Developing Consultation and Education Services for Sexual Assault

American Institutes for Research
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FOR WHOM

This monograph is addressed to staff members in mental health agencies who are responsible for assuring that consultation and education (C&E) services related to sexual assault are provided within the community.

ABOUT WHAT

The monograph provides basic background information about sexual assault, an overview of the major issues, and a guide to strategies involved in addressing the problem at the community level.

WHAT IT IS

The purpose of the monograph is to outline the special role that community mental health centers can play in alleviating the effects of sexual assault on victims, potential victims, and communities and to stimulate planning and activities directed toward the prevention of sexual assault.

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The information was compiled from a number of sources:

- Published and unpublished reports of current research
- Presentations at conferences and workshops
- Interviews with C&E specialists, rape crisis workers, and members of the medical, law enforcement, and criminal justice systems
- Discussions with the staff of the National Center for the Prevention and Control of Rape

Acknowledgments

In preparing to write this monograph, we first listened to many individuals who are concerned on a day-to-day basis with alleviating the damaging effects of sexual assault, including rape crisis center volunteers, mental health counselors and administrators, social workers, police officers, medical personnel, judges, lawyers, researchers, and a few courageous victims. We are indebted to all these persons for sharing their knowledge, experience, and feelings with us. We hope that we have respected their sometimes divergent points of view while communicating their common message that sexual assault is a major social problem which needs to be confronted and understood by all of us.

The process of sorting out and prioritizing the most critical issues and strategies to be addressed in this monograph was accomplished with the dedicated and constructive help of our consultants, who also provided insightful comments about the early drafts of the monograph. These consultants were:

William Goldman, M.D., Acting Assistant Director for Mental Health Services, San Francisco.

Lestina M. Grant, Director of the Consultation and Education Unit of the Community Mental Health/Mental Retardation Center at Albert Einstein Medical Center in Philadelphia.

Carolyn Holmes, Special Assistant to the Executive Director for Consultation, Education, and Prevention and Director of the Rape Counseling and Prevention Program of the Coconino Community Guidance Center in Flagstaff, Arizona.

Lucy Ann Howard, Associate Director of the Washtenaw County Community Mental Health Center, Ann Arbor, Michigan; and Director of the Assault Crisis Center.

Elizabeth Karl, a founder of the Rape Crisis Service of the Hartford, Connecticut YWCA; past Principal Investigator of an NIMH-funded rape crisis training evaluation project; and Co-coordinator of the Court Task Force on Abused Women Statewide Shelter Network for the state of Connecticut.

Barbaraterry Kurtz, Clinical Social Worker on the faculty of the Stanford University Medical School and consultant to the Santa Clara County (California) Mental Health Department; and a founder of the Women's Crisis Center in Ann Arbor, Michigan.

Larry Pierce, Center Director of the Falls County Mental Health/Mental Retardation Center in Marlin, Texas.

Vicky Powell, Team Leader for the Community Services Unit of the West Valley Community Mental Health Center in Santa Clara County, California; and representative of the Santa Clara County Mental Health Department to the county's Task Force on Rape.

Carolyn Swift, Director of Prevention Projects for the Wyandotte Mental Health Center, Kansas City, Kansas; Principal Investigator of an NIMH-funded research project involving consultation in the area of child sexual abuse; and Chair of the Education and Training Subcommittee of the Metropolitan Organization to Counter Sexual Assault, Kansas City.

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I. INTRODUCTION

Sexual Assault—A National Problem

Sexual assault is a violent crime against the body and will of a person. The motivations of assailants are complex, but the act is primarily an expression of a need to control or to humiliate and degrade the victim. The effects on victims are pervasive and sometimes long-lasting, often including overwhelming emotional trauma, physical injury and even death. The impact of the crime extends beyond the victim to families, friends, and the community. At a broader level, sexual assault is a problem which creates concern about violence and its possible root causes as well as the personal safety and rights of all individuals.

The prevalence of sexual assault in all parts of this country has made it a national issue. According to FBI figures, a forcible rape was reported to the police every 9 minutes in 1976—a total of 56,730 reported offenses.[1] But these figures do not represent the true extent and seriousness of the problem.

- In the ten years form 1967 to 1977, there was a 105.4% increase in the number of forcible rapes reported by the FBI and an 88.6% increase in the rate of forcible rape (number of crimes per unit of population).
- These figures include only those cases which were reported to local police and subsequently to the FBI: The FBI has estimated that perhaps only 20% of the actual assaults that occur are ever reported.
- These figures include only cases of "forcible rape" against females; they do not include sexual assaults against males, nor sex crimes against children such as incest and molestation.

In recognition of the seriousness of the problem and the unmet physical and mental health needs of victims and others affected by the crime, the U.S. Congress enacted legislation in 1975 to establish a National Center for the Prevention and Control of Rape, within the National Institute of Mental Health (Public Law 94-63, Title III, Part D, Sec. 231). The same law (Title III, Part A, Sec. 201) directed Community Mental Health Centers (CMHCs) to establish consultation and education services which "promote the prevention and control of rape and the proper treatment of the victims of rape." One of the responsibilities of the National Rape Center is to assist CMHCs in carrying out their mandate for C&E services related to sexual assault. A specific category of research-demonstration grants has been designated by the National Rape Center to assist CMHCs in developing, testing, and evaluating models of C&E programs pertaining to sexual assault. This monograph has been developed to make CMHCs aware of the issues involved in establishing such services, as well as the special role that can be played by the mental health field in community efforts directed at prevention and treatment.

[1]Federal Bureau of Investigation, 1977.

The Role of Mental Health Agencies in Dealing with Sexual Assault

Public Law 94-63 signaled the first official recognition at the national level that sexual assault constitutes a serious mental health problem. The fact that C&E services are specifically mentioned in the legislation reflects the commitment of policymakers to primary prevention of sexual assault, as well as the intent that mental health agencies should focus on providing support for community programs in promoting the proper treatment of victims and offenders.

In working with the community, the C&E specialist might encounter the attitude that it is inappropriate for a mental health agency to respond to what is viewed as a medical and legal problem. Other persons feel strongly that sexual assault is a political problem, stemming from the unequal status of men and women in our society and from cultural values which support the aggressive male role and the submissive female role. Many groups, particularly those with a feminist orientation, feel that sexual assault victims have *situation-based* needs and that not every victim is a potential client for direct mental health services. There is a concern that the identification of sexual assault as a special target area for mental health services tends to create or foster the idea that the effects, and perhaps even the causes, of the crime are primarily victim-centered. That is, mental health treatment may imply that the victim had

pre-existing problems which contributed to the assault, and therapy may be directed toward solving these problems rather than dealing with the immediate crisis. Most feminists feel that no assumptions should be made about the overall mental health of victims, but that attention also should be focused on conditions in the community and the broader social system which tolerate or encourage the crime.

It is important that the C&E specialist and other mental health professionals be sensitive to these divergent points of view. When they are encountered, the C&E person should be prepared to demonstrate that there is a legitimate role for mental health agencies in community efforts aimed at the prevention and treatment of sexual assault. This role should not be that of a usurper or an adversary. Neither should this role be limited to clinical services, although this is an important contribution that the CMHC can make to a community-wide effort. What needs to be communicated is that the field of mental health has special knowledge and resources to offer, including:

- Experience in promoting prevention through public education campaigns and consultation activities with key individuals and groups in the community,
- Training in crisis intervention techniques to provide immediate physical and emotional support for persons in acute stress,
- Training and resources to deal with the long-term psychological effects of trauma suffered by some victims and/or their friends and families,
- Established entreé to and working relationships with other public agencies, and
- Understanding of the psychosocial determinants of behavior and awareness of the natural social networks (families, neighborhoods, and communities) that can support or inhibit positive mental health.

Many communities have rape crisis centers, women's self-help groups, and similar grass roots organizations which have pioneered public awareness of sexual assault and services to victims. Many hospitals and clinics have personnel who are specially trained in dealing with the medical and emotional needs of victims, as well as in procedures for collecting legal evidence for prosecution of offenders. Across the country, there are police departments with sex crimes investigation units and public prosecutors' offices with victim-witness assistance programs. Where such resources exist, the primary mission of the C&E specialist is to coordinate mental health services with these ongoing activities—to maximize rather than duplicate the efforts of others. Where such resources do not exist, it becomes the responsibility of the mental health profession to take the lead in initiating public awareness and promoting the development of appropriate services.

Definitions and Limitations

Throughout this monograph, the terms "sexual assault" and "rape" appear. The terms are not used interchangeably. Rather, they reflect two different interpretations of the offense. The FBI has defined "forcible rape" as "the carnal knowledge of a female through the use of force or the threat of force."[2] State laws which are patterned after this definition determine that the crime can be prosecuted only when a *female* is the victim. Some states further limit the definition of "rape" to include only the act of vaginal penetration by a male. Most of the available statistics are based on such narrow legal definitions. "Rape" is used in this monograph when it is appropriate to the data (as in the FBI statistics) or when it was the term used in cited literature.

"Sexual assault" implies a broader definition which is less closely tied to existing statutes. The term is used in this monograph to refer to any sexual assault which is against the will of the victim, including vaginal penetration, oral copulation, sodomy, and penetration by an instrument or device; the victims of sexual assault may be males or females of any age.

At the present time, most of what is known about sexual assault is based on reported cases of "rape" in which adult males have assaulted adult females. This monograph does not deal directly with either incest or the sexual assault of males,[3] but many of the ideas in the monograph can be generalized for the development of programs serving victims of either sex or any age.

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[2]Federal Bureau of Investigation, 1976, p. 15.

[3]Currently, the understanding of incest and methods for dealing with it are qualitatively different from what is known and done about other types of sexual assault; there is scant literature about sexual assault of males and a low incidence of male victims reporting the crime.

As new and expanded programs for sexual assault victims become available and visible to the public, we can expect that more victims will report the crime, and persons suffering the long-term effects of previously unreported assaults will seek counseling. New services and changes in existing services may be required. The C&E specialist can and should play a key role in mobilizing an effective response to these emerging needs. The ability to understand and to plan for these needs will depend on a continuing process of self-education. The information in this monograph is a beginning, but the C&E specialist also should be prepared to keep abreast of the current literature and the changing service demands within the area served by the CMHC.

Assessing the Literature

There are a number of resources available to the person seeking information about sexual assault. However, any reference should be carefully evaluated by the reader in terms of the quality of the information it provides. Persons who familiarize themselves with the literature soon become aware that:

- There are many gaps in the research about sexual assault, and some of the research that has been done is poorly designed and of questionable validity.
- Even among those who are the most knowledgeable about sexual assault, there are areas of disagreement about what is myth and what is fact.
- New information appears almost daily in books, journals, and the popular media—some of it supports and some of it contradicts what we previously thought to be true.
- There are no easy answers to questions about the causes, the prevention, or the treatment of sexual assault.

There has been a definite shift in the past few years in the way in which sexual assault is understood and discussed, and the literature should be assessed against this backdrop. Historically, rape has been viewed as a sexual act, representing a response to "pent-up sexual urges." Rapists were assumed to be either pathological or reacting in an understandable if deplorable way to unusual pressures such as wartime stress or the seemingly provocative female. Much of the literature published prior to the 1960s reflects this bias and tends to focus on the psychological dynamics of the rapist.

During the 1970s, rape crisis centers began to be established either as alternatives to existing services or to a total lack of services. Often staffed by rape victims themselves, the centers assisted victims in dealing with their psychological as well as physical trauma. The experience gained from these centers and a growing sensitization to women's roles in society sparked a noticeable move to change ideas about the nature and causes of sexual assault. Consequently, in the past decade a view of sexual assault as the expression of power and/or anger by men has emerged. Much of the current writing in the field reflects this point of view. Also, there is an increasing focus on the sociological characteristics of the crime—where, when, and how it happens, how it might be prevented, and its effects—as well as a continued interest in the psychological motivations of the offender.

Where to Go for More Information

There is no single reference which provides a complete understanding of sexual assault. Citations which appear in the text and additional resource materials are listed at the end of each chapter. They are all useful reading for a newcomer to the field. The references were selected on the basis of (a) recency and relevancy, (b) frequency of citation by other authors, and (c) availability. Some excellent resources providing guidelines for treatment and support services for victims are being published by rape crisis centers and other treatment and prevention projects around the country; however, because the materials are not available in large quantities, they are not listed here.

In addition to this monograph, the National Rape Center is developing resources in the following areas:

- A bibliography on literature pertaining to sexual assault, 1965 to the present
- Guides to printed materials (police, counseling, medical, community education)

- Guide to and evaluation of audiovisual materials
- A nationwide directory of sexual assault programs
- An annotated bibliography and self-assessment guides to assist in the evaluation of rape prevention and treatment programs
- Training materials for medical personnel who deal with sexual assault patients
- Monograph on rape and the elderly

Inquiries should be addressed to the National Center for the Prevention and Control of Rape, 5600 Fishers Lane, Room 10C-03, Rockville, Maryland 20857.

References

Federal Bureau of Investigation. *Crime in the United States, 1975. Uniform crime reports*. Washington, D.C.: U. S. Government Printing Office, 1976. (Stock No. 027-001-00016-5).

Federal Bureau of Investigation. *Crime in the United States, 1976. Uniform crime reports*. Washington, D.C.: U. S. Government Printing Office, 1977.

II. THE NATURE OF SEXUAL ASSAULT

The purpose of this section is to familiarize the C&E specialist with what is presently understood about sexual assault using survey statistics, research studies, and the experiences of those working directly with victims and offenders. In most cases the picture which emerges is quite different from the general public conception (or misconception) of the problem.

It is important to keep in mind the major limitations on the information currently available, such as an inadequate research base and incomplete statistics. The data which are available tend to significantly *underrepresent* the magnitude of the problem. For example, most of what is known about the causes of sexual assault is based on research with *convicted* rapists (a very small percentage of the offender population); what is known about the event itself and its effect on the victim is based for the most part on cases which have been *reported* to authorities or victim treatment centers. It is becoming increasingly apparent that sexual assault is not as infrequent or "unusual" in terms of the place, time, and circumstances of the attack as is commonly believed.

How Widespread is the Problem?

Major obstacles in determining the true extent of sexual assault are the related issues of reporting and definition. The most commonly cited national statistics about incidence (the FBI Uniform Crime Reports) include only those crimes that are reported to the FBI by the local police and that are defined as "the carnal knowledge of a female." Despite legal reform efforts to redefine sexual assault to be inclusive of assault against males and acts other than vaginal penetration, many states still make a legal distinction between the crimes of rape or carnal knowledge and acts labelled by such terms as "sodomy," "sexual abuse," or "gross sexual misconduct." Only a few states specifically include oral or anal intercourse or penetration by objects or devices as falling within the legal definition of "rape" and thus reportable to the FBI. In addition, many states specifically exclude the sexual assault of a woman by her husband as a criminal offense.

A second limitation of statistics based solely on police data is the indication that sexual assault is one of the most underreported of all major crimes. Estimates of the extent of the underreporting vary widely. For example,

- FBI Uniform Crime Reports for 1973 estimated that only 20% of the rapes committed in that year were reported to the police.[4]
- ". . . most women working with victims believe that at least 90 percent of actual rapes are never reported."[5]
- ". . . one in five rapes, or possibly one in twenty, may actually be reported."[6]
- A survey of a representative sample of 60,000 households and 15,000 commercial firms conducted by the Law Enforcement Assistance Administration in 1975 resulted in an estimate that 151,000 rapes had occurred that year; approximately 56% of the victimizations were recorded as having been reported to the police.[7]

No one knows with any degree of accuracy how often rape or sexual assault is committed in this country. However, the most *conservative* estimate is that fewer than one-half of the assaults committed are ever brought to the attention of the police. There are a number of reasons for the failure to report. The ones most frequently cited by victims are fear of retaliation; feelings of shame and embarrassment and the desire to avoid publicity; the belief that nothing will be done; and an unwillingness to subject themselves to the unsympathetic treatment often accorded victims by some medical, law enforcement, and criminal justice systems.

Even when the crime is reported, there are some alarming attrition rates between the victim's complaint and conviction of the offender.

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[4]Percentage estimates of unreported rape are not included in more recent FBI reports.
[5]Gager & Schurr, p. 91.
[6]Brownmiller, p. 190.
[7]Law Enforcement Assistance Administration, p. 32.

- As a national average, 19% of all forcible rapes reported to the police in 1976 were "unfounded"—that is, police officers judged that no forcible rape offense had occurred or there was insufficient evidence for making an arrest.[8]
- Only 52% of the "founded" rape cases reported to the police resulted in an arrest; this compared with an arrest rate of 79% in cases of murder, and 63% in cases of aggravated assault.
- Of those arrested for rape, only 69% were prosecuted.
- Of those prosecuted, only 42% were found guilty of the substantive offense, 9% were found guilty of a lesser offense, and 49% were acquitted and/or dismissed.[9]

Those who have studied the prosecution of sexual offenders feel that the chances of a case coming to trial and ending in conviction increase proportionately with the degree to which the case fits a prevailing cultural stereotype of sexual assault as a vicious act performed by a stranger in a dark alley. Even cases which clearly can be classified as criminal offenses under the law may not be investigated or prosecuted because of the prosecutor's determination that the jury is unlikely to convict. For example, some juries will not vote to convict an offender if the victim is sexually active, has no visible physical injuries, or was not hysterical at the time the crime was reported. Other "questionable circumstances" may be the fact that the victim and offender knew each other; or the victim was using alcohol or drugs; or was in the "wrong" place such as a bar or a dark parking lot. In many communities, victims who are members of racial minorities or subgroups such as prostitutes and lesbians may have little credibility with juries.

There are a number of other stereotypes which further limit society's definition of what constitutes sexual assault. Although often labelled as "myths," such stereotypes are pervasive and powerful in their effects on society's treatment of the problem as well as the responses of the individuals involved. Many rape crisis centers report that a major part of their job is not only countering misconceptions about sexual assault in the community but also educating victims who have internalized the misconceptions and blamed themselves for having been assaulted. By the same token, offenders often invoke these stereotypes to justify their criminal behavior, i.e., "She was asking for it," or "I couldn't help myself."

Few of society's stereotypes about sexual assault stand up under the burden of evidence collected by those who work with victims and offenders. Information compiled by rape crisis centers, task forces on sexual assault, and groups such as the National Organization for Women has shown that some of the most commonly accepted stereotypes are contradicted by the realities of the situation.

Stereotype: Only young, attractive women are sexually assaulted.

Victims are chosen because they are *vulnerable,* and the offender may not even know or remember what his victim looked like. Sexual assault can and does happen to anyone. Reported cases include infants and women in their 80s and 90s and victims from all social and economic classes and races.

Stereotype: Women who are sexually assaulted have put themselves in jeopardy by hitchhiking, being out alone at night, having a "bad" reputation, etc.

Over one-third of all reported assaults are committed by men who break into victims' homes. As far as provocation is concerned, the National Commission on the Causes and Prevention of Violence found that only 4% of the sexual assaults they studied involved any "precipitative behavior" on the part of the women.[10]

Stereotype: Sexual assault is an impulsive act.

Studies with convicted rapists have indicated that an overwhelming majority of sexual assaults are planned in advance, and offenders often wait for the most opportune time to attack.

Stereotype: Sexual assault represents a need for sexual gratification.

More than half of convicted rapists are married at the time of the assault, and many of those who are unmarried report that they have

[8]In many states "evidence" of sexual assault requires the presence of semen or visible injuries on the victim. Such evidence may be difficult to obtain for several reasons: Many offenders are sexually dysfunctional, i.e., they do not ejaculate; many victims cleanse themselves after the crime, thus destroying the evidence; and bruises may not appear for two or three days following the attack.

[9]Federal Bureau of Investigation, 1977.

[10]National Commission on the Causes and Prevention of Violence.

willing sexual partners. The primary motive of most convicted rapists is the need to act out feelings of aggression, dominance, and hatred; they use sex as a means of venting their anger and exercising control over their victims.

Stereotype: It is possible to tell a rapist by the sinister way he looks or acts.

Studies have shown that an overwhelming majority of rapists do not differ significantly from the norm in their physical or psychological characteristics, except for a tendency to express rage and aggression. In fact, rapists may be young, attractive, and personable. Many studies have found that in about half of the cases the rapists and victims knew each other at least slightly. Often the offender was a neighbor, boyfriend, or relative of the victim.

Stereotype: Sexual assault can be avoided if the woman resists.

Sexual assault is, by its nature, an act of aggression and domination, and victims report that their principal concern is to do what they think is necessary to survive and escape.

Stereotype: All women secretly want to be raped.

This stereotype is based in part on the mistaken notion of rape as a sexual act and confuses a woman's sexual *fantasies* with the reality of sexual assault as a brutal, degrading act. This stereotype is most insidious when it allows the assailant to believe that all women want to be overpowered and subdued. Such men often justify their actions by what they believe to be the woman's desires and thereby exonerate themselves from wrongdoing.

Stereotype: Women "cry rape" in order to get revenge on a particular man or to protect their reputations.

The sex crimes analysis squad of New York City has reported that *false claims,* in which there is proof that the crime has *not* taken place, constitute only about 2% of the rape complaints in that city. This percentage corresponds to the number of false claims for other violent crimes.[11] On the other hand, the higher number of crimes which are not "founded" by the police often is cited as evidence that women use the charge of rape to punish boyfriends or husbands or in order to protect themselves from gossip or censure. However, unfounding reflects many factors, such as lack of evidence or lack of willingness by the police to believe the victim—unfounding does not necessarily mean that the victim has lied.

Stereotype: Most sexual assaults are interracial.

In most sexual assaults, both the victim and the offender are members of the same race.

Despite accumulating evidence that many current beliefs about sexual assault are erroneous, stereotypes about the nature of the act and the characteristics of offenders and victims continue to be reflected in the cultural norms and values. It has been a major goal of most rape treatment programs to dispel the misconceptions by providing training and education for the community. However, a need remains for the strengthening and expansion of such efforts if treatment for victims is to be improved and if the prevention of sexual assault is to be achieved.

Who is the Assailant?

The body of research about the characteristics and behaviors of men who commit sexual assault is still relatively small, and most of the literature consists of anecdotal and case material based on the psychoanalytic model. Even the findings of systematic, controlled studies are limited in their generalizability to all sexual offenders for several reasons.

- Offenders who are known to their victims (estimated to be about half of the population of rapists) are seldom reported or prosecuted; the extent to which the motivations and characteristics of these men differ from convicted rapists has not been studied.
- Most research has involved the study of convicted rapists; because of low arrest and conviction rates, as well as acknowledged race and class biases in the criminal justice system, incarcerated rapists are probably not representative of the total population of rapists.

[11] Brownmiller, p. 435.

- Sex offenders seldom self-report to mental health professionals; thus, little information has been collected about offenders who have avoided coming to the attention of public agencies.

There is no universally accepted psychological profile of "the rapist"—experts agree that not all offenders are alike and that a broad spectrum of behaviors is included within the definitions of sexual assault and rape. Yet it appears that three components—power, anger, and sexuality—are present in nearly every case. The prevailing view among researchers, prison psychologists, and rape crisis workers is that the rapist is primarily motivated by hostility and anger, with a strong need to dominate and humiliate his victim. These feelings may be expressed along a continuum of aggressive behavior, ranging from relatively nonviolent intimidation to brutality and murder. Some psychiatrists believe that some rapists progress along this continuum to increasingly violent acts as they experience the growing need to establish control in their lives through their victims.

A major unanswered question is why the need for power and control should be expressed through the means of sexual assault. Various contributing factors have been suggested, including:

- A general hostility toward women and the view that sex represents a means of gaining control over them; an inability to establish satisfying relationships with women;
- Lack of security, affection, and identification with parents or their surrogates in early childhood, resulting in feelings of alienation, inadequacy, and failure; confusion about sex roles;
- Low frustration tolerance; impulse-control functions that break down under relatively normal life stresses;
- Naiveté concerning relationships and appropriate sexual expressions;
- Serious deficiencies in social relationships and social skills; deficits in moral and ethical standards; a tendency to misinterpret social cues.

The relative importance of these variables can only be speculated. It is almost certainly true that biological, social, cultural, and political factors are all influences, but continued investigation is needed. While it is important to disprove the old stereotype of the rapist as a madman driven by sexual compulsions, it is equally important not to foster new stereotypes which are based on inadequate research. It does appear on the basis of present knowledge, however, that the man who commits sexual assault is suffering from deficits in his social and emotional development. The result is a person for whom the act of sexual assault expresses an inability to satisfy basic needs in appropriate ways.

Who is the Victim?

Sexual assault can and does happen to *anyone*—women, children, or men of all ages, races, ethnic groups, or socioeconomic levels. While it is true that the majority of *reported* cases involve young adult females, at least some of this can be attributed to the greater willingness of young women to report the crime. It should be noted that during the past few years there has been increased reporting of sexual assault of young boys and adolescent males, particularly in large metropolitan areas. There are no prerequisites for becoming a victim, unless it is the characteristic of perceived *vulnerability*—of being viewed by the offender as an easy target on which to vent his feelings of frustration and aggression.

Vulnerability may be a function simply of the age of the victim, with both the very young and the very old at high risk because of their inability to resist. Physical weakness is only one factor. Many of the elderly live alone and are the prey of men who commit assault in the course of burglary. Also, children and old persons living in institutional settings are sometimes assaulted by their caretakers. There apparently are no age limits on sexual assault. Among the victims seen by Ann Burgess and Lynda Holmstrom over a one-year period in their Victim Counseling Program at Boston City Hospital were a 1-year old girl (the victim of attempted assault), a 3-year old boy (the victim of sexual molestation), and a 73-year old woman (the victim of rape).[12] Medical personnel in another large city have reported seeing victims ranging in age from 6 months to 91 years.[13]

[12]Burgess & Holmstrom.

[13]Hayman & Lanza.

But vulnerability to sexual assault is more than a matter of age or living conditions—often it is the result of other major social, emotional, and physical circumstances in the lives of the victims. For example, persons with physical handicaps which limit their abilities to detect danger or resist attack, such as the blind and the deaf, constitute one high-risk group. The mentally disordered and mentally handicapped are other susceptible groups.

"Deviant" or alternative lifestyles also may place persons in particularly vulnerable situations. For example, the risk factor for alcoholics and drug addicts may be increased by a weakened physical state or a tendency to frequent high crime areas. Prostitutes are easily victimized because of the hours and conditions of their work. Adding to the vulnerability of such individuals is the knowledge on the part of the assailant that alcoholics, drug addicts, or prostitutes may be unable or unwilling to report their assaults to the police. If they do report, they may not be believed by the police, prosecutor, or jury. Similar pressures to keep silent about the crime exist among various cultural and racial groups, and male and female homosexuals. It is likely that the assailant's awareness of such pressures increases the risk factor for these groups as well.

There is another aspect of vulnerability which places nearly all victims at risk, regardless of their personal characteristics or situations. This is vulnerability to the *stigma* of the crime, stemming from social attitudes that have defined sexual assault as something that doesn't happen to "nice" people, to those who "really" resist, or to those who have a social or familial relationship with their attackers. In the face of such attitudes, victims often accept the stereotypes and assume the blame for the assault. Largely through the efforts of feminist writers and rape crisis workers, there now is a growing awareness among many victims that they are not responsible for having been assaulted and that they are entitled to appropriate support services.

Rape crisis centers and mental health facilities report increasing contact with individuals who have been assaulted in the past and who, for the first time, are seeking help to deal with the unresolved effects. As hotline services become known in the community, calls are received from persons who were victimized a number of years previously. It is not at all unusual for clients of mental health centers to reveal past histories of sexual assault. A major need in all communities is greater awareness of these "hidden" victims. It is appropriate that the C&E specialist work with community agencies and direct service providers within the CMHC to develop programs which are responsive to their needs, as well as the needs of more immediate victims.

What Are the Effects?

The possible effects of sexual assault on victims are many and varied, ranging from physical injury to long-term psychological disturbances and social disruptions. *There is no typology of effect.* Some victims may be in an immediate crisis situation but recover quickly, while others may show no immediate reactions but require counseling for their unresolved feelings long after the event. Not everyone will need comprehensive crisis intervention services, but almost everyone will need some measure of support and advocacy in the period following the assault to regain a sense of control over their lives.

Within the context of individual differences, several variables may impact on the type and degree of stress experienced by the victim. Obviously, the amount of violence employed during an attack, the use of a weapon, or being subjected to sexual acts which the victim defines as unnatural may contribute directly to the fear and shock felt by the victim. However, there are other characteristics of the attack which should be considered in trying to understand its effects on the victim. For example, in cases involving children, the reactions of the family may be more severe than those of the child, and the family crisis may obscure the needs of the child or cause the child additional trauma. If the victim knew and trusted the assailant, self-blame, guilt, and loss of trust in those thought to be friends may be predominant reactions; the long-range psychological impact may be more severe than if the attack were by a stranger. On the other hand, feelings of fear and powerlessness may be the predominant reactions to sexual assault by strangers and to gang rapes.

The effects of the assault will be mediated by the developmental stage of the victim and the availability of a social support system. For example, the effects on adolescents may be intensified by worries about self-identity and the response of peers and parents, while married victims may be overwhelmed by feelings of shame and concern about

the reaction of the spouse; the fears of the elderly may center on their continued ability to live alone and to maintain their independence. Finally, both the immediate and long-range effects of sexual assault will be influenced by the victim's general level of adjustment and ability to cope with adverse situations *before* the attack. Again, the effects will vary with the individual—for some, the assault may be accepted with fatalism; to others it may be a breaking point; and to others it may be a crisis, but one which is relatively quickly resolved.

The immediate reactions of victims can range from total withdrawal to hysteria. Some, especially those who felt that their lives had been in danger, may be in a state of crisis requiring immediate intervention. Those who have worked with rape victims have identified two major stages in the crisis situation which typically must be worked through: the acute phase and the period of integration or adjustment. In the acute phase, the victim's behavior is usually characterized by disorganization, difficulties with problem-solving and decision-making, feelings of helplessness and vulnerability, and the fear of being alone. The primary needs during this phase are for help in getting back in control of one's life and for reassurance that support and protection are available. *The acute crisis situation does not always happen immediately;* some victims may decline help right after the attack, but go into a state of crisis requiring intervention services and counseling weeks or even months later.

During the period of integration or adjustment, most victims are pulling themselves together and outwardly may not appear to be experiencing emotional stress. Some may tend to deny or repress the assault. However, control of the emotions may be only tenuous, even though many external problems have been resolved. It is not unusual for the victim to experience episodes of great stress during the adjustment period and to require continued support. This is particularly likely to happen at the time of a court appearance if the assailant is being prosecuted. The primary need of the person during this period is for continuing contact with someone who is able to help the victim anticipate and deal with any new crises which may occur.

It would be unrealistic to suppose that rape support services will help all victims to become optimally healthy and functioning individuals. At minimum, though, services should be provided which enable the victim and others who are affected by the assault to return to a usual level of functioning as soon as possible.

Some Possible Effects of Sexual Assault

Physical

- Injury, pregnancy, venereal disease
- Shock
- Loss of appetite, insomnia, nightmares, loss of libido

Emotional

- Hysteria
- Lack of affect
- Feelings of helplessness and loss of control
- Fear of retaliation, of meeting the attacker, of being alone
- Feelings of shame, self-blame, guilt, humiliation
- Disrupted sexual functioning
- Depression (ranging from moderate to severe)
- Loss of self-esteem; damaged self-concept
- Inability to deal with own rage and hostility
- Repression, denial
- Perceptual distortions

Social

- Disturbance in victim's coping mechanisms
- Violation of trust in others, lack or loss of support from significant others
- Marital and other family problems, divorce
- Inability to relate positively to men
- Loss of privacy
- Community stigma

Economic

- Medical costs
- Legal costs
- Time lost from job or loss of job
- Change in residence
- Divorce
- Withdrawal from school

It needs to be emphasized that the effects of sexual assault go beyond the individual who is victimized. The negative effects, and sometimes even a crisis situation, will be experienced by the victim's family and other persons who are close to the victim, by community agencies and individuals who deal with the victim, by the offender and his family and friends, and by the community at large.

Implications for the C&E Specialist

Sexual assault is an *interactive* phenomenon, involving social factors which pre-exist the triggering motivations of the offender and effects which extend far beyond the assault itself and its impact on victim and assailant. When the act is viewed as an isolated event in which only certain types of people are involved, preventive efforts tend to be misdirected and the development of appropriate and encompassing services is hindered. For example, the concept of the rapist as an impulsive, sexually disordered individual may obscure the need for primary prevention programs which teach *all* children better ways of relating to others. Stereotypes about victims will influence the way they are treated by the police, medical personnel, the courts, and other community agencies, including the CMHC itself.

A major contribution which the C&E specialist can make is to foster within the community an understanding of sexual assault as a complex social issue which affects the entire community and requires many lines of attack. The overall goal should be to focus public attention on the true nature of the act and the many and varied needs of those concerned through the promotion of:

- Public understanding of sexual assault as an act of aggression, not lust, and awareness that there are no simple solutions to sexual assault;
- Public awareness of the vulnerability of all persons, and public education efforts which are targeted at people of all ages, races, social and economic levels, and both sexes;
- Understanding among agencies and individuals dealing with victims that sexual assault is a frightening and humiliating experience, and awareness of the wide range of victim needs (emotional, psychological, physical, legal, and social), as well as the variety of individual responses to sexual assault;
- Attention to the need for services that provide both immediate support and follow-up contact and advocacy, and that are easily accessible and responsive to the victim's own recovery pace;
- Attention in community agencies to the needs of those who are *indirectly* affected by sexual assault—the victim's family and friends, the offender's family and friends, and the caregivers themselves;
- Attention to the need for treatment, counseling, and rehabilitation services for assailants;
- Primary prevention efforts that counteract sex role stereotyping and teach children and adolescents how to deal with their own feelings and personal relationships in positive ways;
- Public awareness that the effects of sexual assault on the community and the individual can be minimized with the help of supportive services;
- Public sensitivity to cultural values and norms which foster male dominance and a view of women as sexual objects;
- Awareness among lawmakers of the need for improved legislation for the prosecution of sexual assault; and
- Awareness among policy and decision-makers of the need for resources for programs designed to prevent and treat sexual assault.

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III. THE ROLE OF CONSULTATION, EDUCATION, AND PREVENTION IN DEALING WITH SEXUAL ASSAULT

Sexual assault may constitute a new concern for community mental health workers. This does not necessarily mean, however, that CMHCs need to develop entirely new or different C&E programs to deal with the problem—many existing strategies and linkages with the community can and should be used. This section offers some definitions of "consultation," "education," and "prevention" within the context of services for sexual assault and provides some examples of who and what may be involved in each process.

Consultation is . . .

Mental health consultation is a cooperative activity in which mental health personnel work with community individuals, groups, institutions, or agencies to aid them in the mental health aspects of their work. In practical terms, CMHC staff members have defined consultation in various ways: "Mobilizing community resources"; "Helping a certain group become more effective by providing expertise in mental health issues or administrative functions"; "Developing other people's abilities"; and "Developing effective delivery and communications systems." Consultation takes place in a number of contexts—its focus may range from client-centered clinical case conferences to consultation on policy issues at the state or national level.

Consultation About Sexual Assault

A recent study of the consultation process[14] has indicated that the most effective consultations include three conditions: (a) the client recognizes that a problem exists; (b) the client acknowledges the need for assistance; and (c) both the client and the consultant are agreed on what the consultation will accomplish. There is an underlying premise that the consultant will be able to provide expertise that is not available within the resources of the individual client or client agency.

In the case of consultation for the prevention and treatment of sexual assault, the mental health professional may not be an acknowledged expert in the eyes of the community. Such consultation primarily will involve agencies which have direct contact with victims or offenders—rape crisis centers, law enforcement personnel, the medical system, and the criminal justice system. These agencies understandably may feel they have a broader understanding of the problem and more experience in dealing with it than does a mental health agency.

The initial goal of the C&E specialist in such circumstances is to make the resources of the mental health field visible and acceptable. The first step is self-education and self-assessment to determine what the C&E process has to offer the primary agencies. Next, it is important to develop an awareness within the CMHC that sexual assault is a legitimate mental health issue and, more specifically, that it is a viable area of responsibility for the C&E specialist. The next step is to identify problem areas in the community where consultation services can make a useful contribution. Finally, there may be a need to develop strategies for informing individuals and agencies that mental health professionals are able to be helpful. This might be communicated directly through existing C&E contacts or by relying on other CMHC staff members to open agency doors to the C&E specialist as someone who has the expertise to deal with problems related to sexual assault.

Consultation is essentially a problem-solving process, but agencies sometimes need help in recognizing and defining the problem before any solutions can be addressed. This is particularly true in the case of sexual assault. The police, for example, may not be aware that department policies and procedures are serving as obstacles to the reporting of sexual assault. Physicians may not be aware that unsystematic procedures for collecting and preserving evidence are hindering efforts to prosecute the crime. Prosecutors may not be aware of the traumatic

[14]Larsen, Norris, & Kroll.

effects of the trial on the victim. These are only three examples of instances where the C&E specialist may have an appropriate role to play in problem *definition* before the consultation can begin.

There are various types of consultation, usually classified according to whether the focal point is an individual, a program or agency, or the community as a whole. The range of possible services,[15] along with some examples of consultation which is specifically centered around sexual assault issues, include:

1. ***Client-centered clinical case conferences***
   Here, consultation focuses on a discussion of the problems of an individual client of the consulting agency, for purposes of diagnosis, treatment, and case disposition. Some examples of this type of consultation would include discussing therapy for a victim-client with a counselor at a rape crisis center, providing ongoing case consultation for the center, or arranging for referral of the victim-client to a mental health agency. Within the CMHC, consultation might be with members of the direct services staff about a client whose history includes sexual assault. In communities with programs for released offenders, case consultation could be provided to counselors, social workers, or probation officers.

2. ***Client-centered staff development***
   This type of consultation uses a discussion of the client of the consulting agency as the basis for staff development and training. For example, discussion of the reactions of a victim's family could be used to help police understand how family dynamics affect the victim's needs, ability to cope, or decision to report. For a medical facility, the discussion of a victim's behavior in the emergency room could be used to promote a better understanding among nurses, physicians, and other staff members of the symptoms of acute situational crisis.

3. ***Agency-centered staff development***
   Consultation of this type focuses on the more general needs of an agency for increased knowledge and skills for staff members. Appropriate activities in this category would be arranging seminars and workshops in crisis intervention for law enforcement or medical personnel, or providing information to the prosecutor's staff about the needs of victims in understanding the criminal justice system procedures. Another appropriate activity would be training for rape crisis center workers in record keeping or evaluation.

4. ***Agency-centered program development***
   This type of consultation aids the administration of an agency in originating, planning, and implementing sexual assault programs. Some appropriate activities would be meeting with hospital administrators to develop a standard protocol for the examination and treatment of victims or working with administrators in the criminal justice system to develop a victim-witness assistance program. With rape crisis centers, the consultant could plan a program to recruit, select, and train volunteers or to educate the public about personal safety.

5. ***Community-centered mental health consultation***
   Consultation in this category may be with community commissions and boards whose purpose it is to plan the future directions of mental health activities in the community. A prime example of this type of consultation would be meeting with the CMHC's own advisory board to examine resources and to set priorities for the center's C&E program for sexual assault. Other examples would be meeting with a task force on sexual assault, consulting with county supervisors or other local officials to discuss the community's entire human services delivery system, or consulting with groups studying proposed changes in laws related to sexual assault.

The success of mental health consultation is affected by several factors. The most important are the ability of both parties to agree on goals and possible accomplishments, the consultant's willingness to understand the pressures and requirements of the consultee's job, and the openness of both parties to learn from each other.

[15]Adapted from Caplan, 1970; and McClung & Stunden.

Education Is . . .

Mental health education is the dissemination of knowledge about issues and behaviors which contribute to individual and community mental health or illness, including information about emotional stress, services available in the community, and appropriate utilization of those services. Audiences for education may be specialized groups or the general public.

The distinction between consultation and education is not always clear. Perhaps the best way of delineating the two functions is to think of consultation as something which is carried out under an agreement with the consultee and which is centered around a specific objective or problem which needs to be resolved. According to Caplan,[16] the real focus of consultation is help *plus* education. Education, on the other hand, is usually initiated by the CMHC, is usually directed at a larger target audience, and is less focused on the individual's perceived learning needs. In education, the mental health professional identifies the objectives and selects the topics to be covered in the educational activity.

Education About Sexual Assault

Education, like consultation, should begin with a self-assessment of the C&E specialist's own need for information and own capability for providing appropriate services. This should be followed by an in-house assessment of the need of other staff members for education about sexual assault, as well as the commitment of the CMHC as a whole to provide the resources which will support the C&E program. Only a third step should attention be turned to the needs and resources of the community.

Before developing an educational program, the C&E specialist should first determine if other groups or agencies in the community are already providing public education about sexual assault. Often, police crime prevention units or rape crisis centers have well-developed presentations which they offer to any audience on request. It would be wasteful of time and resources to duplicate these efforts. Even worse, the CMHC program might appear to be competing for audiences with established programs. In the case of rape crisis centers, many depend on fees from public speaking as the only source of funding. It is more appropriate—and effective—to look for ways of enhancing the work of others and to assume the role of public educator only if it is apparent that there is a real need which is going unmet.

Education about sexual assault may be directed at a wide range of target groups, from the general public to individuals in policy or decision-making positions. Some of these target groups, and examples of activities appropriate for each, include:

1. ***The general public***
   Education for the general public should be designed to reach as broad an audience as possible. Appropriate activities include preparing public service announcements for broadcast over local radio or TV stations, preparing fact sheets or news releases for the press, or arranging for distribution of flyers, brochures, or posters about available crisis intervention services or upcoming community meetings.

2. ***Populations which are at risk***
   This type of education is designed for specific audiences, and both the message and the language should be carefully tailored for the age and educational level of the target group. Some appropriate activities would be conducting a home safety workshop for members of a senior citizens center, conducting a rap session about dating in a high school, or presenting a program to parents about the effects of violence in TV shows for children.

3. ***Clients and their significant others***
   This type of education usually centers around providing information that will help individuals to have a better understanding of their situation and to make better use of the services which are available to them. Two examples would be presenting information on court procedures to victims and their families, or providing information to victims about medical examination procedures, the possible after-effects of medication, and the need for follow-up examination to detect venereal disease.

[16]Caplan, 1977, p. 18.

4. ***Community members in occupations which intersect and affect the lives of others***
Obvious targets for this type of education are members of the clergy or caregivers in human services agencies who are in a position to counsel victims and their families or other persons at high risk. Education for such persons might be directed toward making them aware of the issues associated with sexual assault and the services which are available.

   Some of the newest and most innovative mental health education programs are now being provided to people in service occupations, such as bartenders and hairdressers. Such persons often perform an informal counseling function for the community. Appropriate education for these groups usually centers on information about prevention, ways of dealing with persons in crisis, and ways of identifying and referring individuals in need of professional services.

5. ***Persons in positions which influence and affect public policy***
Some examples of this type of education would be providing information to a group trying to effect legislative changes or supplying data to local politicians as they prepare for pending changes in sexual assault laws.

There are some general principles which apply to both consultation and education activities and which may affect the acceptance of C&E services by the target groups in the community.

- Where services are limited or community attitudes are not supportive, C&E regarding sexual assault initially may involve more education than consultation.
- The person responsible for delivering C&E services must build rapport with the target group or groups, sometimes a slow process, and strive to establish credibility both personally and professionally.
- Direct personal contact with members of the target group is important in order to identify their information needs and to be able to tailor the consultation and education program to meet those needs in appropriate ways.
- The reputation of the overall CMHC program and the quality of direct services will impact on acceptance of the C&E efforts. However, it is important to build a separate identity and credibility for the C&E program in dealing with issues related to sexual assault so that the goals of the C&E effort are recognized as being distinct from the objectives of the CMHC direct treatment component.

Prevention Is . . .

Although prevention is an inherent part of both consultation and education, it is discussed separately here as a means of emphasizing its primacy as a goal of community mental health. There are three levels of prevention within the context of mental health services. *Primary prevention* is aimed at reducing the incidence of new cases of dysfunction in a population by modifying or eliminating causes which would place the population at risk. *Secondary prevention* involves treating cases of dysfunction once they occur in order to alleviate immediate effects and reduce the duration of the disability. *Tertiary prevention* attempts to minimize the destructive, long-term effects of dysfunction. Although consultation and education services for sexual assault are relevant to all three types of prevention, the *ultimate* goal is *primary prevention of sexual assault* by eliminating conditions in society which foster or tolerate its occurrence. Primary prevention attacks the root causes, going beyond efforts to improve treatment or strengthen the defenses of potential victims.

Prevention of Sexual Assault

Conventionally, prevention of sexual assault has emphasized altering the behavior of the potential victims of the crime—primarily women. Women have been cautioned to restrict their activities or to learn self-defense so they will be less vulnerable to assault. The result of this approach is not necessarily the prevention of sexual assault, but rather the prevention of assault of women who are cautious or able to defend themselves. The young, the weak, the vulnerable, and the uninformed continue to be victimized.

Those who work with victims and offenders believe that the causes of sexual assault are rooted in our social system, especially factors such as the following:

- Stereotyped social and sex roles often inculcated in children in which boys are expected to be aggressive and are discouraged from expressing their feelings, while girls are taught to be passive and acquiescent and are discouraged from being assertive or independent; the result is that many men learn to deal with their feelings in aggressive ways and many women are psychologically vulnerable to threats of violence
- Sensationalization of sexual assault and other types of violence by the news and entertainment media
- The exploitation of women as sexual objects in advertising and marketing (e.g., record jackets, cosmetics, etc.), in pornography, and in prostitution
- The attribution of causes of sexual assault to situational, external factors such as the lack of street lighting or inadequate police protection

The purpose of primary prevention should be to create awareness of these factors and to promote changes in the individual, institutional, and societal response to the underlying problems. A way to start is through educational programs which explore topics such as personal rights and respect for others, sex-role stereotyping, sex education, constructive ways of handling and expressing feelings, and the socialization process.

The Role of the C&E Specialist

No problem as pervasive and deep-rooted as sexual assault can be changed by one individual or one agency. The proper role of the C&E specialist in promoting prevention and improved services is as part of a community-wide effort, in which C&E programs raise awareness and the level of understanding, foster the coordination of existing resources, stimulate the development of new or improved resources on the part of appropriate individuals or agencies, and, if necessary, fill gaps where resources do not exist and cannot be developed elsewhere.

Therefore, the role of C&E staff members will vary depending upon the community. In an ideal situation where there is a well-developed community network of services, the C&E specialist may only need to make known the CMHC resources which are available to other groups or to identify and communicate potential problems. In another context, C&E activities may be shared with other individuals or groups which have the expertise to deal with sexual assault, or may be used to fill the gaps in an existing network. In a community totally lacking in resources and awareness of the problem, the C&E specialist may be required to assume leadership in deciding what needs to be done and in implementing these decisions. The remaining sections of this monograph are intended as a guide for C&E persons in carrying out whatever role they identify as being needed in the community.

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IV. PLANNING C&E PROGRAMS FOR SEXUAL ASSAULT

Because of the wide diversity among mental health centers, this monograph cannot present a step-by-step plan which reflects or responds to the needs and resources of every community. Instead, the focus is on general issues and strategies. The principles are applicable anywhere, but the specific approach will have to be tailored by the C&E specialist to fit the local circumstances. The purpose of this chapter is to provide a *guide* for planning and a *checklist* for determining what is already being done in the community about the problem of sexual assault, what needs to be done, and who might become involved in the effort.

A Comprehensive Network

Few communities are totally lacking in resources. Before implementing a program which may duplicate the work of others, it is important to determine if any services are already operating. The major goal in planning should be to *maximize existing resources* whenever possible. An example of the types of services which might be provided by a comprehensive community program is shown in Figure 1, along with an indication of how these services might relate to mental health goals of primary, secondary, and tertiary prevention. It is possible that the network which is appropriate for your community may vary in some aspects from this hypothetical case. The important point is that a systems approach should be employed for the most effective community organization and planning. The purpose of the C&E plan should be to:

- Identify existing community services and resources within the various components in the network
- Identify those components of the system where resources are weak or nonexistent
- Identify existing and missing linkages among agencies working on the same or related components in the system
- Prioritize the major community needs
- Determine the role of C&E in developing or augmenting needed services
- Promote interagency cooperation in developing, improving, or expanding the necessary services
- Provide a system for evaluating ongoing activities as a means of improving the components and linkages in the system and gaining support for the overall program.

The remainder of the chapter outlines a general framework for the C&E planning effort. The information is based on the premise that the C&E specialist will play a major role in coordinating a comprehensive community network.

Step 1. Self-assessment and education

The responsibility for providing C&E services for sexual assault may have come to you because of your own interest in the problem, or it may have been an unsought assignment. It is important to assess your own feelings and attitudes and the level of commitment you are prepared to make. If you do not have a sense of commitment or feel that you lack either time or expertise for the task, it may be possible and even preferable to share or delegate some of the responsibility.

Suggestions:

- Do some reading about the nature of sexual assault; honestly compare your own attitudes with the facts which are available.
- Talk to persons in the community who are engaged in prevention or treatment programs, such as school psychologists, probation officers, or rape crisis workers.
- Be alert for new information as it appears in the popular media and the scientific literature.

PRIMARY PREVENTION:

Health Promotion/Prevention for at-Risk Populations

- In conjunction with crime prevention unit of local police department, presentations on personal and home safety are given to community organizations; presentations on hitchhiking are given to local high school classes and youth groups.
- C&E specialist consults with teachers, on request, about classroom management of students with social and emotional problems.
- Seminars on human development and sexuality are offered by CMHC to teachers for inservice credit; the course also is offered to the public under the sponsorship of a local community college.
- In collaboration with the local YWCA and campus organizations, a "Rape Prevention Week" is being sponsored on a local university campus. Rape crisis workers, mental health experts, law enforcement and medical personnel will speak; booths have been set up to distribute literature about prevention and treatment services.
- A task force on sexual assault composed of community leaders has been formed to assess community needs for public education and services.
- Public service announcements attacking the stereotypes of sexual assault and advertising the availability of local services have been prepared for broadcast over radio and TV stations.

SECONDARY PREVENTION:

Prompt and Appropriate Treatment for Victims and Others

- Workshops in crisis intervention are given by C&E specialist for local law enforcement personnel.
- Local law enforcement and medical system personnel are collaborating on the development of a medical protocol specifying the collection and preservation of legal evidence.
- Arrangements have been made with local police and medical facilities to contact a friend or advocate as soon as a victim reports to an agency.
- The rape crisis center has been paid to develop and print a brochure for victims about legal and medical procedures.
- The rape crisis center, working with women's organizations, has established a temporary shelter for adult and child victims of sexual assault or violence.
- Guidelines for protecting the privacy of victims have been adopted by local news editors.
- Arrangements have been made with the CMHC clinical staff to conduct group or individual therapy sessions with friends and family members of victims; similar sessions are being planned for friends and families of assailants.

TERTIARY PREVENTION:

Prevention of Long-term Effects/Rehabilitation

- The CMHC is conducting workshops for community caregivers (clergy, social workers, visiting nurses, etc.) on long-term counseling and support for victims of life crises.
- Volunteer teams from local women's organizations contact victims, their families and friends, and the families and friends of offenders to inform them of the availability of counseling services at the CMHC and the rape crisis center.
- The local criminal justice system is funding a rehabilitation and counseling program for released offenders which provides help with jobs, education, etc., as well as family and personal therapy.
- The local bar association provides free legal aid for victims of violent crime.
- The public health department provides free medical care for follow-up treatment (tests for pregnancy, VD, etc.) to victims referred by physicians, clinics, and hospitals.
- The need for a victim-witness assistance program has been discussed with the prosecutor's office; members of the sexual assault task force are contacting county, state, and Federal agencies to locate funding sources.

Figure 1. A hypothetical community network for the prevention and treatment of sexual assault

- Try to find out what other communities are doing—the problems they encountered, the reasons for their successes and failures, the lessons they learned.
- Participate in an educational program given by a local, state, or national organization for the purpose of informing people about sexual assault.
- Determine the time and talents you have to give; assess your own skills; delegate responsibility or enlist the help of others if possible.

Step 2. Assessing CMHC commitment and resources

It will be important to determine the place of the sexual assault program in the overall mission of the CMHC, and the degree to which other staff members accept the need for the effort. In nearly every case, the commitment of the CMHC director and advisory board to the C&E program will be a critical variable in its effectiveness, as will be the support and possibly the involvement of other colleagues.

This step is basically an inventory of the resources which exist and *are available* within the CMHC—that is, what does the CMHC (and C&E specifically) have to offer that will strengthen the overall network? Keep in mind the other resources in the community; it would be wasteful to develop in-house expertise in areas that other agencies are better equipped to handle.

Suggestions:

- Do some in-house education: Share information about sexual assault with other staff members; arrange for discussion groups, films during lunch hours, guest speakers at staff meetings, etc. Make questionnaires available for others to use in self-assessment of attitudes. Provide factsheets with local statistics about sexual assault. Show the possible relationship between sexual assault and mental health problems encountered by therapists such as anxiety or family dysfunction.
- Decide who, besides yourself, may be available and willing to work on C&E services related to sexual assault. Are any staff members interested in and sensitive to the problem? Are they also effective in working with community people? How much time can be committed to the job? (NOTE: While it may increase credibility to involve female staff members, it should be kept in mind that both men and women have proven to be effective workers in C&E programs related to sexual assault. The important factor is not necessarily the person's gender, but the amount of understanding, empathy, and concern shown by the individual.)
- Determine what staff resources (and support for the program) might be developed through in-service training or consultation. For example, training of the clinical staff may lead to improved direct services for victims, offenders, and their families. Encourage the CMHC director to support these activities.
- Determine if the CMHC can make unique contributions based on its visibility and credibility for delivering C&E services. Does the CMHC already have good access to agencies and groups in the community? What existing C&E services can be expanded to deal with sexual assault? What are the particular strengths of the C&E effort, as viewed by the community? Where might C&E efforts be considered intrusive?
- Establish with the CMHC director and the advisory board how much time you will spend on C&E for sexual assault and how these activities will relate to your other job responsibilities. What data will they require as evidence that the time and resources devoted to the problem of sexual assault have been effectively utilized?
- On the basis of a realistic appraisal of the strengths and weaknesses of the overall C&E program, prioritize what you *can* and *should* do. Be prepared to be flexible—to relinquish some tasks to other groups and to assume responsibility where there are gaps in existing services. *Do only what you can do well,* without jeopardizing or interfering with the work of others in the community and in the CMHC.

Step 3. Assessing the extent of the problem in your community

Don't assume that there is no problem because no one talks about it or because victims have not reported. Sexual assault happens in every community; the fact that there are few *recorded* cases in your area may be a prime indicator of the need to promote awareness, concern, and services.

Suggestions:

- Obtain statistics about the *reported* incidence of sexual assault from the police. Compare these statistics with information from other sources who may be knowledgeable about the true extent of the problem in the community, such as medical personnel, rape crisis workers, mental health counselors, school counselors, venereal disease clinic personnel, public health nurses, the clergy, etc.

- Determine the level of community awareness and willingness to admit that a problem exists from media coverage of issues related to violence and sexual assault; the attitudes of public officials; your personal contacts with community caregivers, groups, and civic organizations. Be prepared for communication obstacles caused by personal fears; inability to talk candidly about sexual assault; stereotypic views of victims, offenders, and causes; uncomfortable or defensive attitudes on the part of some males.

- Try to identify the circumstances under which assaults are most likely to occur. Do some community mapping of sites where assaults have happened to identify areas where preventive efforts may be needed, such as improved lighting and police patrols or adult leadership for teenage gangs.

- Prepare a flowchart showing services available to victims and points at which victims enter and leave the system. Identify problem areas. Is there an awareness of the need for services and education for others in addition to victims—for example, offenders, friends and family members, individuals and groups at risk?

Step 4. Assessing community needs and resources

Information obtained in Step 3 will indicate where there are general problem areas and gaps in services within the community network. However, needs assessment is more than a listing of nonexistent resources. It also involves looking at the adequacy of *existing* resources in terms of their quality, quantity, and accessibility. Similarly, resource assessment should be more than a catalog of available services. It also should include the identification of groups which are not already involved in prevention or treatment programs, but which might have a potential contribution to make in terms of personnel and other resources.

In assessing needs and resources, it is critical to involve knowledgeable community agencies and individuals—police officers, physicians, nurses, prosecutors and defense attorneys, members of the human services system, the clergy, feminists, educators, elected officials, and, if possible, victims and offenders. Information should be shared about what prevention and treatment services are available, how adequate they are, and what is needed and wanted. It is advisable to follow up leads to other persons who might be interested in the problem, although not already involved in the community network. Use contacts made during this step to enlist the support of key persons within agencies or groups for the next step in the planning process.

Suggestions:

- If there is a rape crisis center or crisis line in the community, find out what activities they are engaged in; explore the possibility of mutual consultation and education between the CMHC and rape crisis workers, including training of CMHC staff members by rape crisis counselors. Other community action groups may be interested in collaborating on or assuming responsibility for programs in public awareness and prevention.
- Determine the procedures, policies, and resources of the local police. This may include looking at such things as whether there is special training for personnel in human relations and investigatory procedures for sex crimes; the presence or absence of laboratory facilities; the degree of responsiveness to calls, etc.

Many police departments already are engaged in consultation and education in the schools, as well as preventive activities such as public speaking or classes in self-defense.

- Determine which medical facilities and private physicians provide emergency medical treatment; ask what their procedures are. Is there a standard protocol for examination of sexual assault victims? Do physicians routinely and accurately collect evidence for prosecution? Determine accessibility to care as indicated by hours of service, costs and billing procedures, and location in the community.
- Investigate how the criminal justice system handles sexual assault cases, including what the local and state laws are, under what conditions prosecutors will bring a case to trial, how judges and juries have disposed of cases in the past, etc. What support services are available for victims of violent crimes and their families? Is there assistance (job placement, counselling, etc.) for released offenders and men on probation? Are there rehabilitation and prevention programs for juvenile offenders?
- Make a list of other community agencies and natural networks and the resources which they might provide for prevention, treatment, and rehabilitation. Some examples of such support systems are church groups, women's clubs and organizations, legal aid societies, free medical clinics, school counselors, rap groups, etc.
- Identify services that are needed but do not exist, such as public education; primary prevention programs in the schools; victim access to medical care, long-term counseling, advocacy during the process of legal prosecution, protection and financial assistance; counseling and rehabilitation services for offenders, family therapy, etc.
- Assess whether the existing services are adequate. For example, determine if public education efforts are reaching the intended audiences. Determine if medical procedures for victims include immediate treatment *and* follow-up to prevent pregnancy and V.D., if medical personnel collect evidence for legal prosecution, if police and prosecutors keep victims informed of the progress and disposition of legal cases, etc. Determine what changes in the legal process might facilitate prompt and just prosecutions, and reduce the trauma and anxiety of victims.
- Assess whether the attitudes of the police, doctors, nurses, prosecutors, judges, etc., toward victims of sexual assault seem to be primarily supportive or judgmental.
- Talk with educators, youth directors, church leaders, rape crisis workers, elected officials, and other community leaders about which kinds of *preventive programs* would be most appropriate for your community (for example, presentations on personal and home safety, education in the schools, seminars for parents, meetings with neighborhood groups, etc.).
- Prepare a written document which summarizes the needs and resources of the community. Check its accuracy with others involved. Use this document in planning the goals and objectives of the C&E program and in promoting community involvement and support.

Step 5. Initiating community planning and coordination

This stage of the planning process includes two interrelated activities: (a) working with other groups and agencies in developing their own services and objectives and (b) working toward a community-wide system of coordinated services. In areas where there has been little attention to the problem of sexual assault, the two activities may have to be carried out as developmental stages in a long-range plan. In other areas, agencies already may have developed their own objectives and programs, and the prime need may be for a plan to coordinate these efforts.

There are four possible starting points, depending on the level of services in the community:

1. ***Community has minimum awareness or services:***
   Decide how the resources of the mental health profession might be used to mount a credible public awareness campaign, to collaborate with others in such campaigns, or to acquire materials and resources from outside the community for informational and educational purposes.

2. ***Community has some services but there are gaps within some agencies:***
   Decide if C&E entreé to agencies and groups for other purposes can be used to generate a better awareness of the problem of sexual assault and the development of services. Can these channels be used without jeopardizing the original intent of the other programs? (NOTE: keep appropriate CMHC staff members fully informed of your objectives and activities.)

3. ***Community has good services but there is a lack of coordination:***
   Decide if and how the C&E staff might serve as linking agents between groups, especially between "establishment" agencies and grass roots, activist, or alternative organizations.

4. ***Community has high awareness and concern but services are ineffective or inappropriate:***
   Decide how C&E can be used to re-focus the community's understanding of the problem and to help guide the allocation of resources to meet the real needs of the community.

Regardless of the starting point, four factors are key to the effectiveness of any community plan:

- The various groups and agencies comprising the community should be involved in defining their own problems and needs.
- Members of community groups (including agencies, ethnic and racial minorities, and high-risk populations) should be actively involved in implementing the plan as speakers, advocates, organizers, counselors, trainers, etc.
- The *natural* support systems within the community should be identified and used.
- The obstacles which keep some individuals and groups from utilizing public services should be recognized and removed.

Perhaps more than any other mental health issue, sexual assault is a problem which is a legitimate concern of many groups and agencies with separate areas of expertise and responsibility. Territoriality is likely to be a major issue in promoting a coordinated prevention and treatment program. Planning should center on ways of preserving the integrity of each group, while at the same time fostering overall cooperation and interaction. Within the community there may be competing goals, inflexible systems, or resistance from persons in key positions. One of the major contributions that the C&E specialist might make during the early stages of planning is to work toward the resolution or avoidance of conflict by promoting an understanding among agencies of how other agencies work and the responsibilities and constraints under which they operate.

It is often the case that the initial impetus for community action programs will depend on the dedication of a few individuals—this is sometimes necessary to get the program off the ground. However, an early goal in the planning process should be the mobilization of a core group of reliable persons from as many support systems as possible so that implementation of the program is not dependent on one or two persons. The planning group also should include community decision- and policy-makers in both formal and informal positions of influence, such as county commissioners, the district attorney, chief of police, reporters, and editors.

Suggestions:

- Arrange a special meeting on sexual assault; invite representatives from the CMHC, the medical profession, law enforcement and criminal justice systems, the educational system, women's groups, rape crisis centers, the media, elected officials, etc. Present the draft statement of community needs and resources. Work toward the appointment of a board or task force to develop a plan.
- Be prepared to spend some time in increasing the awareness of the planning group; encourage discussion of such issues as reluctance to participate, distrust of the motives or abilities of another group, and territoriality. Use problems arising in the group as indicators of where C&E efforts should be concentrated.
- Explore with the group the appropriate role to be played by each system, what potential resources are available, and how they can be matched with community needs. Focus on what each system is prepared to do, as well as what responsibilities it is willing to relinquish to others.
- In concert with others, decide what programs need to be created or expanded.

Step 6. Developing goals and objectives

A goal is a general and usually long-range statement of the *end* toward which an effort is directed. Goals are relatively easy to formulate and to agree upon, since they are stated in terms of positive and worthwhile outcomes with which there can be little argument. Objectives, on the other hand, are the specific tasks which must be carried out to achieve the general goals. Nearly always, *many* objectives must be attained before a goal can be met. Objectives involve the assignment of responsibilities, the allocation of resources, and the setting of deadlines and standards of performance. Since any one of these factors may be a cause for disagreement and misunderstanding, it is important to devote some time early in the planning process to the formulation and acceptance of program objectives by all those concerned.

Objectives should parallel the overall goals, but should clearly state:

- What tasks will be done
- Who will be involved in each task
- When the work will start and finish, and milestones for completion of interim tasks
- How the work will be evaluated

Objectives are your plan of action. The more specific and complete they are, the easier it will be to know how to proceed and the less wasted effort there will be.

Suggestions:

- At the time goals are formulated, think in terms of the steps that will be necessary to reach the goals, and define the objectives during the early planning stages.
- Include both short-term and long-term objectives; set priorities for the order in which the objectives will be met.
- Get agreement from all individuals and agencies involved that the objectives can be met with available resources and within the specified time limits.

Step 7. Developing evaluation plans

It is the responsibility of any public agency to monitor and evaluate its services to (a) demonstrate to others, particularly funding sources, the value of those services; (b) identify ways of improving them, (c) collect information that will help others who need to develop similar programs; and (d) collect data that will make the agency accountable to its constituencies.

Good evaluation always begins *early* in the planning process, when the goals and objectives of the program are being formulated. If the objectives have been clearly and specifically stated in operational terms, then the framework of the evaluation plan has already been completed before the program or activity begins. That is, you will know what is to be done, who are the participants and target audiences and what are the desired outcomes. Evaluation then consists of looking for answers to two general questions: Are we doing what we set out to do? What are the effects?

A distinction needs to be made between evaluation of the *outcomes* of a program (in this case, the degree to which it has furthered the goals of improved prevention and treatment) and evaluation of the *process* of program planning and implementation. Good evaluation combines these two components.

Process evaluation should be an ongoing activity, enabling you to solve problems as they occur and to alter your objectives or your ways of meeting them before your time and resources are consumed in ineffectual approaches. There should be periodic meetings with others involved in the community plan to discuss the following kinds of questions:

- Are services being implemented as planned?
- Where are the problem areas? What changes need to be made?
- Is there continuing communication and cooperation between individuals and agencies involved in the system?
- Is a base of support and expertise being developed that will survive personnel changes, fluctuations in funding, or a shift of public attention away from sexual assault as a major social issue?

- Are the services producing any unplanned or unanticipated results? Can the positive ones be capitalized on and the negative ones be minimized?

In outcome evaluation, determining if the program objectives have been met is relatively straightforward and observable when the objectives are well-defined. A major stumbling block for novice (and sometimes experienced) evaluators is the tendency to select outcome measures which have no direct relationship to the objectives of the program, although the measures may be appropriate to overall goals. For example, a goal for the community might be the reduction of the number of cases of sexual assault in a high crime area. If the number of assaults decreases between the time the prevention program started and the time its effects are evaluated, this decrease might appear to be a valid and easily obtained measure of success. However, many extraneous factors may have affected the number of assaults, such as the time of year or changes in street lighting. In fact, if the program is effective the assault rate may actually appear to rise as more victims become aware of services and report the crime. Quantitative measures, such as the assault rate, the number of calls to a hotline, the number of meetings held, or the amount of time spent on an activity, may be useful but should be considered as only partially related to the quality or effectiveness of the effort.

Determining how effective the program has been is more difficult than determining if the objectives have been met. It helps to keep in mind that "effectiveness" is a value judgment, and that effectiveness will be defined in various ways by the consumers of the evaluation results. For example, one major goal of a community program might be the improvement of medical treatment for assault victims. Related objectives might include the development and use of a protocol specifying preexamination and examination procedures; the implementation of well-defined steps for collecting and preserving legal evidence; and the provision of printed information for victims about their legal and medical options. The criterion for success of the activity on the part of the medical staff may be the improved efficiency with which examinations are conducted (e.g., less time needed for exams, better use of auxiliary health personnel, etc.) For the rape crisis advocate, program success may mean that the victim is being informed about the risks of certain medical procedures and is allowed to make some choices for herself. "Effectiveness" for law enforcement personnel might require that legal evidence is being routinely collected and that a large percentage of victims are choosing to prosecute. The first step in planning this type of evaluation is to determine the intended uses of the data—who the consumers are, and what they will consider to be appropriate outcome measures.

Generally, multiple outcomes and evaluation methodologies will be required. There is no one criterion for success that will serve the needs of all the evaluation consumers. Examples of some possible program outcomes are:

- Changes in skills, knowledge, and attitudes
- Client satisfaction
- Increased use of facilities
- Support of key persons in the community
- Public awareness and knowledge
- Community acceptance of program

Once decisions have been made about which outcomes are most relevant to a particular program, thought should be given to the kinds of information that will be collected. This in turn will determine the data collection methods and instruments that need to be selected or developed. For example, changes in skills, knowledge and attitudes are best measured by observing behaviors; however, it often is more efficient to measure such changes indirectly by means of written tests, questionnaires, or interviews. Measures of the use of facilities may involve a review of agency records, interviews with clients, or simple head counts. Information about community acceptance of the program may be obtained from telephone surveys or questionnaires, or may be assessed in less standardized ways such as by the demonstrated support of key community leaders or the continued allocation of community funds to the program. The important point is that methods for collecting information should be chosen only after careful consideration has been given to the types of behaviors or conditions being measured.

There are a number of principles for the construction of data collection instruments related to how the questions should be framed, how and by whom the instrument will be administered, and how the data will be recorded and analyzed. If the evaluator is unfamiliar with these principles, he or she should enlist the help of someone who has had

training or experience in doing evaluation or, at a minimum, read some reference materials such as those listed at the end of this chapter.

It is assumed that the main point of any program activity is to produce positive change in individuals, agencies, or the community. One way to measure this change is to obtain baseline data about the conditions prevailing before the activity or activities begin and to compare these data with those obtained at the end of the project. This means that the data collection instruments should be developed and administered *prior* to the treatment or intervention. Thus, planning for evaluation is one of the first tasks in program development.

Additional Resource Materials

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V. TAILORING C&E PROGRAMS FOR SPECIFIC AGENCIES AND AUDIENCES

To provide an effective network of prevention and treatment services, several agencies, support groups, and the general public need to be involved. This section of the monograph discusses major issues related to each of these groups and lists suggestions for fostering their support and involvement. The final pages address some possibilities and constraints of working in rural communities and some special problems of potential victims in high risk groups.

There are several principles which are generic to all consultation and education programs and therefore applicable to interactions with all of the agencies and groups you will be including in your network. These principles are briefly highlighted below.

- ***The initial contact with an agency or audience should be carefully planned.*** An effective approach is to identify and involve someone within the target group who is interested in the problem of sexual assault and who can act as a change agent. Keep key persons informed and obtain necessary clearances for any activities which involve that group or which may be seen as an infringement on its responsibilities. Your first message should be "How can we work together?"
- ***It is counterproductive to operate with preconceived ideas about the kind of cooperation a group will give.*** If you stereotype a group on the basis of its image in the community or assume that one or two individuals are representative of the whole group, you may not be open to the possibilities for a good working relationship. You need to hear directly from key persons within each group about its willingness to cooperate.
- ***Any community agency has limitations, constraints, and responsibilities which need to be understood and respected.*** What appears to be unwillingness to cooperate may be an inability to do so because of lack of resources and personnel or conflicting priorities within the agency. Always weigh what the agency *ought* to do against what it *can* do. After assessing the problems that block cooperation, strategize ways to solve them. For example, it may be useful to offer staff training or program consultation.
- ***Lines of communication need to be kept open.*** Don't assume this will happen automatically. Ongoing dialogue between the agency and the CMHC and among agencies must be carefully developed and maintained. Each agency should be informed about the role and function of others in the network, and there should be a system for sharing problems and monitoring their resolutions. Respond to requests for information or help; provide systematic feedback through meetings, newsletters, etc.
- ***Be prepared for resistance and setbacks.*** You should expect to encounter resistance from at least one agency, community support system, or individual. Change is a slow, uncomfortable process. If you reach an impasse with one group, temporarily shift your energy where the likelihood of payoff is greater. Be prepared to be tested and criticized for your failures and only rarely commended for your successes. You will need persistence and patience to reach your goals.
- ***Successful efforts create new or expanded opportunities for C&E programs.*** Because sexual assault is a problem which requires the involvement of many groups and agencies, it provides an unusual opportunity to introduce C&E programs to new target populations. The process by which a community plan is developed should be considered as a model for mobilizing a network of resources around other community problems.

Working with Rape Crisis Centers

Rape crisis centers have been in the vanguard of the anti-rape movement, playing a major role in drawing national and local attention to the prevalence, causes, and effects of sexual assault. They are staffed primarily by trained volunteers who counsel victims, accompany them to the hospital or to the police, explain the medical and legal procedures, and serve as victim advocates during court trials. Many volunteers have themselves been victims of sexual assault, and their services

include strong empathy and identification with the victim's needs. In addition to direct services, many rape crisis centers conduct public awareness and educational activities through speakers' bureaus, and provide materials and training for police and medical personnel. Rape crisis centers or women's centers are often the first, and sometimes the only, contacts that victims have with community agencies.

Three potential problems need to be addressed in promoting cooperative relationships between the CMHC and rape crisis centers. The first issue concerns philosophical and political differences that may exist between the two groups. Many feminist-oriented rape crisis centers view sexual assault as a crime against women by a male-dominated society. As a result, they may have chosen to function autonomously within their communities. These centers tend to emphasize peer counseling and self-help and to consider traditional psychotherapeutic methods inappropriate in that such methods may convey the impression that the victim is in some way responsible for the assault. Many rape crisis centers feel that they should be the first point of contact for victims, many of whom may need only crisis intervention support to deal with the immediate situation. Subsequently, those victims needing follow-up counselling may or may not be referred to mental health agencies, depending on the resources available in the rape crisis center. There is a need in many communities for improved coordination between the two services, based on a common respect for their differences and a commitment for working together to provide the skills needed by the community.

A second major issue in some communities is the real or imagined exploitation of volunteer groups by publicly-funded agencies. Some volunteer groups perceive that "establishment" agencies are now receiving money to do what the volunteer groups have been doing without public financial support. Some groups also feel that they have the best expertise for dealing with the problem of sexual assault and that mental health centers may attempt to supplant the services they provide. To add to the controversy, representatives of public agencies have sometimes asked rape crisis workers for information or training when developing grant proposals or programs without paying for the service of the rape crisis workers or acknowledging their help. Where perceived or real exploitation of volunteers is an issue, there is a need for (a) informing the volunteer groups about monies available for research and development and working with them jointly to develop proposals; (b) sharing the resources that have been provided to public agencies with volunteer groups whenever possible and appropriate; (c) providing help and support to volunteer groups in seeking their own funding sources; or (d) formally contracting with rape crisis centers to pay them for providing materials and doing consultation and education such as public speaking or staff training.

The third issue is that of "professionalism." Some mental health therapists have questioned the competence of noncredentialed volunteers to provide psychological treatment to victims of sexual assault. Conversely, some rape crisis workers feel that the training of professional counselors is inappropriate for dealing with the trauma of violence and the therapists' own feelings about sexual assault. Arguments about professional qualifications tend to obscure two important questions—who is able to provide the needed support for victims and their families, and when is it in the victim's best interest to be referred to another service? For example, one victim may prefer to be counselled by a rape crisis center volunteer and another may be more comfortable at a community mental health center.

Community mental health centers need to be sensitive to these potential points of dispute so that both groups may share their knowledge and experience. Rape crisis centers are viable service delivery systems, worthy of CMHC support as community self-help efforts.

The list below shows some areas where knowledge, experience, or responsibility might be shared with rape crisis centers. In some cases, the rape crisis center will have more expertise to carry out an activity, and in other instances the CMHC will be better equipped for the job. These decisions will have to be made jointly depending on local circumstances.

- Linkage to other support systems in the community for referrals and services
- Case consultation
- Screening and training of volunteers; group sessions for volunteers
- Training in counseling victims and families, making referrals
- Collection of statistics on the incidence of rape in the community; information about state laws and reporting requirements

- Access to and development of materials: educational, training, bibliographies
- Training in self-defense
- Public and agency education about how victims are responded to by the police, medical system, courts, and community
- Communications workshops
- Preparation of handouts for victims explaining medical and legal procedures and community resources
- Implementation of prevention programs for the community, including educational and training programs

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Suggestions for supporting and working with rape crisis centers: **Make office space and supplies available; share a telephone line. Sponsor a rape crisis center staff member's attendance at a regional conference or workshop. Include a staff member on a standing committee or task force. Arrange for continuous therapy for victims when needed. Help develop a referral file. Assist in producing educational materials. Share journals and other literature with staff. Co-sponsor a symposium on sexual assault. Offer assistance in record keeping and self-assessment of the rape crisis center. Assist the center with its funding problems by purchasing services (public speaking, training for police or medical personnel, etc.) or helping the center to procure grants. Increase the center's visibility and legitimacy in the community by recognizing its expertise and services and encouraging other agencies to use its services.**

Working with Law Enforcement Agencies

When someone is sexually assaulted, particularly when physical injury is involved, the first person on the scene is likely to be a law enforcement officer. This person's response to the victim will have a significant impact on how the victim, family, or friends initially perceive the situation and are eventually affected by it.

Many cities and counties now have sex crimes investigation units which are staffed by men and women with special training in recognizing the needs of victims as well as in the legal aspects of the crime. However, in many communities, especially rural ones, the responding officer will be the policeman on the beat with little or no specialized knowledge for dealing with the emotional trauma of the victim and others. Where this is the situation, a prime goal of C&E efforts should be to promote awareness within the law enforcement agency of the crucial role played by law enforcement personnel in providing the support which will allow victims to regain feelings of personal safety and control following the assault. Another goal should be to make education and training available so that police officers can carry out this role skillfully. For example, the police department could be encouraged to develop a protocol or guidelines for handling sexual assault cases and to train officers to use the protocol. Police officers also can be involved effectively in prevention efforts as speakers to community groups or in the schools. In some places, joint presentations have been made by the police and by representatives from women's groups or the mental health agency.

It is true that some law enforcement personnel display negative or uncaring attitudes toward victims and their advocates, although such instances are becoming less frequent as training programs in crisis intervention and human relations are provided to officers. In communities which have instituted such programs, it has been found that it is possible to change harsh or judgmental reactions by teaching specific techniques which help law enforcement personnel to be more effective in carrying out their duties. For example, victims are more apt to cooperate in prosecuting the crime when they feel they have been treated in an understanding and concerned manner by the investigating officer. Where such training programs are not viable, another approach is to identify someone on the force who is sensitive to victims' needs and to work toward having this person given primary responsibility for sexual assault cases and for sharing his or her knowledge with fellow officers.

At the department level, there may be policies or attitudes, both overt and covert, which minimize the seriousness of sexual assault and

prevent the allocation of adequate resources and personnel to its investigation. This situation is most likely to occur in communities where there is little awareness of the problem or where there is pressure on the law enforcement system to direct its energies elsewhere. Better community education, as well as consultation with police and other community officials in policy-making positions, will help to identify sexual assault as a priority for police attention.

Local or state laws and policies also may impede the optimum response of the law enforcement system to the crime. In locales where the law treats rape on the basis of a narrow definition, the arrest rates for rape will necessarily be low. A less obvious cause of low arrest rates may be the policy of a district attorney's office to prosecute only air-tight cases. The police may not vigorously pursue investigations when they know the prosecutor probably will not bring charges against the suspect; and the leniency of judges to offenders may in turn influence the prosecutor's willingness to bring a case to trial. Cooperation with law enforcement agencies should be based on awareness of the legal and political restrictions within which they operate. A long-range goal should be to educate policymakers about the legal and judicial issues that prevent appropriate treatment of victims and that inhibit apprehension and prosecution of offenders.

Some appropriate activities for which consultation and education services might be provided to law enforcement agencies are:

- Counseling and case consultation for police officers
- Training in human relations and crisis intervention
- Consultation on screening of candidates for sex crimes investigation units
- Liaison between law enforcement agencies and other support systems for victims and their families
- Help with the development of a protocol or checklist for investigation
- Help in developing community education programs to promote public awareness and prevention
- Assistance in obtaining advocacy support for victims

Law enforcement agencies also have knowledge and experience to share with the C&E specialist, including:

- Data on reported assaults
- Knowledge of the offender's modus operandi (MO)
- Knowledge of areas of high crime incidence
- Knowledge of legal requirements for prosecution (e.g., medical evidence and rights of the accused)
- Programs in preventive self defense and home protection

Suggestions for working with law enforcement agencies: **Include a law enforcement officer on the rape task force, or in the training of victim counselors. Solicit continuing advice and information from interested law enforcement officials. Facilitate role playing with officers to increase their sensitivity to victims. Arrange for the police or sheriff to call counselors or advocates at their first contact with victims and to inform victims of available services. Arrange for police to transport victims home from the hospital or doctor's office. Enlist cooperative officers to promote the C&E program with other agencies. Encourage the police to standardize the legal requirements for medical evidence and to educate medical personnel in the proper collection of legally-admissible evidence. If several assaults occur in one section of the community, promote increased patrols in that area. Set up a system to evaluate police procedures and practices. Encourage police to inform the community of the MO and description of known rapists. Provide feedback through proper channels when cases are handled well.**

Working with the Medical System

All sexual assault victims should have access to quality medical care, including physical examination and tests for pregnancy and venereal disease in cases involving vaginal penetration. In addition, victims

are entitled to assurance that the examining physician will collect the physical evidence that will be needed if the victim decides to prosecute. Some hospitals and clinics have sexual assault units which are specially trained to treat the victim's emotional and physical trauma as well as to collect evidence. Too often, however, such resources are lacking, and only the victim's physical injuries receive medical attention. A prime goal of C&E within the medical system is to promote awareness of and resources for dealing with the multiple treatment needs of victims.

A number of issues influence the medical system's involvement in a community network of services. The first of these issues is a problem of territoriality. When victims go to clinics, emergency rooms, or private physicians' offices for treatment, they may be accompanied by the police, family members, friends, and/or victim advocates or counselors. The climate may be confusing, noisy, and emotional, possibly hindering the medical staff from doing its job. As a result, friction and misunderstanding may disrupt the hospital or office routine and seem to work against the effective delivery of medical care to the patient. A first step in eliciting the support of the medical system is to clearly communicate the services and roles of persons accompanying the patient and to demonstrate the usefulness of such support in helping the nurses, doctors, technicians, and others to carry out their duties.

Doctors and hospitals in some communities refuse to treat sexual assault victims. This situation most often reflects the conflict between the medical person's role as healer and the requirement to act as an agent of the law in cases of sexual assault. As legal agents, medical personnal are expected to report the crime, to collect evidence, and to give testimony if a case goes to trial. Many physicians are unwilling to assume this role if it intrudes on their time or other professional responsibilities. Sometimes this resistance can be overcome through C&E activities which raise the physicians' level of awareness about the importance of medical testimony in prosecutions. It also may be helpful to provide doctors with information about court procedures so they feel prepared to testify or to avoid being subpoenaed by writing legally adequate reports. In some cases it is possible to work with the criminal justice system to facilitate physicians' testimony (for example, to get approval for medical testimony to be given by videotape or arrange for physicians to be notified of the precise time they will be needed in court). If all these efforts fail, the alternative is to identify sympathetic doctors, clinics, or hospitals and try to have all victims referred to them.

Even when treatment is accessible, there may be conditions within the medical system which keep victims from receiving the most appropriate or comprehensive care. One common obstacle is the requirement that victims report the assault to the police as a condition for receiving free medical treatment. Often, drugs to prevent pregnancy or venereal disease may be administered without the victim's informed consent and without information about possible side effects. Victims may be openly identified as "the rape case" while waiting in public areas of emergency rooms. In addition, a shower, a change of clothing, or transportation home may not be available. At the least, such conditions are embarrassing to the victim—at their worst, they may be almost as traumatic as the assault itself. Efforts to improve medical services for victims should be aimed at eliminating or modifying as many of these factors as possible.

In order to enable full and competent prosecution of a sexual assault case, evidence of the crime must be available. Some emergency room staff and private physicians may not know what evidence to collect or how to ensure that it is recorded and transported in a way which meets legal requirements. (This is known as "protecting the chain of evidence.") Some Physicians and hospitals do not routinely collect evidence unless victims have already made the decision to file charges. However, victims may not be prepared to make such decisions immediately. It is especially important for legal reasons to establish a standard medical protocol which clearly states the elements of the examination and the proper procedures for collecting evidence (e.g., photographing bruises, testing for presence of semen, combing pubic hair, etc.)

Most medical personnel have been trained only to treat physical problems and have had little or no education about patients' emotional needs. This fact, coupled with the often chaotic conditions in emergency rooms, the number of patients to be seen, or the physician's own need for emotional detachment, may affect the ability or willingness of the medical professional to cope with the anxieties and trauma presented by the sexual assault victim. As a result, many victims receive brusque, impersonal treatment. Where this situation prevails, the C&E specialist should try to promote greater awareness of the total needs of the patient on the part of medical personnel.

The first step may be working with a sympathetic person on the hospital staff to learn about the hospital's policy for treating victims and,

if necessary, how to change policies and procedures. This individual may be in the social service department, on the emergency room staff, on the medical staff, or an administrator. Sometimes the C&E specialist is the best person to make the initial contact. Sometimes it is preferable to match the specialty of the contact person with the appropriate person in the medical system. For example, the CMHC medical director or a staff physician might be enlisted as liaison with community physicians, or CMHC nurses might coordinate the C&E program with nurses in a hospital emergency room. This latter approach assumes, of course, that the key individuals on the CMHC staff are supportive of and knowledgeable about C&E activities related to sexual assault.

There are several areas where the knowledge, experience, and responsibilities of the C&E specialist and medical personnel can be combined to promote optimum care for victims. For example, consultation and education services can provide or facilitate:

- Advocacy for victims and help in informing victims of the purpose of the medical procedures
- Training for hospital or clinic staff in crisis intervention and in legal procedures and requirements
- Liaison between the police, victims, their friends and families, the medical team, and victim advocates
- Liaison between medical personnel and prosecutors in court cases

Together, the medical system and the C&E specialist can share:

- Knowledge about victims' physical and emotional needs
- Knowledge of community resources and referral of victims and families to other agencies
- The development of a protocol for taking legally adequate case histories and collecting medical evidence as required by state and/or local laws*

*The medical protocol should be developed with local law enforcement and criminal justice staff and should ensure that *informed* consent is secured from victims and that their privacy is protected by stipulating that the information and photographs be released only to the proper authorities. The medical protocol should include instructions about how to examine a victim and what evidence to collect. An additional part of the examination process should be the provision of an understandable explanation to the victim about her options for preventing pregnancy and information about possible side effects of drugs before they are offered or administered.

Suggestions for working with the medical system: **Involve medical personnel in community planning as resource persons or members of the task force. Encourage emergency room staff to tell victims about support services available and offer to call a volunteer group or advocate. Better yet, arrange for the advocate service to operate out of the medical facility. In communities without hospitals, secure the cooperation of physicians who are sympathetic to the needs of rape victims; encourage police to refer victims to these physicians. If possible and necessary, arrange free medical care for victims through clinics, public health departments, etc. Demonstrate to medical personnel that the presence of an advocate or counselor at the time of treatment can facilitate examining procedures. Provide victims with information about support services (especially a rape crisis center), dates for follow-up pregnancy and venereal disease testing, names of physicians, etc. Provide consultation for doctors in court procedures, and information about rape to support testimony. Publicly commend medical personnel through proper channels when cases are handled well. Offer help in setting up a system to evaluate procedures and practices.**

Working with the Criminal Justice System

A court trial can be a shattering experience for sexual assault victims. By the time their cases come to trial (perhaps as long as a year after the attack), they have been required to repeat their statements many times, often to persons who try to discredit their words. If enough time has elapsed between the assault and the trial, victims may have successfully integrated the experience into their lives, only to be re-traumatized by the trial. They may encounter prejudice and disbelief from judges, prosecuting attorneys, and juries which severely undermine their self-confidence and self-concept. For example, juries in many states are still instructed by judges to evaluate the victim's testimony in terms of her character and past sexual history.

Several factors contribute to the complexity and difficulties of bringing sexual assault cases to trial. Some of these factors stem from the judicial mandate to protect the rights of the accused, while others are the result of attitudes of the community at large or the procedures of a particular court system. The first obstacle that may be encountered by many victims is a reluctance on the part of the prosecutor's office to bring charges of rape against the accused. This reluctance may be due to state laws which narrowly define criminal sexual assault or which are excessively restrictive on the admissibility of evidence. It may also reflect the prosecutor's interest in increasing the conviction rates. Legally, sexual assault is difficult to prove, even with medical evidence, and there are seldom corroborative witnesses. Unless the evidence is strong and there is a high degree of certainty that the victim will appear credible in the eyes of a jury, many prosecutors will not take a chance on losing the case. Quite frequently, prosecutors plea bargain with defense attorneys, allowing defendants to plead guilty to a lesser charge and thus evade trial. In addition, many judges are lenient in sentencing those found guilty of rape, often attributing the crime to the victim's dress or behavior or the predisposing pressures on the assailant "caused" by a sexually permissive society.

Even after the decision has been made to prosecute, victims may encounter unwieldly court procedures which delay trials, cause them loss of time at work or in school, leave them uninformed about the status or progress of their cases, and make it difficult for expert witnesses, such as doctors, to testify. Once a case goes to court, victims may be subjected to abusive cross-examination techniques. In open trials, victims may have to face defendants' families and friends in the courtroom and may be harrassed by them in the halls. In some states, victims are required to state their names and addresses, leaving them vulnerable to unwanted publicity or possible retaliation by the defendants' families and friends.

One major goal of C&E activities with the criminal justice system is to help prosecutors and judges become sensitive to the traumatic effects that a court trial may have on victims. A long-range goal should be to identify and change, whenever possible, court procedures which exacerbate the trauma and place the victim at risk for publicity and retaliation. For the protection of the community and as a possible deterrent for potential offenders, another important goal of C&E activities should be to encourage more vigorous prosecutions and the elimination or reduction of plea bargaining. C&E efforts might also be directed at setting up a program, in conjunction with the courts, for rehabilitating convicted rapists.

Consultation and education services that might be provided to the cirminal justice system include:

- Training in human relations, crisis intervention and counseling, and working with victim advocates
- Case consultation
- Help in developing materials explaining the legal process; coordination of checklists or protocols used by the law enforcement and medical systems
- Help in developing victim assistance programs
- Liaison with other community resources

Suggestions for working with the criminal justice system: **Invite a member of the prosecutor's office and a defense attorney to serve on the rape task force. Meet informally with the prosecutor's office to talk about policies and the possibilities for making changes in prosecution procedures, assigning one or two persons to sexual assault cases, allowing doctors to videotape their testimony. Plan a meeting between medical personnel, law enforcement, and the criminal justice system to develop a coordinated, standard approach to the prosecution of rape cases. Investigate the possibility of the DA's office paying the victim's medical expenses and instituting a victim-witness assistance program. Mobilize the community to exert pressure for vigorous prosecution; publicize sentencing records and other data on reported rapes, charged cases, and convictions. Direct education efforts at judges, prosecutors, probation officers, parole officers, and local chapters of the American Bar Association.**

The C&E specialist might rely on the criminal justice system for information about:

- Court procedures, causes of delays in trials, reasons for dismissals, acquittals, and plea bargaining
- Jury selection procedures, jury attitudes, and likely criteria for deciding cases
- Legal reforms (e.g., evidentiary changes, definitional changes, jury instructions)
- Victim compensation laws

Working with the Schools

A major objective of C&E efforts, especially as they pertain to primary prevention, should be to develop strategies for working with and in the schools. In many communities, successful C&E programs in schools are already established (e.g., parent and teacher education, and education about drug and alcohol abuse) and these contacts may provide the entrée needed to present programs about sexual assault. It is important to proceed cautiously so that the highly charged issues of sexuality do not endanger ongoing C&E activities in other areas. It is also important to coordinate plans with the CMHC staff person who is responsible for other C&E programs in the schools.

Two major issues need consideration—getting into the schools in the first place and staying there once you have entered. More than perhaps any other public institution, schools reflect the prevailing local standards and attitudes. In certain communities, parents may pressure the schools to offer courses which teach students to understand and deal with major social issues. In other communities, it is not unusual to encounter strong opposition from parents and school boards to any discussion of social or moral issues in the classroom. It is absolutely fundamental to *know the community* before determining what type of program will be acceptable in the schools. Parents, school personnel, and students should be involved in the process. Their support will be needed to implement the program. Such support will depend on (a) awareness of the need for education about such things as relationships, feelings, sex role stereotypes, or personal safety; (b) openness and candor about the information that will be presented; and (c) the clarity with which the goals and objectives of this kind of program are presented.

Once permission has been obtained to work with teachers and/or students, both the content and the tone of the presentation must be carefully written and continuously evaluated. It is especially important that the language not be too graphic, that the information be at the students' level of sophistication, and that "scare" tactics be avoided. If the community perceives that improper methods or language are being used in its classrooms, opposition may be created which could interfere with all mental health programs in the schools.

Schools may be the site of sexual assaults, or students may confide in a teacher, counselor, or nurse about sexual assault experiences. In these instances, it is especially important that school staff be trained to intervene on behalf of a young victim or offender.

Examples of consultation and education services which might be provided to the schools include:

- Counseling and case consultation for students and staff
- Training for teachers, principals, nurses, counselors, students (peer counselling)
- Linkage between schools and other service agencies for students who have been sexually assaulted or students who display inappropriate sexual behaviors
- Education for parents
- Program consultation for the development of courses or units in socialization

Among the resources which the schools have to offer the C&E specialist are:

- An awareness of student problems with sexuality, feelings, and relationships
- Rapport with students and parents
- Support of the PTA/PTO
- Insight into community awareness, openness, level of sophistication, and cultural backgrounds

Suggestions for working with the schools: **Work through parent groups to ask boards and principals for improved education about violence, sexuality and human relations. Consult with teachers about the adequacy of texts and materials in human biology, psychology, social studies, etc. Invite principals or school board members to serve on the advisory committee for C&E in sexual assault. Work through individuals with access to schools—the school nurse, police, etc.—to generate support for primary prevention. Arrange for a resource person to teach self-defense. Focus class presentations on topics such as safety and protection, hitchhiking, boy-girl relations, personal rights, etc.**

Working with Other Community Groups and Natural Support Systems

Not every community has comprehensive legal, medical, and mental health systems which can meet all the needs of sexual assault victims. But every community, no matter how small, has various organizations which can be used effectively to create public awareness about sexual assault and to provide helping services for victims, offenders, their friends, and families.

The type of cooperation that can be developed between C&E and a particular group or organization will depend on the group's membership and purpose. For example, C&E activities with teen clubs might involve rap groups in sex role socialization. Civic and fraternal organizations are good targets for public awareness and education, as well as good sources of speakers and other community liaison workers. Groups with a political focus, for example, the League of Women Voters, the National Women's Political Caucus, or the National Organization for Women, can be a source of information about local and state laws and legal processes; they also may be effective in working with local officials or lobbying state legislators to bring about needed changes in the criminal statutes.

Some groups also may be effective natural support systems for victims or others who are affected by a sexual assault. Many victims or family members feel more comfortable discussing their problems with people whom they know and trust. Mental health agencies can offer guidance to those in the natural network about how to provide support through the period of crisis and integration and also how to recognize if someone needs professional help.

Promoting Public Awareness and Support

Various communication channels and activities can be used to reach the community, such as speaking to service clubs or other groups; preparing brochures, posters, and bumper stickers to advertise the community's support systems; writing or editing news articles for newspapers, community newsletters, radio or television programs; and interviewing or talking informally with community decision-makers. A speakers' bureau or panel composed of service providers and activists (for example, nurses, police, community organizers, rape crisis center advocates) can greatly enhance your outreach and make it easier to match speakers with audiences.

There are some important constraints on the form and content of the messages used to create public awareness. The first of these is the need to *know the community*—its religious beliefs, ethnic or class attitudes, liberal vs. conservative social standards, etc.—and to tailor your information so that it will not offend your audience. The emotional tone of a presentation should be calm and serious. Avoid scare tactics, sensationalism, and flippancy; they only create anxiety and undermine your credibility. It is also important to tailor your information (both the vocabulary and the message) to fit a particular audience.

The timing of public education campaigns is extremely important. Public awareness tends to create a demand for services; if those services are not available or are not adequate to meet a growing need, the impact on the community may be negative. As awareness and services are developed, the level of sophistication of the information provided can be raised to reflect increased awareness.

An immediate crisis in the community (rape, child molestation, or other acts of violence) may precipitate general concern and may be the

best time to reach the public. Be prepared to respond with accurate information about preventive measures and available services. A community crisis also provides an opportunity to develop new networks, to foster change and growth among key individuals in those networks, and to develop community organization strategies leading to changes in agency policies.

Working with the Media

The media (TV, radio, films, newspapers, and magazines) are an important and pervasive influence in informing people and in shaping public attitudes and opinions. If it is accepted that the causes of sexual assault are embedded in our social values, then it is important to examine those media practices which may be at least partially responsible for these values and which may perpetuate many of the myths and misconceptions about the nature of sexual assault.

It is commonly recognized that the way in which violence and sexual assault are presented in the entertainment media (movies, television and some magazines) has a powerful influence in shaping social values and perceptions of viewers and readers of all ages. Less obvious, but of equal importance, are the effects on the audience when the local and national news media sensationalize sexual assault by focusing on bizarre or particularly brutal crimes. This type of reporting reinforces the myth that sexual assaults are isolated acts committed by insane men. In addition, most media accounts are of rapes in which the offender is unknown to the victim, thus supporting the myth that *all* rapists are strangers. Reports will often emphasize the physical characteristics and clothing of a victim, expecially if she is young and attractive, thus building a myth of the prototypical (but not necessarily typical) victim. Such slanted coverage also contributes to the misconception that rape is primarily a sexual act, and suggests that the victim is responsible.

Any C&E effort to create public awareness and sensitivity to the issues of sexual assault should involve representatives of the media. At a minimum, accurate information about the true nature of the crime should be provided to reporters and editors, and reporting practices which tend to sensationalize rather than inform should be brought to their attention. Even when news coverage is complete and responsible, efforts to raise the level of consciousness of newsmen may be beneficial. For example, in many communities there is a critical need to enlist the cooperation of local newspapers in protecting the anonymity of victims by not printing names, addresses, or other identifying information. In the case of the entertainment media, it is sometimes possible to bring about changes in programming by contacting radio and television station managers about particularly offensive or inaccurate programs or about stations' broadcasting practices in general.

The media can be a powerful ally in the promotion of community awareness and in publicizing available services and educational programs. There is likely to be a high return on time and energy spent in establishing a working relationship with their representatives.

Suggestions for working with the media: **Involve the media early in your program. Make personal contact with station managers and editors to articulate your purposes and promote coverage and exposure. Invite reporters to attend public meetings and presentations. Supply statistics or other information for feature articles. Give written commendations to individuals and their supervisors when a story is handled well. Take advantage of the opportunity for public service announcements. Offer to serve as a consultant on local TV or radio programs about sexual assault. Include a media person on a task force for input about public opinion and attitudes. Monitor programming by attending FCC hearings in which citizen feedback is solicited.**

Special Issues in Rural Communities

Several considerations apply to C&E in any type of setting, whether rural or urban—the need to build rapport with the community, to utilize direct personal contacts, and to have strategies for working with opponents as well as supporters of your efforts. In addition, there are some special issues which need to be considered in a rural community.

- ***Limited resources.*** Many resources taken for granted in urban areas do not exist or are not easily accessible in rural communities. For example, the lack of public transportation may prevent many victims from reporting the crime or seeking medical treatment. Medical care may be available only from a few private physicians (who may or may not be willing to treat rape victims) or from clinics and hospitals which are some distance away. Seldom are there rape crisis centers, hotlines, or self-help groups. Police departments may not have the personnel to establish special sex crimes investigations units; the CMHC itself may have a small staff serving a large geographical area, with little or no specialized training in C&E.
- ***Pressures to keep sexual assault hidden.*** Often in rural areas there is a "conspiracy of silence" which isolates the victim and the family. There also may be pressure against reporting or prosecuting the crime to protect the offender, especially if he has status in the community. There may be resistance to public education programs because of the perceived stigma on the community if it is recognized that sexual assault is a local problem. Such pressures make it difficult to get an accurate picture of the number or pattern of assaults which are occurring and to generate support for needed services or prevention.
- ***The critical need for confidentiality.*** This issue is closely related to the previous one. Rural inhabitants usually do not have the protection of anonymity often found in urban communities. Nearly everyone in the community will have either direct or indirect ties to the victim and the offender, and the victim's shame, embarrassment, and fear may be greatly magnified if the assault becomes publicly known. The desire to avoid public knowledge will block many victims and offenders from seeking the help of public agencies.

The acceptance of a sexual assault program in a rural community will depend largely on the rapport which the C&E specialist has with the community, the discretion exercised in dealing with individuals and agencies, and the flexibility of approach. It is important to move slowly and to keep a low profile. Because the network of services in a rural community usually is not large or complex, it may be easier to get things done than in an urban setting. On the other hand, it may be more difficult if a particular individual or agency is resistant to change. The prime need in many rural areas will be for the development of alternative delivery systems (such as church groups, women's clubs, or civic organizations) to provide the resources which are more readily available in larger communities.

Suggestions for working in rural communities: **Schools and churches attract the largest number of people; use these gatherings for public education efforts. Get acquainted with those who know what's happening in the area, such as county judges, teachers, and clergy. Rely on service to the community rather than professional qualifications to establish your credibility. Work through clubs and civic groups to build awareness of the problem and support for improved services. Set up a hotline using a regional rather than local phone number. Consider the effect of the crime on the family and social network as well as on the victim. Be patient and low key in efforts to change attitudes. Consider using interventions which have been evaluated as successful in similar communities; adapt them for your purposes. Be prepared to deal with the problems of incest and/or child molestation.**

Special Issues for High Risk Groups

In nearly every community there are persons who are at high risk for sexual assault, either because of special vulnerability or because they have characteristics which make it particularly hard for them to obtain appropriate services.

Vulnerability is readily apparent in the case of children, the elderly (especially those living alone or in institutions), and the physically and mentally handicapped. For each of these groups, the needs are basically the same—to increase public awareness that they are vulnerable to sexual assault and to provide educational programs which will increase

their own self-awareness and ability to protect themselves. Community agencies need to be sensitized to the special trauma which may be experienced by victims from these groups. For example, because of age or handicap, victims may be isolated from community or family support systems. In the case of children, the reactions of the family may increase the fear and pain of the child, especially if the offender is known to or a member of the family. Children often are cautioned about the dangers of trusting a stranger but seldom are warned that they might be molested by a friend or relative. And yet, the limited data available clearly show that well over half of the reported cases of child molestation are perpetrated by someone related or known to the family.[17]

The issue of vulnerability also applies to those whose living or working conditions force them into high risk situations, such as college students, apartment dwellers, or women who work at night (nurses, stewardesses, factory shift workers, etc.). Members of these groups need education about methods of self-protection; often such education can be delivered through existing communications networks such as campus newspapers, tenants' associations, unions, etc.

One of the greatest challenges to improved services for *all* victims is the removal of barriers to service encountered by groups whose characteristics, values, or lifestyles place them outside the mainstream of community concern. For some of these groups (e.g., prostitutes and homosexuals), a major problem is that of credibility, or public acceptance of the fact that they can be and are victims of sexual assault. For other groups, a major problem is access to appropriate or acceptable care. In urban areas, for example, "street people" or transients may have little contact with community agencies, or their needs may be ignored on the assumption that they are not the responsibility of that community. Many smaller communities have periodic influxes of tourists or students for whom services are not easily available.

In other populations, some of the barriers may be internal to the group. For example, some groups (whether differentiated by cultural, social, educational, or even economic factors) have a traditional view of male-female roles which emphasizes the rights of men over women; in such groups women may feel considerable pressure to remain silent if they are sexually assaulted. In some cultural groups it is the responsibility of families and friends to deal with the offender without involving the police or other outside agencies. In groups where traditional expectations are strong, victims often feel a loyalty to their social structure which makes it difficult for them to act in their own self-interest. In other cases the barriers of language or race may prevent victims from seeking help or receiving it from community agencies.

The principles of dealing with special high risk groups or populations are the same as those outlined for working with other community groups and audiences—be aware of their existence, explore their culture and values, understand their problems, and identify community resource people who can provide special training and education for a particular group. Once this is done, it often is possible to mobilize the group's own resources, to help it define its own needs and to facilitate its involvement in the community-wide network of services.

Equally important is the need to examine, and modify where necessary, institutional responses to groups with special characteristics or needs. Too often, public agencies are oriented toward a white, middle-class population, with little or no consideration given to the possible barriers encountered by those groups who are outside of the mainstream. One goal of the C&E specialist should be to make the community program fully accessible to all.

Where to Begin...

This postscript is addressed to those of you who may be wondering where to begin. It may be beyond the resources of any one CMHC to carry out all of the suggestions in this monograph. The development of a community-wide network of services is not an easy or quick process; however, there are interim goals which can be met with limited time or resources. To help you find your starting place, consider these questions.

- Have you identified the major needs in your community (for example, victim advocacy, improved attitudes on the part of the community or agencies, appropriate legal and medical procedures, prevention programs, etc.)?
- Have you found persons in the community who are interested in the problem and who are in positions where they can help?

[17] de Francis; Kinsey; Landis; Oregon State Department of Human Resources Task Force on Sexual Assault.

- Have you identified something, no matter how small, that you can do to improve the situation?
- Have you determined your immediate goal and given some thought to the next step?

The larger the problem, the more simple and elemental must be the beginning efforts to solve it. In most areas the needs and problems created by sexual assault are so great that even the smallest improvement in attitudes, awareness, and services will be a step in the right direction..

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(The preceding three volumes are part of a series of research reports describing current law enforcement practices in response to rape. They can be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Eight additional volumes will contain information for patrol officers, sex crime investigators, filing and trial prosecutors; administrative and policy issues of police and prosecutors; and analysis of legal issues.)

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