California Social Welfare Archives
University of Southern California, School Of Social Work

Oral History Interview

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Interviewer: Myra Radel Amorosi

Interviewee: Gail Abarbanel
Director, Rape Treatment Center
Santa Monica Hospital, Room 1128
1250 16th Street
Santa Monica, CA 90404

AMOROSI: Gail the first question I would like to ask is something about your background. How you got involved initially, as a youngster perhaps or family situation where social work became an interest to you? Was there anything specific that triggered your involvement with social work?

ABARBANEL: I was born in Los Angeles and grew up in Los Angeles and my mother actually volunteered at Vista Del Mar and at that time Vista Del Mar was different than it is today. It was more like a Jewish orphanage. And in the summer when she volunteered I used to go with her and be there during the day and do activities with the kids and spend time there. And then my parents also took the kids that were in placement at Vista Del Mar on outings. We would have them for dinner on holidays like Thanksgiving and I can remember taking them on outings like to the ballet or to the theatre and we would do things. And I think that probably had a significant influence on me.

AMOROSI: Your mother wasn't trained as a social worker?

ABARBANEL: No, not at all. She was just a volunteer. And my parents also were just people who helped people-- people in our family and other people in the community. So I knew that I wanted to be a social worker.

AMOROSI: At what age?

ABARBANEL: I don't remember the exact age. But I remember when I was ready to go to college I wanted to be a social worker and go to social work school. So I went to UCLA for my undergraduate and then I went to USC for graduate school. I had two professors at USC that influenced me very significantly. In the way I think about things and in my ethical and my social work values. One was Alice Overton and the other was Barbara Solomon.

AMOROSI: When you said they influenced you what specifically was it that triggered even more interest in social work because of these two people?

ABARBANEL: Alice Overton was like an old time kind of grass roots social worker who really gave I think her students a sense of dignity and respect that every client should be treated with. She worked a lot with poor children and families. And Barbara Solomon, I guess you could say, one gave me her roots and gave me her wings. Barbara Solomon gave her students the freedom to explore there academic interests in creative ways and really encouraged us to learn about social work in unique and creative ways. So I had an interest in a writer, an author of books who was Anais Nin, who is a very poetic writer.

AMOROSI: I'm not familiar with her.

ABARBANEL: Just by some strange circumstance at the same time I was in social work school and Barbara was my professor I had the opportunity to meet her.

AMOROSI: The writer?

ABARBANEL: The writer— and I did a project instead of doing the regular social work kind of assignment; I did a project exploring how she dealt with human communication in her writing.

AMOROSI: So not only did you have a background from school but in addition to that you were working with somebody else who gave you a deeper insight or a different insight.

ABARBANEL: It was sort of like a different way to learn what other people might learn in a more traditional way.

AMOROSI: Okay.

ABARBANEL: About looking at situations and communication between people.

AMOROSI: Reaching out to them perhaps.

ABARBANEL: Right. She is an amazing writer and lives a kind of bohemian life. A nd I continued to have a relationship with Barbara throughout my social work career.

AMOROSI: When did you graduate from USC?

ABARBANEL: I graduated in 1968.

AMOROSI: And what degree did you have at that time.

ABARBANEL: I had my M.S.W. Is that what you mean?

AMOROSI: Yes.

ABARBANEL: I had my bachelor's degree from UCLA in 1966 and then I went straight to graduate school.

AMOROSI: And you first work?

ABRABANEL: I had an appendicitis attack on my way to my first field work placement. (Laughs) And so right in the beginning I had an appendectomy.

AMOROSI: Very first assignment. What was your first assignment when you finally got out of the hospital?

ABARBANEL: DCFS was my first placement.

AMOROSI: Where?

ABARBANEL: In Hawthorne/Inglewood.

AMOROSI: So you first assignment was Hawthorne. How long did you stay there?

ABARBANEL: One year. The assignments were one year each.

AMOROSI: Okay, and what was your primary assignment at the facility? What were your responsibilities?

ABARBBANEL: It was a child/family caseload. It was more dealing with social welfare. It wasn't abuse. It was probably organized differently then it is now, DCFS.

AMOROSI: Okay, so initially it was welfare and not abuse.

ABARBANEL: Right.

AMOROSI: And something happened though after that assignment.

ABARBANEL: On my way to the Rape Treatment Center.

AMOROSI: Yes. Something happened—what was it?

ABRABANEL: Well my first social work job was at Jewish Big Brothers. When I graduated I went to work for Jewish Big Brothers. I worked there for six years.

AMOROSI: What type of caseload were you working with?

ABARBANEL: It was a Big Brother caseload and a child family therapy caseload.

AMOROSI: Were you coming into children that were abused at that point? Emotionally/ sexually?

ABARBANEL: Sometimes but not really. The Big Brother caseload was more children who had lost a parent-- either through death or divorce. I learned a lot and then I decided I wanted to do something different. I was thinking about what else I might want to do. It was really several chance events. I saw an ad in the paper for hospital social work. I decided that might be interesting.

AMOROSI: Do you remember about what time frame? When was that?

ABARBANEL: That was in 1974. I remember I was on a vacation and I bought the Los Angeles Times and was looking the classifieds. So I decided to go interview. It was a Santa Monica Hospital job opportunity and they had never had a social worker before.

AMOROSI: So you were a first…?

ABARBANEL: I was the first social worker. I think they had had an accreditation site visit and been told they had to hire a social worker.

AMOROSI: Oh and you were it?

ABARBANEL: I was it and so I decided to that. I was hired really as a medical social worker. And I had never been exposed to a hospital health care environment in a professional way. I had obviously in personal ways.

AMOROSI: In 1974 what did they expect you to do at the hospital?

ABARBANEL: Everything (laughs).

AMOROSI: Totally unlimited.

ABARBANEL: In the beginning I don't think they really knew what to do with a social worker. I actually turned to other social workers working in hospitals to learn about what kinds of programs they had and what kinds of services they offered. And again another social worker was very helpful to me, Eleanor Klein, who was the Director of Social Work at UCLA. And Jim Simmons was in Pasadena at Huntington Hospital. And there was a hospital social work director organization also. I think I learned a lot from them.

AMOROSI: You instituted…?

ABARBANEL: So I began to provide social work services.

AMOROSI: You created?

ABARBANEL: I did and I created the social work department. But it was just me in the beginning and I was doing everything because the needs for social work just came out of the walls. It was pediatric patients, cardiac patients, cancer patients, it was everything.

AMOROSI: How long were you alone?

ABARBANEL: I was alone for probably…the other thing was it was a different environment then because it was before managed care. It wasn't push people out of the hospital. People had much longer hospital stays and it was really quite different. One of the first patient's I saw… I was always really kind of attracted to or interested in the ER in the hospital. And I got called to see a patient who had made a suicide attempt. And when I talked with her I unearthed the fact that she had been raped about six days earlier. She was from a very prominent family in the city and she felt that there was nowhere to go for rape victims. There was no identified agency or hotline, there was nothing, and she felt that she would be blamed and she would bring shame on her family. And I was just so moved by her experience that she would see suicide as the only way out of the anguish…

AMOROSI: Her only alternative to this attack?

ABARBANEL: It was like the way out of her pain. And then just coincidentally a few days later, we had a family practice residency program at Santa Monica Hospital, and one of the family practice residents referred me… asked me to see one of his patient's who was really in crisis. It turned out that she had been raped. She had been taken to another hospital in the community and had received really terrible treatment. She had been left in the waiting room for hours and they came out and said where is the rape? They treated her physical injuries…

AMOROSI: No sensitivity.

ABARBANEL: Nobody talked with her about the impact. She was a young mother with two kids. She had to give her kids to somebody else to take care of. I just remembered she was like a faucet. She was just completely unraveling, really having a crisis and a reaction. So I thought what do we do for rape victims at this hospital?

AMOROSI: What year was that?

ABARBANEL: That was 1974.

AMOROSI: Okay still 1974.

ABARBANEL: I started working there in September 1974. So it was early on. So I decided that I would see every rape victim who came to our hospital ER. And I started reading about rape and trying to learn about it.

AMOROSI: It was self-taught. How to deal as a social worker in 1974?

ABARBANEL: And it was the same year that a nurse in Boston, I have to check… I'm pretty sure this is the date. She had done some work in the Boston City Hospital ER with rape victims and had published an article in a psychiatric journal about rape trauma. It was the first time that it had ever been "named" in a psychiatric journal. Anyway so I decided I would see every rape victim that came to our hospital and as it turned out, when they did come-- there weren't that many at that time, but when they came, they came often on the weekend or at night when I wasn't there. And if I tried to follow-up and contact them, because I wasn't on site when they had been in the ER, it was very hard to connect with them. I don't want to talk about it, I don't want to think about it, I am going to move on with my life. That is the common response.

AMOROSI: Because this was always after the fact. Not the trauma of the immediacy. It was after this had happened and….

ABARBANEL: If I tried to follow-up and contact them the next day and it took a few days or whatever. So I decided that I would put myself on-call.

AMOROSI: This was your decision.

ABARBANEL: Yes this was my decision. And I would come in whenever a rape victim was there.

AMOROSI: And this is policy you're just creating as you go along?

ABARBANEL: Right. One thing I did from the beginning when I started working there was I always wrote memos to my boss about what I was doing and how I was thinking about what I was doing.

AMOROSI: Who was your boss?

ABARBANEL: He was a hospital administrator who had never met a social worker before (laughs). But I always let him know of the needs I was identifying and how I was responding.

AMOROSI: So there was a chain of information. He always was informed as the administrator and you're superior at the hospital.

ABARBANEL: That's the way to build support for what I was doing.

AMOROSI: Absolutely, you were keeping him informed, as you were creating this new policy at the Santa Monica Hospital. Without a role model really, other than what you had picked up on your own, is that correct?

ABARBANEL: Yes.

AMOROSI: Gail, would you remember how you set up the machinery to be notified when a rape victim was coming into Santa Monica Hospital, since this was all policy that you are creating?

ABARBANEL: I don't remember exactly how I did it then. But I think I probably had the nurse in the ER. We had a full-fledged Emergency Room. So it was a busy ER. And I probably had the nurse page me when a victim came in.

AMOROSI: And when this first happened, the first time your beeper went off, and you responded?

ABARBANEL: You know I remember the first victim distinctly. I don't know that I can remember the first few distinctly. I remember some of them certainly. I just remember that it made a huge difference, in terms of connecting with the patient and being able to help the patient, it was so worth it.

AMOROSI: Because?

ABARBANEL: Because, when the trauma is so fresh, before their defenses go up, and it was just much easier to provide. And I saw immediately that the most important aspect of rape treatment was not the physical medical care of the patient but the emotional trauma they suffered was usually much more severe than physical injuries. Most rape victims did not have severe serious physical injuries.

AMOROSI: It was the hidden emotion.

ABARBANEL: It was the psychological impact of the trauma.

AMOROSI: And psychological.

ABARBANEL: This is more invisible. So then I decided that we had to incorporate psychological interventions in the ER medical setting. Now this may be hard to trace exact timing because so many things happened at the same time.

AMORSOI: You were beginning to realize that getting to the patient immediately, the victim, while they are still extraordinarily vulnerable, and needing the most assistance so that they don't…

ABARBANEL: That a social worker has to offer which is crisis counseling and support and advocacy and accompanying them through the procedures.

AMOROSI: And being a support system. Because what you've described they weren't getting this emotional/psychological support.

ABARBANEL: No.

AMOROSI: It was a physical examination.

ABARBANEL: Right.

AMOROSI: Without any of the emotional care that a rape victim is requiring at this point.

ABARBANEL: I mean this was before hospital protocol, trained police officers and rape kits. This was before there was any kind of infrastructure.

AMOROSI: And sensitivity.

ABARBANEL: And sensitivity. We developed a model for providing care--especially for the psychological piece of the care. In the medical setting there was a doctor in the hospital who had a research background. There was a national rape center in the federal government in the department of mental health in health and human services for probably like an eight year period. It was actually later abolished during President Reagan and it was never reinstituted. But there was a National Center for the Prevention and Control of Rape was what it was called.

AMOROSI: So there must have been guidelines.

ABARBANEL: No there weren't guidelines. But was applied for a grant to take our model and disseminate it across the country. So we actually got a grant to make a film and a training package about our model for providing victim care. We had a national meeting of a few people who had knowledge in this area. We developed the materials and then we did pilot testing in Louisiana and Boston and different parts of the country, rural and urban sites, and we made a film. And then it was disseminated by the federal government.

AMOROSI: Who is the "we?"

ABARBANEL: It was me and other people who worked on it.

AMOROSI: People that you brought in?

ABARBANEL: Obviously to make the film and the training materials. And I'm trying to remember when I got the second social worker…?

AMOROSI: That's what I was curious about.

ABARBANEL: I would have to look back at my…

AMOROSI: This was all your creativity based on your own work. You said there was a doctor who had some exposure for applying for the federal grant. But you're putting all this together in the first instance and creating all of this.

ABARBANEL: Right. And I was doing all the other medical social work at the same time. And at some point I started adding staff for social work coverage.

AMOROSI: Were they doing the other aspects of social work at the hospital while you focused on the rape trauma syndrome?

ABARBANEL: I think the first person I added, because of the hospital needs, was a discharge planner actually, now that I remember.

AMOROSI: A discharge planner?

ABARBANEL: Yes.

AMOROSI: And that term means what?

ABARBANEL: That means somebody who helps patients with their plans for after-care, when they leave the hospital, if they need a nursing home or in-home care. Actually, I just remembered something else I did, which was a really… Alice Overton kind of social work thing to do, which was, this wasn't about the Rape Treatment Center, but the hospital had this family practice clinic. And they saw people who couldn't afford private practice medical care. It was a low-cost medical care clinic. They actually has a means test they used to give these families-- this horrible means test to establish eligibility.

AMOROSI: Economic eligibility?

ABARBANEL: Yes, economic eligibility, it was terrible. And they used to task them questions that I thought were really inappropriate.

AMOROSI: Invasive.

ABARBANEL: Inappropriate, invasive.

AMOROSI: Demeaning.

ABARBANEL: You didn't even need to ask them to decide that you could take this patient into your clinic and provide care. So I remember I did a study to show them they could establish eligibility without asking questions about how much they spend on food and rent and so forth. And they abolished the means test. So that was a good thing. But that wasn't about the Rape Treatment Center. That was early… now it's coming back to me. Because I think when I first came they called her a social worker but she wasn't an MSW she was just like a means test person working in this clinic.

AMOROSI: She had a specific purpose.

ABARBANEL: She reported to me. So when I saw what she had to do and feeling uncomfortable about doing it. Then we worked out a way to change it and get rid of it.

AMOROSI: She was an assistant.

ABARBANEL: Yes. She was probably more like an administrative clerical person. I think they called her a social worker because she dealt with the financial aspects of eligibility for these medical care services-- anyway so back to the Rape Treatment Center.

AMOROSI: Now you're providing films.

ABARBANEL: In the beginning the Rape Treatment Center really was providing services for victims seen in the hospital ER and then doing this national training project kind of put on us on a national scale. The other thing I remember happening and I have this article was that when we had 17 victims, I think that was the headline in the Los Angeles Times, it was like a Los Angeles Times story, because that was like such a big number. Now I can have that in a week. But I can't remember the time period. But it was the first hospital to have a hospital based rape treatment center. Now around this time is when the women's movement started and speak-outs and rape crisis centers started to be formed. Which across the country were sprinkles of kind of grassroots volunteer organizations that were mostly formed by women who had been raped to help other women. And they were kind of volunteer paraprofessional organizations. At that time the biggest issues for rape victims were how the police treated them or mistreated them. How the hospitals treated or mistreated them. There is a lot of bad treatment with victims. The rape crisis centers-- I remember what I did initially when I was like oh God what are we doing for rape when I saw this woman who was suicidal. I started trying to talk to other people to find out what they were doing. There was a hotline in Los Angeles and I remember talking to them about how could hospital do better or what could hospital do. And they were very anti-police. They were very anti-police reporting because they thought the police were bad to victims. We should get victims not to report so they won't be treated badly.

AMOROSI: Were these people who were manning the hotlines, were they trained social workers?

ABARBANEL: Now there are more standards that the state imposes. But in those days a lot of them were victims who hadn't resolved their own issues about being raped. Anyway they were very anti-police and I just decided it's not a good idea to do that. It's better to try to educate the police and fix them then to try to keep victims out of the criminal justice system. For every reason, for community safety, and for the victim feeling like she has support from the legal system. We never coerced anyone but we always encouraged reporting and that created some negative feelings on the part of some of these other agencies towards the Rape Treatment Center. You know we were more

institutionally based but it was really more a philosophy issue. You realize when you have seen two victims or three victims of the same rapist and if one victim doesn't report somebody else can get raped. I just thought it was better to fix the police.

AMOROSI: You had a practical goal. You were trying, from what you're saying, to understand why some responses of victims especially in a counseling situation would be very negative for society overall because they had been treated improperly and were passing on or possibly in an effort to protect other victims they might be giving advice that is not sound. But because of their own experiences they were taking a certain path.

ABARBANEL: It's also there are so many things wrong with that picture and I think now things have turned around a lot across the country. I think over the last two decades even the more radical rape crisis centers realize that it is better to collaborate than to isolate yourself.

AMOROSI: To educate as many as possible so that everybody is working towards a common goal.

ABARBANEL: It wasn't an easy task. I can remember the first time we ever put on a training program for the police at the hospital and I still actually have one of these I made paper airplanes and threw them during the training.

AMOROSI: I can visualize that.

ABARBANEL: (Laughs) Yeah I'll have to show it to you.

AMOROSI: I can well visualize because there is a certain… early on what I saw and this was in the early seventies…

ABARBANEL: Yeah you were in the D.A.'s office.

AMOROSI: I was seeing from a law enforcement standpoint on the other side how the attitudes of a lot of police officers, there weren't too many female officers, these were male-- it was a male bastion. And there attitudes sometimes were totally unrealistic and they were very insensitive

ABARBANEL: Right.

AMOROSI: They needed to be educated. This comes about slowly it doesn't happen overnight.

ABARBANEL: No, I just had somebody Friday at work. It's a lifetime commitment. It really is.

AMOROSI: Yes it is a lifetime commitment. Now the film or films that you were able to make and sending them across the country.

ABARBANEL: First we field tested in different sites and different communities and had some really interesting experiences and learned a lot about different ways rape was handled in a different place. I remember in Louisiana it was considered a coroners case. The coroner did your rape exam. But anyway we pilot tested a videotape and then a film was made and it was disseminated.

AMOROSI: Now the film if you'll forgive me I just want to really hone on this. The educational film that you were putting together was to sensitize and give some method of sequence for what should be done when a person who is raped comes into a medical facility.

ABARBANEL: It was the medical and psychological aspects of victim care. How to integrate psychological interventions in the medical care process and it also demonstrated how to provide medical and evidentiary exams.

AMOROSI: To preserve the forensic…

ABARBANEL: In a sensitive way. So it modeled how the doctor should talk with patient and interact with the patient while they did the technical procedures.

AMOROSI: Basically it's a learning tape for the medical personnel who are going to be in contact with the victim. Certainly the police and also for the other technical people that come in contact with the victim how to preserve evidence of the rape itself.

ABARBANEL: Yes, Yes. And also the crisis, the advocates or counselors, it included their role.

AMOROSI: To my knowledge this is a very early…

ABARBANEL: Yeah very early.

AMOROSI: A very, very early training device.

ABARBANEL: Right.

AMOROSI: So that even for later prosecution you're preserving evidence.

ABARBANEL: That's right. This was before DNA.

AMOROSI: Where all they had was blood type. In those days you're just talking about whether it was possible that this donor could have left this sample. The semen even matched his blood type. There weren't identifying markers in those days to my knowledge.

ABARBANEL: No.

AMOROSI: What you were doing was the very beginnings of how everybody who is involved would be educated in doing this in a way that would be more sensitive to the immediate needs of the victim herself. To protect her as much as possible and yet protect the law enforcement interest and give her psychological well-being a start as well.

ABARBANEL: Right.

AMOROSI: So that they weren't in contradiction with each other. And were the tapes used by various states or cities?

ABARBANEL: Yes they were used by hospitals. There was a big article in the American Hospital Association magazine about what we were doing which I have.

AMOROSI: Is this the late seventies then?

ABARBANEL: Yes it was. It got a lot of publicity.

AMOROSI: Now Gail you're talking about adult women?

ABARBANEL: This was about the adult victim it wasn't about children.

AMOROSI: You were not branching off at this early stage in the seventies with either children or with women who might have been institutionalized who were raped. None of these other categories these were just adult women.

ABARBANEL: Yes adult victims.

AMOROSI: And not with males either-- males that have been raped. It was strictly adult females.

ABARBANEL: The same procedures and the same guidelines apply to male victims but the victim pictured in the tape was a female.

AMOROSI: That would really have been avant garde.

ABARBANEL: Yes.

AMOROSI: Now you're trying to disseminate a tape which is going to be used nationwide.

ABARBANEL: That is kind of our model for victim care for others country.

AMOROSI: Can you tell me what happened when you got this team onboard utilizing these new techniques. Did you see a difference in ease of prosecution? Did you see more

of a mental recovery by the patient in a shorter period of time? What were the reactions in reality to what you set in motion?

ABARBANEL: You have to institutionalize the training it can't be just like once-- okay there's a new way to treat victims. Your dealing with a large group of people who turnover and take different jobs. I think at some point we realized you have to have guidelines and requirements and standards that are formally adopted by professional organizations. So in the beginning we worked with the Southern California Hospital Council. It was probably 1976 and we put on a local training conference and it was the first conference in the United States on hospital based rape treatment. And we did it in conjunction with the Hospital Council because that gave it more clout to help it get adopted. Then we started to develop a protocol. I was on the committee and first it was at a local level, then a state level and then a national level. We realized you had to get this kind of training into the schools that prepare people for the professions, the academies that train police officers, into social work schools, nursing schools and medical schools. We started doing a lot of training and consultation.

AMOROSI: Did you see that there was a credibility issue with the victim's believability to staff and law enforcement or was this not an issue?

ABARBANEL: I think we realized it was not just credibility issues but it was that for most of the people who work in hospital ER's are nurses and this really hits close to home. Because you have these patients come in and they live in your neighborhood. They got raped a restaurant parking lot you have been to. So it touches on your own vulnerability. And a lot of the blame the victim attitudes that you see are really a way to distance yourself from feeling vulnerable. I think we realized we had to address those issues in the training so that the nurses could be more responsive to the victim's needs. Obviously this is still an issue today 25 years later.

AMOROSI: I had often early-on seen that victims do blame themselves. They feel that they were walking down a dark street when they should have known better or they didn't scream.

ABARBANEL: Right.

AMOROSI: Even though there was a knife and they were threatened that if they screamed they were going to be cut. But because they didn't attempt and then frequently they were questioned, didn't you scream, didn't you do this, didn't you do that? It was almost an accusation and then they took the blame. Another issue is that I saw married women then coming back and indicating that their husbands wouldn't any longer have sexual relations with them or blame them for the rape itself. The added emotional trauma that when the victim was trying to overcome the trauma. Then there's the added stigma that she had caused it and family members accusing her or suggesting that she might have brought it on herself. How did you address those situations or are you able to answer that?

ABARBANEL: Well the first one the resistance issue. I think what has always remained the same from the beginning until today is that I and we, who work at the Rape Treatment Center, we have always tried to take what we learned from victim's experiences and translate it into social action. Like policy reforms or prevention programs. I always say that the treatment we provide for victims is the heart and soul of the Rape Treatment Center. Because it inspires everything else we do, it guides everything else we do, it determines… it really does. And in hearing victims describe what happened during the assault, it was clear that the fear that is instilled in them, often results in non-resistance and it's not very different from consent. And we were seeing cases where the victim didn't resist and the case couldn't be prosecuted because of her non-resistance. And we finally had an incredible case where a young woman was taking an RTD bus from downtown, from Arco in the middle of the day on a hot summer August day and she was a UCLA student and she was taking the bus back to the UCLA campus. She ended-up being the only passenger left on the bus. The bus gets to the last stop on Hilgard right where the turnaround is and the driver says there is only way you're getting off this bus. She begs him to let her off the bus. He refuses. She tried to open the door but he had control of the locking mechanism. She was locked in that hot bus. And he came towards her and grabbed her and she froze. She was incapable of resisting. And he took her to the back of the bus and raped her. Her case was rejected for prosecution because of her non-resistance. That was like the final straw for us. The DA said the way the California law is written it has resistance requirements in it. So we decided that we were going to change the law. We did a lot of research. This was a real significant event in the history of the Rape Treatment Center. It was probably 1978 or 1979. W e did a lot of research on the law and the law had been written in 1872 and it had never been changed. There was no other crime that had resistance requirements. Not even the other sex crimes like sodomy or forced oral copulation that men can be victims of, only rape, vaginal rape. It was a very discriminatory law because it meant rape victims had to behave in a different way than any other violent crime victim. And it was based on this archaic view of women and rape. I remember there was a doctor working in our hospital who was French and she had gone to medical school in France and she had been taught that women's thigh muscles were strong enough that they could hold their legs together to resist a rape. So we decided to change the law and we did all this research and we formed some alliances and partnerships. And then we decided we had to educate the public about this issue, and this case was the perfect case to educate the public, because people could identify with being in that bus. And Mel Levine was our assemblyperson and me and legal counsel for the Rape Treatment Center, Aileen Adams, we testified and we wrote the California Rape Law and we got the law passed. It was an incredible victory.

AMOROSI: What year was that?

ABARBANEL: I think the new law went into effect in 1979 or 1980. But it was all based on what you described. You saw it in your practice as a DA and we saw it in our ER when victims described their experiences. A lot of times non-resistance was the safest strategy. There was a little research at that time that showed that resistance might be successful but it also increases the chances you will be more seriously harmed. And we of course presented that when we were presenting the argument that the law shouldn't…

you know you shouldn't have to make the choice that you are going to take a bigger a risk to have your case prosecuted.

AMOROSI: That you might have your throat slit.

ABARBANEL: Yes exactly. It doesn't mean that you shouldn't resist. It means you have to use your own judgment. You shouldn't be penalized for choosing what you think is the safest strategy.

AMOROSI: So therefore a woman who absolutely might freeze out of fear.

ABARBANEL: Or might even choose non-resistance. Not being frozen just because she thinks it is the safest strategy.

AMOROSI: Or believes that it will be over faster.

ABARBANEL: And she won't get killed.

AMOROSI: And she will survive. Their judgment shouldn't be at issue. It's a rape.

ABARBANEL: Right. And there were other states that had resistance requirements. Now I think there are only one or two states left. One may be Louisiana.

AMOROSI: But California was the first to take this off?

ABARBANEL: I don't know if we were the first but we were one of the first. I can't remember if we were the first.

AMOROSI: So actually in the late seventies and you do have the materials because that should go into the archives.

ABARBANEL: It was a really exciting thing to do. It was very rewarding. And the bus driver case never got prosecuted because you couldn't go backwards once you change the law. But it did result in changing the law. And we had a lot of other case examples.

AMOROSI: I'd like to clarify that because by the time the statute of limitations would have run. If it had never been filed it could have been prosecuted.

ABARBANEL: When the crime was committed the resistance requirements were in the law so you couldn't.

AMOROSI: But at the time of the crime it would have been ex post facto. He has to be held to the standard, the bus driver in that situation, but from that point on you were making a precedent and putting on the books by deleting the restraint requirement making this a law that could be prosecuted without unfairness to it because the restraint had been removed or resistance I don't mean restraint the resistance aspect.

ABARBANEL: We have worked on several legislative reforms but they all came out of cases. Everything came out of a case. The campus rape program and drug facilitated rape program came out of the experiences of victims. I think it is always feeling empowered to make change which is what I tell my staff. This all comes through you and anytime you have a gut feeling that this isn't right or this is discriminatory treatment you act on those feelings. Because often if one victim has a bad experience then two and three it reflects a broader social issue and not just one person's experience.

AMAROSI: You changed that law and kept predators from getting away with their crimes at least in that area. W hat other legislative changes have comes of the Rape Treatment Center?

ABARBANEL: One other one was we had a child, a 12-year-old, who was raped at school by another student at a middle school. She reported it right away and she was brought to the Rape Treatment Center. The case was reported to the police and was going through the criminal justice system. But in the meantime LAUSD has to deal with the accused student and the safety of the school setting. They were going to hold a disciplinary hearing. The child goes with her parents to the disciplinary hearing and the parents are told they can't go in the room with her, she has to go in the room alone and she can't have her counselor and no support person. But the accused student was allowed to have a lawyer and support people in the room. So there was no way that this kid-- this was soon after the rape, she couldn't withstand that hearing on her own. So it was postponed and LAUSD said they were basing their policy and procedures on the California law. That the law had rights for accused students but none for victims. Of course they could have had a more humane policy but it would have been breaking the law to give her the same rights. So we looked at the law and it was true. It was really unfair and there were no rights for victims. Eventually we got them to agree that she could have one person in the room. And at that point the parents decided to have a lawyer in the room. And we decided to change the law. What we did was basically make parity adding equal rights for victims to the rights of accused students. So they had the right to notice, they had the right to accompaniment with a support person and so forth. So we changed the education code. And then when we opened Stewart House we had cases where children were photographed as part of the sexual abuse as child pornography pictures. And those photographs could end up in the hands of the defense and they would be returned to the court. There was no control over the photographs so the child never knew where those photographs were going to show up in the future. So we got a law passed that required that all photographs that were related to the case were put into the custody of the court and were maintained in a locked sealed way so the child would know that they would never be seen again. The other really interesting thing we did was that we had a lot of the cases involving women who were who undocumented who were being raped by people who were posed as immigration officers and they would be told if you don't do what I say I'm going to have you deported or have your kids taken away. It didn't qualify as rape under the law.

AMAROSI: It was sexual blackmail.

ABARBANEL: Exactly it was like extortion or blackmail and it didn't involve the threat of great and immediate bodily harm. So the cases couldn't be prosecuted. So we got that badge of authority rape section passed.

AMAROSI: The appearance of authority.

ABARBANEL: Right using a badge of authority-- so that those cases could be prosecuted.

AMAROSI: They come out of need.

ABARBANEL: They come of seeing the victim have this experience and yeah need.

AMAROSI: The need is there because either the victim is being penalized.

ABARBANEL: It's like seeing the need but also feeling like the possibility exists to make things better. I really feel I got that from social work school. I got that from my mentors like Barbara or Alice Overton. And I think I really learned that in my work. Because it is really easy when you work with victimization to feel isolated and disempowered.

AMAROSI: To think like a victim.

ABARBANEL: Yeah you have to feel empowered to make it better.

AMAROSI: But you feel that your mentors going back to USC gave you the ability to understand to your own power and that you can bring about change. And this is what you have done as a social worker you haven't stopped at remaining in the hospital or at the school level. You have really gone to change and successfully succeeded altering the minds of legislators because you have actual case models. And you're showing them where the laws aren't working.

ABARBANEL: The other thing that really made me feel confident in the ability to do this is having community support for the Rape Treatment Center. When the Rape Treatment Center started to grow in the beginning the hospital supported the growth. Okay you can have another social worker and they could do a little bit of the Rape Treatment Center and do medical social work. And then it got to the point where they said you know no more and they couldn't afford it. So I decided that I would go ask the Women's Auxiliary in the hospital to help me because I figured there would be a likelihood-- I knew nothing about fundraising or anything like that.

AMAROSI: This is the Women's Auxiliary of Santa Monica Hospital.

ABARBANEL: Yes and it turned out there was a women in Auxiliary who had been raped in college and had never told anyone. She had had a horrible rape experience that

she had never told. So she decided she was going to get me help. But when the Hospital Director heard about it he was upset and he called me into his office and said that I couldn't have support from them because they already raised a certain fixed amount of money for the hospital.