Women harassed in the bus

“These filthy women ruin the atmosphere of the bus. Get off, you shameless woman!” the bus conductor’s remark was the final straw. “After hearing that, I just couldn’t control myself,” said the young woman who was recently harassed on a bus in Basila area of the capital.

In a long phone conversation with Prothom Alo Saturday, she recounted the entire incident, saying she felt deeply hurt that not a single passenger protested. Even the man who filmed the incident made insulting comments towards her. When she tried to get off the bus, the driver kept accelerating, preventing her from doing so.

Still, the young woman said firmly that this harassment would not silence her, she would continue to protest.

The incident, in which she hit the harasser bus conductor with her shoe in protest, occurred on 27 October. After a passenger uploaded the video on social media, it sparked a public outcry.

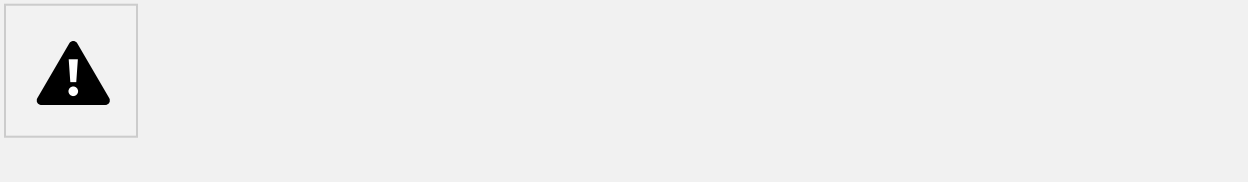
On Thursday, police arrested the conductor, Nizam Uddin, 45, of Ramzan Paribahan, and sent him to jail. Following the young woman’s statement, the state filed a case under Section 10 of the Women and Children Repression Prevention Act (on charges of sexual harassment) on Friday.

The video showed a young woman sitting near the front of the bus, angrily confronting a man over something he said. The man got up and slapped her. Both then raised their shoes at each other; the man struck her and pushed her down.

He repeatedly shoved and tried to hit her as she shouted, “Why are you talking about my clothes?” Apart from two women and one man near the front, none of the other passengers tried to intervene or protest.

The young woman told Prothom Alo that her parents and siblings live in Chandpur, where her father runs a small shop. Eldest of her siblings, she passed SSC and HSC in Chandpur and now studies Law at a private university in Dhaka.

To help with expenses, she does freelance work such as crafts, painting, and occasionally hosting television programmes. She shares a rented flat with a few others in Basila area of Dhaka.



Nizam Uddin, arrested over the harassment of a university student on a bus in Dhaka’s Mohammadpur area.*Courtesy of RAB*

“I didn’t react first”

Recalling the day, she said she had gone to Motaleb Plaza in Hatirpool to repair her phone and later boarded a Ramzan Paribahan bus at Dhanmondi 15 around 2:00 or 2:30 pm to return home. She sat in the middle section. When the conductor came for the fare, she told him she was a student and paid half.

“The conductor sneered and said, ‘You don’t look like a student, judging by your face and clothes!’ I was annoyed but still replied politely, ‘What does my dress have to do with being a student? Why are you talking like that?’ We exchanged a few words then, but I didn’t lose my temper first.”

She said the government started strictly implimenting half fares for students from August last year. But, many drivers and their assistants are reluctant to comply. “They either behave badly for harassment or because they refuse to accept half fare. They get irritated when they hear the word ‘student’. I’ve somewhat got used to this behaviour,” she added.

“But many drivers and assistants are kind. They don’t mind and they even help when students get on or off the bus.”

When asked how the altercation turned physical, she said that as she was getting off the bus near Metro Housing, she heard the conductor shout, “These filthy women ruin the atmosphere of the bus. Get off, you shameless woman!” Furious, she got back on the bus and confronted him.

She said, “The part you saw in the video starts from when I was shouting. From the way it was shown, it looks as though I suddenly became aggressive — but that’s not what happened. I lost control only after hearing the conductor’s final remark.”

Also Read

Driver arrested over harassing female student on moving bus

28 Jul 2022

Some people online claimed she hadn't paid the fare or that no comment was made about her clothes. She refuted this saying, "That's not true. He did comment on my clothes, and I did pay half the fare."

She added, "I've lived in Dhaka for four years and use public transport daily. Women face harassment on buses all the time. If you ride Mohammapur buses, especially in the evening after 8:00 pm, you'll see how drivers, conductors and assistants behave. Ask women, 90 per cent will tell you they don't protest for the fear of harassment."

She continued, "What happened to me isn't just my story, it's every woman's story. You must have noticed in the video, the two women and one man who stood up didn't protest, rather they only tried to stop the scuffle. Not one passenger told the conductor, 'Why are you hitting a woman?' I was completely alone."

When asked about the person who filmed the video, she said, "A male passenger was recording it, with a woman beside him. He wasn't filming to help but for more harassment."

When asked how did she know that, the young woman said she asked him why he was recording, he sneered, 'You people can fight in public, but if I record, I'm the bad guy?' She said she even requested him to delete the video, but he refused. "When the bus stopped near Basila Bridge, they got up to leave and the man shouted at me, 'Move aside! Get out of the way!'"

Moments later, as the bus emptied, she tried to get off. Each time, the driver kept acceleratаing. Finally, she jumped off and losing her balance fell to the ground, the young woman said.

Sexual violence affects women across all age groups, and from all cultural, racial and economic backgrounds, including women with disabilities, lesbians and transgender women.

Sexual assault is more widespread than many people realise. The consequences of sexual violence primarily affect victims and survivors, but may also have detrimental effects on their family and friends, as well as the wider community.

On this page:

What is sexual assault?

Sexual assault refers to criminal acts like rape and indecent assault, but it also includes any sexual or sexualised behaviour that makes a person feel uncomfortable, intimidated, threatened or frightened. It is sexual behaviour that someone has not agreed to, where another person uses physical or emotional force, or the threat of physical or emotional force, against them.

We use the terms ‘sexual assault’ and ‘sexual violence’ here as they cover many forms of unwanted and frightening sexual behaviour experienced by women. We use ‘child sexual

abuse' to describe adult women's experience of sexual assault through childhood and adolescence.

Sexual assault includes:

- rape – forced vaginal, anal or oral sex
- child sexual abuse
- sexual violence from intimate partners
- unwanted physical contact – touching, pinching, rubbing, groping, kissing, fondling
- sexual harassment – dirty jokes, explicit comments, invasive questions about sex
- stalking – repeatedly following or watching someone
- voyeurism – watching someone doing intimate things without permission
- sex-related insults – for example, 'slut', 'dyke', 'homo', 'slag'
- invitations for dates that turn into threats, demands for sex or not taking 'no' for an answer
- indecent exposure – exposing or flashing genitals
- forcing someone to watch or participate in pornography – explicit photos, videos or movies of sexual acts
- offensive written or graphic material – dirty jokes, letters, phone messages, pictures
- having sex with someone who is severely affected by drugs or alcohol, spiking drinks with alcohol or drugs
- unwanted explicit and offensive communication by word, graphic image or social media.

Many forms of sexual assault are criminal offences. Sexual violence is never the fault of the victim/survivor.

Top

Misconceptions about sexual assault

There are many common misconceptions about sexual violence. Such misconceptions can interfere with women receiving appropriate support when they talk about experiences of sexual assault.

Misconceptions can support sexual violence by suggesting that women provoke men or give them permission to commit sexual violence by:

- wearing particular clothing
- flirting
- being in certain places
- being by themselves
- being drunk or drug affected.

These misconceptions can make it difficult for a woman to recognise that she has experienced sexual assault. They might make her reluctant to talk about her experience or to seek help because she feels ashamed or embarrassed.

Top

The health impacts of sexual assault

Intimidating and/or unwanted sexual behaviour from another person can have wide-ranging harmful effects on a woman's health – emotional, psychological, mental, physical, spiritual, gynaecological and reproductive.

The negative impact on women's health and wellbeing can be made worse if they are not believed or if they are blamed when they first speak about being sexually assaulted. This impact many be more severe the longer the time between the sexual assault and receiving appropriate care and support.

The consequences of previous child sexual abuse for women may be wide ranging, long term and complex. Sexual assault has the potential to profoundly disrupt a child's world and the patterns and pathways of their unfolding life.

Sexual violence may traumatise and profoundly violate every aspect of a woman's being. It can affect her emotional and physical health, her sense of self, her relationship with her body, and her sense of safety everywhere, including in intimate relationships and in health-care settings.

Top

What to do if you are sexually assaulted

If you are in immediate danger ring:

> **999** (police);

If you need support, and live in Victoria, call:

> Centre Against Sexual Assault (CASA) 1800 806 292

If you need support and live outside Victoria, call:

> the National Sexual Assault and Family Violence Service on **1800 7377 328** to find your closest crisis support service.

Top

How to help someone who has been sexually assaulted

If you are the friend, relative or service provider of a victim or survivor of sexual assault seeking support, keep these principles in mind:

> listen to her and believe her story of violence and abuse
> take what she says seriously without trying to tell her what to do
> let her speak for herself
> normalise her responses to the trauma of sexual violence
> validate her feelings and individual reactions to the experience
> explore with her what she would like to happen now
> respect her decision.

Victim/survivors report that a sense of emotional and physical safety is fundamental to disclosure and recovery. Take the time to learn about what safety means to each woman and how to assist her in creating a sense of safety.

Top

Another one

What is sexual consent?

Consent happens when all people involved in any kind of sexual activity agree to take part by choice. They also need to have the freedom and capacity to make that choice.

If you are affected by anything you read here, you can talk to us.

We all have the right to not want sex or any other kind of sexual activity – for example, kissing, sexual touching or performing a sexual act.

We also all have the right to change our minds at any time. Or to consent to doing one sexual thing with someone but not another.

Without consent, any kind of sexual activity is sexual violence.

Many of the myths surrounding consent and sexual violence can make victims and survivors feel as though they are somehow to blame. It can also make them feel that what happened to them wasn't 'real' sexual violence.

Learn about the myths surrounding consent

BUT, it doesn't matter if someone doesn't have visible injuries or if they didn't scream, try to run away or fight. It also doesn't matter what they were wearing or what interaction happened beforehand. Or if they experienced feelings of arousal. Or if they knew the perpetrator.

If a person doesn't consent to sexual activity of any kind then it is always sexual violence. And 100% of the blame lies with the perpetrator or perpetrators.

With all the myths surrounding sexual violence, however, working out what consent looks like in real life can sometimes feel confusing.

So, let's break it down a bit…

What does consent mean?

The Sexual Offences Act 2003 says that someone consents to sexual activity if they:

- Agree by choice and
- Have both the freedom and capacity to make that choice.

If someone says 'no' to any kind of sexual activity, they are not agreeing to it.

But, if someone doesn't say 'no' out loud, that doesn't automatically mean that they have agreed to it either.

If someone seems unsure, stays quiet, moves away or doesn't respond, they are not agreeing to sexual activity. In fact, it's really common for people who have experienced sexual violence to find they are unable to move or speak.

Someone doesn't have the freedom and capacity to agree to sexual activity by choice if:

- They are asleep or unconscious.
- They are drunk or 'on' drugs.
- They have been 'spiked'.
- They are too young.
- They have a mental health disorder or illness that means they are unable to make a choice.
- They are being pressured, bullied, manipulated, tricked or scared into saying 'yes'.
- The other person is using physical force against them.

If someone's not sure whether you are giving your consent for something sexual, they should check with you. If they can see or suspect you're not 100% comfortable or happy with what's happening between you, they should stop.

Why 'yes' doesn't always mean consent

Because consent has to involve freedom and capacity to be consent, saying 'yes' is not enough.
Being forced, pressured, bullied, manipulated, tricked or scared takes away our freedom and capacity to make choices in lots of different situations.

For example, if someone is in an abusive relationship, they might say 'yes' to something out of fear for their own wellbeing or the wellbeing of other people – which is a long way away from saying 'yes' because they really wanted to. The fear took away their freedom and capacity to make a real choice.

Most of us would recognise that, if someone stands behind you at a cash machine and asks for your PIN number while holding a knife to your back and you give it to them, you aren't consenting to being robbed.

Well, it's similar with sex. Although, in this case, the 'knife' could be something entirely different – such as the threat of someone sharing a sexually explicit photo of another person. Or spreading lies about them. Or making them feel worthless.

What consent looks like

Here are some examples of what consent does and doesn't look like in practice. Consent looks like:

- Enthusiastically saying 'yes!'.
- Talking to the other person about what you do and don't want, and listening to them in return.
- Checking in with the other person – for example, asking 'is this okay?', 'do you want to slow down?' or 'do you want to stop?'.
- Respecting someone's choice if they say 'no'. And never trying to change their mind or put pressure on them.

Consent is not like a permit or voucher that we can use up until its expiry date or at any point in the future. The person who really wanted to have sex with us last night might not want to have sex with us this morning and that's 100% their right.

It also makes no difference if you're married to someone or in a relationship with them. You still need to get their consent. Every. Single Time.

Consent does not look like:

- Feeling like you have to agree to sex or other sexual activity because you're worried about the other person's reaction if you say 'no'.
- Someone having sex with you or touching you in a sexual manner when you're asleep or unconscious.
- Someone continuing with sexual activity despite your non-verbal cues that you don't want it to continue or you're not sure – for example, if you pull away, freeze or seem uncomfortable.
- Someone assuming that you want to have sex or take part in other sexual activity because of your actions or what you're wearing – for example, flirting, accepting a drink, wearing a short skirt.
- Someone assuming that you want to have sex or take part in other sexual activity with them because you've had sex or taken part in other sexual activity with them before.
- Someone assuming that you want to take part in one type of sexual activity because you wanted to take part in another.
- Someone removing a condom during sex after you only agreed to have sex with one (what is known as 'stealthing').

Please know, however, that these are just a few examples of what consent doesn't look like.

If you didn't want something to happen then you didn't give your consent. You also didn't give your consent if you weren't capable of deciding whether or not you wanted it – for example, if you were a child or if you were drunk.

And if there was no consent then it was sexual violence.

If you're in a sexual encounter with someone and they ask you to stop and you don't stop, you're committing a sexual offence. It's as simple as that.

We are here for you

If you think you might have been raped, sexually assaulted or sexually abused, you can talk to us. We will listen to you and believe you, and you can take the conversation at your own pace.

Talk to us

Age of consent

The age of consent in England and Wales is 16. This is the age when young people of any sex, gender or sexual orientation can legally consent to taking part in sexual activity.

This means that sexual activity between two or more people is always unlawful if at least one of the people is under the age of 16.

It doesn't matter if:

- All those involved are the same age or very close in age.
- Those under the age of 16 have given their consent (in line with the definition above).

However, not everyone who does something unlawful is charged with a crime and taken to court (prosecuted). It is up to prosecutors to decide whether it is in the 'public interest' for this to happen – and, when making this decision, they have to take certain factors into account.

The age of consent exists to protect children and young people – not to turn them into criminals for no good reason or to cause them unnecessary harm. That's why, when deciding whether or not to prosecute someone who takes part in sexual activity with a person under the age of 16, prosecutors are supposed to consider lots of different factors. These include:

- How close in age and maturity levels those involved are.
- The relationship of those involved.
- Whether the person under 16 consented.
- Whether the sexual activity was a normal part of the process of becoming an adult.
- Whether the person under 16 was aged 12 or under.

You can find out more about the other factors here.

Under English and Welsh law, children and young people under the age of 13 are seen as being less capable of consenting than those aged 13 and over.

That's why the Sexual Offences Act 2003 lists different offences for cases involving children and young people aged 12 and under – and why it's a factor for prosecutors to consider when they are deciding whether or not to prosecute someone.

16 and 17-year-olds

Although the age of consent is 16, the law has some extra protections in place for young people aged 16 and 17.

For example, it is illegal to:

- Take a photo or video of someone aged 18 or under engaging in sexual activity.
- Pay for sexual services from someone under 18.
- Take part in sexual activity with someone under 18 if you are in a position of trust – for example, if you are their teacher, social worker, doctor or care worker.
- Take part in sexual activity with someone under 18 if they are a member of your family.

Find out more about child sexual abuse

Getting help and support

Everyone responds differently to sexual violence and abuse – so whatever someone feels is a valid response. But, for lots of people, it can have a long-lasting impact on their feelings and wellbeing.

If you have experienced any form of sexual violence or abuse – whether it was recently or a long time ago – Rape Crisis is here for you. We will listen to you and believe you.

Get help and support after sexual violence or abuse

Abstract

Sexual assault and abuse can result in severe physical and emotional trauma to the victim. Deploying targeted psychotherapeutic treatment that is individualized for the survivor is important to achieving optimal patient outcomes. There are several valid and evidence-based treatments available for posttraumatic stress disorder (PTSD) and interpersonal difficulties that can result from sexual abuse and assault. In this article, the authors discuss psychodynamic psychotherapy, trauma-focused cognitive behavioral therapy (TF-CBT), and eye movement desensitization and reprocessing therapy (EMDR) for the treatment of patients following sexual assault and abuse. The authors also provide practice points on common issues in the management of the treatment of sexual assault survivors, including transference, countertransference, and avoiding retraumatization. Composite case vignettes are used to illustrate treatment techniques.

Keywords: Sexual abuse, sexual trauma, transference, countertransference, trauma

The intersection of sexual assault and psychotherapy is complicated. It was not until relatively recently that the treatment of survivors of sexual assault came to be under the purview of psychotherapeutic treatment.[1] In their 1974 *American Journal of Psychiatry* article, Burgess and Holmstrom reported that there was little information on the physical and psychological effects of rape or how to manage the treatment of a survivor of sexual assault in the psychiatric literature.[1] In the past, rape survivors were thought to need only counseling—that is, direct, problem-focused treatment—rather than broader, more in-depth treatment such as psychotherapy and, if the survivor did undergo psychotherapy, the major focus was on preexisting psychopathology.[2] The United States Centers for Disease Control and Prevention (CDC) estimates that sexual violence affects one in three women and one in four men over the course of their lifetimes.[3] The treatment of survivors of sexual assault gains benefits from several general and specialized types of psychotherapy including psychodynamic psychotherapy, trauma-focused cognitive–behavioral therapy (TF-CBT), and eye movement desensitization and reprocessing therapy (EMDR). In this article, we review these psychotherapeutic treatment methods in regard to managing this patient population and provide additional treatment suggestions to assist therapists in achieving optimal outcomes among survivors of sexual assault and abuse.

PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapy has been shown to be effective in treating patients with posttraumatic stress disorder (PTSD) that might have resulted from sexual assault.[4,5] Gabbard previously described the distinctive features of psychodynamic psychotherapy (Table 1).[6]

TABLE 1.

Distinctive Features of Psychodynamic Psychotherapy

- Focus on affect and expression of emotion
- Exploration of attempts to avoid aspects of experience
- Identification of recurring themes and patterns
- Discussion of past experience
- Focus on interpersonal relationships
- Focus on the therapeutic relationship
- Exploration of wishes, dreams, and fantasies

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When treating a patient who has been sexually abused or assaulted, these distinctive features of psychodynamic psychotherapy remain the focus of the treatment. “Follow the red thread” is a phrasing used to encourage the therapist to focus on the feelings and emotions occurring in the therapy session rather than be pulled into discussing superficial issues.

In order to do this, the therapist must create a safe space for talking with the patient by being empathic and nonjudgmental, attending to the patient’s physical comfort, and demonstrating understanding.[7] Without these elements, a patient might feel retraumatized and unsafe.

Composite case vignette 1. Ms. A is a 28-year-old woman who has survived multiple instances of sexual abuse and sexual assault from men of authority in her life. She initiated therapy with the goal of improving her comfort in and ability to maintain an intimate relationship.

Dr. B—Last week, we talked about your date that you had planned for this past weekend. How did it go?

Ms. A—It went well! He was handsome and charming. We went to the boardwalk, played games, and he put his arm around me and kissed me.

Dr. B.—How did that feel?

Ms. A.—It felt good, I wanted him to… Also, we had sex.

Dr. B.—Oh, okay. How do you feel about that?

Ms. A.—Well, I know I said last week I wasn't going to on the first date, but I wanted to. But, then, he was just a great guy, and guys always want to have sex. A date is always better with sex for them and, so, if we have sex, he's going to like the date more.

Dr. B.—Would you have enjoyed the date more if you didn't have sex?

Ms. A.—Hmm. I don't know.

Dr. B.—Hmm.

Ms. A.—You think I only slept with him so that he'd like me.

Dr. B.—I'm sorry if my words or tone suggested judgment. That wasn't my intention. I'm trying to understand what your feelings are. You've told me that you wanted to have sex with him and that you'd planned not to. So, I'm just trying to reconcile these ideas and better understand what your feelings are on this issue.

Ms. A.—Well, I guess, if I'm being honest, all men want sex. So…yeah, if you want a man to like you, give him sex. It's what they want. Like, even my high school English teacher. I thought he wanted to help my writing, but no. What he wanted was sex.

Dr. B.—[allows for pause] That must have been difficult. How old were you then?

Ms. A.—Junior year…I was 16 when it happened, I guess.

Dr. B.—What happened?

Ms. A.—He had sex with me.

Dr. B.—[pauses]

Ms. A.—I was really into writing poetry, and I would sometimes stay after school to show him what I had written. I thought maybe he could help me get published somewhere. I would workshop with him. One day he decided to put his hand on my thigh and, I guess, see what would happen. I remember I just froze. [starts tearing up] I didn't stop him, so I guess he thought that was a green light.

Dr. B.—How did you feel in that moment?

Ms. A.—Sad. [crying] Sad and just so angry.

Dr. B.—Tell me about the anger.

Ms. A.—Because, why does this always keep happening to me? Did I do something to make him think this was okay? I mean, clearly, I must be doing something for this to keep happening.

Dr. B.—Is that what you were thinking in that moment?

Ms. A.—Yeah, definitely. I still think about that sometimes though. Like, I know it's not my fault, but still I just wonder why I froze instead of doing something.

Dr. B.—How are you feeling right now?

Ms. A.—Sad and mad.

Dr. B.—Yes, it seemed like it was difficult to share that information, but thank you for telling me. I hope that talking about it here will help you feel better.

This vignette also demonstrates exploration of recurring themes and patterns, sometimes of self-recrimination, betrayal, or anger, which can be drawn together to illustrate common patterns in a patient's life in psychodynamic psychotherapy. The therapist in the vignette takes care to ask curious questions and make empathic statements that allow the patient to continue talking. Survivors can feel complicated mixes of emotions when discussing sexual assault. They might remember the feeling of having special, secret attention from someone in a powerful position. They might feel the horror and pain of the assault. They might recall the sting of betrayal because loved ones or caregivers were not able to protect them from harm. Survivors might feel guilt over what they think they should have or could have done differently. These powerful mixtures of emotions should not be shied away from but, rather, they should be held up for examination and consideration.

Practice points for psychodynamic psychotherapy.

- The feelings resulting from sexual abuse or sexual assault can be complicated, intense, and unclear.
- A nonjudgmental exploration of recurring themes and patterns can be helpful in clarifying feelings and actions.
- Discussion of past experience is a cornerstone not only of psychodynamic psychotherapy but of the treatment of sexual trauma.

TRAUMA-FOCUSED COGNITIVE– BEHAVIORAL THERAPY

TF-CBT is a brief, resilience-building model for trauma-impacted children or adolescents and their parents and caregivers that adapts the tenets of CBT for healing from trauma.[8] The components are presented in Table 2.[9]

TABLE 2.

Trauma-focused CBT COMPONENT SUMMARY PHASE

COMPONENT	SUMMARY	PHASE
P	Psychoeducation about trauma impact; parenting skills	Phase 1
R	Relaxation skills to reverse physiological trauma response	
A	Affective skills to address emotional dysregulation	
C	Cognitive processing skills to understand the cognitive model	
T	Trauma narration and processing	Phase 2
I	In vivo mastery to address overgeneralized fear and avoidance	Phase 3
C	Conjoint child–parent sessions to enhance communication	
E	Enhancing safety	

One of the main tasks of TF-CBT is collecting the trauma narrative. Over the course of several sessions, the child is encouraged to discuss in detail the events surrounding the traumatic event.

Composite case vignette 2. The patient is an 11-year-old boy who has survived repeated sexual abuse from his uncle who had also been his basketball coach. After a year of abuse, explicit photographs of several children, including the patient, were discovered on the abuser's phone by his wife and the authorities were alerted. The patient's parents were informed of the abuse, as were the parents of other children, which led to the patient coming to therapy. The patient has displayed sullen affect and has been increasingly withdrawn since his abuse was made known to his parents.

Dr. C.—Today, I would like us to talk about your coach.

E.—Which coach?

Dr. C.—The coach who is in jail.

E.—Do we have to talk about him?

Dr. C.—Do you feel uncomfortable talking about him?

E.—Yeah, I don't like talking about him.

Dr. C.—Why is that?

E.—It just makes me think of bad memories.

Dr. C.—What kind of bad memories?

E.—Just about what happened.

Dr. C.—I think it would be helpful if we could talk about what happened. Can you tell me what he did?

E.—He took pictures of me and the other guys when we had our clothes off.

Dr. C.—Where did this happen?

E.—In the locker room.

Dr. C.—How are you feeling right now?

E.—Sad…like I did something wrong. Freaking out, like I can't breathe.

Dr. C.—Remember your breathing exercise? Do you think need to do that now?

E.—I think I'm okay.

Dr. C.—Okay. If you feel like you need to, you can. Did you also feel that way when he was taking pictures?

E.—Yeah, when it happened, it wasn't just sad it was also…I felt scared because I didn't really know what was happening, and I knew it was wrong.

Dr. C.—Are you feeling scared now?

E.—No, not as much.

Dr. C.—Do you feel safe?

E.—Yeah, kind of. I just don't like talking about it.

Dr. C.—I see that this is tough for you, but I'm glad to hear that you feel safe. You are in a safe place. The feelings you're having now are because of something that already happened. It's okay to feel that way, and it's okay talk about it. I'm here to help you feel less bad.

This vignette demonstrates the task of eliciting a trauma narrative. It might take one or two sessions to obtain the full narrative and, while a well-meaning therapist will want to address cognitive distortions and challenge negative automatic thoughts, the true task lies in gathering the telling of the trauma. Unhelpful thoughts can be processed afterward. Of note, this is the only component of Phase 2. Before eliciting the trauma narrative, it is important to teach the patient and parents/guardians about the impact of trauma, parenting skills, and relaxation skills that can replace the trauma response. Here, Dr. C. does this by offering space for the patient to do the breathing exercise. Reminding a patient that this is an option can be enough of a reminder that the patient has control, but Dr. C. also could have taken time to practice solidifying this skill as a useful method of managing overwhelming feelings. The Vanderbilt University's workbook for eliciting a trauma narrative outlines the goals and process, with an emphasis placed on the gradual and repetitive nature of the psychotherapy.[10]

After collecting the trauma narrative, Dr. C. will work with E. on processing the trauma by examining and testing the validity of cognitive distortions surrounding the trauma. As with psychodynamic psychotherapy, inspecting thoughts as well as putting words to feelings and fears is an important part of TF-CBT.

Practice points for TF-CBT.

- Gathering a traumatic narrative in TF-CBT allows the therapist and patient to later evaluate automatic thoughts and cognitive distortions.
- The therapeutic alliance allows for the painful work of processing trauma to be conducted.

Guilt can be a major impediment to discussing trauma, and working through reluctance with patience, kindness, and optimism is an important part of TF-CBT.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

EMDR is a psychotherapy designed to alleviate distress associated with traumatic memories.[11] During therapy, the therapist will move his or her fingers back and forth in front of the patient's face so that the patient follows with his or her eyes. Some therapists will use other rhythmic techniques such as deploying a metronome or tapping his or her foot or hand. While the patient follows the rhythmic movement with his or her eyes, the therapist will ask the patient to recall a traumatizing event. The therapist then asks the patient to gradually shift negative thoughts to more pleasant ones. While the hallmark of EMDR is the regular back and forth of lateral eye movements—called bilateral stimulation— while focusing on the disturbing memory, there are eight phases, as described in Table 3.[12]

TABLE 3.

Phases of EMDR PHASE TASK

PHASE	TASK
1	Patient's history with identification of targets, traumatic events, and experiences
2	Preparation: creating a therapeutic alliance, building and practicing resilience and self-soothing
3	Assessment: collaboratively developing a target, i.e., a trauma to be addressed
4	Desensitization: reprocessing the memory until distress is decreased
5	Installation: the disturbing event is associated with positive cognition
6	Conducting a body scan to assess for residual bodily distress/somatization

7	Debriefing and closure, including informational and support techniques
8	Re-evaluation: checking in on the level of ongoing symptoms

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Composite case vignette 3. This vignette demonstrates the portion of treatment where the therapist and patient collaboratively choose a ‘target’ or trauma that will be the focus of treatment. Only certain portions of EMDR use eye movement, and determining the target is a portion that does not use eye movement.

Dr. A.—We talked last week about your problems with sleep—that the memories and thoughts pop into your head. We planned that we would be finding targets this week.

Ms. B.—I am not looking forward to this.

Dr. A.—Oh, I get it. It is difficult. I also think you’d feel better after we work though some of the things that have happened to you.

Ms. B.—I guess.

Dr. A.—Where did you want to start?

Ms. B.—Probably with my abusive ex-husband. I was reminded of something when I headed over to your office today. Whenever I smell someone wearing his cologne, I lose it. I was on an elevator once and when a guy got on smelling like that, I pushed all the buttons to get the elevator doors open. They must have thought I was nuts.

Dr. A.—It sounds frustrating to feel like you're at the mercy of these reactions.

Ms. B.—Yeah, it would.

Dr. A.—You mentioned wanting to work on something that happened a little more recently.

Ms. B.—I don't think I'm ready for that one yet. I just don't want to talk about it today.

Dr. A.—That's fine. I want to keep it on our radar to work on in the future. Of course, when you feel ready.

This vignette demonstrates that, again, as with psychodynamic psychotherapy and TF-CBT, the therapist encourages a strong therapeutic alliance and empathy to lay the groundwork for trust and the discussion of difficult topics. The therapist allows the patient to choose what the topic will be. Some patients prefer to start with less traumatic events, while others immediately want to tackle the most distressing target. EMDR differs from other treatments in that bilateral stimulation—the back-and-forth of, e.g., a metronome, two fingers, or of an oscillating light bar—is

used during processing of targets.[12] The therapist would then continue with the patient to process the target using eye movements to desensitize the patient to their distressing memories while practicing self-regulation skills. Though some evidence suggests that eye movements are not necessary to evoke the improvements seen in EMDR,[13] this technique, as a whole, has been found to be effective as a treatment for PTSD.[14]

Practice points for EMDR.

- The source of the bilateral stimulation in EMDR is not as important as the back-and-forth motion.
- Reprocessing targets serves to desensitize the patient to the distress previously evoked by the traumatic memories.
- Continuing to build up self-soothing skills also promotes confidence and a sense of mastery and agency in the survivor of sexual abuse and assault.

GENERAL GUIDELINES FOR TREATMENT

There are several suggested ways[14,15] to work with patients in any psychotherapeutic modality, including normalizing and validating feelings, being nonjudgmental, and showing compassion (Table 4).

TABLE 4.

The basics

Normalizing and validating feelings	“I know this can be hard to talk about. Thank you for telling me.”
Non-judgment	“People respond to trauma in different ways.”
Compassion	“You are not alone in this.”

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Manage transference and countertransference. The therapeutic alliance is categorized by a warm emotional bond. It is not unusual in treatment for patients to have feelings for their therapists. On occasion, a patient who is a sexual assault and/or abuse survivor will use sexualization as a defense mechanism. When patients with abuse histories are decompensated, they might feel that their sexuality is their only valuable part. Attempting to engage with the therapist on a sexual level could be an attempt by the patient to please or placate the therapist or to distract them from painful topics. The most important goal of the therapist in these situations is to maintain appropriate, safe boundaries. A patient might act-in, using defenses in session to replay or re-enact certain feelings or behaviors, and these can be of a sexual nature. A patient, e.g., might want to tell explicit sexual stories or dress provocatively. Again, the role of the therapist is to maintain appropriate, healthy boundaries. This can be done by gently noting when a patient might be acting in a sexualized manner, e.g., “it seems like you are wanting something from me that I can’t and won’t do.” Putting words to feelings rather than acting on them is one of the key components in psychotherapy.

Create a safe place. Creating a welcoming, safe space in the session allows patients to discuss difficult topics. However, even a well-meaning therapist can feel compelled to ask for details that are not in the service of the patient’s well-being and growth. The use of supervision with an experienced therapist-supervisor can be

helpful if a therapist struggles between helping a patient and wanting to know details to address their own curiosity, e.g., “was your attacker attractive?” or “what did you wear to the party?” Awareness of common rape myths—that somehow drinking alcohol makes the individual who was sexually assaulted responsible for letting things get out of control or that rape must be perpetrated with violence—can be helpful in navigating treatment with survivors of sexual assault.[16] Ensuring that the questions being asked are appropriate and helpful to the patient is the minimum acceptable.

Therapists are typically used to hearing difficult stories, but the interpersonal betrayal of sexual abuse and assault can be particularly difficult to bear. One of the axioms of psychoanalysis is “don’t just do something; sit there!” This is particularly useful information when working with survivors of sexual assault. The therapist might feel compelled to act—to intervene, on behalf of a patient, with the patient’s spouse, supervisors, or landlord— but sitting with a patient and bearing witness to the patient’s account is often the most helpful approach. Pain, frustration, and despair are not unusual feelings for a therapist to have but so, too, are hope and joy.

Composite case vignette 4. Ms. B, from case vignette 1, has been seeing Dr. A for treatment for several months. They have been working on Ms. B’s feelings about her sexual abuse.

Dr. A.—You were telling me about that day.

Ms. B.— I am enraged. Furious. I worry that I’ll be engulfed and eaten alive by it.

Dr. A.—That your stepdad abused you?

Ms. B.—Yes, that it happened and that I didn't protect my sister; that it was somehow my fault like my mom said; that my mom was there and didn't do anything; and, even now, she says that it didn't happen or, if it did happen, it was my fault and that my family believes him over me, still, even though they're MY family!

Dr. A.—[starting to feel overwhelmed] – Wow. That is a lot.

Ms. B.—I KNOW. Do you think I don't know?! And this makes it even worse. I'm too much for everyone. They can't stand to be near me, and I'm left alone, damaged, and with nothing.

Dr. A.—[deep breath, remembers Ms. B. is not mad at Dr. A.]—I know your family isn't in your life any longer and that sometimes you feel completely alone. I know you've made a life for yourself.

Ms. B [laughs bitterly]—Well, it's cold comfort to know that he was never punished and that I'm the one who has to be punished.

Dr. A.—I agree. It isn't fair. But you held this secret all by yourself for so many years.

Ms. B.—Ugh, fine. I guess I've felt better since I started coming here, but I feel worse, too. It is so hard to drag myself in here every week to go over this. I feel like I'm falling apart.

Dr. A.—Are you, though? Falling apart?

Ms. B.—I guess not. I feel pretty strong today.

This vignette demonstrates how intense emotions can emerge in session, but, here, Dr. A. creates an environment where Ms. B. can talk about her rage and disappointment. Because Dr. A. is not actually overwhelmed or hurt by listening to Ms. B., Ms. B. begins the process of examining her feelings and reactions. This allows a more nuanced introspection that can bring solace and understanding. If Ms. B. had become too upset or became inappropriate, Dr. A. could have redirected her with a statement like, "I can't hear what you're saying when you're yelling at me" or "time out; I think it's getting too hot. Let's do our five senses mindfulness grounding exercise, and then we can come back to that."

Further reading. Every patient deserves individualized care that is compassionate and helpful. There are some specific resources for sexual assault survivors. The *Sexual Trauma Workbook for Teen Girls* is a guide for recovery from sexual assault and abuse.[17] Additionally, *Opening the Door* focuses on therapy for male survivors of sexual abuse.[18] Finally, the Rape, Abuse & Incest National Network is an American nonprofit anti–sexual assault organization and has many local and national resources that survivors and family can reference.[19]

CONCLUSION

The CDC estimates that sexual violence affects one in three women and one in four men over the course of their lifetimes. Survivors of sexual assault can benefit from several types of psychotherapy including psychodynamic psychotherapy, TF-CBT, and EMDR. Processing abuse and trauma is a helpful and necessary step to recovery and is the main focus in these treatment modalities. General considerations for working with survivors of sexual abuse and assault are awareness of common pitfalls, managing transference and countertransference, and avoiding retraumatization.

REFERENCES

1. Burgess AW, Holmstrom LL. Rape trauma syndrome. Am J Psychiatry. 1974;131(9):981–986. doi: 10.1176/ajp.131.9.981. [DOI] [PubMed] [Google Scholar]
2. Rose DS. “Worse than death”: psychodynamics of rape victims and the need for psychotherapy. Am J Psychiatry. 1986;143(7):817–824. doi: 10.1176/ajp.143.7.817. [DOI] [PubMed] [Google Scholar]
3. Smith SG, Zhang Xv, Basile KC et al. The national intimate partner and sexual violence survey: 2018 data brief—updated release. doi: 10.1016/j.amepre.2018.01.014. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf Available at. Accessed February 6. 2020. [DOI] [PMC free article] [PubMed] [Google Scholar]
4. Levi O, Bar‐Haim Y, Kreiss Y, Fruchter E. Cognitive–behavioural therapy and psychodynamic psychotherapy in the treatment of combat‐related post‐traumatic stress disorder: s comparative effectiveness study. Clin Psychol Psychother. 2016;23(4):298–307. doi: 10.1002/cpp.1969. [DOI] [PubMed] [Google Scholar]
5. Paintain E, Cassidy S. First‐line therapy for post‐traumatic stress disorder: a systematic review of cognitive behavioural therapy and psychodynamic approaches. Couns Psychother Res. 2018;18(3):237–250. doi: 10.1002/capr.12174. [DOI] [PMC free article] [PubMed] [Google Scholar]
6. Gabbard GO. Washington DC: American Psychiatric Publishing; 2017. Long-term Psychodynamic Psychotherapy: A Basic Text. pp. 3–4. [Google Scholar]
7. Cohen JA, Mannarino AP, Perel JM, Staron V. A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. J Am Acad Child Adolesc Psychiatry. 2007;46(7):811–819. doi: 10.1097/chi.0b013e3180547105. [DOI] [PubMed] [Google Scholar]

8. Cabaniss DL. West Sussex, UK; John Wiley & Sons: 2016. Psychodynamic Psychotherapy: A Clinical Manual. [Google Scholar]
9. Cohen JA, Deblinger E, Mannarino AP. Trauma-focused cognitive behavioral therapy for children and families. Psychother Res. 2018;28(1):47–57. doi: 10.1080/10503307.2016.1208375. [DOI] [PubMed] [Google Scholar]
10. Vanderbilt University. Trauma narrative. 2020. https://www.mc.vanderbilt.edu/coe/tf-cbt/workbook/Trauma%20Narrative/Trauma%20Narrative%20Goals%20and%20Process.pdf Available at. Accessed: January 19.
11. Shapiro F, Snyker E, Maxfield L. EMDR: eye movement desensitization and reprocessing. Comprehensive Handbook of Psychotherapy, Cognitive-Behavioral Approaches. In: Kaslow FW, Patterson T, editors. West Sussex, UK: John Wiley & Sons.; 2004. pp. 248–254. [Google Scholar]
12. Shapiro R, Brown LS. Eye movement desensitization and reprocessing therapy and related treatments for trauma: an innovative, integrative trauma treatment. Practice Innovations. 2019;4(3):139. [Google Scholar]
13. Davidson PR, Parker KC. Eye movement desensitization and reprocessing (EMDR): a meta-analysis. J Consult Clin Psychol. 2001;69(2):305–316. doi: 10.1037//0022-006x.69.2.305. [DOI] [PubMed] [Google Scholar]
14. Cusack K, Jonas DE, Forneris CA et al. Psychological treatments for adults with posttraumatic stress disorder: a systematic review and meta-analysis. Clin Psychol Rev. 2016;43:128–141. doi: 10.1016/j.cpr.2015.10.003. [DOI] [PubMed] [Google Scholar]
15. Women's Health: Treating Survivors of Sexual Assault. Women's Health. August 2019. DOI 10.2310/7800.13087. Decker Psychiatry.
16. Hockett JM, Saucier DA, Badke C. Rape myths, rape scripts, and common rape experiences of college women: Differences in perceptions of women who have been raped. Violence Against Women. 2016;22(3):307–323. doi: 10.1177/1077801215599844. [DOI] [PubMed] [Google Scholar]
17. Lohmann RC, Raja S. Oakland, CA: Instant Help; 2016. The Sexual Trauma Workbook for Teen Girls: A Guide to Recovery from Sexual Assault and Abuse. [Google Scholar]
18. Crowder A. Oxfordshire, UK: Routledge; 2014. Opening the Door: A Treatment Model for Therapy with Male Survivors of Sexual Abuse. pp. 1–226. [Google Scholar]
19. Materials. https://www.rainn.org/materials Rape, Abuse & Incest National Network. Available at. Accessed January 30, 2020.