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Clinical Considerations for Treating Adult Survivors of Child Sexual Abuse: A Proposal for Integrating Intersubjective Systems Theory and Feminist Perspectives

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Abstract

The goal of this paper is to offer clinical considerations for clinicians working with adult survivors of extrafamilial child sexual abuse (CSA) by 1) defining the stages of sexual abuse grooming of the child and their entire family system, 2) defining and integrating intersubjective and feminist approaches to treatment, and 3) providing methods for depathologizing CSA survivors' experience of shame. These three objectives aim to increase awareness and knowledge of sexual abuse grooming, as well as offer an integrative theoretical framework for individual therapy with adult survivors of CSA.

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CLINICAL CONSIDERATIONS FOR TREATING ADULT SURVIVORS OF CHILD SEXUAL ABUSE: A PROPOSAL FOR INTEGRATING INTERSUBJECTIVE SYSTEMS THEORY AND FEMINIST PERSPECTIVES

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There has been an abundance of research on childhood sexual abuse (CSA) and perpetrator grooming behaviors (Benoit et al, 2009; Craven et al, 2006; Conte et al., 1990; McAlinden, 2012; Winters & Jeglic, 2017). Child victims and their caregivers can be groomed or manipulated by sexual perpetrators (Williams, 2015). Much of the research on CSA has sought to identify and categorize perpetrators tactics of manipulation that sustain coercion and secrecy with the victim. However, there has been minimal research on how an outsider gains insider status in an entire family system and subsequently commits CSA. Perpetrator relationships to child victims can be categorized as extrafamilial (e.g., a friend or acquaintance of the family), intrafamilial (e.g., a partner, parent, or sibling), or there may be no pre-existing relationship to the victim (e.g., a stranger). Extrafamilial perpetrators, in particular, are not relatives of the child victim but are individuals that manipulate caregivers to achieve positions of trust within a family system (McAlinden, 2012). By subtle methods of manipulation, known as grooming, extrafamilial perpetrators develop a deceptively trusting relationship with potential child victims and their families in order to sexually abuse the child victim. Little is known about how extrafamilial perpetrators interact with entire family systems and how grooming can be viewed more broadly as grooming of an entire family system (McAlinden, 2012). This paper will focus on CSA committed by extrafamilial perpetrators and their duplicitous methods of gaining insider status in a family system.

CSA is a pervasive issue thought to be underreported. Many children do not report abuse for months or years after it occurred for a variety of reasons, including residual feelings of fear or shame (McAlinden, 2012). If the family is groomed to trust the extrafamilial perpetrator, the child victim may not disclose abuse for fear that their caregivers will not believe them. Jonzon and Linblad (2004) found that, of 102 women who experienced sexual abuse in childhood, 39

reported the abuse during childhood and 83 participants disclosed the abuse in adulthood, an average of 21 years after the abuse had occurred. Therefore, many individuals may wait until adulthood to seek or receive help in navigating the emotional and psychological impact of the abuse.

Individual therapy has been shown to be effective in minimizing psychological disturbances for adult survivors of CSA (Price et al., 2001). CSA can negatively influence one's view of self and interpersonal relatedness during early development. Hence, relationally-focused psychotherapies can provide a corrective emotional experience for patients that depathologizes their internalized stigma and feelings of shame (Cohen, 2008). Intersubjective systems theory and therapy is a psychoanalytic approach to treatment that emphasizes emotional attunement using the relational frame, labels organizing principles, and rewrites one's narrative through the therapeutic relationship (Buirski et al., 2020). This paper will argue why the intersubjective systems theory serves as an appropriate psychotherapeutic approach for resolving the psychological distress and relational difficulties that survivors of CSA face by depathologizing maladaptive self-narratives.

Similarly, feminist psychology is a valuable theory for working with adult survivors of CSA, because it acknowledges marginalization based on sociocultural context and fosters empowerment. This paper will provide a rationale as to why integrating feminist ideologies with an intersubjective systems approach to treatment can provide a framework for clinicians to both depathologize patients' feelings of shame and guilt and increase patients' understanding of how they came to be disempowered.

The goal of this paper is to offer clinical considerations for clinicians working with adult survivors of extrafamilial CSA by 1) defining the stages of sexual abuse grooming of the child

and their entire family system, 2) defining and integrating intersubjective and feminist approaches to treatment, and 3) providing methods for depathologizing CSA survivors' experience of shame**.** These three objectives aim to increase awareness and knowledge of sexual abuse grooming, as well as offer an integrative theoretical framework for individual therapy with adult survivors of CSA.

Child Sexual Abuse Statistics and Definitions

The Center for Disease Control defines child sexual abuse as, "Any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child by a caregiver" (Leeb et al., 2008, p. 14). The data collected on CSA likely underrepresents the rate of actual CSA cases (McAlinden, 2012; van Dam, 2001). The Administration for Children and Families (2018) reported that 57,329 children were victims of sexual abuse during the fiscal year of 2016. It is important to note that CSA is perpetrated more frequently on girls than on boys. Specifically, Finkelhor and colleagues (2014) found that 1 in 9 female minors and 1 in 53 male minors are victims of CSA.

According to the national survey conducted by the Bureau of Justice Statistics (2000), 93% of CSA reported to law enforcement was committed by acquaintances or family members of the victim. Specifically, in this survey 59% of child sexual abuse perpetrators were acquaintances, while 34% were family members and only 7% were strangers (Bureau of Justice Statistics, 2000). A nonfamilial perpetrator seeks a relationship with the child's family in order to gain access to the child. Examples of an extrafamilial perpetrator include acquaintances, babysitters, a friend of the family, school personnel, or a neighbor.

Defining Stages of Sexual Abuse Grooming

Sexual abuse grooming behaviors performed by an adult towards a child occur in stages that precede or maintain the perpetrator's ability to sexually abuse a child victim (Lanning, 2010; Leclerc et al., 2009; McAlinden, 2012; Winters & Jeglic, 2017). Grooming entails both strategizing and contact with the victim (Williams, 2015) and has been categorized as covert/implicit, explicit, and chance/opportunistic (Ward et al.,1995). Most definitions of grooming behaviors include several factors, such as identifying environmental settings and vulnerable populations, trust development, coercion, and normalizing sexual behaviors in order to achieve sexual exploitation and prevent disclosure (McAlinden, 2012). The perpetrator will primarily perform covert/implicit sexual abuse grooming tactics, such as identification of vulnerable victims, establishment of trust, and desensitization to touch (Winters & Jeglic, 2017). Although there is no official model for sexual abuse grooming behaviors, the stages of sexual abuse grooming generally involve several consecutive strategies that result in the perpetrator gaining access to vulnerable children and establishing trust with them.

A widely accepted and well-cited definition of grooming was proposed by Craven and colleagues (2006).

> A process by which a person prepares a child, significant others, and the environment for the abuse of this child. Specific goals include gaining access to the child, gaining the child's compliance, and maintaining the child's secrecy to avoid disclosure. This process serves to strengthen the offender's abusive pattern, as it may be used as a means of justifying or denying their actions (Craven et al., 2006, p. 297).

For the purposes of this paper, this definition will be used as the primary definition of sexual abuse grooming of children.

How Children are Sexually Groomed

Research on sexual abuse grooming behaviors indicates that CSA is often a premeditated act involving significant planning and strategizing. Winters and Jeglic (2017) assert that there are four stages: 1) selection of victim, 2) gaining access, 3) trust development (emotional

recruitment), and 4) touch desensitization. Selection of a child victim may entail identifying vulnerability factors, such as limited supervision, as is sometimes found in single-family homes, or unstable family systems involving domestic violence, addiction problems, or mental illness (Olsen et al., 2007; Winter & Jeglic, 2017). Other vulnerability factors to consider are whether the child victim has low self-confidence, a poor relationship with their caregivers, minimal friends, or has been victimized in the past (Berliner & Conte, 1990; Elliott et al., 1995).

After selecting a victim, gaining access is the next step. Perpetrators gain access to victims by seeking opportunities, such as developing communication with a neighbor's child (Winters & Jeglic, 2017). Elliott and colleagues (1995) conducted structured interviews with 91 convicted sexual perpetrators and found that 66% of perpetrators knew their child victims through family, friends, or caretaking (babysitting), while 34% claimed to be strangers. Thirty-three percent of the perpetrators who identified as "strangers" attempted to develop relationships with the targeted child victims and their families prior to engaging in abusive behaviors (Elliot et al., 1995). The perpetrator may attempt to become a part of the family system either as a role model or parental figure (Winters & Jeglic, 2017). Conte et al. (1989) interviewed 20 sexual perpetrators of children and found that they had used various nonviolent coercive strategies to separate children from other adults, such as reward and punishment conditioning, attempting to isolate children from other confidants, manipulation, and triangulation.

The next step, establishment of trust or emotional recruiting, is a pivotal stage in sexual abuse grooming where the perpetrator makes the child feel special. Examples of emotional recruiting are favoritism, befriending the child, developing special interests together, or sharing inside jokes and secrets (Leclerc et al., 2009; Winters & Jeglic, 2017). Elliott et al. (1995) found that the 91 perpetrators interviewed in their study used various strategies to develop trust. For

example, 53% of perpetrators offered to play games with children or learn a new skill, 46% of perpetrators offered children a ride home, 30% claimed to use affection and convey understanding, 14% developed stories that involved lies or magic, and 9% asked for help (Elliott et al., 1995). Conte and Berliner (1990) conducted interviews with 23 child victims and found that half of the children reported favoritism and gifting, such as receiving money or clothes. Another strategy is to prevent the child from relying on other caregivers for emotional needs to gain complacency and eliminate other confidants (Craven et al., 2006). For example, a perpetrator might manipulate a child into believing they are a burden to their caregivers and that they should not go to their parents if they need help. Development of familiarity and trust between perpetrators and their child victims sets the stage for perpetrators to begin sexual abuse with less risk of the child reporting the abuse.

Once the perpetrator has developed trust with the child victim, desensitizing them to physical touch is the next stage of sexual abuse grooming. It is often performed to introduce and normalize physical touch in the relationship before advancing towards sexual touch. Desensitizing a child to touch may also be a method for perpetrators to test the physical boundaries of both the child and caregivers. It can be nonsexual touch, such as hugging or tickling (Craven et al, 2006; Leclerc et al., 2009). In Conte and Berliner's (1990) interviews with child victims, they found that perpetrators often violate their victims in a way that the child could interpret as accidental or unintentional. The goal of this stage is to introduce touch into the relationship in a manner that appears consensual or normal in an effort to gradually introduce sexual touch. Perpetrators may begin to sexualize the relationship in various ways, including talking about sex, coercing the child by conveying the sexual abuse as beneficial, or offering to bathe and dress the child (Elliot et al., 1995).

After establishing a sexually abusive relationship with a child, a perpetrator will maintain the relationship with their child victim through threats, bribes, or identifying a child's vulnerabilities, such as fulfilling a child's need for attention**.** Conte and Berliner (1990) claim that perpetrators seek children who do not have their emotional needs met, making them more susceptible to coercion due to an emotional need to feel loved or valued. Also, perpetrators may discover that children who feel inclined to protect their parent(s) can be convinced that not reporting the sexual abuse protects parents from harm. Perpetrators may maintain the abusive sexual relationship through bribes (e.g., extra privileges or gifts) that make child victims feel special or through threats (e.g., hinting or directly warning that harm will be done to the child or the child's family) (Craven et al., 2006). Elliott and colleagues (1995) found that two-thirds of the sexual perpetrators in their study claimed to use a variety of strategies to maintain the abusive relationship. Specifically, 24% of perpetrators used anger and physical threats, 24% threatened major consequences, and 20% of perpetrators blamed the child and threatened the loss of love. Also, 42% claimed to convey the sexual abuse as an ongoing game or as educational (Elliott et al., 1995). Many of the strategies that perpetrators use to maintain a sexually abusive relationship convey some form of punishment if the sexual abuse were to be reported. Regardless of the specific strategy for grooming a child for sexual abuse, the goal is to prevent the child from disclosing the abuse by eliciting feelings of shame, guilt, embarrassment, love, and fear of abandonment (McAlinden, 2012).

There has been minimal research on how extrafamilial perpetrators come to be accepted within a family system and establish trust with the family members of the child victim (McAlinden, 2012). Furthermore, limited research exists on how perpetrators gain insider status and groom adults within communities and institutions, such as schools and religious

organizations. There are likely overlapping features between grooming of an institution, community, family, and individual. Defining how an outsider gains insider status within a family system could increase our understanding of sexual abuse grooming and CSA more broadly. Furthermore, an increased understanding could assist clinicians working with adult survivors of CSA.

Deconstructing the Stages of Grooming the Family System

This paper will propose clinical considerations for identifying how perpetrators gain insider status within family systems, communities, and institutions to perpetrate CSA. Similar to identifying grooming of an individual, understanding manipulation of family units can depathologize adult survivors' self-defeating narrative. Therefore, it is important for clinicians to be aware of how family systems can be manipulated by extrafamilial sexual perpetrators.

Meaning-making of extrafamilial grooming of a family system differs case by case. However, general themes or strategies will likely apply. McAlinden (2012) suggested that psychological manipulation of caregivers and social environment is an important aspect of the grooming process. Furthermore, it prevents recognition of the abuse. Specifically, extrafamilial perpetrators may be a family's friends, employed caregivers (babysitters), educators, and other respected members of the community (van Dam, 2010).

Extrafamilial perpetrators identify vulnerable children and vulnerable families. For instance, extrafamilial perpetrators may target parents who were sexually abused in childhood, due to vulnerability factors including difficulties in identifying grooming strategies and susceptibility to re-victimization (Craven et al., 2006). Similar to developing a special relationship with the child, extrafamilial perpetrators may establish a friendship with the child's caregivers in order to secure the caregivers' confidence, cooperation, and establish a façade of

normalcy (McAlinden, 2012; Salter, 1995). Another strategy may be the creation of co-dependent relationships between caregivers and the perpetrator. For example, an extrafamilial perpetrator may form a friendship with a single parent and offer to babysit as a favor. Another common grooming strategy is when an extrafamilial perpetrator gains intrafamilial status by dating a single parent and becoming a live-in partner in order sexually abuse the child victim. Perpetrators identify specific vulnerabilities of a family system, such as financial stress, being emotionally overwhelmed, family history of CSA, or other vulnerabilities that put the caregiver in a position of being dependent and unknowingly complicit in providing access to their child.

Other examples of how extrafamilial perpetrators manipulate vulnerable single parents or stressed family systems includes isolating parents from friends or other family members. McAlinden (2012) suggested that perpetrators may even promote substance use and substance use dependency to minimize awareness of CSA occurring in the household. Attempts made by perpetrators to isolate parents from trusted others are premeditated strategies that minimize the chances of the parent raising concerns and increases a parent's dependency on the perpetrator for support.

Grooming a family system includes the extrafamilial perpetrator identifying vulnerabilities of family systems, establishing a positive image, and developing a relationship with the family. A search in the literature indicates limited understanding on strategies extrafamilial perpetrators might use to groom a family system. The following stages have been adapted from the stages of grooming children and are proposed as strategies that are used to groom caregivers in family systems. The preliminary stages include 1) selection of the family 2) trust development with at least one caregiver and 3) integration into the family system. After gaining preliminary trust, the extrafamilial perpetrator may 4) increase the family's dependency

on the perpetrator by fulfilling a desired role within the family system (e.g., caregiving) and/or exploiting caregiver(s) vulnerabilities. Additional stages of the grooming can include 5) manipulation of a caregiver in order to isolate the child from the caregiver, or 6) isolate the caregiver from other family members or social supports.

The extrafamilial perpetrator's tactics and forms of manipulation isolate and silence communication between caregiver(s) and other family members, social supports, and/or the child victim with the intention of coercing the caregiver(s) unknowingly to comply**.** In therapy, the emotional exploration and meaning-making of the perpetrator's grooming tactics upon the patient's family may introduce a shift in the patient's narrative, especially for those who are primarily organized around feelings of defectiveness and self-blame. In other words, identifying and processing how a family system is groomed can be depathologizing for survivors of CSA.

Grooming of Big Systems: Consideration of Institutional Parallels

A perpetrator's manipulation of a community or institution is likely similar to the proposed stages of grooming a family system. Specifically, perpetrators may seek roles in a community or institution to convey a positive image to the public and appear trustworthy (McAlinden, 2012; Slater, 2003). For instance, educators may groom co-workers, as well as the parents in the community, to gain access to child victims. By grooming community members, perpetrators can establish leadership roles that increase their credibility, access to child victims, and maintain an image of trustworthiness.

In 2002, the Catholic Church was brought into the public eye due to an article in the Boston Globe exposing charges of child sexual misconduct by five Catholic priests (Rezendes, 2002). The article resulted in more than 450 priests and clergymen being accused of child sexual misconduct (Plante, 2004). This popularized scandal illustrates how perpetrators utilized their

positions of power to groom entire communities by establishing positions of authority to gain access to child victims, maintain secrecy, and establish complacency within the American Catholic Church. In this example, the perpetrators are actively grooming other institutional and/or community members in order maintain access to children and minimize adult supervision.

Sexual perpetrators use a range of strategies and techniques to identify needs, and actively fulfill those needs, while also reinforcing a positive reputation in the public eye. Similar to grooming a family system, sexual perpetrators will manipulate communities or institutions through developing trust, secrecy, oppression of disenfranchised groups, and exploitation of a system's weaknesses. In therapy with adult survivors of CSA, it may be therapeutically appropriate to identify not only manipulation of the self and family system, but also the grooming of a community or an institution at large.

Impact of CSA in Childhood and Adulthood

Many survivors of CSA experience feelings of defectiveness, shame, and guilt related to their early experiences of abuse. Traumatic events that occur in childhood, like sexual abuse, can challenge one's sense of safety, agency, and ability to establish trusting relationships. Ideally, infants learn basic trust and develop a sense of safety from the relationship with their primary caregiver (Erikson, 1966). However, traumas that occur within a relationship can inevitably lead to an avoidance of close relationships, as well as feelings of shame and defectiveness (Herman, 1992).

Finkelhor and Browne (1985) suggest that a child who experiences sexual abuse can have a distorted view of self and experience difficulty with affect regulation that may continue into adulthood. Children who experience CSA are susceptible to four dynamic processes that impact

affective and cognitive development: traumatic sexualization, betrayal, powerlessness, and stigmatization (Finkelhor & Browne, 1985).

Traumatic sexualization refers to the distorted relationship children have to their bodies due to CSA. Specifically, a child might come to associate a perpetrator's rewards, privileges, and safety with sexual favors; this can distort a child's view of sex and ultimately lead them to view intimacy as transactional or dangerous (Finkelhor & Browne, 1985). The betrayal, as a dynamic process, illustrates the feelings of loss that the child experiences when they realize that a trusted adult is violating their sense of safety. Also, children may experience feelings of betrayal from the lack of protection by other trusted adults (i.e., parents, bystanders). Finkelhor and Browne (1985) stated, "A family member unable or unwilling to protect or believe them—or who has changed an attitude toward them after disclosure of the abuse—may also contribute to the dynamics of betrayal" (p. 532).

In CSA, a child's experiences the powerlessness dynamic as the loss of a sense of agency or control over what is happening to them. They may be overcome with feelings of helplessness. The perpetrator's relationship to the child victim is inherently built upon a power imbalance where factors, such as differences between the child's and perpetrator's age, knowledge, and status make the child susceptible to exploitation. Forms of manipulation (e.g., coercion and threats), as well as feelings of powerlessness, are a result of these differences in power and authority between child and perpetrator. The last dynamic, stigmatization, refers to the attitudes that are communicated to the child (from the abuser and/or others) and internalized (Finkelhor & Browne, 1985). For instance, a child victim may internalize feelings of defectiveness or being "broken" due to shaming messages explicitly and implicitly conveyed by the perpetrator.

In adulthood, survivors of CSA are susceptible to psychiatric concerns such as posttraumatic stress, substance use, anxiety, depression, sexual dysfunctions, suicidal ideation, and increased risk for relationship and parenting difficulties (van Dam, 2001). Although CSA increases risk for psychiatric concerns and maladaptive coping mechanisms, traumatic events are not the sole indicators of psychiatric concerns in adulthood. Specifically, individual differences play an important role in how one reacts psychologically and emotionally to trauma (Herman, 1992; Stolorow, 2015). Therefore, it is important to avoid pathologizing and not assume psychiatric concerns exist solely based on one's experience of traumatic events.

As noted earlier, the subtle manipulations that occur during the grooming process preceding CSA can often result in the child experiencing feelings of helplessness, shame, and guilt (Herman, 1992). Research indicates that women who experienced CSA are more likely to experience feelings of isolation and interpersonal difficulties, and to report less satisfaction in relationships, compared to women who did not experience CSA (Briere & Elliot, 1994). Individuals who do not report CSA for one reason or another, may not receive necessary support and mental health services to relieve emotional suffering, address relationship issues, and overcome feelings of shame and isolation.

Clinical Approaches to Treatment of Trauma

Not surprisingly, individual therapy has proven to be effective in minimizing psychological disturbances in adult survivors of CSA (Price et al., 2001). Although various therapeutic approaches have been shown to be effective for treatment outcomes (i.e., cognitive behavioral therapy, psychodynamic therapy, existential therapy, and psychoeducational or supportive therapy), the primary predictor of successful treatment outcomes is the therapeutic alliance (Norcross & Wampold, 2019; Price et al., 2001). Extrafamilial CSA is a relational

trauma that can result in the child developing mistrust and interpersonal difficulties in adulthood. Therefore, clinicians who prioritize the therapeutic alliance, affective expression, and exploration of relational dynamics can provide opportunities for the patient to have new and corrective relational experiences of emotional intimacy, trust, and safety (Cohen, 2008).

Psychodynamic psychotherapy promotes emotional expression and relatedness through an emphasis on exploration of interpersonal patterns through the therapeutic relationship, current relationships, and past relationships (Callahan et al., 2004). For individuals with early childhood relational trauma, psychodynamic approaches can be an appropriate treatment for assisting patients in processing and reorganizing their relationship to the trauma to develop a more adaptive understanding of self and their relationships with others.

An Intersubjective Systems Approach to Trauma and Treatment of Adult Survivors of CSA

The intersubjective systems perspective is a psychoanalytic approach to treatment that acknowledges subjective experiences as dependent upon current relational contexts. In therapy, this approach focuses on the patient's affective experiences and patterns of relating within the therapeutic relationship to better understand one's character organization and developmental history (Stolorow, 2015). Unlike traditional psychoanalytic approaches, intersubjective systems approach is a relational therapy and values the intersubjective field: the interaction of both the therapist and patient's subjective experiences within the therapeutic context.

An Intersubjective Systems Approach to Trauma

According to intersubjective theory, trauma occurs when one is overwhelmed with painful affect and the surrounding environment does not provide support to appropriately name and integrate those agonizing emotional experiences (Stolorow, 2008). Traumas that occur in

early childhood, such as sexual molestation, may have a greater impact on children who did not experience emotional attunement during early development. Emotional attunement is when a caregiver is able to adapt in response to a child's emotional and developmental needs (Stolorow et al., 1987). Psychopathology or maladaptive defenses can occur when a child's selfobject needs are not met and a repetition of emotional misattunement continues between child and caregiver during early development (Lessem, 2005). Buirski et al. (2020) stated,

> Given the centrality of affects in self- and relational experience, it comes as no surprise that problems with affect can become psychological problems. If affective states are repeatedly experienced as extreme and not well modulated by the environment, we believe that infants develop self-protective adaptations in order to achieve a sense of physiological equilibrium (p.74).

When a child adapts to their caregiver's demands or needs in order to maintain the relationship and to attempt to have their own needs met, this is known as pathological accommodation in intersubjective systems theory (Stolorow et al., 1987). Ultimately, unmet selfobject needs can result in difficulty regulating painful affective experiences (Lessem, 2005).

Early experiences of selfobject failures or emotional misattunements are reflected in an individual's organizing principles. For a child, the continuation of unmet emotional needs and pathological accommodation of others can result in self-blame, feelings of defectiveness, isolation, shame, guilt, and self-contempt (Stolorow, 2013). Sexual perpetrators may target child victims and tactically attempt to fulfill the child's unmet emotional needs for care and attention by addressing a child's maladaptive organizing principle of being unlovable, unworthy, or inadequate. Stolorow (2015) states, "These intersubjectively derived, pre-reflective organizing principles are the basic building blocks of personality development, and their totality constitutes one's character" (p. 124). Organizing principles illustrate beliefs and rules that influence the ways in which individuals relate to themselves and others (Lessem, 2005). For example, an individual's organizing principle may be, "I am unlovable" and therefore they may view

themselves as failing in relationships in adulthood; it was early experiences of rejection that informed this organizing principle.

Without consistent emotional attunement between child and caregiver during early development, a child that is affected by a traumatic event might struggle to effectively cope. Difficulty regulating overwhelming painful affect may result in a pathological accommodation to others' needs, and thus, one might develop maladaptive organizing principles. In sexual abuse grooming, perpetrators may target child victims that are vulnerable to pathological accommodation and therefore, accommodate perpetrators' demands. As a result of the perpetrators tactics to maintain secrecy and silence, perpetrators' grooming tactics may prevent caregivers from recognizing and attuning to child victims' emotional needs. The intersubjective perspective posits that a longstanding history of emotional misattunement compounded with the occurrence of a traumatic event, especially during childhood, can result in difficulty integrating, understanding, and effectively coping with painful emotional states.

Specifically, intersubjective theory posits that traumatic events alone do not predict emotional suffering. Instead, prolonged emotional suffering, isolation, and lack of emotional attunement from caregivers following the trauma are better determinants of posttraumatic impact on psychological functioning (Stolorow, 2016). Stolorow (2013) states, "Painful or frightening affect becomes traumatic when the attunement that the child needs to assist in its tolerance and integration is profoundly absent" (p. 385). Whether the trauma is a single event trauma, complex, or relational, the intersubjective perspective emphasizes the importance of individual differences as greater determinants of the posttraumatic impact. Individual differences include one's developmental history of emotional misattunement that inform one's organizing principles.

One's organizing principles may contain feelings of worthlessness, powerlessness, inadequacy, and of being unlovable.

Goals of Intersubjective Therapy in Practice

Intersubjective therapy is a phenomenological, contextual approach to treatment that values the combined subjective experiences of both the therapist and patient as the platform upon which meaning-making and deep understanding can occur. The therapeutic relationship is the vehicle for change, where the patient can come to feel understood, curious, and motivated to explore previously avoided or threatening emotions and beliefs.

In an intersubjective approach, the subjective experience is valued with the understanding that early experiences of affect regulation and integration directly inform an individual's current sense of self and view of relationships. In treatment, rewriting the patient's pathologizing self-narrative involves the exploration of affective states and learned patterns of relating by experiencing a trusting relationship with the clinician. Over time, the patient ideally feels deeply understood by their therapist, which promotes the integration of previously avoided affect.

An important aspect of achieving this corrective emotional experience is the therapist's validation of the unvalidated unconscious (Lessem, 2005). The unvalidated unconscious are parts of the patient's self (skills, strengths, traits) that were not brought into the patient's awareness during early development. The therapist's recognition of these parts of their patient establishes corrective selfobject validation that allows for a new self-experience. The therapist's empathetic stance, emotional attunement, and illumination of the patient's organizing principles serves as a selfobject function that was missed during the patient's early relationships (Buirski et al., 2020).

The intersubjective systems approach has several aims. As previously mentioned, one aim is to provide a corrective emotional experience for the patient by demonstrating empathetic

listening and emotional attunement. Emotional attunement is when the therapist is able to convey emotional understanding of the patient's subjective experience through nonverbal and verbal communications. This includes labeling the patient's affect, offering potential interpretations of their affective experiences that occur within the intersubjective field, and together, co-constructing meaning that promotes a corrective selfobject experience. Buirski and colleagues (2020) highlight the importance of "empathetic introspective inquiry" between both the therapist and patient (p. 42). Specifically, the therapist models attunement to the patient's experience, which demonstrates empathy and elicits a mutual understanding that is contextually bound by the subjective experiences of both patient and therapist. The therapist strives to deeply understand their patient by articulating, interpreting, and illuminating the patient's affective states.

Unlike other psychoanalytic approaches to therapy, intersubjective systems theory conceptualizes maladaptive defenses and behaviors as an attempt to strive for health. No matter the severity of maladaptive behaviors and defenses, these behaviors are compassionately conceptualized as an individual's nonconscious attempts to prevent retraumatization after failing to have their emotional needs met in early development.

An Intersubjective Approach to Depathologizing

An important and less explored concept in intersubjective theory is depathologizing the patient's negative view of self. Buirski et al. (2020) emphasize, "Patients disparage their own affective experience, not out of some mistaken need to catastrophize but out of fear of, or repetitive experiences of, invalidation by significant others in their life" (p. 122). From this perspective, depathologizing a patient's view of self and distressing affective states is different than cognitive reframing in cognitive behavioral therapy because the goal is not to change thought patterns (Buirski et al., 2020). Instead, a therapist depathologizing the patient's painful

affect or negative self-perceptions aims to empathize with the patient's maladaptive defensive patterns and validate aspects of the patient's identity and their affective experiences that were not previously recognized (Buirski et al., 2020). The process of depathologizing can help patients to develop a cohesive sense of self while also eliciting self-compassion.

Considerations for Integrating Clinical Theory and Practice: Intersubjective Systems and Feminist Approaches

In an intersubjective approach to working with adult survivors of CSA, it seems that depathologizing is a pivotal aspect of treatment, as it addresses affective experiences of shame and negative view of self. Empowerment, a pivotal concept in feminist psychology theory, provides further insight into how depathologizing is an essential therapeutic intervention when treating adult survivors of CSA. Specifically, clinical considerations will be provided for clinicians working with survivors of CSA committed by an extrafamilial perpetrator. Since extrafamilial CSA is common and this population often suffers from feelings of disempowerment and negative self-perceptions, gradually depathologizing one's role in CSA and creating a positive view of self can validate early experiences of emotional misattunement by trusted caregivers. Additionally, this paper will illustrate how a feminist approach can be beneficial in depathologizing trauma. This paper will also highlight cultural vulnerabilities tied with perpetrator grooming and manipulation. Overall, these clinical considerations aim to increase awareness of grooming stages of both an individual and family, and to offer clinical suggestions to depathologize adult survivor's feelings of shame about CSA.

1. Integrating the Feminist Approach

The primary principles and theoretical framework of feminist psychology offers an additional perspective to conceptualizing trauma. It also enriches the intersubjective approach to therapy

when working with adult survivors of CSA. Specifically, feminist theories of trauma and intervention complement the intersubjective aim of depathologizing disparaging self-experiences. A feminist perspective to therapy is vital for shifting feelings of shame and guilt about early experience of CSA. However, unlike intersubjective systems theory, feminist psychology emphasizes the psychological impact of sociocultural contexts by considering the influence of patriarchal structures upon disenfranchised populations (Cohen, 2008). A feminist approach to therapy does not promote a set of interventions or symptom reduction. Instead, feminist psychotherapy is an eclectic approach to therapy that integrates a sociocultural lens to further understand one's psychology, identities, and suffering. This lens strives to achieve feelings of empowerment and, thus, psychological growth (Brown, 2004).

In a feminist approach to therapy, the therapist recognizes that individual suffering is, in part, the result of systemic oppression and disenfranchisement. Expressly, the therapist collaborates with the patient to identify the ways in which an individual has been made to feel othered—defective, invalidated, and alienated—based on their status within a sociocultural context (Lerner, 1993). Feminist therapists consider environmental and sociological variables that have systematically caused an individual to feel disempowered based on developmental, societal, and cultural factors including but not limited to sex, gender, age, ethnicity, race, sexual orientation, religion, socio-economic status, and disability. Patients are encouraged to view themselves as the experts of their own experiences and clinicians focus on empowering patients to strengthen their sense of self-cohesion. Similar to intersubjective theory, a patient's distress and maladaptive patterns of behavior are viewed as attempts to manage distressing affect and strive for health.

2. Empowering the Patient

According to Brown (2004), feminist analysis of trauma emphasizes both individual and contextual variables that contribute to the patient's distress. Feminist therapists focus on empowering the patient by illuminating areas of strength and resilience. In feminist approaches to trauma-focused treatment, identifying *how* the patient has experienced disempowerment and threats or violations to their safety is crucial. The patient's experience of otherness and disempowerment is viewed from a multicultural context. Brown (2004) states,

> By placing client's experience of trauma and powerlessness within a conceptual framework that identifies the contribution of ethnicity to the risk for trauma, these feminist strategies create powerful validation of clients' hunches that their victimization is indeed inextricably linked to their position in the social hierarchy of value (p.469).

The clinician creates a therapeutic duality of validating their patient's sense of victimization while gradually depathologizing their negative view of self. Co-constructing meaning from a patient's sociocultural factors in regard to their feelings of disempowerment and victimization can be deeply validating and bring new meaning to their sense of self-cohesion.

3. Depathologizing CSA from a Feminist and Intersubjective Approach

Integrating feminist perspective within an intersubjective approach for CSA survivors could assist in depathologizing patients' experiences of powerlessness, stigmatization, and feelings of betrayal, shame, defectiveness, and guilt. For adult survivors of extrafamilial CSA, pathological accommodation of the perpetrator's needs and a disavowal of their own emotional needs may have been a pragmatic method of survival. Buirski et al. (2020) claim, "We ward off feelings that we fear will be disruptive to our relationships to needed others and arouse feelings of shame in ourselves" (p.198). In treatment, the therapist would strive to co-construct a narrative with the patient about their history and affective experiences that empathizes with the patient's developmental traumas, while also identifying the patient's strivings for health. Together, co-constructing the patient's narrative puts words to the affective experiences that

were previously disavowed. The creation of a new narrative strives to increase one's experience of self-compassion and positive self-regard.

An adult survivor of extrafamilial CSA might make sense of internalized messages from the perpetrator by viewing themselves as "all bad" and intimacy as unsafe or transactional for sexual favors. From a feminist perspective, depathologizing entails collaboratively identifying the sociocultural factors that shape the patient's identity and developmental history, and how these factors relate to victimization and resilience. Brown (2004) claims, "Empowerment takes many forms in feminist practice, but with trauma survivors, an emphasis will be on identifying how the trauma was disempowering and on developing effective strategies for responding to it" (p.468). Therefore, co-constructing the patient's narrative to include a sociocultural perspective may increase insight into how they came to internalize shame. This may then promote the patient mourning the effects of their victimization and affective experience of disempowerment.

4. **Identifying Stages of Grooming and Depathologizing Adult Survivors Negative View of Self**

This paper proposes that if feminist principles are integrated into treatment, it may enhance an intersubjective approach to treating survivors of extrafamilial CSA. This integrative approach prioritizes emotional understanding, co-constructing the patient's self-narrative, and depathologizing one's negative view of self. Clinical considerations for this approach to working with survivors of extrafamilial CSA include identifying how the patient's sociocultural context and sociocultural vulnerabilities inform the stages of grooming by an extrafamilial perpetrator. For instance, depathologizing from an intersubjective-feminist approach may include guiding the patient's exploration of sociocultural factors through Winters and Jeglic's (2017) first three stages of grooming a child victim: 1) victim selection, 2) gaining access, and 3) trust

development. The process of depathologizing a CSA patient's negative view of self entails unearthing perpetrators' lessons of abuse that the victim has internalized as a part of their own identity.

In therapy, exploration of victim selection (stage 1) and gaining access (stage 2) would incorporate labeling the patient's feelings and beliefs regarding their sociocultural factors, such as the child's age when the abuse occurred, gender dynamics, cultural expectations of children and adults, beliefs involving power and authority, and other significant sociocultural factors. For example, a patient who identifies as a cis-gendered female may benefit from exploring feelings of powerlessness as it relates to her environment, learned sociocultural perceptions of womanhood, her experience of patriarchal oppression, and expectations of women in her sociocultural context.

As noted previously, there are several vulnerability factors that make a child and their family more susceptible to coercion and CSA. For instance, a single parent household, poor relationships with caregivers, lack of social supports, history of abuse, and negative sense of self (Winters & Jeglic, 2017). In therapy, identifying developmental, familial, and sociocultural vulnerability factors that put the patient and their family in a position of being vulnerable to grooming are opportunities for adaptive meaning-making. A therapist and adult survivor of CSA may explore the perpetrator's method of victim selection and their strategies for maintaining victim access based on several vulnerability factors. For example, an adult survivor of CSA may identify how the perpetrator targeted a low-income, single-parent household. The therapist and patient may process how the perpetrator strategically established the façade as a trustworthy adult and established a caregiving role as a low-cost babysitter to "help" the single-parent. In therapy, the patient may identify how the perpetrator took advantage the patient and their family

to maintain victim access and promote the family's dependency upon the perpetrator. In this example, the patient and therapist can understand how the perpetrator may have used favoritism and shame-based threats to capitalize upon a patient's feelings of inadequacy, promote shame for the abuse, and maintain secrecy**.** From this therapeutic stance, an emotionally attuned therapist may be able to help their patient develop a new understanding of how they came to internalize shame, while also considering how the methods of grooming strategically reinforced the patient's feelings of powerlessness.

The clinician and patient's exploration of the third stage, trust development, may entail identifying how the extrafamilial perpetrator sought to exploit a child victim by targeting their emotional vulnerabilities. This would entail understanding how the perpetrator manipulated a child victim by attempting to fulfill unmet emotional needs, such as affection, validation, or emotional intimacy. Buirski et al. (2020) claim, "We ward off feelings that we fear will be disruptive to our relationships to needed others and arouse feelings of shame in ourselves" (p.198). Extrafamilial perpetrators develop trust by the use of bribes or favoritism. These methods can lead a child to disavow their feelings and thoughts, reinforcing silence and pathological accommodation as a method for survival.

The cost of these coercive methods can result in the child taking responsibility for the abuse and blaming themselves. A sociocultural view of trust development would incorporate exploring themes of the perpetrator's privilege and the patient's current relationship to power, privilege, and authority. In therapy, it would be important to note themes of disempowerment the patient experienced as they relate to their development, CSA, and sociocultural background. Exploration of the patient's feelings, perceptions, and beliefs about the development of trust with the perpetrator creates opportunities to co-construct a new narrative that depathologizes the

patient's role in CSA; this can also lead to exploration of the development of trust within the therapy relationship.

5. **Making Sense of the "Why Me?" with Patients**

To make sense of trauma, Brown (2004) notes that survivors often ask, "Why did this happen to me?" Common answers to that question reflect internalized shame and self-blame. For example, a patient might reflect that they were deserving of the abuse. A feminist approach to depathologizing acknowledges how the patient's experience of oppression is reflected in society and how they internalized societal beliefs to understand why they were the victim of CSA.

Brown (2004) explains, "Self-blame, while a coping strategy that appears to be an attempt to insert a sense of control into an otherwise out-of-control experience, frequently contains themes of sexism, racism, heterosexism, and so on" (p. 469). A method of meaning-making from a feminist perspective is recognizing how the personal experience of oppression and coercion is connected to a greater phenomenon of oppression in society. For instance, the "Me Too" movement is an example of how survivors of sexual harassment and/or assault created a social movement to bring awareness to the prevalence of sexism and sexual violence in Western society, empowering survivors to shift self-blame through unifying in their shared experiences. Together, understanding connections between the personal experiences of disempowerment, oppression, and dehumanization and sociocultural constructs can depathologize patients' learned view of themselves.

6. **Exploration of Betrayal with Patients**

The therapist's recognition of both the patient's conflicting feelings and exploration of how the family was groomed in this process can provide both cognitive understanding as well as meet the patient's psychological selfobject need for acceptance of previously disavowed

emotions. For instance, a patient may be tormented by feeling betrayed by family members due to perceived neglect, unknowing compliance with the abuser, and/or sociocultural vulnerability factors. In therapy, explorations of the patient's feelings of betrayal towards caregivers as well as their perpetrators invites the patient to mourn the relational losses, failures, and traumas associated with the sense of betrayal (Brown, 2004).

Conclusion

CSA often goes unreported until adulthood, if at all. Clinicians who use an intersubjective approach to treatment should consider integrating feminist perspectives when working with adult survivors of extrafamilial CSA. Integration of feminist theory with an intersubjective approach strives to empathetically attune to the patient's affective states, while gradually depathologizing a patient's maladaptive behaviors, negative view of self, and perception of their role in CSA. This integrative approach aims to empower patients' sense of agency, self-cohesion, and affect regulation. Depathologizing patients' sense of defectiveness from this integrated approach allows for meaning-making of the sociocultural context in addition to their developmental selfobject failures. Specifically, clinicians may promote curiosity of patients' experiences of oppression and disempowerment as it relates to their identity and experiences of extrafamilial CSA.

This feminist approach to treatment may include identifying the stages of grooming, both of the individual and family. Specifically, it is important for the therapist to be aware of grooming strategies and to promote exploration of a patient's feelings of disempowerment, internalized stigmatization, relational disappointments, and feelings of betrayal. These considerations for clinicians treating survivors of extrafamilial CSA emphasize the importance of the therapeutic frame to elicit a corrective emotional experience that fosters the expression of

previously disavowed emotions without the threat of retraumatization. The clinician's empathic stance and focus on the patient's internal experiences promotes new cognitive and emotional understanding that gradually shifts internalized feelings of shame to a more adaptive self-narrative.

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