popularly held view that rape is a violent act committed by a stranger, victims making an assault claim must contend with other myths, for instance, that an unwilling woman cannot be raped. Another myth is that women falsely accuse men of rape as a form of revenge or to avoid being caught for infidelity. In addition, a mental patient-victim must contend with the view that her rape claim is a delusion, a fantasy. These unexamined myths often discredit victims before the collection and analysis of evidence on which an objective evaluation of her complaint could be based.

Mental patient-victims of rape constitute a class of victims who, along with children and prostitutes, are among those least likely to establish themselves as credible witnesses in court. Indeed, that any of these women

7Indeed, almost all sexual assaults in psychiatric facilities are, because of the closed nature of mental hospitals, by definition, nonstranger assaults. The assailant is known, if not by the victim, by staff.
have progressed to court with criminal and civil complaints is extraordinary. A mental patient-victim may be less able than other women (or be seen by police and prosecutors as less able) to withstand the difficulties of going to trial.

The patterns of rape (and other sexual assaults) of mental patients fall outside the boundaries of credibility recognized by police and identified by LaFree, Rose and Randall, and McCahill et al. Police, judges and juries, as well as (and perhaps most significantly) hospital staff are likely to discredit a patient-victims account, counterdefining it on any combination of the following grounds: 1) The act never happened (it is a fantasy, a misplaced memory of an earlier trauma); 2) The accusation is "false" (because the patient was confused, overreacted to a nonsexual touch, was angry at the staffer); 3) The act was consensual, or the patient was provocative or sexually preoccupied ("it's hard to call it rape"); 4) Eyewitnesses, if there are any, may be other patients who are themselves discredited as witnesses; 5) The patient-victim is likely to delay in reporting to staff and others; 6) The patient-victim may not be able to fully cooperate with the investigation.

How do police react to victims who are officially labelled and treated as mentally ill? Do they simply discredit these women as "unreliable complainants?" Under what conditions are patient complaints founded? Beyond the problems which symptoms such as impaired affect or cognition may present to some, but not necessarily all, hospitalized mental patients, there are properties of institutionally-situated assaults which would predict a delay in reporting and limit patients' capacity to cooperate with the police (e.g., waiting until the next shift, waiting to be released, inability to speak clearly because of medication, mental "instability").
Situationally-Bound Definitions

The accounts I have analyzed suggest that the way a patient defines the meaning of the act (for herself and to others) is situationally-bound. Some mental health professionals have suggested that our study will be biased by false reports made by former patients who are "angry at having been institutionalized." Although I do not believe that the study is biased in this way, such counter-claims suggest a relationship between how a patient defines what she experienced, the institutional context within which it happened, and the collective process of defining. Instead of overreporting incidents, I have discerned an inclination among former patients to avoid reporting.

Ambiguity of meaning, resulting from a victim's ambivalence about participating in an act, often characterized situations where the assailant was a staff member. However, we also uncovered one example where a patient redefined an assault committed by another patient. The patient-victim attempted to protect the male patient who had just assaulted her from being physically abused by attendants (who grabbed him and were "beating him against the wall"), by telling the nurse that "nothing had happened." She redefined the act in order to protect a fellow patient from staff, thereby acting on her identification as a patient among other patients, rather than as a patient to be protected from other patients by staff, that is, as a rape victim.

Claims by mental health professionals that patients are angry at being institutionalized are, however, borne out in many accounts. This was expressed directly, often by naming the hospital experience as the "real" rape and the fact of being a mental patient as the "real" victimization.
Normative expectations about institutional safety entered into patients' initial definitions of what happened to them. Two opposing definitional themes emerged from patients' accounts. One was a positive image of the hospital as a "safe" place, an asylum to go to when you feel afraid and unable to cope with the world. "Bad" things aren't supposed to happen in a place where you need to feel safe. Women who expected safety were not necessarily empowered to report by that vision alone. Many reacted to this as to a shattered expectation and simply lost their feeling of safety. The opposite image of the hospital as "bedlam" and, therefore, a place where "you can expect to be sexually mistreated" similarly did not encourage reporting.

The Power to Define

Rape victims do not have the power to socially define the meaning of their assailants' actions, without being subjected to protracted and sometimes extensive processes of accrediting and discrediting by others charged with the responsibility of investigating and prosecuting the alleged assailant. Their situational definitions are subjected to the counterdefinitions of others, who have greater social power to act. No victim has the power to arrest and convict the perpetrator. Under most conditions, however, victims of crimes other than rape can bring charges without having their credibility as persons challenged. Rape victims are often subjected to extreme personal discredittings, as they bring their word against the word of a man who has sexually assaulted them. The process of personal scrutiny is so extreme that it is often referred to by victims, as well as by victim advocates, as a second assault.

The scrutiny which rape victims routinely experience is apparently
justified by the belief that many rape charges are false, and that to act as though such charges are true would unjustly punish accused men by damaging their reputations, possibly costing them their jobs, and potentially resulting in felony convictions. One consequence for the victim of being treated as incredible is being denied an opportunity to "devictimize" herself by acting on her own definition of the situation. It is not merely that the criminal justice system fails to arrest, try, convict, and punish the assailant (which may or may not be what the assaulted woman wants), but also, that inept investigators counterdefine the victim's reality, fail to validate her experience, and treat her as "unworthy" of being believed.

Mental patients are vulnerable to the power of staff and others to redefine their definitions of a situation. Staff and therapists have the authority to define reality for patients. As patients and rape victims, the women we interviewed shared a "double powerlessness" to define their circumstances.

Conclusion

The definitional aspects of the current research problem suggest an ambitious agenda for further research. My analysis has focused on the situationally-bound properties of victims', staffs', and investigators' definitions of mental patient rape complaints. The victims' accounts speak directly to only a few aspects of this question, primarily the problems patient-victims have in self-defining the act. Their accounts demonstrate the distinction between consent (how they felt in the situation) and their
behavior at the time of the assault (the criteria of third party definitions the situation). Research on the criminal justice processing of rape complaints suggests that in no case is a rape complaint brought by a mental patient likely to be defined and treated as a "real" rape, regardless of the victim's definition of the situation or her behavior at the time of the assault. Future rape research on the criminal justice processing of rape complaints should specifically focus on the complaints made by persons labelled "chronically mentally ill" and "hospitalized mental patient". It would be a significant contribution to the field simply to develop accurate estimates of the number of such complaints within a given jurisdiction. Another important contribution would be a thorough analysis of how law enforcement personnel process these special cases, including a description of the conditions under which problematic cases are founded.

Perhaps the most critical actors in defining and processing patients' rape complaints are psychiatric facility staff, for their reactions and efforts preserve or fail to preserve corroborating evidence. The response of staff may also be instrumental in convincing law enforcement personnel to treat patient complaints as legitimate rape complaints. Facility staff also profoundly influence victims' definitions of the act and the distinct psychological impacts of the assault upon the patient-victim. The accounts of facility personnel, included in the larger study to which this dissertation belongs, only partially address the question of how staff define patients' rape complaints. Further research needs to be conducted in psychiatric settings, where complex definitions are collectively formed, to observe and analyze the interactional context within which accusations (highly problematic verbal claims) are made and accredited.
Chapter Five

The Social Aftermath of Institutional Sexual Assault:
Strategies of Disclosure and Silence

Introduction

Research on the aftermath of rape generally emphasizes two major concerns: identifying the psychological impact of the rape on the victim, and analyzing the processing of rape complaints within the criminal justice system. The present study represents, in part, a variant of the latter concern, insofar as we have addressed how allegations and complaints are presented by victims and handled by authorities, both institutional and extrainstitutional. This chapter focuses on patients' reports of sexual assaults, some of the reasons they don't report and the consequences of not reporting. The emphasis here is on what the victim does in reaction to the assault, in anticipation of the consequences of interacting with the "system."

Studies of victims generally concentrate on the psychological sequelae of rape -- what has come to be known as the "rape trauma syndrome" (cf. Burgess and Holmstrom, 1974). Considering the psychiatric histories of the population in this study, speculating about sexual assaults "causing" or augmenting psychological symptoms or prolonging careers as institutionalized mental patients is natural. However, instead of examining what happened to women who were assaulted, my focus is on a) understanding what they did in reaction and response to the assaults (the range and consequences of and reasons for those actions and reactions) and b) describing the social
structure of complaint processing, as viewed from the perspective of the mental-patient complainant. What are the active ways inmate-victims attempt to construct their social environments after the assault in order to restore safety? What are the social structures through which their reported accounts are processed and "founded" (defined as "real") by institutional authorities? How do patients manage the processes of reporting, and creating and sustaining a credible account (and in the process, do they create or restore a credible self)? These questions, of necessity, explore how staff (and others) regard patients as well as how patients calculate and adjust their own actions, in light of staff reactions.

Patient-victim responses take one of two major forms which, because of their active, choice-making and interactive quality, should be viewed as "strategies." I have categorized responses as strategies of disclosure (telling, complaining, reporting) and strategies of silence (avoidance or escape). In an ideal sense, these strategies represent mutually exclusive choices. In practice, however, a woman may choose one, and in the face of unanticipated or unwanted consequences, switch to the other. Her choices depend upon emergent definitions of the situation: her definition of the act, what she perceives as the structural limitations imposed by her circumstances, and the reactions of others (the assailant, staff to whom she reports, etc.) to her and the complaint. The full consequences of victims' strategic choices evolve in the process of disclosing and/or silently attempting to avoid further assaults. These main strategies, and the processes and consequences they evoke, together comprise a social aftermath of sexual assault.
Disclosing Sexual Assaults: An Overview

Patterns of Disclosure and Case Attrition

For the most part, what we know about rape is the result of victim disclosure. Few rapes are witnessed by persons other than the victim and the assailant(s) and, as documented by a number of researchers, few victims ever disclose (report) sexual assaults to the police.¹ Thus, the efforts of feminists, criminologists, policy makers, victim advocates, and others who seek accurate estimates of the true prevalence and incidence of rape are severely hampered. Of course, not all disclosures are formal police reports, seeking intervention by the criminal justice system. Sometimes the disclosure is no more than the victim telling someone else of the assault in order to get some form of physical, emotional, or medical support, or advice on what to do next. What happens during this kind of disclosure may greatly influence whether the victim reports the assault to the police.²

Disclosure may have a number of purposes for the victim, which change over time. The purpose of disclosure may be indicated (and later shaped) by specific forms of disclosing strategies. For instance, victims who disclose immediately or soon after the assault may intend to seek protection from

¹ Estimates of the percentage of actual rapes and attempted rapes which are reported range from approximately 10 percent (Russell, 1983) to 75 percent (LEAA, 1976). Most researchers, prior to Russell's representative San Francisco survey, estimated that approximately 20-25 percent of all rapes and attempted rapes were reported to the police (cf. Schram, 1978; Brownmiller, 1975; Amir, 1971).

² Feldman-Sommers and Ashworth (1981), for example, found that the normative expectations of family and friends regarding the reporting of rape was the principal predictor of the likelihood that a victim would contact the police.
further harm, punish the assailant, and/or secure some form of support. Many victims disclose assaults in order to do something to protect other women from similar trauma and risk. However, not all victims disclose the fact that they have been assaulted. Some never tell anyone, preferring to find silent ways of protecting themselves or "accommodating" to their situation, rather than risking the consequences of disclosing (e.g., shame, disbelief, reprisals). Some victims of sexual assault disclose only long after the fact, and then only to friends, therapists, or researchers.

Disclosure immediately or soon after the assault may be made to friends, family members, doctors, teachers, rape crisis workers, and/or the police. The formality or official character of a disclosure depends on the person (or agency) to whom it is made. "Tellings" to friends and counselors are informal; disclosures for the purpose of obtaining immediate medical or emotional care from a hospital or rape crisis center are more formal, and how they are handled is subject to official control (by statutory stipulation, and usually, some degree of bureaucratic rules); and reports to the police are official allegations of a crime. Disclosure to the police may result in numerous subsequent and detailed descriptions of the assault and the surrounding circumstances to criminal justice personnel. Disclosures which result in criminal charges and prosecution may be increasingly detailed and protracted over long periods of time.

An initial disclosure may result in the decision (by pressure or choice) to continue disclosing the facts of the assault to other people. For example, the victim may tell a believing friend, who urges her to contact a rape crisis center, where counselors, in turn, support her in making a police complaint. Other disclosures stop at the first telling or never go beyond the level of
informal tellings to trusted persons. There are good reasons why women choose not to report to the police and avoid criminal prosecution. However, some disclosures never progress beyond this informal level because the person to whom the victim disclosed failed to understand, believe, or support the process of disclosing. For instance, disclosures by children who do not have the vocabulary or cognitive development to explain what happened and feel frightened and "funny" about it, may be heavily coded. A naive listener could easily fail to pick up on the disclosure and, thus, unwittingly fail to respond to the child victim's "test" disclosure. Therapists have noted of childhood sexual assault victims that many report only once. If they are disbelieved or challenged, then they usually rescind their allegation (Groth, 1982 unpublished statement). The disclosures of (some) chronically mentally ill persons share these properties. Their verbal descriptions may be heavily coded because of mental confusion (perhaps the direct result of the assault) and/or because they are wary of the listener's reaction.

Types of Disclosure and the Pattern of Attrition

What we know about rape and other types of sexual assault is the result of victim disclosure (although it is not limited to what victims say). What we know is shaped by the interactive and, in some cases, formal processes which follow from disclosures. The disclosure process and the forms disclosure take, influence several coexisting "levels" of knowledge. For example, the "tellings" which occur between women create a rape folklore, and provide the primary basis of women's self-protection and defense strategies. The noncriminal complaints made by rape victims to rape trauma counselors and therapists specializing in assault are fast becoming
incorporated into a body of clinical knowledge about rape. Reports made to police provide a basis for our social knowledge of the prevalence, incidence and patterns of rape. Rape researchers employing survey techniques which correct the shortcomings of projections based on police reports, also contribute to our social knowledge.

In tracing the disclosure process, we observe a continuous attrition of cases, representing losses in what is known about rape and by whom. Because of the process of attrition we know little about rape, and even less about the sexual abuse of children and vulnerable adults\(^3\) who are unable to verbalize clearly, sustain a protracted process of disclosure, and/or prevail against the challenges of disbelieving listeners. By understanding how case attrition varies according to structural conditions associated with the context in which assaults occur, we can understand how it is we "know" so little about the sexual abuse suffered by persons confined to institutions.

How does a sexual assault of a patient in a mental hospital become "known" as a social fact to mental health administrators and staff, and/or become a crime statistic? The disclosure process, for institutionalized persons, involves the following forms: a) Telling. The victim tells someone that they were assaulted, talks out what has happened, seeks support, and seeks advice and/or support for making the assault more public and/or making a police report; b) Hospital Complaint. The patient-victim tells a member of the hospital staff and attempts to generate a serious response by the hospital staff.

\(^3\)By vulnerable adult, I mean those adults who are verbally and/or interactionally incapacitated or disabled, either permanently or temporarily, including persons who are chronically mentally ill, developmentally disabled, and brain injured. It is important to recognize, however, that their vulnerability is at least partly the result of social "handicapping."
staff; c) Reporting. The staff and/or patient with the assistance of the staff make a police report; and d) Founding. The patient-victim (with or without the assistance of staff) or the staff (with or without the assistance of the patient-victim) discloses facts of the assault to police investigators, in order to establish the incident as a "real" rape (or other kind of sexual assault) in the eyes of the law.4

Case Attrition: Comparing Extra- and Intrainstitutional Assaults

Each element of the disclosing process results in the attrition of some number of cases. Based on the victim accounts in this study, which I cannot presume are representative of all institutional sexual assaults, I hypothesize that there are points in the process of rape disclosure where "attrition" (the cessation of disclosing) is most likely to occur. The pattern of case attrition for institutional incidents appears to be somewhat different from that for extrainstitutional sexual assaults.

All caveats regarding representativeness and the appropriateness of comparisons withstanding, I have plotted the attrition of our thirty-six sets against a model of extrainstitutional case attrition I created from estimates provided by several sources, including the prevalence and reporting estimates of extramarital sexual assaults provided by Diana Russell (1983). Of the 930 women interviewed in Russell's study, 407 reported 693 incidents of extramarital rape and attempted rape.5 Only sixty-six of the cases (9.5

4By extension, the facts of the incident are disclosed to others who place the burden of authenticating rape complaints on the police, rather than taking the word of the victim.

5Russell does not employ a "set" framework so we do not know the number of same-assailant assaults in her sample.
percent) were reported to the police. This represents a loss of 627 cases at this point in the disclosure process. For estimating the percentage of cases lost at the founding stage, I used the last published "unfounding" estimates in the FBI's *Uniform Crime Report* (1976), which report that in 19 percent of all rapes and attempted rapes reported to them in 1976, "no forcible rape offense or attempt occurred." Applying that figure, an additional thirteen cases (2 percent of the total assaults) were potentially lost. In order to estimate the attrition of cases as they progress through the criminal justice system, I utilized figures provided by Brownmiller, based on her review of the FBI's 1973 *Uniform Crime Reports* (1975: 189-91). She estimated that only 3 percent of the actual number of rapes and attempted rapes result in conviction of the assailant. Only half of the assailants are apprehended (51 percent), of which three-quarters (76 percent) are prosecuted. Slightly more than half are convicted (53 percent). Applying Brownmiller's statistics to Russell's prevalence data, we can plot (see Table XIV) the attrition of cases at each critical point of the disclosure process and during subsequent remedial efforts by civil authorities. The points during the disclosure and remedial processes at which the greatest number of cases are lost are the police reporting and apprehension stages. The founding process is a critical stage in the development of cases and, as Clarke and Lewis (1977), and McCahill et al. (1978) have shown, a good number of valid cases are *illegitimately* unfounded by the police. However, fewer cases are lost at this stage than are lost prior to reporting or at the apprehension stage.
TABLE XIV

ATTRITION OF EXTRAINSTITUTIONAL SEXUAL ASSAULT CASES

<table>
<thead>
<tr>
<th>Occurrence</th>
<th>Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Assaults</td>
<td>693</td>
</tr>
<tr>
<td>Reported Police</td>
<td>64</td>
</tr>
<tr>
<td>Founded</td>
<td>52</td>
</tr>
<tr>
<td>Apprehended</td>
<td>27</td>
</tr>
<tr>
<td>Prosecuted</td>
<td>21</td>
</tr>
<tr>
<td>Convicted</td>
<td>11</td>
</tr>
</tbody>
</table>

(Percentage of assaults resulting in conviction = 1.6%)

Intrainstitutional disclosures include a structurally-determined intermediate "telling" to hospital staff (including ward level, therapeutic, and administrative personnel), which constitutes an internal "complaint" stage not usually present in extrainstitutional abuse cases, and signifies a legal (but, in practice, discretionary) obligation for staff to report to the police. The patients we talked to rarely knew if their disclosures to staff resulted in any kind of internal written report. Therefore, strict differentiation between informal staff "tellings" and "formal hospital complaints" isn't possible. I have plotted both kinds of reports as "staff tellings" and presumably, some of them become part of official record keeping. My analysis of staff interview data may provide an estimate of the number of "tellings" which are written up as complaints. Not all patients tell staff, however. Those who do tell are subjected to the "founding" (accrediting) efforts of staff.
TABLE XV
ATTRITION OF INSTITUTIONAL SEXUAL ASSAULTS

<table>
<thead>
<tr>
<th></th>
<th>Occurrence</th>
<th></th>
<th>Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Assault (Sets)</td>
<td>36</td>
<td>55.5%</td>
<td>36</td>
</tr>
<tr>
<td>Staff Tellings</td>
<td>20</td>
<td>55.5%</td>
<td>16</td>
</tr>
<tr>
<td>Police Reports</td>
<td>7</td>
<td>35.0%</td>
<td>13</td>
</tr>
<tr>
<td>Founded</td>
<td>5</td>
<td>71.4%</td>
<td>2</td>
</tr>
<tr>
<td>Apprehended</td>
<td>5</td>
<td>100.0%</td>
<td>0</td>
</tr>
<tr>
<td>Prosecuted</td>
<td>4</td>
<td>80.0%</td>
<td>1</td>
</tr>
<tr>
<td>Convicted</td>
<td>4</td>
<td>100.0%</td>
<td>0</td>
</tr>
</tbody>
</table>

(Percentage of assaults resulting in conviction: 11.1%)

The percentage of criminal convictions (compared to the total number of assault sets) in our sample of institutional assaults is more than three times greater than Brownmiller's estimate and almost seven times greater than my extrapolation based on Russell's data. Remember, however, that my sample of accounts is highly biased in this regard, because of the purposeful inclusion of four civil suits (all of which included prior criminal prosecution). Even if these cases were not part of the sample, these "findings" are likely distorted by the small number of cases. However, the pattern of attrition suggests an hypothesis about the particularity of institutional assaults: the greatest number of cases are lost before they get to the police; and while assaults involving institutionalized victims are less likely than extrainstitutional assaults to be founded by police, once they have been founded, they are much more likely to result in the apprehension, prosecution and conviction of the assailant. Once cases of sexual assault are reported to the police, and the police are able to establish their legitimacy as criminal complaints, district attorneys may be extremely effective prosecuting assailants. Successful prosecution is aided by a unique feature of institutional rapes —
that the assailant can almost always be identified (by the victim and staff), and apprehended by the police.

As with extramural cases, the greatest loss of institutional cases occurs prior to the police report stage. Fourteen cases were not disclosed to staff or to anyone else at or near the time they occurred. This represents a loss of thirty-nine percent of the total number of sets. Although staff were told of twenty cases (patients chose not to tell staff but to tell others in two cases), only seven of these incidents resulted in police reports. One of the police reports was made directly by the patient and a patient advocate, and in a second instance, at the insistence of the woman's husband. This represents, at best, an additional loss of thirteen cases (36 percent of the total) because staff failed to report them to the police. Two more cases dropped out during the police founding process.

Therefore, there are three critical stages for establishing the social facticity of mental patients' rape: the telling, the reporting, and the founding by police. The first two fall within the influence of institutional personnel. The third, while primarily a function of police attitudes and processing practices, may also be influenced indirectly by institutional staff who are willing and able to act as agents in processing the victim's complaint.

Strategies of Disclosure

Reasons For Not Telling and Not Reporting

A significant number of subjects did not tell anyone about the assault
at the time it occurred. Several had never discussed the assault with anyone until our research interviews. The women we talked with gave many reasons for not reporting, some of which closely parallel the reasons provided by extrainstitutional victims of rape, such as fear of assailant reprisal, fear of disbelief, and shame. On the other hand, some reasons for not telling or reporting were based in the experience of being a patient in a psychiatric hospital.

**Mental Confusion**

Some respondents did not report because they were physically or cognitively unable to tell anyone for a period of time (patient-victims who were in seclusion or restraints at the time of the assault or experienced postECT confusion). One woman (who told no one about the assault) suspects she was assaulted during a series of ECT treatments when she was sixteen. She remembers the psychiatrist touching her thigh on a couple of occasions and remembers him putting her hand on his penis and making her masturbate him. She recounts that

> even when I was getting straight in my head, I couldn't be sure what all happened and when it happened.

Her uncertainty at the time about what was happening was influenced by the distortion in thinking associated with ECT treatments, but in addition, she couldn't believe that her psychiatrist would do such things.

Whereas fear of disbelief in the face of a report is shared by other victims of sexual assault, psychiatric patients may disbelieve the incident themselves, perhaps seeking verification from their psychiatrist or others that it wasn't an hallucination, that "it" really happened. Patients may know that an act occurred, but they may not be able to define its meaning or the
nature of their participation. (Did they consent or not?) We are aware of one case (not included in our sample) in which a patient who was raped by a penal code patient hallucinated the experience as "consensual" sex. Evidence gathered in the course of bringing rape charges against the assailant for raping another patient established that what the first victim had experienced as an hallucination was indeed a rape. This incident exemplifies how the mental condition of the victim at the time the event may distort the true meaning of the act, and thereby shape the reactions, not only of others, but of the victim as well.

**Situationally-Normalized Behavior**

Some women did not tell staff because, from their experience, sexual abuse, and other forms of abuse and neglect, were "normal" (normalized) in hospitals, and therefore, they believed staff would not take their reports seriously. As one woman said:

> It was really common. That's the one thing that really blows me away is [sic] I accepted it totally. When you're in a hospital, you're in a community, and that's the only community that exists for you. And [there] it [sexual abuse] was something we knew happened.

Sometimes staff or therapist responses to specific complaints reflected this anticipated normalization of sexual harrassment, abuse, and assault, and sometimes they did not. But whenever patients interpret abuse as "normal" (whether it is an actual feature of the environment or the acquired view of a person with an extensive patient career), we can predict that all but the most extreme assaults will go unreported.
Fear of Staff Misinterpretation

Some subjects feared that their reports would be misinterpreted by staff as "acting out" and result in some form of punishment, such as "being put down," "shot up," or taken to a "side room." Some patients who had been assaulted by a staff member feared that a report would be interpreted as an attempt to get the staffer in trouble, with the result that other staff would not like them or would view them as "troublemakers."

Dependency

Psychiatric patients, like child victims of incestuous sexual abuse, are often victimized by the persons and within the social contexts upon which they depend for emotional and physical security. Reporting carries great risks; hence, nonreporting is hardly surprising. An assault by a caretaker during a time of extreme vulnerability can leave the victim confused and shocked. This confusion is likely to delay or entirely inhibit a report.

Both Bart (1975) and Smith and Nelson (1976) report an inverse linear relationship between the victim's degree of acquaintance with assailant and the probability that the assault will be reported to the police. The San Jose reverse record study (LEAA, 1972) also concluded that the victims decision to report was influenced by whether she knew the rapist. Assaults committed by authority figures probably account for the most underreported type of extramarital sexual abuse.

All psychiatric facility staff are in positions of authority over patients, although some, particularly psychiatrists, have more authority than others. None of the women we interviewed who were assaulted by psychiatrists reported the assaults to staff or the police. One victim of a staff physician's
assaults told her father (albeit in a coded fashion). He disbelieved her, insisting instead that, "They are helping you here."

**Forms of Disclosure Particular to Mental Hospitals**

**Tellings** are informal and nonofficial accountings of an incident by the patient-victim to other patients, her psychiatrist, a staff person or family member, in order to gain support, protection, and/or attention. The telling is not a formal complaint because the patient or the listener treat it otherwise, and/or because the content of the complaint is not (yet) sufficiently organized to demand formal staff action. Tellings may be highly coded and abbreviated verbalizations intended to test staff reactions and achieve sufficient support before the patient-victim assumes all the risks and burdens of a detailed accounting. Tellings are, therefore, often ambiguous and can be discounted the first time(s) they occur.

Tellings may become official hospital "complaints" if the patient, staff, or outsiders "take them seriously" and/or decide to treat them "formally." The patient must then sustain the account through multiple tellings to different staff and administrators. Tellings do not necessarily generate a remedial staff response for the immediate victim, but they may eventually provide a basis for staff to credit some future patient account of assault. For example, staff in one local psychiatric unit had been told by a patient that she had been sexually fondled by a night shift psychiatric aide. They discounted the telling but later, when another patient ran screaming from her room, at the moment the same aide approached her, they realized that the prior telling
had probably been "real." These separate tellings corroborated each other. The second telling was written up as a special incident report, an official complaint generating an internal procedural response.

**Complaining:** A complaint is a formal account of an assault that is initiated by a patient (or staff member) stating the patient's claim that she was assaulted. A staff member converts a verbal complaint to a written form, often a "special incident report" (SIR), which summarizes the facts and circumstances surrounding the incident, and the staff response. Some patients, knowledgeable of their rights, initiate disclosure in the form of a complaint, addressing the "right" staff member with the statement, "I want to make a complaint." Others may contact a patient's rights advocate or family member, and ask them to initiate a formal complaint — to act as their agent. When the process of reporting begins with a "telling," staff will determine, as individuals or in some collectivity, what "telling" is "real," or possibly "real," and whether it requires a formal and official staff response.

The basis for treating a telling as a complaint may be the factual elements of the story, and/or the reputations of the patient and the alleged assailant, or the patient's use the right "legal" words which serve as indicators to staff that the patient is likely to pursue her complaint until she is somehow satisfied. If the patient has also told others (or is likely to tell outsiders, including hospital administrators or social workers), staff may be more inclined to treat the disclosure as a formal complaint. Staff will also treat an allegation formally if they believe it is likely to result in litigation. Formal treatment also arises from the enforcement of hospital policies and

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6 Sometimes complaints are made directly by staff who witness a sexual assault/abuse of a patient.
protocols, particularly if they are widely supported. Other conditions which may encourage written incident reports and formal treatment of complaints, include the existence of prior complaints involving the alleged assailant and prior similar problems in the unit or hospital.

Complaints are internal hospital reporting procedures whose primary purpose is to legitimate the decisions and actions of hospital staff and administration relative to legal and professional standards of care, in the event of a civil suit or licensing problem. Information contained in the complaint and control over the problem (however it is constructed by the hospital) remain within the hospital. Complaints provide an official record of what the patient said and how hospital staff responded to the fact of the complaint, and they may also describe the basis upon which the patient's story was judged probable or not. Complaints transmit information between levels of the unit/hospital hierarchy. In some cases they become part of the patient's medical record, and in all cases, they become part of the administrative records of the hospital. A complaint is an opportunity for events and behavior occurring within one shift and unit to be known and responded to by members of another shift, and other members of the hospital hierarchy. Complaints may be reported to the police if the staff perceive that the patient's story is accurate or if they decide that the best course of action is to involve outside authorities.

**Reporting** is the process of bringing sexual assault complaints to the police or comparable outside authorities (such as San Francisco's Sexual Trauma Services, part of the City and County's Public Health Department), which can investigate them as sexual assault allegations. The distinction between telling or complaining, and reporting is that reporting involves
outsiders in the processes of crediting and remedying the allegation. Telling and complaining announce the allegation within a smaller and more restricted social arena. Telling may keep the allegation within the unit or ward, or within the patient's circle of outside friends and family. Complaining keeps the information within the hospital and may be restricted to the immediate chain of command. Making a report, and thereby involving outsiders in the determination of the patient's claims, represents a significant threat to medical and hospital control and also generates considerable apprehension on the part of staff when a co-worker is the alleged assailant.

Specific Strategies

Our data suggest that differences in the ways patients disclose an assault to staff may be strategic choices. Patients usually attempt to balance their need to tell and be believed against the feared consequences of not being believed and therefore, being open to reprisals or continued assaults, as well as possible staff misinterpretation and "punishment."

Each patient's strategy, although only one feature in the calculus of believability, has particular consequences for how staff credits the patient's story. On one end of a continuum are disclosures which involve no apparent strategy, for instance, if the assault was interrupted at the point of initiation and the patient reported immediately. This kind of disclosure involves no (apparent) calculation by the intended victim and, instead, seems to be a spontaneous expression of outrage, fear and inviolability. A staff respondent told us about a patient in a county hospital psychiatric unit, who awoke to discover a man climbing into her bed. The patient broke away from him and ran to the nursing station, all the while shouting her "report"
to the staff. No time elapsed between the attempted assault and the report. According to the staff informant, this report demanded the immediate attention of the staff because of the patient's loud and urgent delivery, and also because it was "so spontaneous." Because they immediately attended to the patient's shouts, staff saw the would-be assailant leave the patient's room and, thus, were able to begin to corroborate her claim. The absence of apparent calculation by the would-be victim reinforced her believability, and made her appear to be without guile or without motivation to give a false report.

Reasons for delaying disclosure to staff are different from reasons for not reporting at all. Delays are usually the result of evaluating the risks of reporting against the risks of not reporting, and making a strategic choice. In one case, the patient did not tell staff the first time the orderly made her have intercourse with him, but when he "hit on me again, I told them." In other cases the patient-victim waited until she felt it was safe for her to tell someone.

Alice was subjected to an escalating series of sexual assaults during the full eight hours of a night shift. The assailant, a psychiatric technician, entered her room six separate times and each time committed at least one sexual assault against her. His "visits" each lasted 15–20 minutes. He would leave for a while, presumably in order to tend to his other duties and avoid the suspicions of other night shift staff. Each time he returned, he escalated the severity of the assault. He started by touching her stomach and thighs. He ended by forcing fellatio and vaginal intercourse. Alice didn't yell or report to the other staff during the assailant's absences. Initially she was not sure what was happening. As the assault escalated, she became afraid she wouldn't be believed, that her report would be misinterpreted as "acting out," and that her release from the locked unit, scheduled for the next day, would be delayed. In the end, she became afraid that the assailant and his friends
on the shift would kill her if she complained. So she waited until the next day, well after the next shift took over and she was sure that he (and his friends) weren't there, to tell the first staff person she saw that "something happened to me last night." The staffer asked what she meant, listened, and immediately went for the supervising nurse. Then, the long series of tellings, complaints, and reports began.

In spite of the logic of Alice's decision to delay reporting, some staff saw the delay as inconsistent with her claim, supportive of the alleged assailant's claim of innocence, and as "evidence" that she was being manipulative.

Delay is an element in the calculus of believability frequently used as a condition for discrediting assault complaints and victims. Immediate and spontaneous telling supports the veracity of the claim and the claimant, while a delay may suggest a false accusation, particularly when the accused is known to staff and/or a specific motive to fabricate can be attributed to the accusing patient. However, there are also risks to the patient of staff misinterpreting spontaneous yelling as "acting out."

Strategies of disclosure may also involve the recruitment of internal or external agents. The patient-victim begins with convincing one person to believe her account (or at least take it seriously) and to act for her. How far a patient-victim is able to pursue this strategy depends upon her own capacity to endure, regardless of how she may be challenged, and the unpredictable reactions of those she seeks to agent her complaint. Among those respondents who sought agents, most sought agents only within the institution (their psychiatrist, other professionals, and, less often, ward staff) while a few attempted to recruit outsiders such as family members and/or attorneys and patients' advocates.
Problems and Conditions Affecting Patient Disclosure

A victim-patient must face many challenges to sustain her report. Few rape victims can handle the pressure of multiple interviews, without feeling punished and disbelieved. The chronically mentally ill victim's capacity to sustain a report over time is threatened by the possibility that her mental or emotional functioning will deteriorate at some time during the disclosing process. A local rape crisis counselor described a mentally ill woman (not an inpatient) who was raped, and subsequently called the crisis center for help. With the support of the counselor, the woman went through a physical examination and police interview. The counselor described her as handling it very well until the next day, when she "decompensated," interrupting her ability to continue through the processes of disclosure and to cooperate with police in the subsequent apprehension and charging of the assailant. A severe reaction (what one victim called "going off") can happen at any time during the disclosure process, and can make accurate crediting and founding of the allegation difficult or impossible.

State of the art clinical practice for treating rape victims limits the number of times victims must relate the details of the assault to investigators, in order to reduce additional stress on victims and enhance the probability that victims will report. Rape crisis specialists hypothesize that relatively low reporting rates are party an outcome of victims' fear of repeated retellings and the anticipation of feeling (or being) disbelieved that multiple interrogations exacerbate. The rare patient-victim, whose first disclosure is taken seriously, may still have to repeat her story many times to satisfy the hospital hierarchy (ward staff, nursing supervisor, resident on
call, chief of psychiatry, hospital administrator) that there is sufficient cause to call the police. Upon arrival of the police, the victim must repeat everything at least once more. Imposing a demand for sustained and repetitive disclosure, in order to handle the complaint within the normal bureaucratic order of the hospital, can cause the victim to rescind her story or may precipitate an augmentation of her symptoms.

**Disclosing to Staff**

Even in the post-patient rights era, when inpatients have increased connections to the outside for adjudication of grievances and abuse, patients victimized in the hospital still turn first to staff (if they seek redress at all) to reveal the assault and to assist them. More than half of the women we interviewed told hospital staff they had been assaulted. Mostly, they told ward-level staff, although some also told their hospital therapist. However, many respondents believed that the simplest disclosure involves risks, for example the complaining victims may be discounted and defined as a troublemaker, if staff believe her accusation is motivated by anger at them, or she may be subjected to augmented treatment if she becomes upset in the course of describing what the staff perceive as a fantasy. These are examples of what Goffman (1961: 35-38) described as "looping" -- an aspect of the mortification of self which is central to the "moral career of the inmate" and one way in which, in institutions, the "autonomy of the act" is violated.

The individual finds that his [her] protective response to an assault upon self is collapsed into the situation; he [she] cannot defend himself [herself] in the usual way by establishing distance between the mortifying situation and himself [herself] (pp. 35-6).
Telling other patients, staff members or others what she experienced, represents an important way the victim can define the act for herself. In the course of telling others, she can test out whether it "counts" as a serious problem, whether the shame and/or guilt she feels is justified; and whether she has support for feeling assaulted, for complaining, and for her identity as a credible self. Telling is also a way of gaining protection from the assailant and an opportunity to map out other protective strategies.

Disclosure to staff makes possible the initiation of staff collective actions to protect the patient from further harm and to restore "sexual safety" to the unit, but does not guarantee it. Staff members' initiation of such collective action depends on their conditional belief in the patient-victim's story. However, staff may or may not collect evidence and conduct the investigations necessary to establish the conditional legitimacy of the allegation.

The process of crediting the patient's account often leads to a crisis on the ward (Deutscher et al., 1976) and challenges staffs' estimations of the quality of patient care they provide, the reliability and character of their co-workers, and their handling of similar allegations in the past. So serious are such patient allegations that many staff employ a variety of discounting, discrediting and challenging techniques to disavow such claims. In order to get staff to take their claims seriously and to credit their accounts, patients, like other victims of sexual assault, sometimes must sustain accountings in the face of humor, ridicule, anger, significant skepticism, the challenge of

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7In the absence of proactive prevention capacities, staff must react to a reported or discovered abuse in order to initiate any actions which will increase the level of safety for the environment as a whole.
close questioning, and hostile attempts to uncover discrepancies. Few of the women we talked to were capable of sustaining such an effort and those who endured criminal and civil trials were unique.

Staff Responses to Patient Accounts

I have identified, from the stories of patients, three typical staff response to patient tellings of assault:

**Conditional belief** This is a supportive, nonchallenging response to patient accounts which treats allegations seriously (as if they were true). The response may be based on the staffers assessment of what "really" happened or on a formal procedure for treating patient allegations of sexual assault.

**Normalizing** Staff believe the accounts, but discount or normalize the seriousness of the assault. This response usually prompts the alleging patient either to drop the claim or take it elsewhere, perhaps to outside civil authorities or patients/victims advocates. If a claim is not pursued, it is not likely to surface again or even become part of the hospital's official incident records. An example of normalizing a patient's disclosure of sexual assault and its consequences is provided in the following account:

A woman patient in a state hospital was repeatedly grabbed and molested by a male patient on the stairwell connecting her ward with other hospital services such as the cafeteria. Each time these "mashings" were discovered, they were broken up by male attendants, who told the assailant to stop. No other action was taken by the staff to prevent these abuses from continuing. Finally, the woman told her psychiatrist, who responded in a manner he may have seen as validating and supportive but she did not, that, "This is something you have to consider here, because there are all kinds of people around. Just be careful."

The psychiatrist seemed to believe the patient. However, by normalizing the situation, he handed back
to her sole responsibility for keeping herself safe. The woman did not make a formal complaint, nor did the attendants who discovered the "mashings," nor did the psychiatrist who was told. The woman saw no evidence of collective action on the part of the staff to remedy her situation. Instead, she took her own preventive steps. She started avoiding the stairwell, which meant that, except for the food her roommate occasionally brought her, she didn't eat for several days. Furthermore, she felt even more distrustful of men and psychiatry than she had before. From her point of view, the hospital staff knew of the assaults and apparently either didn't care or couldn't/wouldn't do anything about them.

**Challenged** The initial stance toward the claims and the patients is explicit disbelief, which may be communicated as a) outright denial of the claims based on how staff assesses the credibility of the accounts; b) disbelief of the patient-victims themselves (a general denial of patients' credibility); or c) intimidation tactics which do not explicitly deny or disbelieve patients or their accounts, but rather, discourage them from pursuing the disclosure. Intimidation tactics may include pointing out the serious consequences of a patient's allegation for the accused, the hospital, etc. When patients meet this response, they often rescind their story or drop their claim. Sometimes, however, patients are able to sustain their accounts in spite of challenging tactics, eventually forcing procedural treatment of their claims.

**Disclosure to the Police**

Staff more frequently than patient-victims make police reports. Therefore, to understand why such a small percentage of complaints reached

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8Her primary self-defined problem at the time she was admitted was an extreme fear of men. She had been raped twice before she was institutionalized, once by her stepfather and once by an acquaintance.
the police, we must understand the conditions influencing staff disclosure to the police. Few patient allegations of institutional rape are reported to the police because, unless the patient is capable of making the report herself, staff often notify police of only those claims they believe are "true." This is explicit in the policies of some hospitals.

Hospital personnel and administrations are often unclear about what patient allegations they ought to report. Some staff are unclear about how and what they should report, in light of patient confidentiality requirements. There is good reason for this uncertainty. The law is ambiguous and sometimes contradictory, and allowing hospital personnel, particularly physicians, considerable discretion in determining the "fact" that an assault occurred.

The California Penal Code (Sections 11160-11161.5), for example, requires:

Hospital administrators, or persons in charge of a ward or hospital, and physicians and surgeons to report immediately the fact of a sexual assault to local law enforcement authorities by telephone and writing.

However, the penal code does not clearly state what constitutes the "fact" of a sexual assault. It only specifies that local law enforcement officials must be notified prior to commencement of the required physical examination, if the patient consents to an examination.

The California Welfare and Institutions Code (Section 5328.4), which contains administrative regulations that direct hospital and professional practice relative to confined mental patients, does not clarify how the fact of sexual assault shall be determined, except to indicate that a) physicians or hospital administrators have the authority to determine the probability that a
patient has been sexually assaulted and b), once the occurrence of an act is determined by the hospital authority (physician or administrator), some "acts" must be reported, while others may be reported. It states:

The physician in charge of the patient, or the professional person in charge of the facility or his designee, when he has probable cause to believe that a patient while hospitalized has committed, or has been the victim of . . . rape, forcible sodomy, [or] forcible oral copulation, . . . shall release information about the patient to government law enforcement agencies.

The physician in charge of the patient, or the professional person on charge of the facility or his designee, when he has probable cause to believe that a patient, while hospitalized, has committed, or has been the victim of assault or battery may release information about the patient to government law enforcement agencies.

The Welfare and Institutions Code requires that hospital personnel report the most serious of sexual assaults (rape, forcible sodomy, and forcible oral copulation), yet leaves to the discretion of staff the reporting of "lesser" assaults, even though this contradicts the apparent intent of the Penal Code (see above). The Welfare and Institutions Code also falsely suggests to hospital authorities that they can determine what are indeed legal, not medical matters — that is, whether or not a "rape" has occurred. Moreover, the ambiguity in the law reinforces the a priori reluctance of many mental health professionals to report patient allegations to the police. Staff and administrators don't want police investigators coming into the hospital and potentially disrupting their established order and uncovering their mistakes. Specifically, staff want to continue to screen real from false complaints and, indeed, they believe that a large number of patient complaints are false.

Some psychiatrists believe that they must reserve for themselves the
responsibility (power) to determine what is a "real" allegation and what is the product of a patient's delusional system. Not only do they believe it is their professional right to make such determinations (and that to disallow these determinations would undermine their clinical judgment and ability to treat patients), but some also contend they can make such determinations on the basis of evaluating the patient's (available) history and psychiatric profile alone. However, their ability to make such judgment calls may be severely impaired by prevalent attitudes among psychiatric professionals about the veracity and reliability of patients who make accusations of sexual assault.

Many of the staff we have interviewed do not readily acknowledge the possibility that patients in their care are vulnerable to sexual assault, particularly by other members of the staff. Some told us that many patient allegations are probably "false" because: a) patients are angry at the staff and making an accusation is a way of getting even; b) patients are angry at being hospitalized/institutionalized; c) the belief that they have been raped is part of their delusional system; d) patients "think" it happened and their "thinking is at an angle"; and e) psychotics are sexually preoccupied.

Staff subjects tell us that the most conscientious and caring mental health workers are often extremely demoralized by working in "climates of accusation." Some complain that hospital administrators are extremely arbitrary in handling accusations, particularly allegations against staff, whose rights they often fail to adequately support. There are other institutional and work factors which inhibit staff from making police reports. Treating every allegation of sexual abuse as warranting a police investigation could disrupt the work routine, "excite" the patients (as one psychiatrist told us), and maximize the stress experienced by staff. To call the police or other
outsiders, such as local rape crisis specialists, would undermine the discretion and control staff currently exercise in determining there is "probable cause to believe that a patient while hospitalized . . . has been a victim . . . of [sexual assault] (California Welfare and Institution Code, Section 5328.4).

Sexual assault prevention and intervention is inhibited by certain organizational and structural arrangements common to psychiatric facilities. For example, responsibility for implementation and enforcement of many regulations regarding patient rights and safety is decentralized to individual units and wards. Administrators rely on ward-level staff and professionals to keep the environment safe and handle patient complaints, while providing no structural equivalent to the "morbidity and mortality" committee,\textsuperscript{9} where staff could improve their understanding and practice. As one hospital administrator explained, when we asked him how ward staff would handle a patient complaint and, more importantly, how he would learn of such complaints, considering the absence of written policy,

\begin{quote}
I rely on the professional judgment of the staff to handle patient complaints appropriately. They know the patient and the situation, and I trust that they know what to do. If they think I need to know something, they will tell me (paraphrased).
\end{quote}

While administrators and physicians would reserve for themselves final authority to determine the "fact" of a sexual assault, the ward level staff, to whom this authority may be delegated in practice, often function without adequately specified procedures. In many settings, staff are not told how they should handle patient complaints, what kinds of information they should take

\textsuperscript{9} In medical hospitals, morbidity and mortality committees analyze medical errors, mistakes, and untoward occurrences.
seriously, and the limits of their responsibility *via a vis* those higher up in the ward or hospital hierarchy.

**Strategies of Silence**

Donald Cotton, based on his study of jail rape, outlined the post-assault self-protection choices of male prisoners (1982). First, the inmate can ask the authorities for help and, therefore, be regarded as a "snitch" and be open to the risk of severe retaliation. His other choices bear striking similarity to those of mental institution rape victims. The prisoner-victim can choose not to tell the authorities and risk being subjected to repeated victimization, or there are at least three ways he can escape. He can literally escape and plead extenuating circumstances, if caught; he can escape by "going crazy" and be transferred to a psychiatric facility; or he can commit suicide. Female victims of sexual assault in mental institutions also have a limited range of self-protection strategies. If they choose not to tell or if their disclosures to staff are rebuffed, they may employ "silent" safety strategies or simply give up and cooperate with the assailant's sexual demands.10

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10Psychologists would probably label what I am calling "silent strategies", as "blocking" or "walling over." From the perspective of symbolic interaction, we can see this as constructing a definition of the situation which supports a definition of self as nonvictim, the incident as noninjurious, and the future as probably safe. There are also negative consequences inherent in this choice of strategies. As Blumer put it, there is an "obdurant reality" which resists our definitions. In this case, the definition of "nothing having happened" does not permit developing strategies that allow the avoidance of future assaults. Indeed, the assailant's definition of the situation as nonrape or consensual is reinforced by the post-assault strategy of silent avoidance and the assaults may continue.
The range of silent strategies reported by the women we interviewed, included strategies of avoidance, sociation, transfer and escape. Avoidance strategies included actually physically avoiding the assailant, as well as spaces where he was likely to be. Given the range of assault locations discussed in Chapter Three (bedrooms, stairways, grounds, treatment rooms, etc.), this could mean staying away from nearly every place within the institution. To avoid being assaulted in their rooms each night, two subjects feigned sleep. It didn't help, however.

Women also employed a range of "sociation" tactics, for example "latching onto" a trusted staff person. Janice latched onto a female staff member whom she trusted and stayed with her in spite of the fact that it greatly prolonged her confinement on a maximum security ward (a jail within a jail).

Right after that [the assault] happened, I got into the state hospital and spent three weeks in a maximum security ward. I latched onto a female staff member. It seemed like I trusted women more at the time. And I made sure I was with that person. To stay with her I had to be in a maximum security ward. And to be in a maximum security ward, you have to act out. So I kept on acting out so I could be with her in order to feel safe. I felt safe there. She understood.

Our respondents did not always use such extreme sociation tactics, however. Often, they simply broke away from the assailant and joined a crowd of other patients.

Afterwards I tried to stay close to people and there was a woman friend who was admitted to the ward who I stayed around.

On the way to the dining room an orderly grabbed me from behind and kissed me. I broke away from him and then caught up with the rest of the patients and stayed with them.
Some women protected themselves from further assault by transferring or escaping. This was sometimes accomplished at great cost. For example, one woman with a long history of self-destructiveness (and also, a long history of being sexually abused, including incestuous assaults by her father), cut herself in order to be transferred to a medical facility and away from the janitor who had assaulted her. Another woman, Candice, who was assaulted twice during a single hospitalization in a state hospital (once by a psychiatrist and later by an orderly), employed two tactics to protect herself from further assault. Immediately after the assault, until she left the hospital, she made sure she was always around other people. For awhile she stayed close to another woman patient. During this period she thought about escaping from the hospital, which she eventually did. In order to avoid being caught and returned to an institution, Candice left the state until she "was able to get herself together."

**Conclusion**

In the two year period of this study, we have encountered a number of facilities with staff committees to develop protocols for handling consensual sex between patients, and a few that are developing thorough procedures for
handling patient accusations of sexual assault. However, these procedural innovations are not usually accompanied by parallel staff retraining programs. At best, such policies can provide only a modicum of concern for preventing sexual assault, for they are, primarily, instruments directed to legal concerns, which aim to bring hospitals into compliance with the law and reduce criminal responsibility and civil liability. The collective efforts we have observed do not yet address prevention or the profound clinical significance of sexual victimization during psychiatric treatment. In order to prevent sexual assaults, the efforts of staff will have to be directed toward discovering assaults and encouraging victims to report. Instead, the attrition of legitimate cases is encouraged by placing the sole burden of disclosure on victims. At the same time, hospitals have failed to address the behavior and attitudes of staff, which actively discourage disclosure.

The immediate clinical consequence of undisclosed and discredited sexual assaults is the welfare of undiscovered and untreated victims. Clinical literature on the impact of sexual assault suggests that people with psychiatric disabilities are most vulnerable to extreme rape trauma sequelae (cf. Frank et al., 1981). Undetected assaults and, therefore, the absence of treatment or counselling focused on them, may create or exacerbate psychiatric symptoms and disability. Our data suggest that behavior, which in a different context would be understood as a logical, adaptive or self-protective response to assault (such as avoiding certain physical spaces and extreme fear of men), may be misinterpreted by mental health

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11As a direct result of this study and the focused concern it generated, one community mental health system has adopted a policy requiring that all of its contracting hospitals contact the police about every patient allegation of sexual assault or sexual battery.
professionals and institutional staff as an escalation of symptoms of mental illness, or failure to adjust to the institution.

Almost half of the respondents in our study did not disclose incidents of assault or abuse to the staff, largely because they assumed they would not be believed. Many also feared they would be punished by staff for being "troublemakers," and a few feared reprisals by the assailant. The serious impediments to prevention that result from nondisclosure are that psychiatric institutions are environments where sexual assaults are invisible, and institutions remain environments that are not identified by key individuals and policy groups as legitimate targets of rape education and prevention work. The facts which would provide the basis of collective action do not emerge, except as isolated instances requiring immediate reactions by individual staffers.

One aspect of patient disclosures stands out as noteworthy. Even though patients feared staff would not believe them, and in spite of the expressed resentment toward the institutions, more patients told staff than kept silent. However, most patients relied on staff alone to credit their accounts and provide them with protection. Only a few patients, who told family members or friends who then acted as agents for the complaint, employed a broader strategy of disclosure. One respondent was unique in her persistent efforts to disclose. She called the city police and got no response. Then she told a psychiatric resident, hospital security, the patient's advocate, and the ward psychiatrist (during a community meeting), before getting the full remedial response she wanted.

For the most part, patients depended on staff to act as their agents: to tell appropriate others, remove the patient and/or assailant from the setting,
process a formal complaint, and call the police. If a staff member took the accusation seriously, the patient would continue to disclose. If staff ignored the complaint, patient-victims often stopped seeking assistance to remedy the situation. An analysis of staff accounts of post-assault remedial actions is necessary in order to understand more fully how these respondents manage patient allegations of sexual assault, what shapes their responses, and under what conditions they take on agenting roles for patient-victims. It is clear, however, that most disclosures of patient sexual assault (if they are made at all) are made to staff, and if staff do not act, most incidents will become "hidden" experiences of sexual victimization.
Chapter Six

Opportunity Structure and the Normal Order

Overview

Rape and the opportunity to rape (which are separate phenomena) are not always random or incidental to the contexts within which they occur. If they were random acts, we would not be able to imagine how rape could be prevented nor would rapes so frequently share similar features and patterns. Instead, the "causes" of rape are often embedded in the social context of the act itself. For example, the social relationships and practices that permit the would-be sexual abuser to "predict" the likelihood of committing the act without being detected, and that the victim will not report or be believed if she does tell, constitute an "opportunity structure" which awaits only the impulse and manipulation of the assailant.

Rape is a crime of opportunity. Some number of rapes occur when an unplanned opportunity to rape presents itself to the would-be rapist (a victim was available, and the time and place allowed the act to be committed without being detected). Menachem Amir (1971: 336), in his study of the patterns of forcible rape, estimated that approximately one-fourth of all reported rapes in Philadelphia were unplanned. Most rapes (71 percent), however, are, according to Amir, planned by rapists, who either have particular victims in mind and take steps to lure them into the rape
situation, or plan the acts and leave the selection of victims to chance. Both planned and unplanned rapes are contingent upon the existence of a "opportunity" to rape. Planned rapes may be considered instances where the rapist manipulated preexisting "opportunity" features and/or created an opportunity. An unplanned rape represents the simple coincidence of opportunity and impulse.

As we have seen in the patterns associated with institutional assault, staff-perpetrated sexual assaults are different from those committed by patients. Patient-perpetrated assaults are more likely than those committed by staff to be single, forcible acts, resisted by the victims, and reported to staff. Staff-perpetrated assaults are more likely than those committed by patients to be multiple acts, nonforcible in nature, unresisted, and unreported by the victim. Staff- and patient-perpetrated assaults also differ in the degree of apparent planning on the part of the assailant, and in their "opportunity" properties. The patient-perpetrated assaults we analyzed were most frequently unplanned, spontaneous acts, which occurred only when specific opportunities presented themselves (e.g., the absence of staff surveillance and availability of a "target"). Staff-perpetrated assaults appeared to be planned and deliberate acts, in which would-be assailants created (or took advantage of) specific opportunities and attempted to select as victims those patients who were least likely to resist, report, or be believed.

A consideration of the "opportunity" properties of rape refocuses our attention from the rapist and victim onto the situational features and environmental context of rape, that is, time; place; physical organization of the space and its tangible features, such as lighting; and the social
arrangements and behavior common to the setting. Thus, we can consider the specific social arrangements and relationships that promote or inhibit rape, as well as those social and physical properties of environments which make them either safe or unsafe from the risk of sexual assault. In this way we may build a social theory of rape prevention.

Goldstein (1975:19) argues that some environments (such as churches and theaters) do not elicit or facilitate the expression of aggression. We can interpret this statement to mean that the cultural values and norms attached to some environments (e.g., churches) and the social arrangements of others (e.g., the highly public nature of theaters) inhibit or, rather, do not encourage acts of overt physical violence, such as rape. From Goldstein's perspective, psychiatric facilities (as treatment environments) are places where rapes should not happen. First, psychiatric facilities, as places of refuge for mentally disabled and vulnerable people, are, at least nominally, places where rape is unthinkable because of the values attached to treatment settings. Second, as highly supervised environments, psychiatric facilities are places which, we would assume, inhibit rather than facilitate violent aggression. However, as we have shown, patients are raped in psychiatric hospitals. And, as I suggest in this thesis, the normative as well as physical properties of institutions, in general, and hospital psychiatric facilities, in particular, support rather than inhibit, the sexual abuse of patients.

The sexual abuse of institutionalized mentally disabled adults shares significant structural features with the intrafamilial sexual abuse of children (incest). For children, and in some cases wives, the family (like a mental institution) is a "total institution" within which all activities are organized and managed by a single (hierarchical) authority (Goffman, 1961). Staff of
institutions, like parents in a family, are responsible for the well-being of their charges and it is the caretakers' prerogative to define what constitutes "well being" and limit the means by which it may be achieved. "Caretaking" takes place completely outside the view and control of nonmembers, and usually without the collaboration of the dependent child or patient. Most important, there exists a structurally comparable victim dependence, in both families and institutions, upon caretakers, including the assailant. Like incest, each precondition of institutional sexual assault is at least partially embedded in the "normal" social organization of psychiatric facilities.

In mental institutions, the opportunity for would-be offenders to commit rape and other sexual abuse is structured and supported by aspects of "normal" social organization. The kinds of social relationships promoted within facilities contribute to the incidence of abuse, and mitigate against its detection and prevention. This is evident as we consider the various dimensions of the act: the vulnerability of the victim, the uncontrolled presence of would-be assailants, the specific situational conditions under which assaults take place, and the social aftermath of assaults (internal disclosing and external reporting). Institutional practice and social relationships contribute to each of these factors (or properties of the act) and, therefore, to the incidence of institutional rape. To the degree that an element associated with individual assaults is a predictable element in a facility's social organization, it is part of an organized structure of opportunities.

In the remainder of this chapter, I will discuss several factors of institutional social organization that are or may be associated with the incidence of sexual assault. Although this is doubtless an incomplete list,
environmental factors (aspects of normal social organization) which contribute to the incidence of sexual assault and abuse of patients include the following:

- **Factors which create specific opportunities for the rapist to commit aggressive acts undetected by staff**, for example, poor supervision of incapacitated and restrained patients, and poor security of isolated areas.

- **Practices and attitudes which promote the vulnerability of patients to sexual abuse and reduce their capacity to resist**, for example, treatment-related incapacity, circumstances and practices which promote dependency of patients on staff, attitudes and behavior of staff toward patients which promote the objectification of patients and social distance (rather than identification) between staff and patients.

- **Staffing and placement practices which fail to exclude and control sexual abusers**, for example, negligent hiring and dismissal practices, gender-integration of wards and patient care, integration of violent inmates with the general inmate population, and poor supervision of male staff and patients regarding sexual behavior.

- **Organizational factors which inhibit the detection and prevention of sexual abuse**, for example, absence of adequate protocols for the handling of patient complaints, absence of rape awareness among staff and patients, absence of neutral structures/means for disclosing and discussing potential problems and incidents, absence of proactive prevention policies.

- **Structural factors which reduce the likelihood of sanctions against sexual assailants**, for example, informal dismissal procedures for suspected staff assailants, practice of not calling in police to investigate patient complaints, and police and district attorneys' failures to treat complaints by inmates as legitimate criminal complaints.

If my thesis is correct, that the social relationships and patient management practices common to psychiatric treatment settings contribute to the incidence of sexual assault, variation among facilities on these elements (or factors) should, if we could measure the independent and dependent variables, account for differences in the incidence of sexual assault. Of
course, an analysis of victim accounts alone gives us an incomplete picture. Our interviews with institutional staff will provide us with additional insights and descriptive data. However, in the absence of institutionally-(environmentally) specific observations and data, additional information regarding overall mental health administrative practices and policies, and specific information regarding how the criminal justice system processes sexual assault complaints, this analysis is incomplete. In spite of these acknowledged limitations, this study suggests questions for future research on institutional rape and for developing a general theory of the etiology and prevention of sexual assault.

Institutional Practices Which Create Specific Opportunities for Sexual Assault

By analyzing factors associated with each of the victim accounts of sexual assault, we have identified the following institutional practices associated with the incidence of assault: staffing practices which allow male staff to care for and escort women patients; inadequate supervision and control of male patients in gender-integrated spaces; inadequate or unsafe supervision of heavily medicated, restrained, or isolated female patients; tolerance and maintenance of "free zones" (unsupervised isolated spaces) where patients can engage in "bush therapy"; inadequate supervision and

1"Bush therapy," a term used by patients and staff, refers to unmanaged and presumably consensual patient-to-patient sexual acts which occur outside on the hospital grounds. "Tunnel therapy" is a similar term which refers to sexual activities occurring in the extensive tunnels which connect buildings at many older state hospitals.
absence of security in isolated inside spaces, such as laundry rooms. Under these conditions, would-be offenders are brought together with available, vulnerable, and noncredible victims in what, from the rapists' perspective, is a "perfect" opportunity.

Although it is the policy of some hospitals to restrict male staff from being alone with female patients, in order to avoid creating such opportunities, in nineteen of twenty-five cases where a staff member sexually assaulted a female patient, he had been left alone with or was assigned the care of that patient. This means a male staffer had been given the job of doing bed checks on women patients, providing precautionary observation while women were secluded and/or restrained, escorting them to some part of the hospital, administering medical or diagnostic care, and, in one case, conducting a private therapy session.

In the six remaining cases of staff assaults, the assailant had managed to create or take advantage of time alone with the patient, without the knowledge of other staff. In three cases, the assailant was a janitor. In the majority of these cases the assailant used an unsupervised space or nonsecured area to commit the assaultive act.

The gender-integration of wards within psychiatric facilities is obviously a major contributor to the opportunity structure of rape. An additional problem is the presence of male patients with a history of violence and sexual offenses within the general patient population. Once admitted, it is difficult for staff to adequately supervised them and many acts of sexual harrassment they commit are undetected, normalized, and/or unsanctioned.
Factors Which Promote the Vulnerability of Patients and Reduce Their Capacity to Resist

There is no evidence that men who rape women in institutions are motivated in their violent "desire" by psychological and sociological factors different from rapists in any other social setting. Some staff assailants may indeed be, as Groth (1979) would describe them, compulsive sexual offenders who have not been detected and who found an accessible easy-to-victimize population. Certain patient-assailants may have been caught and labelled as sexual offenders, and sent to the psychiatric facility qua sexual offenders. Based on our data, however, a more likely explanation is that the majority of sexual abusers of psychiatric patients are not themselves victims of a "compulsive" psychopathology, but rather express so-called "normal" aggressive male sexual behavior which is further encouraged by the objectification and dehumanization of patient-victims.

The most salient and immutable feature of mental institutions is the presence of mental patients. Because of the mental conditions which bring patients to hospitals, but even more because of the social powerlessness (cf. Scheff, 1961; Rosenhan, 1978) which attends their status as inmates, mental patients are particularly vulnerable to sexual exploitation, abuse, and assault. Rosenhan describes the overwhelming powerlessness of psychiatric inmates.

Neither anecdotal nor "hard" data can convey the overwhelming powerlessness which invades the individual as he [or she] is continually exposed to the depersonalization of the psychiatric hospital. It hardly matters which psychiatric hospital — the excellent public one and the very plush private hospital were better than the rural and shabby ones in this regard, but, again, the features that psychiatric hospitals had in common overwhelmed by far their apparent differences.
Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment. He is shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but may only respond to such overtures as they make. Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. His personal history and anguish is available to any staff member (often including the "grey lady" and "candy striper" volunteer) who chooses to read his folder, regardless of their therapeutic relationship to him. His personal hygiene and waste evacuation are often monitored. The water closets may have no doors.

Some of the ways in which patients are "managed" and regarded by staff create "legitimate" and noncredible victims. I use the term "legitimate" victim in the sense that is described by Schwendinger and Schwendinger (1969: 480–83): someone who is considered "worthless," a legitimate object of victimization. In the same vein, a noncredible person is, in the more general sense of the term credible (worthy of being believed, having behaved in a manner which entitles one to trust), one who is not seen (by one or more persons) as worthy of being believed. Persons, more specifically classes of persons (i.e., mental patients), become "legitimate" victims and "noncredible" persons through interactive processes. The processes of being and becoming institutionalized, which Goffman (1961) described as the "mortification of the self," represent processes of becoming victims in this double sense.

The "less than human" are, as we have learned from deviance theorists "legitimate victims" (cf. Schwendinger and Schwendinger, 1969; Sykes and Matza, 1957).

Inferior social status frequently is the deciding factor in determining who is a "legitimate" victim. Therefore,
lower-class individuals, racial minorities, and women are often held to be more "legitimate" and deserving when they are victimized.

If the inferior social status of the victim is not already evident, inferiority may be attributed to him [or her] on some other basis in order to maintain a view that is consistent with the image of the "deserving" victim (Weis and Borges, 1973: 76).

The status of mental patient is, itself, an inferior social status and one which carries with it many elements of what we may see as a de facto "victim" identity. As one staff informant said

"Every patient is a victim. They wouldn't be here if they weren't. Once here, some victimize others. But they are all victims."

Having been victimized and/or being seen as a victim$^2$ is, itself, grounds for being treated with contempt and disregard. According to Weis and Borges

In a competitive society, which stresses winning and losing, one notes a cultural contempt for victims or losers only mildly tempered by a humanitarian concern which demands compassion for those less fortunate. The basic justification for treating victims harshly and withdrawing support from them revolves around the victim's responsibility and the notion of retribution. The victim's behavior, often invoking moral indignation, is thought to warrant punishment (1976: 231).

Assailants, as well as third parties, may minimize or deny the deviance of the assault and the injury to the victim by employing linguistic techniques

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$^2$Being a victim is not an ontological state. Individuals either are labelled as victims by assailants and/or third parties, take on victim identities (learn and exhibit behavior which our culture/society associates with being a "victim"), or temporarily act as victims because they have experienced injuries and seek special help and/or institutional remedies.
which "neutralize" the meaning of the act (cf. Mills, 1940). Sykes and Matza (1957) have outlined major types of rationalizations used by juvenile delinquents to justify their deviant behavior, two of which are germane to the present discussion. One involves denial of the injury (it didn't really cause harm); another involves denial of the victim (somehow the victim deserved to suffer what happened to them). As Weis and Borges (1976) maintain, these neutralization techniques operate in both the assailant's and society's definition of rape to create a (false) situation of no injury, no offender, no victim, no act. We expect that these neutralizing techniques operate as well in third party definitions of patient rape (i.e., staff, civil authorities, parents, etc.) to expiate feelings of guilt as well as to minimize their responsibility and possible negligence relative to the act.

The attitudes of caretakers and the general public toward persons labelled as mentally ill enable caretakers to objectify patients, enable assailants to deny the deviance of their act, and inhibit the discovery of deviant acts by third parties. One example is the view of mentally disabled persons as "too out of it" to notice, to care, or to be aware of what is happening to them. Therefore, sexual acts committed against them don't count as rape. Although staff interrupt "sexual" acts when they discover them, we have encountered situations where staff discovered sexual assaults in progress but did not regard them as such because they presumed, without asking the woman, that they were "consensual." This presumptive assignment of consensuality to witnessed sexual behaviors may derive from the belief that "schizophrenics are hypersexual" or from a normalization of unwanted sexual touching in the institutional context. Presumptive assignment of consent is also an example of what Rosenhan (1978) described as the common staff
practice of not asking patients to explain or interpret their behavior. It is staff who determine the meaning of acts and situations as they affect patients, not patients themselves. The commonly held view, that a patient's rape fears and accusations are only expressions of her neurosis or delusional system, or a means of acting out her anger at being institutionalized, enhances the likelihood that a legitimate patient complaint will not be taken seriously and abusers will, therefore, not be stopped or sanctioned. The failure of some staff to see how it is that "such unattractive people" can be sexually assaulted also supports the rapist's impunity.

Rosenhan has described the attitudes of caretakers toward the mentally ill "exquisite ambivalence" (1978: 296) which shifts between hostility, fear, and dread on the one hand and sympathetic good intentions on the other (301). These attitudes, concluded Rosenhan, lead to avoidance and dehumanization. Rosenhan noted that staff rarely asked patients what may have caused an outburst or "symptomatic" behavior, mostly did not respond to patient-initiated contact, and never located the cause of a patient's problems in the behavior of staff or in the nature of the institutional experience. Instead, staffers made presumptive interpretations of patient behavior, derived from their psychiatric vocabulary.

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3We are aware of (apparently) consensual sexual acts between patients, which staff regarded as nonconsensual. Without asking for the participants interpretations, staff called the police and/or had the woman transported for physical examination and evidence collection. The failure of staff to ask the woman if she had been assaulted and/or if she wanted to make a police report reveals, what in the context of extramural victim support and criminal investigation, would undoubtedly be criticized as extremely poor practice.

4This practice fails to discourage sexual abuse. It can also prohibit patients from engaging in consensual sex.
One tacit characteristic of psychiatric diagnosis is that it locates the sources of aberration within the individual and only rarely within the complex of stimuli that surrounds him [or her]. Consequently, behaviors that are stimulated by the environment are commonly misattributed to the patient's disorder. . . .

The notes kept by pseudopatients are full of patient behaviors that were misinterpreted by well-intentioned staff. Often enough, a patient would go "berzerk" because he [or she] had, wittingly or unwittingly, been mistreated by, say, an attendant. A nurse coming upon the scene would rarely inquire even cursorily into the environmental stimuli of the patient behavior. . . . never were the staff found to assume that one of themselves or the structure of the hospital had anything to do with the patient's behavior (Rosenhan: 296).

As my study has found, the propensity of staff to make presumptive interpretations of patient's behavior often means that staff miss what in any other context would be evidence of sexual assault (e.g., torn clothing, sudden and frightened outbursts when the assailant appears, elaborate avoidance behavior, etc.). Furthermore, staff members generally see patients as noncredible persons particularly prone to making false claims of being raped.5

Patient vulnerability to nonforcible rape by staff is heightened by their social circumstances. Patient-inmates are often emotionally deprived, isolated from their outside supporters, and often isolated from each other. In some cases, they may be victims of nonforcible rape by staff persons who they like or to whom they turn because they need warmth and affection. Because they are isolated, living under conditions which restrict their movement and choices, and often poor, inmates are also vulnerable to such tangible

5Our impression, derived from conversations with administrators and facility staff, is that staff attribute false claims either to the patient's psychiatric condition (it is part of their delusional system) or to their inmate status (they are angry at staff and this is a way of getting even).
incentives as food, money, or substances to which they are addicted (tobacco, sugar, caffeine, alcohol, drugs). They are also vulnerable to bribes of special privileges and favors.

The structural similarities between incest and sexual abuse of institutionalized women is clearest when we examine the parallel social processes and relations which shape the capacity and probability that the victim will be able effectively to resist the abuser. Like children in the case of intrafamilial sexual abuse, patient-inmates often feel powerless to prevent abusive treatment. Indeed, they are powerless in the sense that Weber (Gerth and Mills, 1946:180) has defined power: patients are not able to have (or protect) their will over and against the (often collective) will of staff. The powerlessness of persons institutionalized as "mentally ill" has been more than adequately described by other researchers (cf. Rosenhan quoted above). However, as one member of our research team has argued, the realization of powerlessness and the fear that this powerlessness is absolute alone can explain some patients' failures to resist unwanted sexual overtures and acts.

One reason patients rarely resist assaults is the same reason we [non-institutionalized woman] rarely resist street harrassment: we fear a deepened sense of our impotence and shame if we are ignored when we say "stop." We fear finding out how trivial and powerless we actually are. It feels better to pretend we could stop harrassment if we chose to. We pretend not to hear, instead of facing the ignominy of first acknowledging the insult and, second, not being able to stop it, and third, facing the (likely) escalation of the harrassment. Knowing for sure the depth of the power imbalance feels more degrading than tolerating its expression by "choosing" not to fight back.

The power imbalance is partly based on who "cares" less than whom. Women are socialized to be hurt by male contempt. Men are socialized not to care about our anger and not be hurt by our disapproval. This emotional
power imbalance is then compounded in institutions by "normie" - "sickie" power differences, authority differences, and the physical incapacity that results from being drugged (J. Stone, 1983 memo).

The social distance between staff and patients, characteristic of total institutions, serves the rapist by reducing the likelihood that patients will report abuses (especially those committed by staff), and that patients will be believed if they do report. Furthermore, the social distance which protects staff from "dysfunctional over-identification" with patients and promotes peer bonding encourages the normalization and trivialization of patient-to-patient sexually abusive behavior, and the nonawareness and denial of abuses committed by staff members. Social distance discourages staff from informing patients of their rights, potential dangers or the consequences of a special incident report. Social distance also discourages staff and patients from engaging in joint actions to prevent sexual abuse. This last point is critical as it is hard to imagine effective safety work in this area that would not involve collaboration across patient-staff distinctions.

Practices Which Fail to Exclude and Control Abusers

To the extent that sexually assaultive and abusive acts may be committed by men not known to be sexual abusers, it is not possible for hospitals or any other social environment to exclude all abusers. On the other hand, some men employed by or placed in psychiatric institutions have formal (meaning written and recorded) histories of sexual abuse which, if known, should be grounds for excluding them from employment in settings
which treat vulnerable persons, and for establishing special controls if they are patients. In analyzing the accounts of patient-victims, it was clear that in a number of instances, hospitals failed to exclude and control men with histories of sexual violence. In the case of patient-perpetrated assaults, this often appeared to be a "simple" problem of poor surveillance, a problem attributed by institutional personnel to staff shortages. However, from the one case mentioned in the introduction, it is possible that some units may take on the characteristics of a rape "scene," where the continual sexual abuse of patients is an enduring part of the social setting, controlled by or with the knowledge of at least some members of the staff.

**Personnel Practices**

Screening efforts on the part institutional employers sometimes fail to exclude from employment persons with histories as sexual abusers. Inadequate screening and negligent hiring were involved in at least two and possibly three of the cases in this study. In order to be employed as a psychiatric technician in the State of California, a person must complete an established vocational training program and be licensed. These qualifying steps presumably act to screen out from licensing and employment convicted sex offenders. They do not necessarily screen out persons who have been arrested or fired by a previous employer for committing a sexual offense. In one case that we are aware of, the employer, a county hospital, apparently didn't check with the licensing bureau. If they had, they would have found that the technician had lost his previous job (and his license was temporarily revoked) when he was found naked in bed with a female patient. There is probably even less control over the screening and hiring of nonlicensed personnel, such as
janitors.

If the employee is alleged to have committed an assault against a patient, he is usually protected by established hospital grievance procedures. Those formal procedures with which we are familiar usually involve the immediate suspension, with pay, of the accused, if the administration finds the patient's complaint to have potential merit. Once a determination has been made (by the police and/or designated institutional office) that the patient's allegation is (or may be) founded, pay is withheld and moves to terminate the employee are initiated. In the end, in spite of evidence amassed to substantiate the claim of the victim, unless the accused admits to the charge or acquiesces to informal pressures, it is exceedingly difficult to terminate an abusive employee whose crime has not been established through criminal prosecution and conviction.

Our preliminary analysis of interviews with staff suggests that informal practices for controlling and sanctioning staff-assailants may be more typically relied upon by supervising staff than formal dismissal procedures. We know of several cases where staff-assailants have been offered an opportunity to resign (without anything going into their records) by their supervising nurses. The supervisors knew that the staffers had "been sexual" with female patients, and yet they chose to handle the problems informally. Offering the assailant a chance to resign seemingly protects patients from further exploitation by the particular assailant. However, this method of handling assaultive staffers does not prevent the employee from seeking similar employment in another hospital. It also fails to provide a strong lesson to other would-be assailants on the staff. Indeed, informally "getting rid of" a staff assailant protects staff and administration from having to deal with this
aspect of patient abuse and rights. The problem is defined in its "smallest" and least problematic dimensions, as a single staff member's "lack of judgment," rather than as a more general problem within the setting. The audience that is aware of the problem is also restricted. The ward supervisor and the staff on that particular shift know that the abusing staffer has resigned under pressure but hospital management as well as other personnel may remain uninformed and nonaccountable to outside authorities. The licensing agency has no complaint to move on and law enforcement agencies are not in a position to act on what is, by definition, a highly problematic crime.

Patient Placement and Supervision

Preventing patient-perpetrated assaults is only partially a problem of excluding sexual violent males from general psychiatric units. Five of the patient-perpetrated assaults (all acts of forcible rape) were committed by men known to the patient-victim (or the staff) as potentially violent. Two assaults were committed by penal code patients. The other patient-perpetrated assaults were not committed by men about whom the staff had (or should have had) reason to believe would be sexually violent or abusive. However, the assaults they committed might have been avoided/prevented had the staff

6Scheff (1961) described how mental hospital attendants (ward staff) exercise greater control than administrators and professional staff over policy and reforms within the hospital. The ward staff Scheff observed saw themselves as the best managers of patient behavior and the final arbitors of patient complaints. Presumably staff attempt to exercise this control in order to control their working conditions. The handling of sexual assault complaints, as well as informally dealing with directly observed staff inproprieties at the ward level, are two kinds of internal and informal systems of social control.
made greater efforts to sanction overt sexual overtures (sexual harrassment) by patients towards other patients, provide adequate surveillance of isolated and risky areas, and supervise male patients. One woman described the scene on her gender-integrated ward as one where "men are always hitting on you. Staff stop them [when the men get physical and if staff observe them] but then laugh about it." She did not believe that staff took such incidents seriously.

Organizational Factors Which Inhibit Detection and Prevention

Presuming that patient allegations of sexual abuse are untrue, delusional, or unimportant naturally results (if the patient does not persist in telling and no one acts as an agent for her) in the failure of ward staff to detect that particular instance of abuse. In a larger sense, the presumptive discrediting of patients generally inhibits victim disclosures and staff investigations, which would reveal the information necessary to create greater safety from sexual assault within the environment. The discrediting of patients partially derives from the social distance which characterizes the relations of patients and staff. It also derives from more formal organizational features of psychiatric institutions and facilities. For example, the absence of adequate reactive as well as proactive policies regarding the sexual assault of patients inhibits adequate staff response and prevention.

Few hospitals have thorough procedures for handling sexual assault allegations. Even fewer (and possibly none) have proactive prevention policies or programs. Indeed, we have found not one hospital where ward staff have
ever received any kind of rape prevention and awareness training, or even been given an opportunity to discuss and interpret hospital policies for handling rape complaints. Whereas medical hospitals typically hold morbidity and mortality conferences where the mistakes, errors, and untoward consequences of medical practice are thoroughly discussed and analyzed, no such "safe" structure for learning exists within psychiatric facilities for staff to impersonally analyze the errors and patient complaints which arise daily.

The absence of thorough policies for handling sexual assault complaints by patients places a greater burden of response on individual staffers than if the choices open to them were prescribed. The complaint policies of which I am aware usually explicitly state that the shift/ward supervisor determines the veracity of the complaint before calling the police. The means by which a staffer may determine the veracity of a patient-victim's complaint (e.g., subjecting the patient to multiple retellings) may, as discussed above, discourage the patient from pursuing the complaint and, furthermore, discourage other patients from making future complaints. The problem of discounting and/or discouraging true reports could be reduced by a) referring all sexual assault complaints to an internal or external specialist trained in interviewing rape victims and/or b) training all staff about rape, in general, and victim interviewing, in particular.
Structural Factors Which Reduce the Likelihood of Criminal Sanctions

In addition to the informal dismissal procedures which circumvent the formal identification of staff-assailants, the separation of psychiatric facilities (whether absolute or conditional) from the criminal justice system reduces the likelihood that assailants will be severely sanctioned for their crimes. We recently interviewed several staffers of a California facility. They were angry and frustrated with their local district attorney, who had refused to prosecute a rape case. The D.A. did not believe that the nonconsensual nature of the act could be established, even though the rape had been witnessed by two staffers and the victim's psychiatrist argued that the woman was completely unable to give legal consent. Numerous mental health professionals have complained to us that they, too, have been unable to get police and county prosecutors to act on crimes which occur within their institutions. The attitude of police, they say, is one of separatism — "You take care of the inside and we'll take care of the outside."

As frustrating as the separatist attitudes of police and prosecutors may be, this division is the result of years of "accepted practice" which institutional personnel have supported and encouraged. The formal policies of many institutions, as well as the Welfare and Institutions Code of the State of California, place the burden of establishing the fact ("truth") of a patient's allegation of criminal assault upon institutional professionals before they contact the police. Staffers go along with the explicit and implicit expectations of administrators, that they should assume the authority of the criminal justice system in distinguishing legitimate from illegitimate claims. Staffers also tell us they are reluctant to call the police with every
complaint because, "Most are false reports and nuisances," "Accused staffers are treated as guilty until proven innocent," "It will encourage patients to make false reports," "The presence of police will heat up everybody," etc. During a meeting I participated in to establish formal reporting policies, a psychiatrist argued strongly that treating patient reports of rape as if they were criminal complaints would undermine the authority and control of the professional. Unless, however, patient reports of sexual assault are treated as criminal complaints (that is, as conditionally true) and, therefore, evidence corroborating the complaints is sought and analyzed, the acts cannot be treated as crimes, and assailants cannot be deterred or punished.

Summary

The research identifies and systematically analyzes a set of thirty-six institutionally-situated sexual assault accounts in order a) to develop an understanding of the special properties and patterns of institutional sexual assault, b) to identify the institutional features and practices associated with the incidence and detection of sexual abuse and c) to develop concepts and hypotheses to direct future research on the causes and prevention of institutional sexual abuse. The language of normal science helps to clarify the direction of this study and focus future research. My first objective was to assess two "dependent" variables: the incidence (and, of necessity, considering the descriptive, inductive nature of this inquiry, the unique properties) of institutional sexual assaults and the disclosure of sexual victimization by inmates of psychiatric institutions.
All studies that ask individuals (victims) to describe crimes committed against them are limited by their dependence on victims to self-define. However, direct victimization surveys are the best available means for estimating the incidence of crime. This is particularly true for rape, because few victims actually make police reports. This study represents the first rape victimization study of institutionalized psychiatric patients. While it was not possible to determine the incidence or prevalence of rape for this population because we could not create a standard sample, we were able to describe the patterns associated with a limited number of institutional sexual assaults. Analysis of the patterns of rape in this special context contributes to the sociology of rape. As Wolfgang, in his forward to Amir's *Patterns of Forcible Rape*, wrote

> Age, sex, and race do not alone make for the phenomenology nor sociology of rape. The dimensions needed are much deeper and broader. But most importantly, perhaps, are the interlinkages, the patterns, regularities, and uniformities discovered in the analysis (in Amir, 1971: viii).

I believe that we established the feasibility of interviewing chronically mentally ill persons and successfully obtaining from them reliable and valid data, which is no less valid or reliable than what might be collected from any other group of respondents providing accounts of similar experiences. Epistemological questions can be raised when one attempts to analyze accounts of subjects whom others might presume are noncredible. Because of the highly stigmatizing and problematic nature of rape and mental hospitalization, one can also expect to receive highly interpreted accounts of reality. The answers to the epistemological questions are pragmatic ones. The
accounts were collected and analyzed on the basis that they were conditionally true. That is, I presumed that the subjects were credible.¹ As for the potential of highly distorted accounts, the patterns which resulted from my analysis are now open to challenge and either confirmation or disconfirmation by future researchers.

The second objective of this study was to identify and describe a set of "independent" variables (institutional conditions, relations, practices) which are causally associated with assault and/or long term sexually abusive circumstances, and inhibit or enhance their detection by facility staff. My findings do not explain (or identify) variations among institutional settings, nor test the potential impact of institutional conditions, relationships and practices on the incidence and detection of sexual assault. Instead, analysis of the victims' accounts suggests a) that the definitions of sexual assault held by actors in the situation influence victim resistance, victim disclosure, staff reactions and prevention work; and b) that "normal" institutional features and practices contribute to the incidence of sexual assault, as well as inhibit patient disclosure and staff detection of sexual assaults.

We have discovered² that there is no single definition of sexual assault, which permits the accurate assessment of incidence and prevalence in institutional environments, and adequately explains how victims experience

¹See the Methodological Addendum for a fuller discussion of validity and reliability issues.
²It is presumptuous to claim that I have "discovered" something which was certainly apparent to the actors studied in this inquiry. It is more accurate to describe my definition of the assaults they experienced as a construction rather than a discovery. I have constructed an analytic framework from accounts of sexual assaults, which enables theoretical formulations, and potentially explains the situated experience of sexual assaults from the multiple perspectives of victim, staff, criminal justice and civil law perspectives.
assaults and the resulting damage/harm. What a victim experiences as unwanted sexual touching (the definition of sexual assault used in this study), may be seen by staff as unimportant or a nonfact, by police as consensual, and by a jury on a civil case as nondamaging. Therefore, measurement of the dependent variable (incident or disclosure), as well as the collective action which may arise from "knowing" an assault or disclosure, is confounded by multiple and contradictory definitions of the situation. In addition to the great potential for multiple and contradictory definitions of the situation (the meaning and fact of the act) held by the various actors, it is also likely that the victim's definition will not prevail, unless she is extremely self-confident and able to act decisively, or unless she has recruited an agent capable of acting for her. Often, the defining circumstance of mental patients is that they are not confident enough to define situations over and against the definitions of nonpatients, nor are they fully able (or enabled by others) to act on the basis of their situational definitions and/or recruit advocates.

This study described aspects of institutional policy and practice at the core of the opportunity structure of institutional rape. These elements are potential foci for future research, as well as sexual assault prevention efforts. Our interviews with institutional personnel yielded an additional eighty sets of institutional sexual assault. Analysis of these data will undoubtedly expand and elaborate the list of factors which contribute to the opportunity structure of institutional rape, and represents the next step in our empirical research on institutionally-situated sexual assaults.
Chapter Seven

Theoretical Significance

This work intersects, and contributes to a number of sociological areas, most notably the sociologies of rape and total institutions, and the social psychology of identity and victimization. It is firmly embedded in the symbolic interactionism tradition, with its focus on actors' definitions of situations giving rise to (and emerging from) individual and collective action; and phenomenology, in its microscopic analysis of institutional rapes, in order to reveal potential interactional elements and underlying rules of organization.

Sociological Study of Rape

This research directly takes up three issues of concern to the sociological study of rape: the social etiology of rape, the methodology of studying rape, and the social processing of rape complaints. As briefly described in the introductory chapter, there has been considerable theoretical and some empirical work on the social etiology of rape. Sanday's (1981) conclusions about rape-prone and rape-free societies are analogous to my central hypothesis about the etiology of institutional rape: that attributes of the social setting, including social relationships, contribute to the incidence and patterns of rape, and the likelihood that rape will be discovered and prevented. In order to develop and test my hypothesis, it will be necessary for ethnographers and empirical sociologists clearly to define and elaborate
(for measurement purposes) the opportunity elements I have suggested, identify facilities which vary in exhibiting rape-prone characteristics, and develop "hard" data that document both allegations and actual incidents of institutional sexual assault. I hypothesize that an increase in the number of sexual assault allegations would indicate increased sexual safety in the psychiatric facility, and that an increase in the number of assault allegations which are taken seriously by staff would be inversely related to the actual number of assaults.

It is not possible to test my hypotheses about the etiology and prevention of institutional sexual assault, given our current level of knowledge. Not only is more ethnographic work needed, which should be carried out in institutions, but new methodologies for determining the incidence of institutional sexual assault must be invented, as well. With a few notable exceptions, such as Russell's (1983) representative victimization survey, most sociological assessment of rape incidence and prevalence has been derived either from police or rape crisis center statistics, or convenience samples such as ours. Neither methodology is sufficient, particularly for assessing forms of sexual assault that a) the victim is not likely to report to the police (e.g., nonstranger rapes, sexual assaults that do not involve genital penetration, and institutional rape); b) take place in inaccessible settings, such as institutions; and c) the victim does not define as rape, and therefore the self is not defined as a victim of rape. Mary Koss (1983: 89) writes

In victimization studies, it has been assumed that a negative response to the question, "Have you ever been raped?" means that a woman has not experienced sexual assault. However, a negative response could also mean
that a woman has had an experience that would legally qualify as rape but for various reasons, including her belief system [definition of the situation], she does not conceptualize her experience as rape. For example, if the offender were an acquaintance or used only moderate force, the victim might conclude that the label rape was not applicable to her assault and might respond negatively when asked if she had been raped. This type of woman could be called an "unacknowledged rape victim" and would be missed by the typical victimization methodology.

Sexual assaults against institutionalized mental patients are, for the reasons described above, grossly underrepresented in all victimization surveys, as well as in police statistics. New methodologies which enumerate institutional sexual assaults would not only correct distorted rape prevalence and incidence estimates, but because they would focus on the most problematic conditions under which sexual assaults occur, they would undoubtedly influence the overall development of methodologies for studying rape.

Rose and Randall's (1982) symbolic interactionist study of the processing of rape complaints by police contributes to our understanding of how police investigators define events as crimes through interpretive processes (cf. Cicourel, 1974). Their empirical study in the social construction of reality focuses on the problem of attributing case legitimacy to a verbal allegation of rape, and emphasizes the particular problem of assigning credibility to the alleging victim. My study of patient-victim disclosures and case processing suggests additional elements in the processes and conditions under which rape allegations are legitimated, and demonstrates the need for further research which addresses how police (and other authorities) process rape complaints, and under what conditions they establish the legitimacy of such rape complaints by persons presumed to be noncredible. Such a study would
contribute to the development of specific theories regarding rape complaint processing. It would also contribute to the development of sociological theories on the construction and negotiation of social identity.

Symbolic Interaction

So far this dissertation has dealt exclusively with the problem of rape, albeit within a special situation and involving a special class of victims. The social psychological orientation of the inquiry has been embedded within the stated and more general purpose of providing an ethnography of institutional sexual assault. Social psychological propositions about total institutions, deviance, victimization, the negotiation of social reality, and the social negotiation of credible selves have been raised but not developed in the course of this research, and have been only superficially referred to in this written work. In order to satisfy the sociological imaginations of writer and readers alike, I would like more thoroughly to explore the relationship between the current ethnographically-oriented work and a set of more abstract sociological considerations, keeping in mind the caveat that these comments are not grounded in direct observations of the social situations to which they refer but are, rather, theoretical extrapolations and interpretations.

The first question we must ask is, "What is the sociological problem being addressed, besides rape itself?" More specifically, "What are the major lines of social activity we are trying to explain?" For example, what does
this work tell us about social processes within total institutions, victimization as a kind of "social career," the social processing (i.e., accrediting and legitimating) of verbal claims (stories), and the presentation and management of credible selves under highly problematic conditions? This is by no means an exhaustive list of sociological questions and problems which touch upon or may arise from an appreciation of the present topic, although they are some of the more interesting ones.

**Total Institutions**

Erving Goffman introduced the concept of total institutions and delineated their common general characteristics and social arrangements in an effort to "develop a sociological version of the structure of the self" (1961: xiii). Goffman argued that during incarceration in a total institution, the self is subjected to a process of mortification which arises from institutional practices, including: (1) barriers the institution places between the inmate and the outside world, particularly insofar as s/he is dispossessed of certain roles which are parts of her/his self; (2) admission procedures which strip the individual of her/his personal possessions and certain manifestations of her/his identity; (3) deference requirements which humiliate the inmate and attack her/his self-esteem; (4) verbal and gestural profanations; (5) contaminative exposure and physical violations; and (6) disruption of the usual relationship between the actor and his acts by regimentation and "looping" processes (1961: 14-38).

The current work gives us little new data about the character of total
institutions or the overall processes of self-mortification which Goffman hypothesized. We can, however, fit the present work within the theoretical propositions about the sociological structuring of self raised by him and view sexual assaults within mental hospitals as another type of physical contamination and mortification of the body to which inmates are sometimes exposed. Indeed, rape is, as Goffman himself stated "the model for interpersonal contamination in our society" (1961: 28). Sexual assaults suffered during institutionalization are but one more means whereby

[the] territories of the self are violated; the boundary that the individual places between his [or her] being and the environment is invaded and the embodiment of self is profaned (p. 23).

Furthermore, the social aftermath of institutional sexual assaults, insofar as it may be expressed in the inmate's claims of having been abused, represents a situation that Goffman has referred to as a "looping" (1961: 36-38). In the process of "looping," the individual finds that her/his "protective response to an assault upon self is collapsed into the situation" and s/he "cannot defend himself [or herself] in the usual way by establishing distance between the mortifying situation and himself [herself]" (1961: 36). Goffman provides several illustrations of looping, one of which is the situation where an inmate's conduct in one sphere or in one type of activity is thrown up to him or her by staff as a comment upon his conduct in another sphere. Looping is one way in which the "autonomy of the act itself

1Perhaps we can, on the basis of the current study, add one type of mortification not considered by Goffman: the direct identity threats of assailants, in which the would-be victim's "noncredibility" is evoked in order to accomplish the sexual assault, an act we can construe, using Goffman's framework, as clandestine bodily mortification.
is violated" (1961: 38).

This form of "gaslighting" not only violates and frustrates the ability of inmates to act autonomously (develop and present credible selves), but it is also a technique of social control. Without using the same language, Scheff (1961) shows how staff use looping strategies against patients to maintain their own control over the ward setting.

By transforming the ward's problems into problems of patients, the staff protected the legitimacy of traditional practices. With this technique, the ward doctor and staff, in collaboration, dealt with [a patient's complaint of physical abuse by a staff member in a ward meeting]. The staff member resolutely denied the charge, and made counter-charges against the patient. Other staff members joined in, making the patient's charges an occasion for recalling the history of the patient's past misdeeds. In the general confusion, the doctor and still other staff members found it easy to obscure the issue further by asking misleading and obfuscating questions of the complaining patient. The patient saw the futility of his complaints in this situation and sat down (pp. 98–99).

I have noted instances in the accounts of patient-victims where respondents were subjected to looping tactics by staff members to whom they had made assault claims. In those instances where a patient's claim was discredited, it was on the basis of their "total identity" as a mental patient, rather than as a result of examining the specific behavior or situation embedded in the claim. The effect was not only the failure to recognize legitimate abuse claims and therefore reorder the social environment in light of an awareness of injury, but the actor's (claimant's) self was further mortified by discreditation. Staff exercised exclusive control over the situation, including the resultant definition of the situation as a false claim made by an angry or delusional patient. Through "looping" tactics or verbal
techniques which "transform ward problems into patient problems," staff continually reconstitute their version of normal social order in the mental hospital and successfully negotiate their interpretation of inmates' claims as reality (Sheff, 1961: 98–99).

Articulated Careers: Mental Patient and Victim

Goffman (1959) used the concept of "career" to refer to the changes over time which are basic and common to the class of persons who have been, at one time or another, subjected to the process of psychiatric hospitalization. In justifying his view that mental patients share common social histories, Goffman writes

Persons who become mental hospital patients vary widely in the kind and degree of illness that a psychiatrist would impute to them, and in the attributes by which laymen would describe them. But once started on the way, they are confronted by some importantly similar circumstances and respond to these in some importantly similar ways. Since these similarities do not come from mental illness, they would seem to occur in spite of it. It is thus a tribute to the power of social forces that the uniform status of mental patient can not only assure an aggregate of persons a common fate and eventually, because of this, a common character, but that the social reworking can be done upon what is perhaps the most obstinate diversity of human materials that can be brought together by society (1959: 529).

Goffman is concerned with what he terms the "moral" dimension of the mental patient career, by which he means "the regular sequence of changes that career entails in the person's self and in his framework of imagery for judging himself and others" (1959: 528). He identifies three phases of the
mental patient career — the prepatient phase, the inpatient phase, and the ex-patient phase. We can view the careers of sexual assault victims, perhaps more so than other classes of victims, in much they same way. For victims of sexual assault (particularly victims of protracted situations of sexual abuse and exploitation), as for mental patients, there are discernible phases in which the individual is transformed from an autonomous actor to a nonautonomous object acted upon by others.²

Indeed, the moral careers of mental patients and sexual assault victims resemble each other. For each there is a phase where the actor's normal relationship to their act is disrupted. Both classes may be subjected to extraordinary assessments of responsibility and certain identity attributes (such as being "crazy" or "sexually promiscuous") may be viewed as determining the legitimacy of their claims by assessing judges. Both mental patients and sexual assault claimants may be called upon to explain and justify their actions — to make motive statements. In each situation, the actor may judge her/himself and others harshly and both classes of actors may be socially stigmatized.

However, there are also significant differences between these two careers. The victim "career" of the person who has suffered a sexual assault — that period in which her ability to act autonomously is socially disrupted, is usually temporary. The nondeviant victim of sexual assault is much better

²The defining language incorporated into the penal statutes covering rape in many states refers to the assailant as "the actor." Presumably, this term clarifies agency in all those ambiguous circumstances under which a sexual assault may occur, including those circumstances characterized by the absence of physical force and in which consent is not germane (i.e., so-called statutory rape). However, one can reasonably ask, "If the assailant is called "the actor," what then is the counterpart term?"
able to negotiate definitions of the situation with those empowered to assess the legitimacy of their claim than is the victims who is also labelled as deviant. And most importantly, the "career" of the sexual assault victim is not usually organized and imposed within the structure of a total institution.

The present inquiry asks the question, "What happens to the social structuring of the self when these two careers intersect?" We have seen, for example, that the social reality (the external meaning) of sexual assault is subsumed and obscured by the more powerful identity of "mental patient." Is this true as well for the internal self-reflective aspects of the experience? Can we reasonably hypothesize that the debasement and violation of self suffered by mental patients enhance, or conversely, overwhelm the debasement and violation of self experienced by sexual assault victims?

The Negotiation of Problematic Claims

In order to discuss the relationship of the present work to the negotiation and management of social reality, we must shift our focus from particular, situated deviant acts to the more problematic question of how meanings and definitions of the situation, actors, and acts are socially constructed. To make this transition, we must shift to more abstract sociological representations. First, the principle class of actors with which we are concerned (patient-victims) are, in abstract terms, members of a class (mental patients) which society labels as deviants. They carry what Garfinkel (1956) refers to as "total identities":

... identities [which] refer to persons as "motivational" types rather than as "behavioral" types, not to what a
person may be expected to have done or to do . . . but to what the group holds to be the ultimate "grounds" or "reasons" for his performance (p. 202).

By engaging in the lines of action with which we are concerned (e.g., self-protection, resistance, and alleging sexual assaults), these actors attempt to take on roles over and against the definitions of more socially powerful actors (e.g., staff, police, family, nondeviants). The problem for mental patients is not sustaining a credible self under trying conditions, but rather, creating a credible self over and against the countervailing presumptions of powerful others. The inmate-victim who chooses to disclose a sexual assault must negotiate a credible identity and account, over and against two highly discrediting labels (inmate and rape victim), often against the self-justifying counteraccounts of institutional personnel. The disclosure (claiming) process illuminates some of the social props by which identities are socially constructed and definitions of the situation are negotiated. To observe those occasions when inmates do not disclose assault or, when they do, when and how they are discounted, is to observe some of the social processes whereby victim identities are socially created.

The sexual assault allegations of mental patients represent the paradigmatic instance of negotiating a problematic verbal claim under highly problematic conditions. The claim, in the case of rape, is seldom more than a verbal one — the word of someone that something bad has happened, for which someone else may be punished. It is subject to social negotiation processes to define what actually happened, responsibility (consent), and motive in making the claim. The claimant's objective is to convince others (including official investigators) of the validity of her claim (and, therefore, her credibility) and, in the case of persons labelled as mental patients, of her
capacity to sustain the claim through multiple, long-term assessments. The burden of making and sustaining the claim is on the claimant. She must present a sufficiently organized verbal account of a past event and, in the process, demonstrate sufficient "evidence" that she is "credible." Her credibility is, indeed, the product of negotiation. For the nondeviant rape victim, this is a matter of negotiating a highly specific situated credibility. For the mental patient, her essential noncredibility is presumed, and the situated credibility of her account can only be successfully negotiated if it is corroborated by a credible other, and/or it is conditionally treated as such.

Lofland's (1969) work on deviance and identity is useful in establishing the problematic nature of mental patients making and sustaining allegations. Actor and audience, according to Lofland, tend to define the labelled deviant's current acts, including neutral and morally positive ones, in morally negative terms. They also negatively reinterpret the deviant's past acts in order to justify the deviant label. Lofland also points out that places such as mental hospitals give rise to the imputation of deviance.

The relationship of social constructions of identity and efficacy in claim making can be demonstrated by considering a different kind of situation — instances where actors claim expertise or competence in order to perform some kind of specialized task. There are a few similarities between deviants making rape allegations and individuals claiming expertise arising from the fact that both situations involve primarily verbal claims about relatively intangible conditions, the ultimate "proof" of the claim's legitimacy is the result of social negotiation, and the process of making the claim is intricately bound to the process of creating and sustaining a credible identity. However, their formal differences are great. In the case of a
person claiming to be an expert, the claim is not accredited solely on the basis of acquired credentials, but also on the basis of face-to-face demonstrations of competence, past works, ongoing and, ultimately, future performance relative to the specific claim. The claim is conditionally established, not on "total identity" terms but on "behavioral" terms (what one does or says one will do, rather than who one is labelled to be). The interactions which characterize the negotiation of a claim of expertise do not center on imputations and avowals of motive because, as Mills (1940) would argue, being and becoming competent (an expert) is normal, socially expected behavior which does not require justification. Instead, the expert claimant is "allowed" to continue to act as an expert (competent) until s/he proves differently.

The socially imposed "total" identity of the patient-victim most significantly shapes the social conditions and processes whereby actions are interpreted and claims are assessed and (usually) discredited by investigators and interrogators. Thus, in the process of making a rape allegation, the deviant identity is socially recreated. Making of allegation, which could represent an opportunity for the hospitalized mental patient to defend herself (create and claim a credible and nonviolable self), becomes instead an opportunity for nondeviant others, in their disbelief, to reconstruct her social definition as a noncredible (not worthy of being believed) deviant and make her a victim again.
The goal of the research was to explore the relationship between sexual assault and the particular social context within which it occurs. More specifically, we identified features of psychiatric environments which contribute to the incidence of sexual assaults and the processes of rectifying and remedying the assault which arise from the social relationships and arrangements specific to the context. Given the undeveloped state of the literature, the absence of any kind of prevalence or incidence data regarding rape and other sexual assaults in psychiatric facilities, and some of the unique and formidable problems associated with the research which I discuss below, my goal has been the development of concepts and hypotheses to guide further inquiry rather than the testing of hypotheses. We have done so by collecting first- and secondhand accounts of institutionally-situated assaults and discerning their unique properties and dominant patterns.

There are special methodological and design problems in conducting rape research. Perhaps the most difficult problem is recruiting and accessing subjects. As discussed above, perhaps as many as 80 percent of all rapes are unreported to the police. This means that studies which recruit subjects from the pool of victims who report to the police or other disclosure points, such as victim treatment centers, are likely dealing with highly biased samples. Much of the empirical rape research, therefore is limited in its
generalizability because it is based on convenience samples.\(^1\) In any rape study, however, there will be problems of reliability and comparability of data which arise from the sensitive and emotional nature of the issues; differences in the interpretation and awareness among subjects, as expressed in their different definitions of rape and the variety of psychological reactions to the assault; and the retrospective nature of the data.

These problems are magnified and new ones are added when the inquiry is focused on institutional sexual assaults. In our study, it was not possible to conduct interviews of institutionalized women. Such an approach would have exposed the patient-respondents to unjustified risk and would probably have been impeded by institutional personnel. In addition, the data collected during times of psychiatric crisis would undoubtedly have presented extraordinary reliability problems. However, a design which utilized an institutionalized sample of respondents would have produced a larger sample size, resulted in accounts which were less retrospective and potentially more corroborable, and allowed greater generalizability than the current convenience sample.

**Data Collection**

The findings presented here were derived, principally, from an analysis of interviews and case documents associated with twenty-six female former

\(^{1}\) Russell's recent rape incidence and prevalence survey of San Francisco, based on the random selection of residents within San Francisco census tracts, is a notable exception in this regard.
mental patients\textsuperscript{2} who had been sexually assaulted while confined in some form of psychiatric facility. The subjects were recruited through public media advertising, and networking efforts with patients' advocates and self-help groups. This latter recruitment strategy involved several group presentations on the research. Subjects were asked to contact the project if they had experienced any form of sexual abuse or assault while confined in a psychiatric facility.\textsuperscript{3} Those who responded were informed of the purposes of the study, the risks of participation, and asked a limited number of screening questions to establish whether or not their account fit within the parameters of the inquiry. If their account involved some form of unwanted sexual touching which occurred while they were hospitalized, and if we felt we would be able to collect reliable and valid data at little or no risk to the subject, we scheduled and conducted an in-depth interview, which usually lasted about three hours.

Subjects were asked to describe the assault itself and the circumstances surrounding it. Close attention was also paid to the subjects' descriptions of the institutional environment in which it occurred -- the physical characteristics, as well as the social relations and practices within the unit. Proceeding the interviewing phase, the principle investigators (LeGrand and

\textsuperscript{2} Twenty-three subjects were interviewed directly. Three were identified through a search for sexual assault civil suits brought by psychiatric inpatients and the details of the sexual assault were generated by an analysis of the documents associated with their cases. One litigant was also interviewed.

\textsuperscript{3} We defined sexual abuse and assault as any form of unwanted physical touching which the subject experienced as "sexual". This definition excluded sexual overtures which were strictly verbal and/or gestural. Our definition also excluded physical acts which the victim felt violated her physical rights and sexual privacy but were not sexual in intent, such as strip searches and physical examinations conducted under semi-public conditions.
Musick) reviewed documents associated with two civil suits. One suit involved four plaintiffs who claimed tort damages arising from separate assaults at a local county locked psychiatric unit. The other involved a single plaintiff who was assaulted while confined in the locked psychiatric unit of private general hospital. Before hiring the two interviewers who conducted the majority of victim interviews, I spent several hours talking with one of the litigants. From this informal and unstructured interview and the case review, I developed a basic outline of questions the research would address. These questions were elaborated upon by the interviewing staff prior to the first interviews.

Although the questions remained, for the most part, open-ended inquiries intended to elicit descriptive responses, it was necessary to structure the interview guide about half-way through the interviewing phase, in order to exercise firmer control over the interviewing process and to refine the focus of the inquiry. In order to minimize the emotional risks to the subjects, I hired two women with extensive prior experience working with psychiatric patients to conduct the majority of the interviews (I conducted five interviews). One was a psychotherapist and the other had worked as a psychiatric nurse. The psychotherapist remained with the project until the victim interviews were almost completed. The second interviewer worked with the project during the first summer and conducted four interviews. Although both proved to be skilled and sensitive clinical interviewers, neither interviewer was a sociologist and it required increased efforts on my part to ensure that the uncovering of descriptive, rather than interpretive and
clinical data, was emphasized.4

We experimented with a variety of strategies and formats for transmitting the "findings" of each initial interview to each other and for me to "manage" the interviewing process.5 We held several analytic meetings which did not work as well as I would have liked them to — a consequence, I believe, of neither interviewer being accustomed to this form of analysis and the widely different perspectives we held. I made suggestions regarding new avenues for the interviewers to explore, as well as how to phrase questions so that the primary research questions would be adequately probed. Although this continual reshaping of questions is appropriate to an exploratory and semi-inductive inquiry, the changes and "interference" it involved proved to be a major focus of stress and conflict within the interviewing team. It also required much more supervision time than I was able to give. The structured interview guide helped focus the interviewing process and reduced the amount of discretion exercised by the interviewer.

The structured interview guide also functioned as an intermediate step in the content analysis of earlier interview transcriptions and notes. Eleven interviews were conducted prior to the development of the structured interview guide. All by two of these interviews were taped and verbatim.

4An example of this distinction is conveyed in the following: The subject being interviewed had contacted the local rape crisis center after the assault (she was the only one of the respondents to do so), and instead of asking the respondent to describe what she did, who she talked to, what happened at the center, etc., the interviewer asked the respondent how she felt about calling them.

5One interviewer wrote extensive memos in the form of methodological, observational, and theoretical notes (Schatzman and Strauss, 1973), the other interviewer was not familiar with this method of data management and development and, therefore, her transmissions took the form of "clinical" notes.
transcriptions made. Half of the more structured interviews were also taped. Several interviews were conducted by phone and not taped. The interviewer was asked to dictate summary notes at the conclusion of each interview. The transcriptions and summary notes were edited to remove all information which identified individuals and facilities.

Analysis

The interviews (as well as the case documents associated with four civil suits) produced the data from which I created the "assault sample" — a sample of thirty-six assault sets and eighty separate assault incidents which provided the primary empirical basis for the analysis.

The assault sample was analyzed in order to discern the patterns associated with the assaults. The analysis of patterns — one which Schatzman would term a "dimensional" analysis — concerned itself with the following: the nature of the act, the status and characteristics of the assailant, the temporal and locational properties of the incident, the circumstances of the victim at the time the assault occurred, the approach (modus operandi) of the assailant, the reactions of the victim to the assailant, and the strategies employed by the victim after the assault to protect herself from further harm.

My analysis took two forms. Primarily, I conducted a formal content

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6The reader is reminded that these accounts are derived from a convenience sample of former patient-victims. I make no claims regarding the "representativeness" of the subject sample nor the accounts they have provided.
analysis of the descriptive information provided by the subjects and "precoded" in the semi-structured interview guide. I developed three codebooks which covered a) subject demographics, b) the assault set characteristics, and c) incident characteristics. The interview schedules, transcriptions and extant notes were coded by myself and three others. In order to ensure inter-coder reliability, we followed a standard process whereby all coding questions were entered into a coding log. After we had discussed (as a group) and resolved coding questions, new coding instructions were written into the codebooks and all subjects were recoded on that item. The log also reflected unique circumstances. We did not employ a panel of judges to validate our coding decisions however, each subject was coded, and her data file reviewed, at least twice. The coded data was then converted to machine readable format (cards) and SPSS\textsuperscript{7} data files were created. After the initial frequencies were created for every variable in the formal code, I reviewed the data and recoded almost all of the subjects.

In the process of reviewing the data (both individual accounts and the frequencies), new categories and dimensions emerged, for example, the notion of disclosure forms. In addition to using SPSS to assist in the content analysis, I developed analytic files on each of the salient issues and processes I identified during the course of the research. Into these files went ideas, quotes, statistics, and commentary derived from the interviews with patients, staff, and others, as well as notes from the literature and my participation in

\textsuperscript{7}SPSS refers to Statistical Package for the Social Sciences (Nie, Norman, et al., New York: McGraw-Hill, 1975.)
related activities and networks. The files included such first order topics as: prevalence, reportage, opportunity, etiology, penal codes, definitions of rape, staff reactions to complaints, and hospital policies and practices regarding patient sexuality. The files also included derived and analytic topics such as: disclosure processes, attrition stages, opportunity elements, safe environment factors. These files help form my overall analysis of victim accounts and will be a primary basis for analyzing staff interviews and integrating the sociological analysis with the legal analysis.

Problems of the Research

Access and Time

The greatest practical problem I faced in this research was in accessing a sufficient number of research subjects within a reasonable timeframe. I had planned to interview fifty women and had assumed that this number was small enough that we would be able to advertise, recruit, screen and interview within a six month period. As it turned out, the interviewing started in July of 1982 and did not conclude until August of 1983. The slow pace at which respondents contacted us had tangible negative consequences for the study. The intensity of the research was diluted and the morale of the research

During the course of the research, in my dual capacity of investigator and Director of the Institute which sponsored the research, I participated in numerous panels, informal consultations, workshops, and meetings with community mental health facilities, patient advocacy services, and rape crisis treatment programs. In the last year I was elected to the Board of Directors of an advocacy service and asked to serve on the rape committee of San Francisco's Commission on the Status of Women. This "network" activity exposed me to many of the policy and historical facets of mental facility administration, patient rights litigation and advocacy, and anti-rape work.
team was reduced. The funds originally allocated to this part of the overall project were insufficient to meet the cost incurred by the protracted interview phase and resulted in reducing the scope of the study. The focus was for too long on respondent recruitment rather than upon emergent analysis and inquiry. We were also not able to impose any theoretical sampling of the "independent" variables (environmental factors, victim circumstances at time of assault, type of assault, assailant status, etc.) on the small sample.

We advertised our study in a number of local newspapers, including the free newspapers usually found in local coffee shops and gathering spots, through the first ten months of the study. We sought the cooperation and approval of the local community mental health service and made numerous personal presentations to clinics, mental health advisory groups, advocates, and service providers. We advertised in two national consumer newsletters. Our recruiting efforts were intense and quite time consuming. For example, our round of meetings, human subjects proposal submission (and resubmissions), and follow-up meetings with the local community mental health system took place over a four month period and involved approximately fifty staff hours. This effort produced one victim account.

The difficulty we had in recruiting subjects speaks to the problems of accessing as research subjects persons who are labelled chronically mentally ill, and the reluctance and difficulty of institutional victims to come forward to disclose two highly stigmatizing life events — having been institutionalized and having been sexually assaulted. We were aware of several victims of assault who we were not able to directly contact, because the recruiting protocol we had established to protect research subjects' privacy required that we assume a passive role. We asked advocates to whom particular
patients had reported, for example, to inform the patient of the study and how to reach us. A couple contacted us and at least as many did not.

**Reliability of the Data and Credibility of the Subjects**

Obviously one of the greatest problems which we face in presenting our findings can be summed up with a question often asked us: "How can you be sure the subjects told you the truth?" My answers are many but essentially boil down to this: in order to conduct this research, I have had to assume these respondents are no more or less likely to misrepresent or distort their accounts of past events than any other type of respondent would distort or misrepresent similar content. Beyond that *a priori* assumption, I imposed a rule of "analyzability" to determine whether or not I could include a subject's account within the sample. That is, if I (or the other interviewers) could not make sense of what the woman was recounting (if the account could not be analyzed), the interview process was truncated and there was no attempt to analyze the data. A related reliability check was in the form of subjectively evaluating the plausibility of the victim's account. One respondent, for example, claimed large set sizes (seven and ten). We have no

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9It would be naive, I believe, to evade the political nature of the credibility question. Rape victims and mental patients are subjected to extreme forms of *a priori* discrediting (as discussed above and by numerous other researchers). My position as a researcher, was first to ask and deal with reliability and validity issues as the interview process unfolded. As my research and involvement with rape treatment specialists has increased, I have also become aware that victims of sexual assaults (in general), because of the shame they feel, are probably less likely to tell at all than they are to exaggerate or falsely report a sexual assault. Should we assume that former patients are different in this regard? This is an empirical question.

10There were several such situations, and all but one were identified during the screening interview or during the first moments of contact. I conducted one full interview (three hours) with a woman whose account simply did not "make sense" and it was, therefore, excluded from the main analysis.
way of knowing whether or not her numbers are accurate estimates or gross overestimates (they could also be underestimates). The set analysis, however, corrects for the potential of victims to misestimate the number of incidents included within a set as its unit of analysis is the set as a whole. Finally, we considered whether or not the respondent's account was internally consistent. This was easier after we began using the structured interview guide, as several sets of questions addressed the same dimensions of each assault set.

The accounts of our respondents, like those of most victimization surveys, cannot be corroborated. We would not, for a number of ethical and practical reasons, go back to an institution to check out a victim's story. Even if we did, there would be no reason to believe that we would get a more accurate picture of what happened from staff. In the end, however, the purpose of this research was not to establish the fact of individual sexual assaults, but rather, generate a conceptual and theoretical understanding of the overall phenomenon. Perhaps this work will enable those who are in a position to develop the information which could corroborate a victim's claim (staff and law enforcement personnel) to establish the fact of assault.
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