Patterns of Rape and Approaches to Care

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The family physician is likely to be involved in the care of the rape victim. This paper focuses on the social and legal definitions of rape as well as the incidence of rape. The Rape Trauma Syndrome is explained and normative responses of victims are discussed. Eight common myths about rape are identified which the victim and the physician may share. In discussing the myths, guidelines for counseling the rape victim are delineated: encourage the victim to talk about her feelings; as the physician, remain nonjudgmental; provide information or resources to the victim; view the aftermath of rape as a response to a life-threatening event; and enlist the support of the victim's significant others. Finally, the importance of understanding the available community resources is stressed.

Rape is the fastest rising violent crime in the United States.[1] With the advent of the women's movement, there has been a confronting of this phenomenon in terms of its mythology, public attitudes, occurrence, and prevention.

The family practice physician and the family nurse practitioner will be called upon to administer to the medical and psychological needs of the rape victim and her family. This paper discusses normative responses to being raped, and points out how caretakers can be most helpful.

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Definition of Rape

Rape can be defined socially and/or legally, depending on one's perspective. *Socially*, rape has been defined as the seizing and taking away by force.[2] In a broad social context, rape could be considered a logical extension of cultural values that see men as possessors of women. The social definition of rape frequently is provided by the woman as victim.

All victims would agree that rape is an act of violence, most having felt certain that they would be killed by the rapist: rape is perceived as a brush

with death which accounts for the severity of responses in victims. Sex is the vehicle for this violent act. "Rape is a crime against the person, not against the hymen."[3] Burgess and Holmstrom[4] have noted a consistency of symptom reporting by victims which they have named the *Rape Trauma Syndrome:* "The syndrome includes physical, emotional, and behavioral stress reactions which result from the person being faced with a life-threatening event."

The response to rape has been compared with war victim responses to traumatic situations. The degree of powerlessness and helplessness experienced by the victim no doubt sets rape apart from other life events. Notman and Nadelson[5] have compared rape responses to responses to other situations of stress: "Since it is an interaction between an extreme environmental stimulus and the adaptive capacity of the victim, it is similar to other situations described in the literature on stress, including community disasters, war, surgical procedures, etc."

Another aspect of the social definition of rape is the fact that mutual consent to the act is lacking as the rapist displays hostility and gratification-seeking. Notman and Nadelson[5] stress this notion: "The experiences that we call rape range from surprise attacks with threats of death or mutilation to insistence on sexual intercourse in a social encounter where sexual contact is unexpected or not agreed upon. Consent is crucial to the definition of rape. The importance of mutual consent is often overlooked and misinterpreted; many people assume that certain social communications imply willingness for a sexual relationship."

Legally, rape is carnal knowledge of a person by force and against that person's will, if there is sexual intercourse and force without consent. Force refers to the use of actual physical force to overcome a victim's resistance or the threat of great and immediate bodily harm.[6]

Hilbey[7] and Connell[8] have identified three major factors of the legal defense in a rape case:

1. *Identification*—that the man accused is the perpetrator of the crime.
2. *Penetration*—that a sexual act took place.
3. *Lack of consent*—that intercourse was not a voluntary act on the part of the woman.

Applications of the legal definition of forcible rape vary and the victim becomes doubly victimized—by the rapist and by the society.

Incidence of Rape

Rape is one of the most under-reported crimes[9] because of the fear, embarrassment, and humiliation experienced by the victim. In 1973 the Federal Bureau of Investigation documented 51,000 cases of forcible and attempted rape, a rise of 62 percent over a five-year period compared with a 45 percent rise for other criminal acts. It has been said that only one in five rapes are reported.[10] In 1975 at the University of California, Davis, 150 rape victims were seen in the Crisis Clinic. For several years the Crisis Clinic has cooperatively worked with the Emergency Room of the Sacramento Medical Center (the teaching hospital of the University of California, Davis) to be of service to rape victims. As victims come to the Emergency Room, the Crisis Clinic staff is automatically notified in order to give emotional support and information. The staff member introduces herself to the victim (it was decided that female therapists were likely to be less threatening to the victims than male therapists). The therapist then tells the victim what to expect, ie, physical and pelvic examination and a brief interview with a police officer, so that she can predict what will happen in the next few minutes. This is of paramount importance; in the rape situation, the victim probably had very little predictor power unless it was to envision her own death. Finally, the staff member offers an open-ended interview with the victim to deal with the experience of rape.

The staff assumes that there are many more victims in the Sacramento County area who do not report this crime. Additionally, a liaison has grown between the Emergency Room and the Crisis Clinic and the Rape Crisis Line of Sacramento (a part of the Sacramento Women's Center). The Rape Crisis Line staff who receive calls from rape victims insist that in one year many more than 150 women have called in to report a rape.

Responses of Victims

Rape is a violent act which for most victims is a major and unforgettable crisis. The victim will state that she had an overwhelmingly frightening

experience during which she feared for her life and paid for her freedom with the sexual act. The victim's own life-style becomes severely disrupted as well as the lives of those close to the victim: family, friends, and co-workers. The victim's family and others may believe that "she asked for it" since they believe that rape can only occur that way. Rather than support the victim emotionally, the family may withdraw, be openly critical, or wonder how they failed as a family. The victim's social partner may feel that the victim is untouchable, dirty, or no longer worthy of respect. Seiden[11] points out that when society, the family, police, or psychotherapists assume that the victim contributed to the rape, this contributes to the victim's own victimization. The rape victim already blames herself for the assault. Many women will ask: "What do I do to bring this on," which assumes that the woman could have avoided rape. This self-blaming process often serves as a means of controlling the unpredictable future. That is, if she could find out how she could have avoided rape, then she can control her future since she feels out of control at the present. Paradoxically, a simultaneous, seemingly universal phenomenon occurs, and rape victims will state: "I can't believe it happened to me." This phenomenon manifests the sense of shock, bewilderment, and trauma.

Phobic reactions are also common for the rape victim and represent a defensive reaction. Burgess and Holmstrom[4] have identified six major phobic reactions that they observed in 146 victims during a one-year period:

1. Fear of indoors (especially those women raped in their beds)
2. Fear of outdoors (women attacked outside of their homes)
3. Fear of being alone
4. Fear of crowds
5. Fear of people behind them
6. Sexual fears (especially with victims who had no prior sexual activity)

Some rape victims feel suicidal. Crum[12] has pointed out that "to live is to cooperate or to participate in your own violent dehumanization. To die is to refuse to participate, to have maintained the self." As a result of rape, the victim has most likely experienced an incredible degree of powerlessness and helplessness. Rape has been called "the ultimate violation of self."[13] Hilberman[14] reminds us that it "is best understood in the context of a crime against the person and not against the hymen." Feeling suicidal is concomitant to feeling isolated due to the social stigmatization of rape, the inability to put into words the terror and guilt, and the inability to find people who are genuinely empathetic. Many rape victims will say they feel as if they are "going crazy" as they live through a total disruption, a crisis, unparalleled to any other life experience.

Interestingly, anger is not a primary or immediate emotion for many victims. That seems to be experienced later. Maccoby and Jacklin[15] have stated that in general women tend to be slower to anger than men. When rape victims begin to experience anger, it is apparent in dreams, or more specifically nightmares, in which the rapist is killed, maimed, or otherwise put into a powerless position. Anger also is not a primary experience for the rape victim because she is so engrossed in trying to figure out how she brought it on. When she can stop her self-blame, she can redirect her energies to the man who violated her.

Common Myths about Rape

The responses to rape that a victim has are also contingent on the myths that most people have grown up with and to some extent share as a result of relatively common socialization experiences. The stigmatization process is based on myths which essentially and subtly imply that women fabricate rape incidents. Hilberman[14] points out that the notion of the woman as a liar typifies attitudes about rape victims.

This image of women as liars is likely the explanation for the assumption that women often make false charges of rape against men, even men they don't know. Law enforcement personnel are aware that false charges of crime do occur, but it is only in rape that it is assumed that the usual safeguards of the system are inadequate to protect the innocent from a lying witness. Contrast a charge of rape with that of robbery, where it is understood that property is taken from the victim without his/her consent, and there is no need to prove that fear of death or grave bodily harm was at issue. . . .The District of Columbia Task Force suggests that the law

grants more protection to property than to the person, especially if the person is female.

The myths which help to maintain the stigmatization process serve to depict the victim as responsible and not innocent. The myths are simply that—myths:

Myth—Most rapists see an attractive woman and are absolutely overcome by uncontrolled sexual impulses.

Fact—Rape is a violent, planned, aggressive act. Factors such as physical attractiveness or age of the victim do not deter rapists.

Myth—Rape is impossible if the woman struggles enough—rape can be avoided.

Fact—Most women are smaller and weaker physically than the attacker. Additionally, rapists may threaten a sleeping child in an adjoining room if the woman does not submit. Frequently, rapists have actual weapons and may already have harmed, or may plan to mutilate or kill, the victim. A counterattack by the victim may not be protective.

Myth—Women provoke rape.

Fact—In a similar fashion, one might assume that bank tellers provoke bank robberies. This myth assumes that men have no responsibility, and that in essence women are responsible for men's sexual and/or aggressive impules. The person who is robbed is not accused of asking for it.

Myth—Only "bad" women get raped.

Fact—All women are potential rape victims. To assume that "bad" women are the victims serves to further split women into the good/bad dichotomy and to help maintain a double standard of sexuality.

Myth—Women cry rape when they are trying to retaliate against a man.

Fact—Rape is under-reported. Women already feel stigmatized and guilty and are more likely not to report rape.

Myth—If you are going to be raped, you might as well relax and enjoy it.

Fact—This notion discounts the seriousness of rape as an aggressive, violent act, and assumes that women want to be raped. It suggests that a man should relax and enjoy being mugged and beaten.

Myth—Rape occurs outside of the woman's home.

Fact—Over half of the rapes reported in one study,[16] occurred in the victim's home. Being in one's residence does not guard against rape.

Myth—Most reported rapes involve black men raping white women.

Fact—Most reported rapes are intraracial, not interracial.

Counseling the Rape Victim

Rape victims are a special group of people who require skilled, sensitive, and empathetic helpers.

When the Crisis Team at Sacramento Medical Center decided to systematically set up a counseling program for rape victims, it was decided that the counselors would add to the victim's own victimization by not checking blind spots. Initially, the staff sat down and bravely, but cautiously, told of their own beliefs surrounding rape. It was a difficult process, but a necessary one. Consultants from the local Women's Center who had been working on a rape telephone line and from the nearby university participated in the group sessions. After this the group began role-playing situations which brought out the importance of listening and acknowledging what is heard.

The range of responses was unexpected. It was as if staff members themselves were rape victims. The realization that each counselor was vulnerable and could be a rape victim heightened awareness as dreams became nightmares, and social partners were looked at with new suspiciousness and caution.

The effects were gradual. Going to the supermarket was different. I started watching men like the grocery baggers. . .parking and getting into my car took on a new meaning. I felt like I was in a mental cage. My car keys became potential weapons against some predator. I started waking up in the middle of the night certain that a strange man was in my house. . . .I checked my windows and doors more carefully. I knew my time was coming. *(Female Staff Member)*

In working with rape victims, I went through a period of incredible hostility and anger towards men. They were all no good bastards and I had a right to act in any way. . . .I also experienced a time of finding sexual relations difficult—of finding myself in the midst of lovemaking and suddenly feeling as though I was a victim. *(Female Staff Member)*

Any group of people interested in being with rape victims should do its own soul-searching. The myths are there and need to be revealed—before the victim comes in.

As rape victims were counseled, it became evi-

dent that rape and attempted rape shattered and changed the lives of rape victims and then had a ripple effect upon families, friends, lovers, husbands, boyfriends, and children. Rape obviously does not merely harm the victim—its impact is felt by the significant others in the victim's life. Indeed, the very fabric of human relationships is disrupted by the rape experience.

The victim needs to feel safe and to feel that she has an empathetic listener to tell her strong feelings to as well as to describe what may seem to the victim to be unspeakable acts. The "controlled" victim described by Burgess and Holmstrom[4] appears to have a calm or subdued demeanor about her, unlike the "expressed" victim who demonstrates her feelings more clearly. To pressure the "controlled" victim to talk is to replay the rape experience of force. The victim must be allowed this style of being; it is hers and must be respected as such. Medea and Thompson[17] discuss this need for control on the part of the rape victim:

> At this time the victim has little or no desire for outside help. She may well resent it. Her emotional well-being depends on her believing that she has coped with the matter, and she needs time to adjust.

What was learned from the soul-searching of the staff at the Sacramento Medical Center was that the staff's responses to rape were upsetting, and at times seemingly unbearable. The rape victim's subjective experience is not only greater but is also apt to feel devastating. To be most helpful in dealing with rape victims, the following are offered as critical guidelines for any concerned helpers:

1. *Encourage the victim to talk about her feelings.* The actual rape and events surrounding it may be considered secondary to what the victim herself experienced. Sometimes, the victim has a difficult time articulating to another person what transpired, either because of guilt or embarrassment. If this is the case, encourage her to write down what she remembers. This will serve to give her some sense of control. Also, she is not likely to go to court for some time, and she is apt to have more credibility on the stand if she states she wrote down the events of the rape. If the victim is not interested in this strategy, encourage her to draw, paint, or write poetry—whatever avenue of expression suits her individual style. If the victim chooses not to talk about her feelings with you, find out if she has other people with whom she feels she can talk and in whom she can confide. Avoid pushing the victim to ventilate. Pressure to make her talk is analagous to the pressure felt in the rape experience itself. Let her know you're available. Tell her you'll contact her later.

2. *Don't try to determine the validity of the rape.* Any determination of rape is made in a legal sense. If you question the victim's story in a legal manner, you are subtly or directly judging her and she is apt to feel more guilty and responsible. Being judgmental of rape victims is not helpful and should be dealt with elsewhere. If this is a continuing personal style, reconsider your motives for working with rape victims. The experience of rape is a subjective one.

3. *Provide information on police procedures, legal resources, medical facilities, victim of violent crime application, and supportive community groups.* In having factual information about resource groups, the patient will be in a better position to make major decisions, eg, whether to prosecute, the possibility of pregnancy or venereal disease, dealing with significant others.

4. *Assume that a wide range of emotional and behavioral responses are part of a major normative crisis.* The victim will often imply or state directly that she feels out of control or is afraid of "going crazy." Obviously it is important to know something about the victim's prior style of coping under stress. How did she deal with critical situations? What does she do under pressure? Has she had any major losses? If so, in what manner and how long did she grieve? What are her strengths? What events or concerns did she have before the rape?

Many rape victims will move and change their telephone numbers, especially when the rapist threatened he would return. Other fears include a fear of being indoors or being outdoors, fear of crowds, strangers, fear of being alone, fears of all men, even spouses, lovers, etc.

A sense of isolation or alienation is common. Rape victims feel and are, in fact, stigmatized. As a result, some victims cannot express what they feel and may not have empathetic listeners. Not only is there projection on the part of the victim, but there are projections onto the victim.

For several months after the rape, victims experience nightmares during sleep, and in the waking state report intrusive thoughts about the assault experience. Asleep or awake, the working-

Appendix 1.

Sexual Assault (Female) Protocol

University of California, Davis-Sacramento Medical Center

Consent by patient, parent, or guardian is required on Emergency Department and Permission for Release of Information (ie, Police Medical Report) forms.

The victim of rape has endured a major crisis both physically and emotionally, and the need for all Emergency Department staff to act in a manner reflecting courtesy, compassion, and respect cannot be overemphasized. All staff members should also exercise specific care in handling the person's right to know what is happening to her. The patient's right to privacy should be respected and delays in examination and treatment should be avoided. Without special concern for the rape victim, the Emergency Department experience may become an additional trauma rather than an opportunity for assistance.

Special Considerations

1. Law enforcement personnel must request examination.
2. Adult examination: performed by Emergency Department staff physician. Pediatric examination (less than 16 years old): performed by Emergency Department physician in consultation with pediatrician on-call.
3. BE AWARE: If there are signs of violence (bruises, lacerations, etc) officer may request photographs. Clothing may also be requested; if so, have officer sign clothing sheet.
4. Psychiatric Crisis Clinic: staff member meets victim at Emergency Department registration, escorts her to Crisis Clinic, and is present and supportive during interview by officer. Information and a pamphlet is provided with information about pregnancy, veneral disease, treatment, follow-up, etc.

Nursing Implications

1. Patient is in a situational crisis and should not be left alone.
2. Patient must be completely undressed and clothed in only hospital attire preceding examination.
3. *Do not* allow patient to void before checking with physician conducting examination.
4. Label specimen containers and slides, and complete laboratory envelopes, Police Medical Report forms, and Health Agency forms prior to examination.
   - Authorization for Release of Information must be signed on Police Medical Report form.
   - Physician must *sign* crime laboratory envelopes *and* witness sealing of contents within.

Equipment

barrier drape
examination gloves
vaginal speculum
cervical scraper
12 cc syringe filled with nonbacteriostatic saline
lubricant
soft-leaded pencil
lired-top tube
2 glass slides
comb

vacutainer holder and needle
Sacto County VDRL and cervical culture requisitions
plastic slide container
specimen container (plastic urine tube and cap)
1 culture tube with charcoal media
1 sodium citrate tablet
4 addressograph labels
medical report (both copies to officers)
3 crime lab envelopes

Examination

1. Physician should explain procedures to be done.
2. Ascertain if victim has changed clothes, bathed, douched, etc, since assault.
3. Observe clothing for missing buttons, torn fabric, pertinent stains, etc.
4. History—age, marital status, parity, last menstrual period, date of last coitus, time elapsed since assault, brief history of what has occurred, including inquiry about oral or rectal intercourse as patient often will not volunteer this information.
5. Record any bruises, lacerations, or other signs of violence on body.
6. Gynecological examination: patient in dorsal lithotomy position.

•observe external genitalia, perineum, for evidence of violence, scratches, matted pubic hair, etc.
•obtain pubic hair combings: pass comb through hair several times allowing loose hair and lastly comb to drop into open crime lab envelope.
•vaginal examination: use water-moistened speculum to preserve evidence; record presence or absence of hymen, signs of internal trauma.
•vaginal swab for gonococcal culture: place in charcoal media (culture tube) labeled with stamped name sticker.
•vaginal smears: prepare two slides using vaginal scraper (slides labeled with patient's name and hospital number placed in labeled plastic container then in crime lab envelope).
•vaginal wash: approximately 12 cc nonbacteriost tic normal saline solution instilled into vagina then solution withdrawn and placed in specimen container with 1 sodium citrate tablet (container labeled with stamped name sticker and "vag wash," then placed in crime lab envelope).
•additional specimens may be taken if other forms of intercourse are suspected.
•routine bimanual examination.
•8 cc clotted blood drawn for VDRL.

Specimen Disposition and Records

1. Medical Report Sexual Assault form: both copies given to officer or placed in crime lab mailbox if officer has left.
2. Place three crime lab envelopes (containing (1) pubic hair combings; (2) vaginal smears; (3) vaginal wash) in crime lab mailbox outside utility room door.
3. *DO NOT* allow these specimens out of your possession until placed in crime lab mailbox. Sacramento County Health Agency specimens (gonococcal culture and blood specimens) will be delivered by Emergency Department staff to Health Agency laboratory, 2221 Stockton Blvd., 9 AM to 5 PM, Monday through Friday.

Treatment

1. Probenecid 1 gm orally, followed by K penicillin G 4.8 million units intramuscularly. (Alternative antibiotics: ampicillin 3.5 gm orally with above probenecid in Emergency Room or tetracycline 1.5 gm orally in Emergency Room then every six hours for four days, contraindicated for use in established pregnancies.)
2. Gynecology clinic—six-week follow-up appointment for pregnancy test, abortion referral, syphilis testing, etc.
3. Crisis Clinic—follow-up for management of post-assault, emotional distress of patient, or child and parents; arranged between patient and Crisis Clinic staff.
4. Optional: treatment for pregnancy prevention, diethylstilbestrol 25 mg twice a day for five days (contraindicated in established pregnancies).

through process is constant and at times, seemingly unbearable.

As one might expect, rape victims are apt to feel asexual as a way to avoid any sexual encounters which might serve to remind them of the experience.

Anger toward the rapist does not become apparent until the victim has become less angry and blaming toward herself. Then she will become less immobilized and depressed and will experience a stronger sense of control.

5. *If possible, and only with the victim's consent, enlist the support of her significant others.* These are people she needs to trust, lean on, and rely upon. Frequently the significant others, especially spouses, need to be helped to understand what the victim encountered, and how she's feeling. At times, the family will blame the victim as part of the stigmatization process. The family is apt to feel some emotional pain as well.

Aside from the usual individual-victim—individual-helper encounter, it has also been useful to implement a self-help group composed of rape victims. Seeing others dealing with the trauma of rape, gaining support for oneself, and diminishing one's isolation are critical aspects in the reorganizing process. The victim learns from other rape victims and can develop a bond with others who really know what rape is about.

Community Involvement

Rape not only affects the victim and those close to her, but also has an effect on the community in which she lives: the hospital, the police and prosecutor's office, possibly a crisis clinic, a women's rape crisis line, employers, educational institutions, and clergy may all feel the impact, directly or indirectly. Therefore it behooves the community to cooperate in the educational, legal, and demystification tasks at hand with respect to rape. This may sound easy but is, in fact, an enormous task in terms of energy, time, and incentive requirements. One example may be helpful. A psychiatric resident (woman) and the author were asked to be the speakers for a weekly Psychiatric Grand Rounds, which is an educational service for mental health professionals, ie, psychiatrists, psychologists, psychiatric social workers, nurses, technicians, and related mental health students. The usual lecture was given without any expectation of negative responses to the topic. In trying to delineate the myths, and speak about rape matter-of-factly, it became evident that the topic was emotion-laden, hence not easily susceptible to rational approaches. Mental health personnel who, it was erroneously assumed, were an enlightened group, were outraged and skeptical, and seriously questioned the premises of the lecture. It seemed that these people were no different from the lay public—they too had their biases, and to some extent share the beliefs in the mythology surrounding rape. They had to be reeducated in the same way that the rape victim and her significant others had to be.

Similarly, there was resistance among the law enforcement personnel. Their mythological belief systems were perhaps even more significant. If the police or prosecutor's office staff for one reason or another did not feel the victim had credibility, then the investigative process would either proceed very slowly, or otherwise be nonexistent. This is the human condition: people are individually and collectively governed by their value systems, prejudices, biases, and enthusiasms. One suggestion for coping with this situation is to become acquainted with the police. Learn to appreciate, in the most sincere sense, the pressures of their job, their endless struggles with crime, and their daily confrontation with human exploitation. The job of police and prosecutors alike is a pressured one, seldom appreciated, understood, or celebrated.

In this author's experience, the police were not only unappreciated but, in turn, would not appreciate other agencies in town who were victim advocates, ie, a rape crisis line. There was mutual aloofness, distrust, and accusations from both directions. As a result, the Crisis Team at the Sacramento Medical Center assumed the role of mediator, enlisting the goodwill of the law enforcement personnel and the crisis line to provide the best possible service for the rape victim. As one can imagine, this position was tenuous at best.

The staff members became translators and middle-people and carefully treaded their way. The oppositional attitudes of these two agencies were probably based in philosophical differences as well as the felt need for control from both parties. If this process is not accepted on the part of any hospital or crisis intervention service, then the rape victim will be re-victimized and scapegoated. The hospital and mental health center's Kissinger-like role is a diplomatic one and is crucial to the well-being of the victim: she may and probably will need both agencies' good will. The police and prosecutor's office are determining factors in locating and bringing the rapist to trial. The rape crisis line may need to provide supportive-informational resources, eg, child care, transportation, legal and other informational resources, emotional support, and other much-needed help.

A rape crisis line is often an integral part of a Women's Center, which could be considered "radical," especially if it is not based at a university. The crisis line and crisis center often represent a departure from traditional mental health services. The line will be an advocate for the victim. The mental health clinic may not, and usually does not, focus solely on women. All too often the mental health center and the rape crisis line are unsure of each other for a variety of reasons. The line is often composed of interested women who may not have directly related professional credentials, who may not be interested in working within the system, who refuse to accept society's traditional stereotypes of women, and who may not have men on the staff. On the other hand, the mental health center hires only those with professional credentials and related experience, may be less involved in women's issues, may ascribe to traditional values in their care of mental health clients, and who believe in working in the system, often through bureaucratic channels. Obviously, the staffs of the mental health center and the rape crisis line work in two different styles. Cooperation is highly possible between the two, but it does not come easily or quickly. However, it is of utmost importance for the victim that they meet to discuss differences, goals, and dreams. If the hospital-mental health center cooperates, the victim will be encouraged by the crisis line to come to the hospital for care, for an evidentiary examination, and for the determination and prevention of venereal disease.

Equally important in the demystification of rape is education, and an interested educator becomes quickly known in a community if willing to speak to college classes, medical and other professioal schools, clergy, media personnel, auxiliary societies, schools, and general public information outlets. It is gratifying to see people changing their minds as they are provided with new and relevant information. Public speaking is a demanding, tiresome, yet exciting approach which, it is hoped, reaches potential rape victims.

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