Mind Rape – A mental Abuse that warrants a Name

Remedy

What the Mind Rape Victim Needs to do

There are many life events that affect people and that they need to recover from. 'Mind rape' is one such event that can occur. When it does it often lies hidden behind many of life's other difficult events receiving no consideration for the mental difficulties it causes. It is the nature of things that events affect the physical body and affect the emotions. The emotions are felt in the body. It is an unfortunate fact that many people believe that you can cure a mental condition by talking about the causes for the mental condition and if you can pinpoint the cause then a cure is in sight. I have learnt from experience after spending many hours of my time trying to explore the causes for various mental conditions I have had. I have tried obtaining the cure by the mere fact I have found the cause. I failed.

Finding the cause and thus a cure is not always helpful because the cure may not lie in the cause of the condition assuming one can find the cause. The cure relies on being able to do something, even though that something may be wrong, and to learn from the outcome. The cure to a condition lies in what is happening in the here and now and what are the educational gaps are in ones social, physical and mental understandings. Replacing the educational gap with knowledge changes a situation in ways that no amount of counselling can do. It is advantageous to learn the skill of remaining calm and centred when exposed to situations beyond ones ability to handle. This enables a person to develop some of the skills needed, even if they cannot manage to obtain all the skills required. If the approach is right then one develops the ability to come back to a similar difficult situation at another time. Hopefully, one develop the method to learn a fresh set of needed skills which one was unable to learn in a previous similar situation. The question can be asked what is "calm and centred"? This is something that can only be learnt from experiencing being "calm and centred". Words cannot adequately describe what being "calm and centred" is. Many of the religious traditions work on the tools to enable people to become "calm and centered".

A number of years ago I was in conversation with a person from English Social Services concerning a problem where 12-year-old children were attacking adults in the street. The Social Service worker asked me what I thought needed to be done. I suggested that they find people who have worked in youth services before 1986 and get their views at a conference before their knowledge and experiences are lost. I have pondered this question of what needs to be done ever since.

In 1991 I got hit by a 10 tonne double decker bus. Many of my skills concerning social ability and access to memory went. It took a long time to realise that certain skills had disappeared. It also took many years of trial and error to try and re-develop skills. Before my road traffic accident I had little understanding of people who lacked certain skills. After my road traffic accident I gained an appreciation of people who were unable to do many things because they did not have a skill set and never realised that they needed to gain certain skill sets. It is unfortunate that many people in the medical profession do not understand the concept of missing skill sets.

I have come to the conclusion that a person needs to investigate their own health disability mental or physical using mental tools that can be developed. Before I go on to discuss and present the various tool sets, background information that may not be known by many people needs to be presented.

Stress in mental health is usually described as the feeling of being under too much mental or emotional pressure. In this document I use the engineering definition of stress: "something that causes a state of strain or tension." In the graphs 1 to 5 performance is defined as: "the action or process of performing a task or function and how well this task is performed"

As a help to investigate one's own health disability I have proposed graphs 1 to 3 as a working model of Stress versus performance. The accuracy of the proposed models needs to be determined at the time of investigation into one's own health disability.

Graphs 1 and 2 (page 4) are an approximation of the stress versus performance curves for a human being on being exposed to various forms of stress. The graphs show three stress versus performance curves. Graph 1 looks at the stress experienced by a person internally. One curve represents someone who has no health disability. The other two curves are for people who have health disabilities of low and high stress. As can be seen from the curves in Graph 1 the stress breakdown point for all three occurs at roughly the same level of stress. However, as can be seen the highest level of performance varies. The highest level of performance is for the person with no health disability and the lowest level of performance is for the person with the high stress disability. For all three curves the performance falls rapidly with slightly increasing stress after the stress breakdown point. Here it can be seen that the stress breakdown point is about the same level of stress for all three curves. It can be seen that the internal stress experienced by a person before any performance is delivered is lowest for the person with no health disability and highest for the person with the high stress disability.

Graph 2 looks at the same stress applied to a person as shown in graph 1 except that the stresses are viewed by another person. The other person sees different levels of stress being applied externally and thus would see the person with no health disability, the person with low stress disability, and the person with high stress disability having a stress breakdown point at reducing levels of applied stress respectively. It can be seen that at low levels of applied external stress the levels of performance are the same.

Graph 3a (page 5) is similar to Graph 2. The dotted curves highlights what happens when a small stress is added from the presence of another health disability. The effect of this added stress is to shift the stress breakdown point to occur at a lower stress and the maximum performance obtained to be lower. This can be very simplistic portrayal of events as the adding of a stress disability often causes a particular part of the body to become overloaded with resulting large decrease in performance because of brain overload effects. This is shown in Graph 3b (page 5).

A person spends a long time learning to determine the optimum stress for a particular activity. During this time of learning a person often learns how little things modify their own stress performance curve behaviour. They learn how to change optimum internal stress for a task according to circumstances. This learning may be a conscious or sub conscious activity.

A good example of a stress performance situation is the student essay which needs to be done by a due date date. When there is lots of time before the due date there is often not enough stress to produce a good essay. As the deadline approaches the student's stress increases. There comes a point when the stress has risen high enough to produce the required performance for writing the essay. If the stress becomes too high because the student has misjudged time scales the ability to write the essay can decrease dramatically. The student's internal stress has gone above the stress breakdown point for the task of writing the essay. A student gradually gains the skills for doing particular tasks to bring the stresses to the optimum stress level.

The stress breakdown point for writing the essay for the sake of argument can be considered a constant. If the student happens to get a cold at the time they decide to write the essay, then there is a very strong likelihood that the stress breakdown point for the stress performance curve of writing the essay will change to a new stress-performance curve until such time the student recovers from the cold. This is shown by the dotted lines in graph 3a and 3b. A slight variation of would occur if the

student were to break their leg. Again the stress handling ability as shown by the solid lines falls to that of the adjacent dotted lines. The student may not realise that their stress breakdown point has changed. The broken leg stress does not obviously affect the ability to think. The result is that the student having an essay to write and engaging in the same strategy as before may find that they may not be able to be produce the essay before the student's stress has unknowingly become greater than their stress breakdown point.

Graphs 1 to 3 are fairly simplistic. However, they provide an easy working model of stress against performance that is easy to remember when looking at ones own environmental stress both internal and external. Lew Fazey & John Hardy were two British researchers at the University of Wales in 1988. They proposed a more complex model of stress versus performance. This is shown in Graph 4 (page 6).

Fazey and Hardy proposed a model that showed that as stress increased so did performance until a critical point was reached (point B in graph 4) where it suddenly and dramatically fell to a very low level. In addition, their model proposed that once a performer was on the lower curve, it required a considerable reduction in stress for them to be able to jump back onto the upper performance curve (point A in Graph 4). Could this model as proposed in Graph 4 be what happens in some forms of depression?

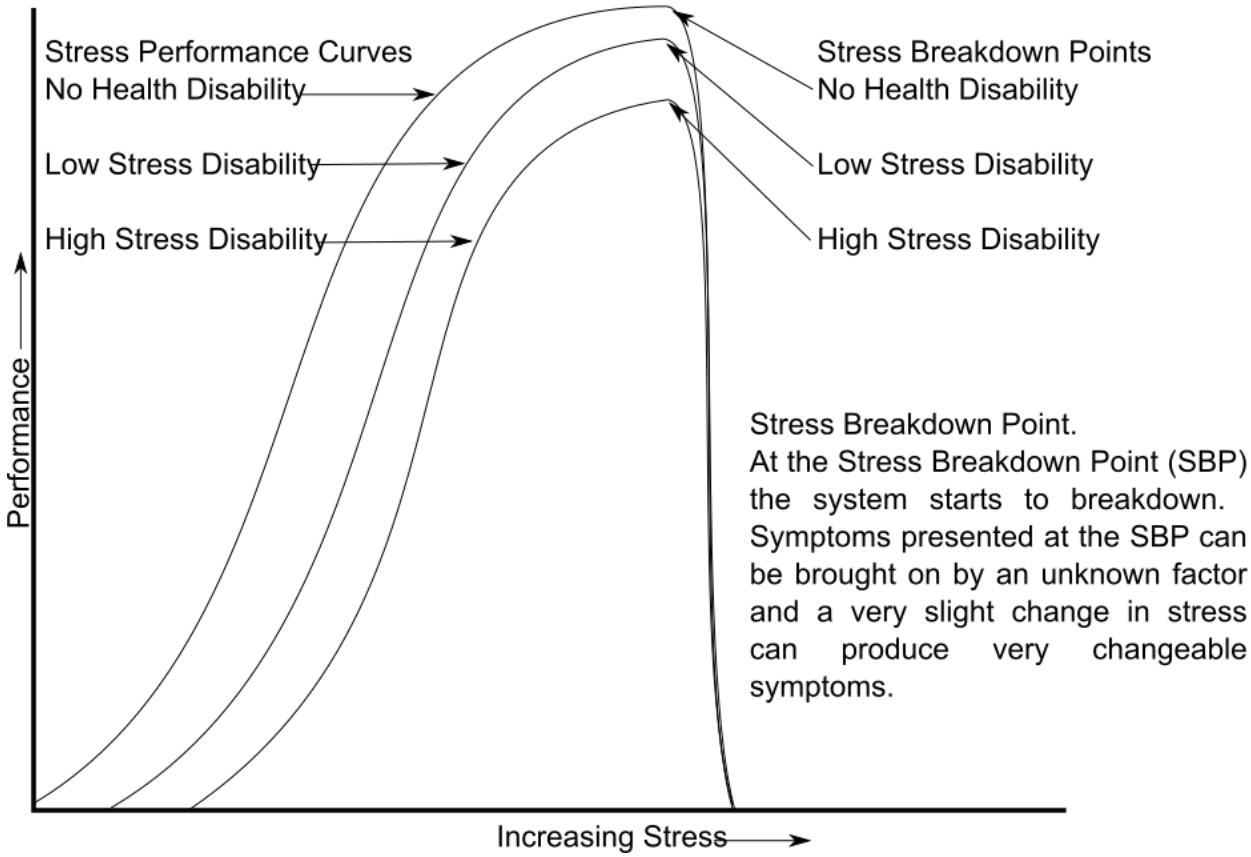
A more complex model proposed by Fazey and Hardy is shown in Graph 5 (page 6). Fazey & Hardy suggested a different set of rules for how anxiety affects performance.
An internet page https://sportspsych.wikispaces.com/file/view/Catastrophe+handout.pdf says
...

- Cognitive anxiety is the "splitting factor" which determines whether arousal has a slow and gradual effect or a sudden and dramatic effect on performance .
- The inverted-u was fine for showing how arousal affects performance with low cognitive anxiety, but with high cognitive anxiety a different pattern occurs .
- Under high cognitive anxiety, if arousal goes past the optimal point a CATASTROPHE will occur – performance drops suddenly; John Hardy compared this to a breaking wave."

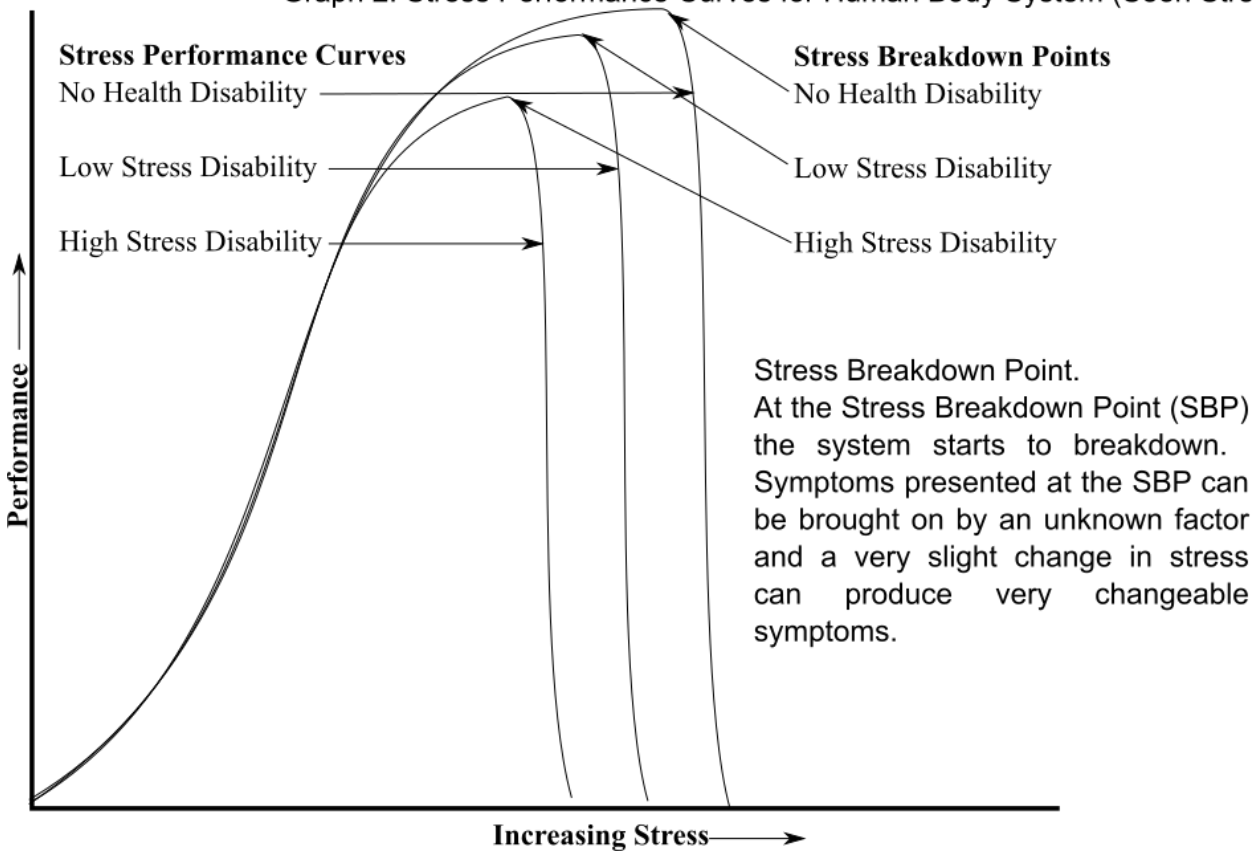
An example of catastrophe model is a person in a field by a car. The person sees a bull running towards him. The person takes his car keys and tries to open the car door. They find this an impossible task. However the physiological arousal will enable them to run across the field and jump over a gate to escape the bull. Cognitive anxiety prevents a skilled task taking place (keys in car door) but allows a low skill performance (running across field and jumping over gate).

The above are five different models of performance versus stress. Which model is appropriate to a particular situation? The answer may not be known. A person may have to determine their working model by trial and error. It is not something that can be determined by the 10 minute consultation with a GP. It also cannot be determined by an hour-long interview with a specialist practitioner be it psychiatrist, neurologist, or psychologist. It can only be done though observation and experiment and this may take weeks or more by the patient with a chronic health disability. The references below (page 7 and 8), reinforce the belief that determination of an investigation for a chronic health disability cannot be made by either a 10 minute interview with a GP or an hour long interval with a specialist practitioner. The evidence also indicates strongly that for difficult life experiences the simple solutions or quick medical fix such as "take this pain killer or antidepressant or antipsychotic" are not based on accurate tested results.

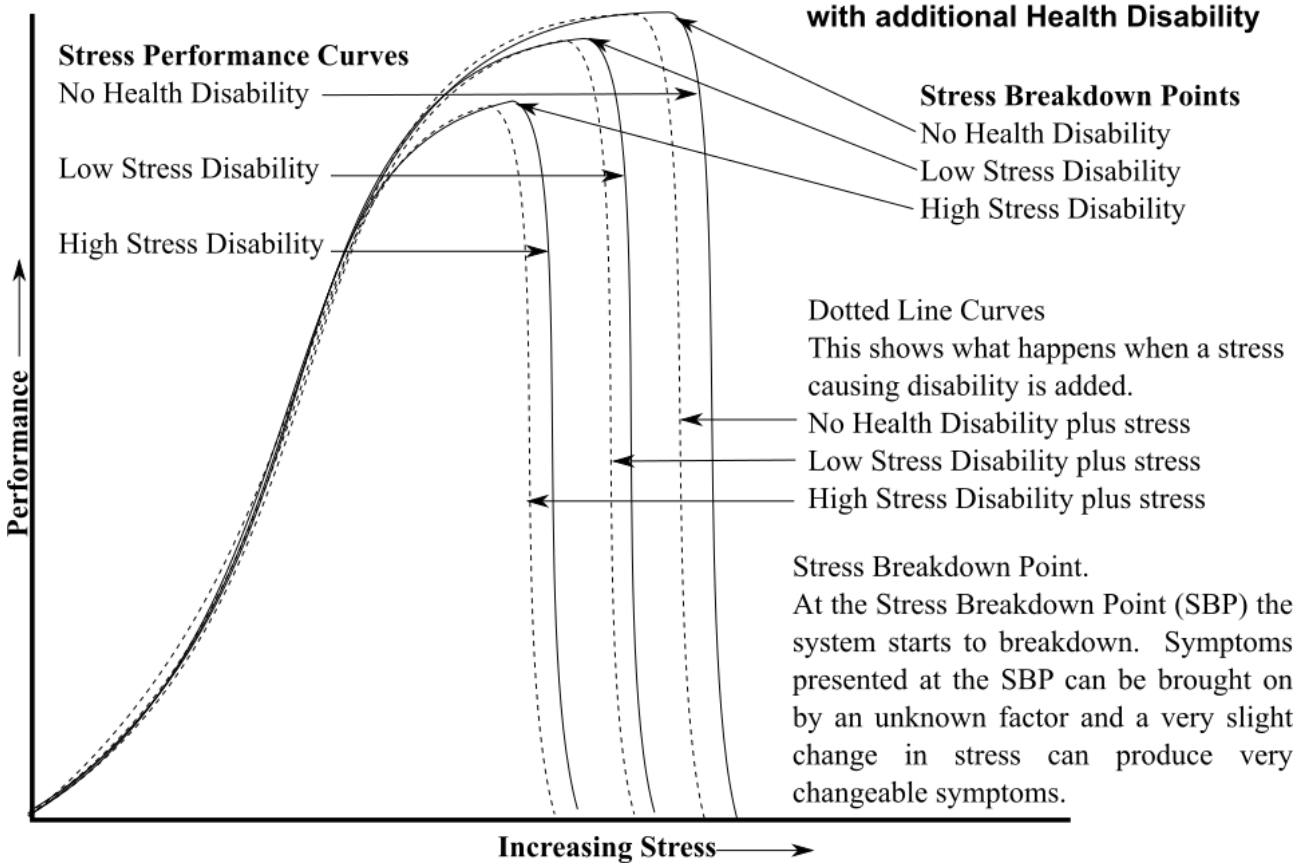
Graph1: Stress Performance Curves for Human Body System (Internal Stress)



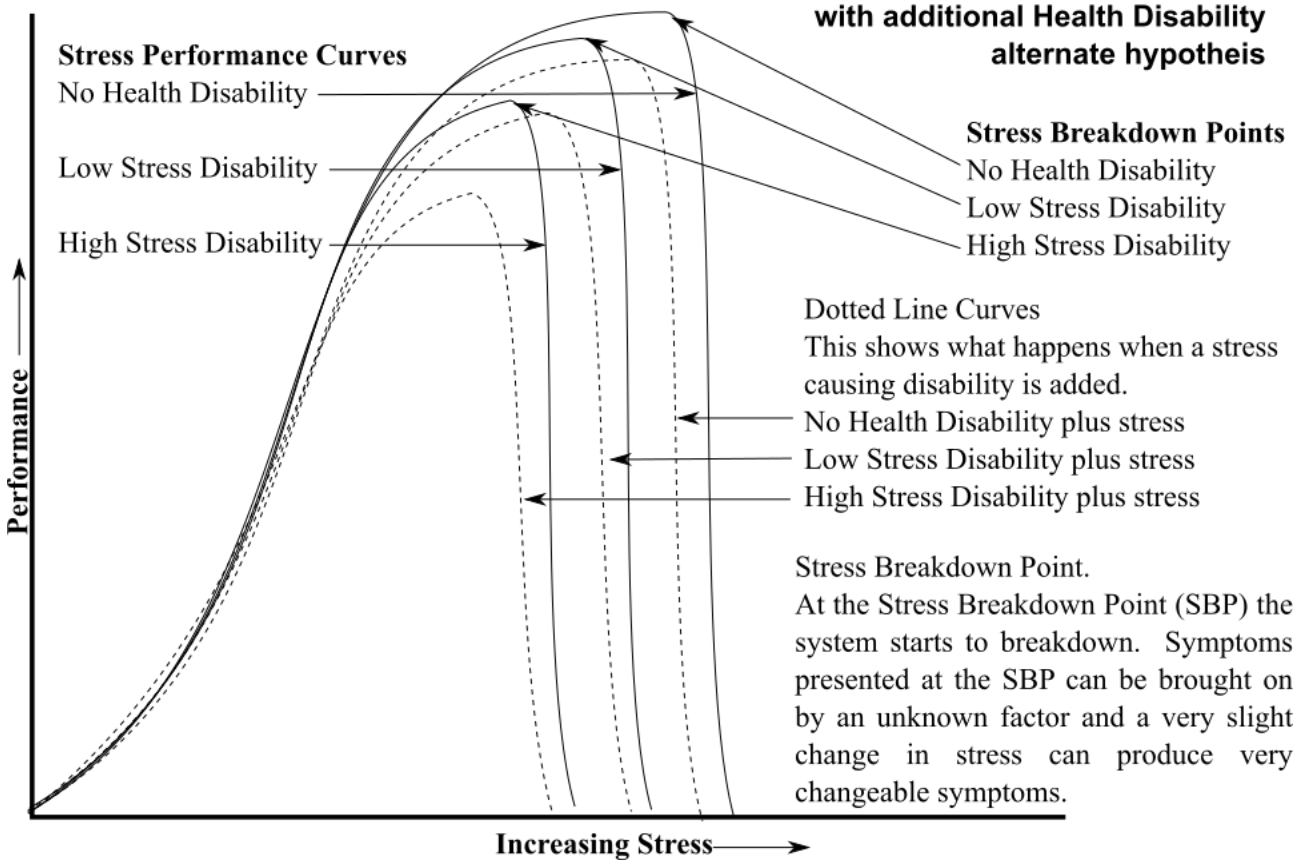
Graph 2: Stress Performance Curves for Human Body System (Seen Stress)

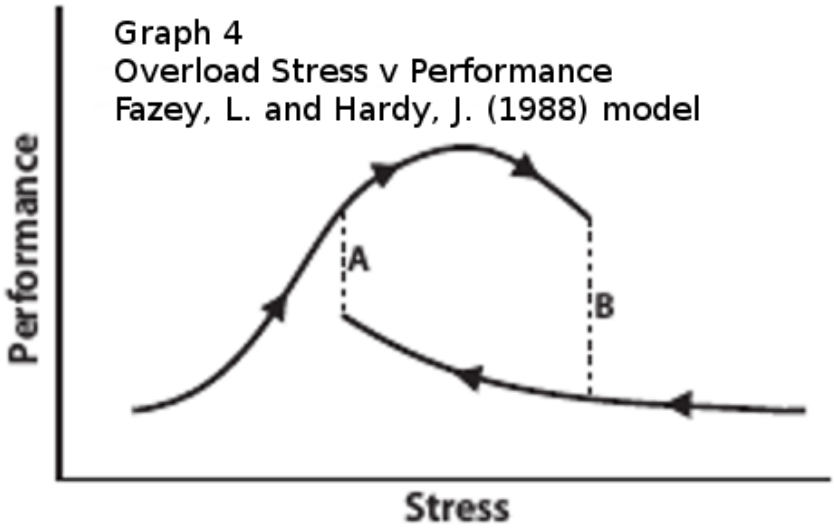


Graph 3a: Stress Performance Curves for Human Body System (Seen Stress) with additional Health Disability

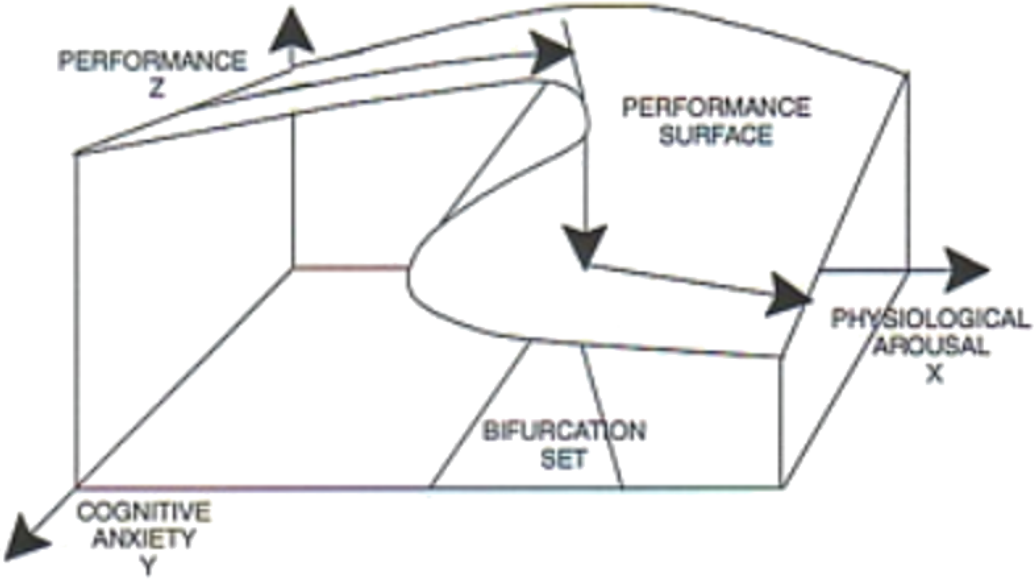


Graph 3b: Stress Performance Curves for Human Body System (Seen Stress) with additional Health Disability alternate hypotheis





Graph 5
Hardy & Fazey's (1987) Catastrophe Model demonstrating the association between anxiety and performance



I am a chronic pain sufferer so I have had to investigate stress-versus-performance in various situations in order to develop strategies and understandings to enable me to function as well as possible in day-to-day living. This has become particularly important as the reduced functioning of older age is becoming noticable. Considering the work of Dr James Davies and others and graphs 1 to 5 I have come to an important realisation. Many of the Mental Health Diagnostics made by psychiatrists have a good likehood of being false. Diagnosis of patients by psychiatrists, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM), is made looking at a person experiencing large internal stresses for one reason or another. These stresses are above or close to the stress breakdown point. Hence they are inappropriate symptoms on which to base a distinctive diagnosis. Change the conditions the patient is exposed to and the symptoms may well change.

An internet page http://www.nature.com/nrn/journal/v14/n5/full/nrn3475.html On the page it says:

"**Analysis**
Nature Reviews Neuroscience 14, 365-376 (May 2013) | doi:10.1038/nrn3475
Corrected online: 15 April 2013
There is an Erratum (May 1 2013) associated with this article.
Power failure: why small sample size undermines the reliability of neuroscience

...A study with low statistical power has a reduced chance of detecting a true effect, but it is less well appreciated that low power also reduces the likelihood that a statistically significant result reflects a true effect. Here, we show that the average statistical power of studies in the neurosciences is very low. The consequences of this include overestimates of effect size and low reproducibility of results. There are also ethical dimensions to this problem, as unreliable research is inefficient and wasteful. Improving reproducibility in neuroscience is a key priority and requires attention to well-established but often ignored methodological principles.

...It has been claimed and demonstrated that many (and possibly most) of the conclusions drawn from biomedical research are probably false [1]. A central cause for this important problem is that researchers must publish in order to succeed, and publishing is a highly competitive enterprise, with certain kinds of findings more likely to be published than others. Research that produces novel results, statistically significant results (that is, typically $p < 0.05$) and seemingly 'clean' results is more likely to be published[2, 3]. As a consequence, researchers have strong incentives to engage in research practices that make their findings publishable quickly, even if those practices reduce the likelihood that the findings reflect a true (that is, non-null) effect[4]. Such practices include using flexible study designs and flexible statistical analyses and running small studies with low statistical power[1, 5]. A simulation of genetic association studies showed that a typical dataset would generate at least one false positive result almost 97% of the time[6], and two efforts to replicate promising findings in biomedicine reveal replication rates of 25% or less[7, 8]. Given that these publishing biases are pervasive across scientific practice, it is possible that false positives heavily contaminate the neuroscience literature as well, and this problem may affect at least as much, if not even more so, the most prominent journals[9, 10]."

1. Ioannidis, J. P. Why most published research findings are false. PLoS Med. 2, e124 (2005). This study demonstrates that many (and possibly most) of the conclusions drawn from biomedical research are probably false. The reasons for this include using flexible study designs and flexible statistical analyses and running small studies with low statistical power. ArticlePubMed
2. Fanelli, D. Negative results are disappearing from most disciplines and countries. Scientometrics 90, 891–904 (2012).

3. Article Greenwald, A. G. Consequences of prejudice against the null hypothesis. Psychol. Bull. 82, 1–20 (1975).
4. Article Nosek, B. A. , Spies, J. R. & Motyl, M. Scientific utopia: II. Restructuring incentives and practices to promote truth over publish ability. Perspect. Psychol. Sci. 7, 615–631 (2012).
5. Article Simmons, J. P. , Nelson, L. D. & Simonsohn, U. False-positive psychology: undisclosed flexibility in data collection and analysis allows presenting anything as significant. Psychol. Sci. 22, 1359–1366 (2011). This article empirically illustrates that flexible study designs and data analysis dramatically increase the possibility of obtaining a nominally significant result. However, conclusions drawn from these results are almost certainly false.
6. ArticlePubMed Sullivan, P. F. Spurious genetic associations. Biol. Psychiatry 61, 1121–1126 (2007).
7. ArticlePubMedISICAS Begley, C. G. & Ellis, L. M. Drug development: raise standards for preclinical cancer research. Nature 483, 531–533 (2012).
8. ArticlePubMedCAS Prinz, F. , Schlange, T. & Asadullah, K. Believe it or not: how much can we rely on published data on potential drug targets? Nature Rev. Drug Discov. 10, 712 (2011).
9. Article Fang, F. C. & Casadevall, A. Retracted science and the retraction index. Infect. Immun. 79, 3855–3859 (2011).
10. ArticlePubMedCAS Munafo, M. R. , Stothart, G. & Flint, J. Bias in genetic association studies and impact factor. Mol. Psychiatry 14, 119–120 (2009).
11. ArticlePubMedCAS Sterne, J. A. & Davey Smith, G. Sifting the evidence — what's wrong with significance tests? BMJ 322, 226–231 (2001).

An internet page http://www.nature.com/nature/journal/v543/n7647/full/543619a.html On the page it says:

Metascience: Reproducibility blues

Marcus Munafò
Nature 543, 619–620 (30 March 2017) doi:10.1038/543619a
Published online 29 March 2017

Marcus Munafò enjoys a stinging survey of unreliable findings in biomedical research.

Rigor Mortis: How Sloppy Science Creates Worthless Cures, Crushes Hope, and Wastes Billions

Richard F. Harris Basic: 2017.
ISBN: 9780465097906

As scientists, we are supposed to be objective and disinterested, careful sifters of evidence. The reality is messier. Our training can give us only so much protection from natural tendencies to see patterns in randomness, respond unconsciously to incentives, and argue forcefully in defence of our own positions, even in the face of mounting contrary evidence. In the competitive crucible of modern science, various perverse incentives conspire to undermine the scientific method, leading to a literature littered with unreliable findings.

This is the conclusion of Rigor Mortis, a wide-ranging critique of the modern biomedical research ecosystem by science journalist Richard Harris. He describes how a growing number of claims over the past decade that many published research findings are false, or at least not as robust as they should be, has led to calls for change, and the birth of a new discipline of metascience.

He begins with the revelation in 2012 by Glenn Begley that only 6 (11%) of 53 'landmark' publications in preclinical cancer research could be confirmed by the biotechnology firm Amgen (C. G. Begley and L. M. Ellis Nature 483, 531–533; 2012). Since then, numerous studies (most recently in psychology and cancer biology) have confirmed that failure to replicate published findings is the norm. The reasons are complex and contested. Harris identifies potential culprits, from the complexity of modern biomedical science to the limitations of tools and training, and perverse incentives in modern academia.

...Robert Kaplan and Veronica Irvin at the US National Institutes of Health (NIH) showed that when the National Heart, Lung, and Blood Institute required preregistration of primary outcomes (the main outcome against which success should be judged) in clinical trials, the proportion of studies reporting a benefit fell from 57% to 8%.

Failure is a normal part of science, but dressing it up as success (for example, by presenting a secondary outcome as the primary outcome) is misleading. So is packaging exploratory, hypothesis-generating work as confirmatory, hypothesis-testing work. Unfortunately, with few ways to publish negative results, such practices are encouraged by incentives to present clean results with a compelling narrative, and be the first to do so.

Academic scientists, by contrast, are incentivized to publish first, to get grants and so on, but only rarely to get the right answer. In the words of Veronique Kiermer, executive editor at the Public Library of Science in San Francisco, California, “It actually pays to be sloppy and just cut corners and get there first”. So what is good for scientists' careers may not be good for science. Simulations support this, suggesting that labs that do sloppy science will 'outperform' more-rigorous ones.

An internet page https://www.psychiatry.org/psychiatrists/practice/dsm states:

“The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) is the product of more than 10 years of effort by hundreds of international experts in all aspects of mental health. Their dedication and hard work have yielded an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment, and research.”.

Unfortunately the DSM ignores the patient’s use of language, the patient’s educational ability and whether the patient has the ability to understand the language as used by the psychiatrist and thus answer the psychiatrist’s questions accurately. If the patient uses language differently than the psychiatrist then a patient’s answers although accurate may be miss-interpreted by the psychiatrist interviewing the patient.

An example of this occurred when someone who was slightly autistic saw a psychiatrist as a patient. The psychiatrist asked the patient if they heard voices. The patient replied that they did. The psychiatrist prescribed anti psychotic medication as if the patient had schizophrenia. The patient had understood the psychiatrist to be asking if they heard them speak and had replied with the meaning that they did hear them speak. The patient had no idea that the question did you hear voices referred to hearing imaginary voices.

J. Moncrieff, one of the contributors to J. Davis’s book “The sedated Society” concludes: “There is little evidence, therefore, that the widespread use of psychopharmaceuticals has any objective benefits and plenty of reasons to be concerned about their effects.”
“The Sedated Society The Causes and harms of our Psychiatric Drug Epidemic” ISBN: 978-3-319-44910-4. [Davies The sedated Society 2017 p81]

As I mentioned previously when a person sees a psychiatrist for help they are often experiencing stresses that are above or close to their stress breakdown point. The symptoms the person exhibits are symptoms of the body-mind interaction when the person is experiencing stress greater than their stress breakdown point. They are not the symptoms of some biologically defined illness, but often the symptoms of the brain responding to a stress overload.

The human body can be viewed as an engineering system just as a car can be viewed as an engineering system. Just as a car has a number of subsystems for example wheels, brakes ect., the human body has a number of subsystems. These subsystems interact between each other in unknown ways yet to be determined. When the system is exposed to a stress above the stress breakdown point the response to an input can be totally unknown and thoroughly unpredictable.

Failure of counselling

n the 1970s I had training in various forms of counselling. I believed in counselling and partook in various counselling sessions. In 1991 I had a road traffic accident which affected me quite badly. I sought counselling for its after effects. What counselling I had had was not particularly helpful. In about 2000 I saw a recognised Zen master and nun. I told the Zen master my tale of woe and in the process of telling it I got more and more emotionally distressed. At some point during my story the Zen master shouted at me to stand up straight. I did so and at that point I discovered that all the emotions that had been tearing me apart as I had been telling my story had vanished. I also realised at this point that maybe the many things that I had believed about counselling were not true. Since then I have met a number of people for whom counselling had been a waste of time.

What happened at that session where all emotion had vanished? I began to look more closely at how movement, posture; movement change and postural change affected strong emotion. This was not that difficult for me to do as I had already done a number of experiments on emotion and posture when I had taught t'ai chi pre 1991 road traffic accident. I have experienced a number of intense emotional episodes which my Alexander Teacher picked up by their hand touch. My Alexander Teacher also showed me how my hand touch was greatly influenced by emotional intent and body muscular control elsewhere in the body. I have had 40 years experience of Alexander Technique which aided me in developing the skills to look at posture movement and emotion. Did the emotions vanish because the tensions located in the fascia had suddenly changed and thus the emotional feedback overload feedbacks to the brain suddenly reduced? (See Fascia page 12).

Looking at posture and emotion requires a more in-depth exploration and possible explanation. This is needed for a person who has a long term health disability to investigate for themselves to see if what I say has some truth or not.

It is nice to talk and one can feel better after talking about an issue because it does enable one to look at an issue in different ways. Talking can change the breathing and change fascia body tensions. However, if the issue is about something that potentially carries a lot of emotion then it is possible that counselling can make things much much worse. It is like a road with a rut in it. Counselling instead of enabling you to fill in the rut will make the rut much much deeper.

Statistics

When a measurement are made of a particular characteristic in a population of people you will get a spread of measurement values. If the sample size is large enough the measurement value versus number of people will approximate to a smooth curve. This smooth curve can be redrawn as a graph of probability versus measurement value. In many cases the values obtained will be able to create a type of curve known as a normal distribution. This type of curve is shown in Graph 6 (page 12). This type of curve is referred to as a normal distribution and it is bell-shaped. Most of the data

values in a normal distribution tend to cluster around the mean and taper of symmetrically towards the end. The further a data point is from the mean, the less likely it is to occur.

The mathematical equation for a probability density function is $(1/\sqrt{(2\pi\sigma^2)})\ e^{-[(x-\mu)^2/2\sigma^2]}$.
x is the measurement value
μ is the mean
σ is the standard deviation
σ^2 is the variance which is the average of the squared differences from the mean.
e is an irrational number e≈2.71828182845904523536...
The equation for the probability density function can be written as below.

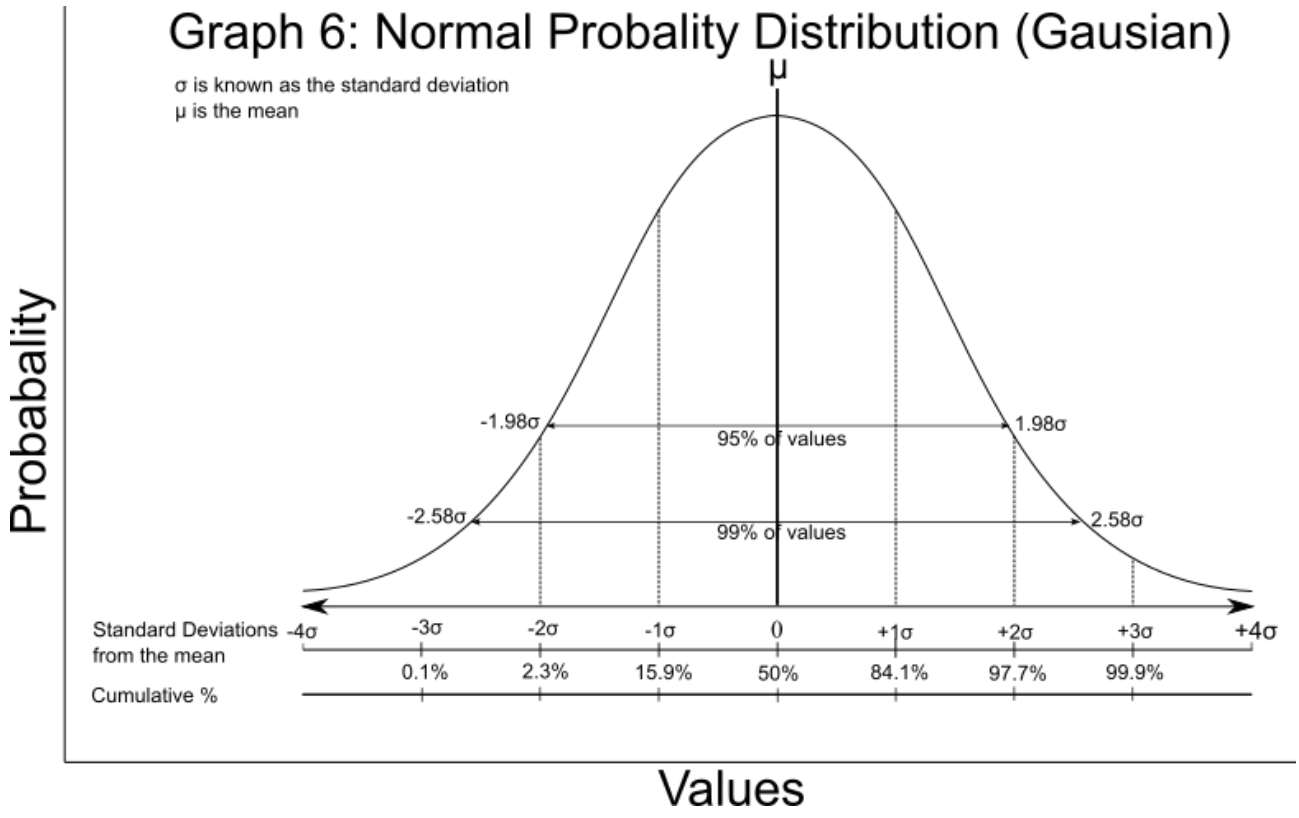
$$f(x \mid \mu, \sigma^2) = \frac{1}{\sqrt{2\pi\sigma^2}}\, e^{-\frac{(x-\mu)^2}{2\sigma^2}}$$

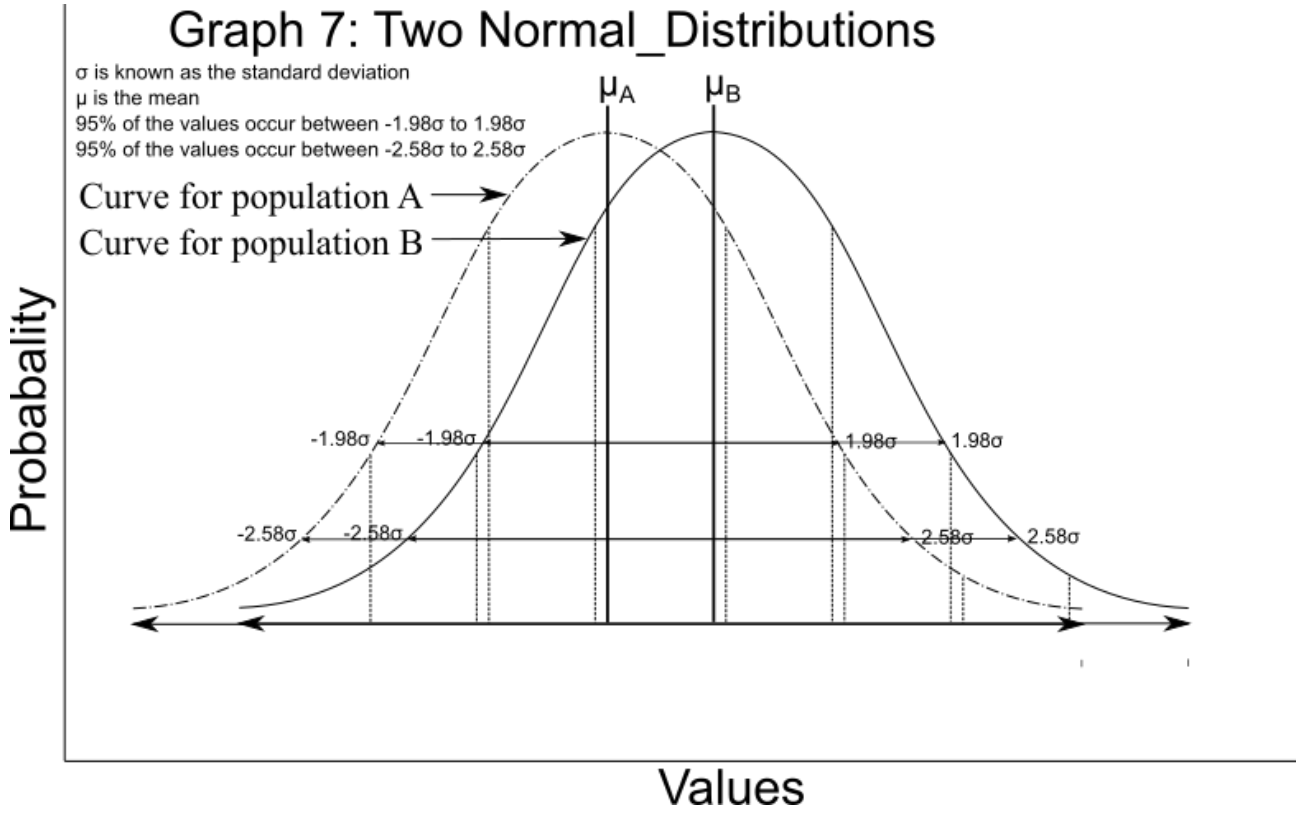
Graph 7 (page 12) considers the case when you repeat the measurements for two groups of people. Population A and population B. When the curves of the results for the two groups of people are plotted you can get the graph as shown in graph 7. The mean for the measurements of Group A is μ_A and that of group B is μ_B. The standard deviation for the measurements of Group A is σ_A and that of group B is σ_B. The mean of the measurements two groups together would be $(\mu_A + \mu_B)/2$.

If there is a drug trial on a group of people there would be a distribution of values. These values would be side effects and how well the condition improved. If this is repeated in another group of people you would get another distribution of values of side effects and how well the condition improved.

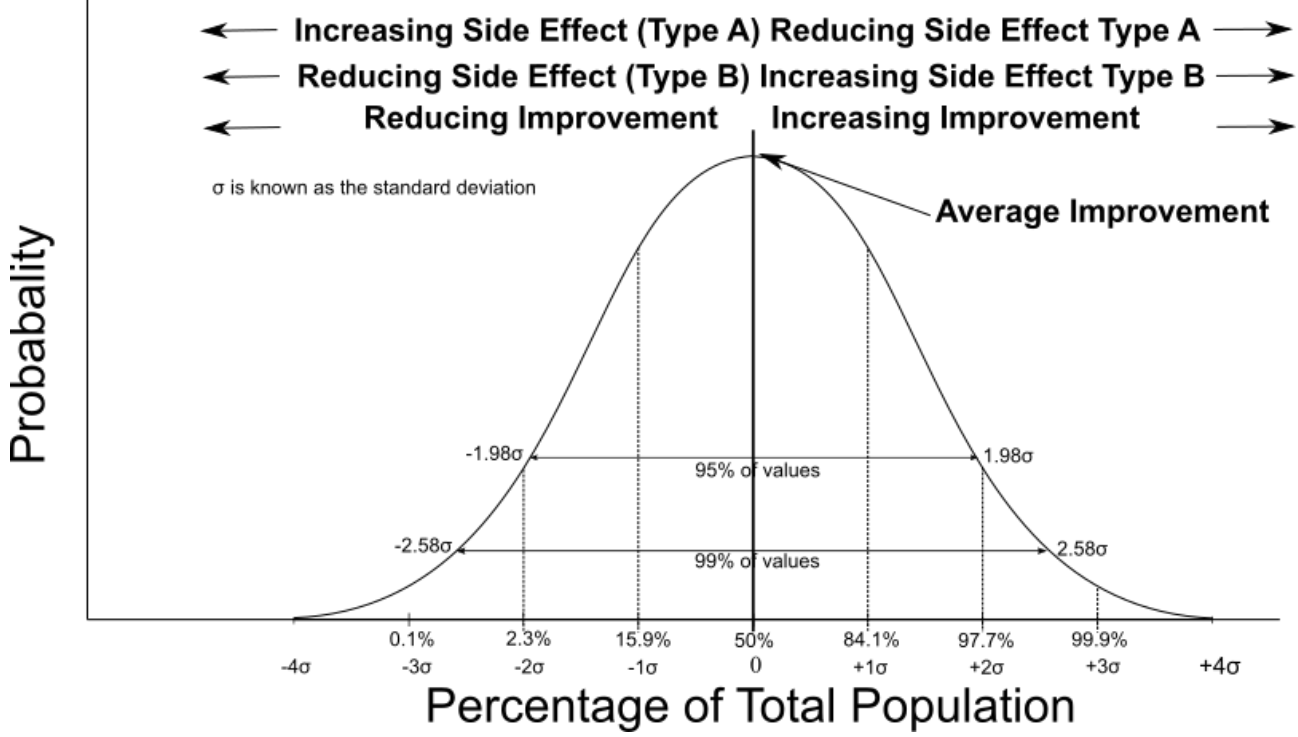
An example of a drug trial on a group of people is shown in Graph 8 (page 13). This sort of result can be used in Evidence based medicine. There is a problem that is often not realised. Where on the curve as shown in Graph 8 does a person reside. The graph shows side effects A and B and treatment result. For a person who is to receive the drug treatment where on the curve do they reside? This is a matter that needs to be considered for each person who is receiving drug treatment and is often not considered when treatment is discussed with a medical person.

Graph 9 (page 13) shows a graph of Treatment Improvement versus Side Effect Stress for health disability. As can be seen from the graph as the drug dosage increases there is a fall in stress from the health disability that is receiving drug treatment. As the drug dosage increases there is an increase in stress from side effects. The graph shows indicates there is an optimum point where there is the least amount of total stress (stress of health disability plus stress of side effect). This optimum point is different for each person and needs to be determined by a process of trial and error. This is a simplified version of events because the real situation may be complicated by the issue of what the health disability is. For example, the optimum point would be different for a cancer or a life threatening illness where the cancer threat or the life threat needs to be eliminated or reduced to a manageable level. Also a person may be receiving drugs for another condition prior to the treatment for the health disability. The additional drug treatment may or may not interact with drugs already given in ways that are not predictable. Also the side effects from the previous drugs and side effects from the new drugs may produce a total stress from side effects. This total stress is not predictable in the person receiving the drugs and thus needs to be determined by trial and error. The optimum point for the additional drug being prescribed needs to be determined by a process of trial and error.

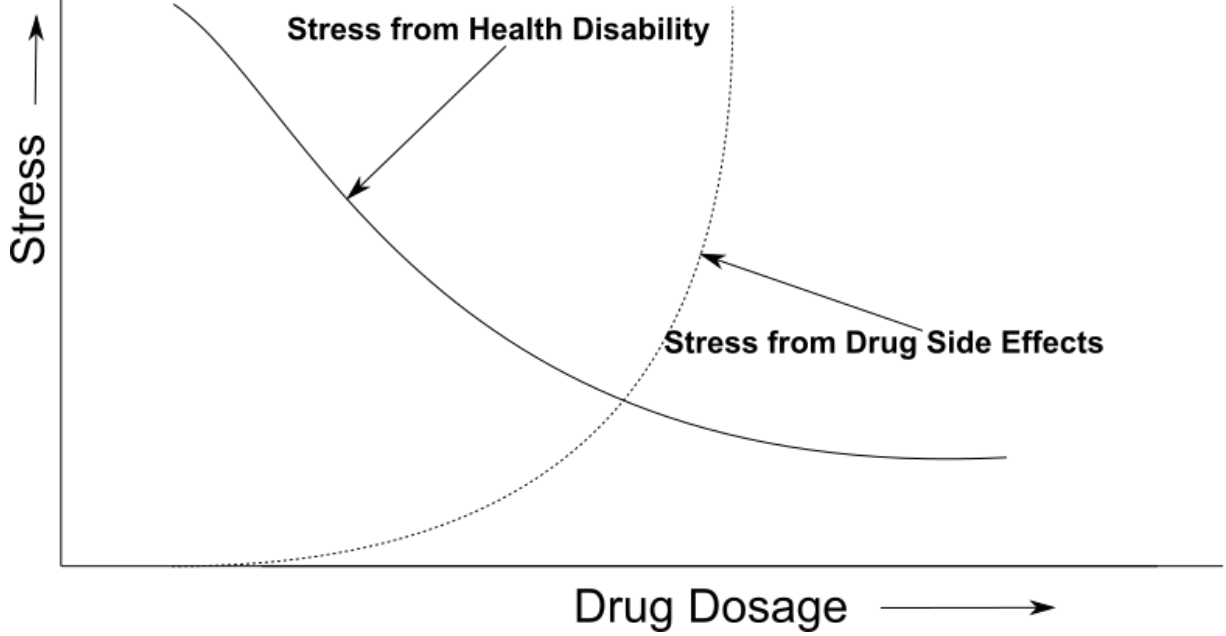

Graph 6: Normal Probality Distribution (Gausian)
σ is known as the standard deviation
μ is the mean
μ
Probabality
-1.98σ
1.98σ
95% of values
-2.58σ
2.58σ
99% of values
Standard Deviations from the mean
-4σ
-3σ
-2σ
-1σ
0
+1σ
+2σ
+3σ
+4σ
Cumulative %
0.1%
2.3%
15.9%
50%
84.1%
97.7%
99.9%
Values


Graph 7: Two Normal_Distributions
σ is known as the standard deviation
μ is the mean
95% of the values occur between -1.98σ to 1.98σ
95% of the values occur between -2.58σ to 2.58σ
μA
μB
Curve for population A
Curve for population B
Probabality
-1.98σ
-1.98σ
1.98σ
1.98σ
-2.58σ
-2.58σ
2.58σ
2.58σ
Values

Graph 8: Normal Probability Distribution for Drug Trial for Drug at one particular dose with Side Effects A and B



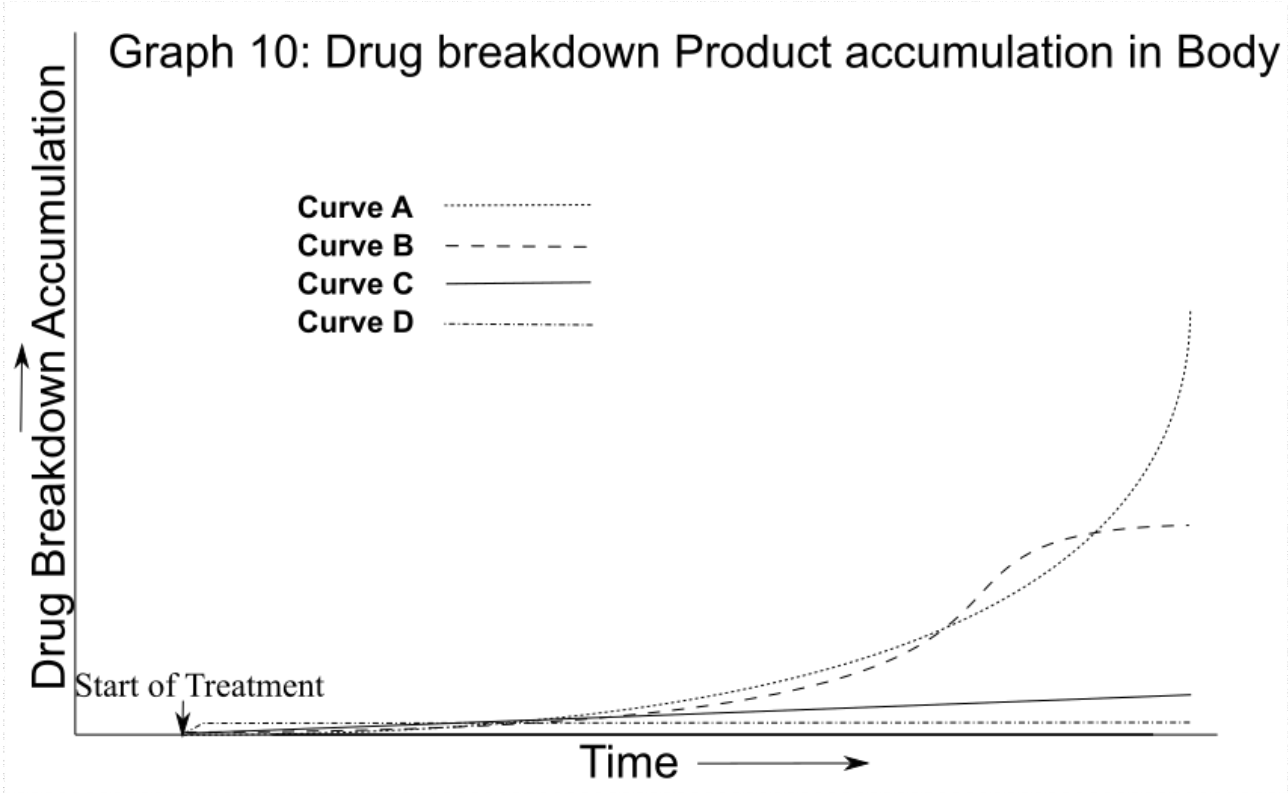
Graph 9: Treatment Improvement versus Side Effect Stress for Health Disability

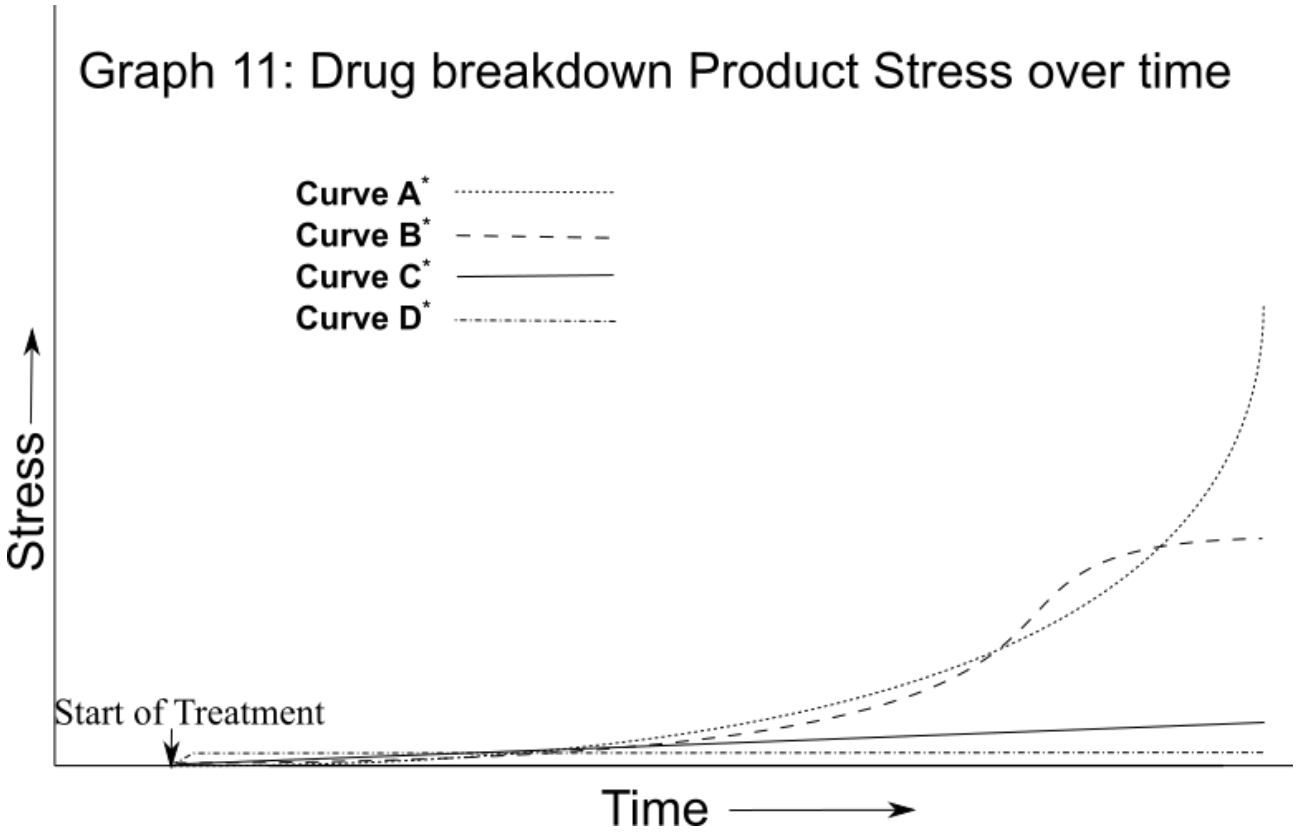


Graph 10 (page 15)
To be commented on

Importance of Sleep
Scientific American Artical

Cat Parasite
Implicated in possible many mental disorders because this parasite can reside in the Brain





Part2 Mind rape remedy and conclusion Part2