Trust, Trusting and Trustworthiness in the Words of Survivors of Child Sexual Abuse

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A Thesis Submitted for the Degree of Doctor of Philosophy in
Applied Psychology

School of Health and Social Care

University of Essex

Date of submission for examination April 2023

Acknowledgements

With deepest appreciation to my participants for their honesty and willingness to trust me; to Danny Taggart for his unerring belief in me and unwavering support, Jackie Turton for her gentle direction and kindness, Peter Beresford for his warmth and humanity, Bernie Sheehan for her brilliance with the English language, my three children for their encouragement and love and the dog for all his patience.

Abstract

298 words

Survivors of Child Sexual Abuse are known to hold silence around the abusive events and their trauma distress. Existing scholarship suggests damaged abilities to trust as one reason for this, and thus trust becomes located as an impaired propensity in the mind of the survivor. Survivors and service providers alike report trust as important when accessing mental, physical, judicial or religious services, and yet very little empirical evidence exists which interrogates the mechanism of trust building, as opposed to generalised trust propensity. Epistemology into trust is hampered by obscured and conflated definitions, and in mental health settings by the apparent dislocation of the survivor's propensity to trust from the trustworthiness of their trustee - be that an individual, an institution or society.

This study has interrogated trust for CSA survivors using a Mad Studies paradigm to address the research questions: How do survivors describe their own trusting abilities? What previous relational experiences inform survivors' ability and/or willingness to trust? How do survivors evaluate potential trustees? How does trust influence disclosure?

Seventeen participants with a range of characteristics were recruited into the study, and Interpretative Phenomenological Analysis used to analyse the data. The researcher is a CSA survivor and an autoethnographic account of her interaction with, and shaping of, the data offers a robust reflexivity to evidence the quality of the study.

The findings demarcate generalised and relational trust; present a 'trust enactment model' of relational trust; delineate the process of building/repairing trust; and advance the utility of 'transactional trust'. The study foregrounds the centrality of trustee trustworthiness, thus challenging survivor trust deficiency as the sole trust-component in relationality when survivors seek services. The study identifies an epistemological lacuna regarding trustee trustworthiness, and indicates the necessity of further research to establish parameters of trustworthiness when working with CSA survivors.

Chapter One: Introduction

"Repeated trauma in childhood forms and deforms the personality. The child trapped in an abusive environment is faced with the formidable task of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy" (Herman, 1992, p. 96)

This statement captures the widely expounded view in empirical, clinical and public discourse of the effect of child sex abuse (CSA) on survivors' trust. This study was conducted to include the voices of survivors alongside these discourses. Because survivors are so often silenced, by themselves and others, research offering a survivor perspective on their experience of trust in the aftermath of CSA is overdue. Using academic approaches that respect and empower survivors and avoiding the lens of mental health impairment, disorder or the so-called 'objective' scientist, the study has sought to restore epistemic worth to those harmed by CSA and provide information that might educate service providers by situating this study as applied psychology.

This chapter will introduce the study and present the frameworks within which it has been conducted.

Trust

Trust "represents a force that works for and through individuals, but at the same time for and through human association" (Möllering, 2001, p. 405). In this way, trust is a dynamic, it moves, it is a reaction or decision (Mayer, Davis and Schoorman, 1995) taken by one person in response to another, whether that 'other' is a person, organisation, institution, society, divine Almighty or even 'the world' (Simpson, 2007). Trust is always relational, always contingent on an expectation of the other. This points to the 'trustor' evaluating the trustworthiness of the ‘trustee’. This evaluation, and subsequent expectation, will be uniquely personal to the trustor, in that it is founded not just on trustee behaviours but also on the trustor’s past experiences, starting with early care-giving relationships (Crittenden, 2016). This propensity to trust (Frazier, Johnson and Fainshmidt, 2013) is known by other names, such as basic trust (Erikson, 1963), generalised trust (Luhmann, 1979), as an antecedent to trust (Gill *et al.*, 2005) and more recently, has been closely related to the concept of epistemic trust (Fonagy *et al.*, 2014). The capacity to trust is said to form part of the psychological make-up of the trustor. The proliferation of terminology and the interwoven nature and reciprocity between trustor and trustee indicate the extent to which trust and entrusting are heterogeneous, and require detailed interrogation to facilitate effective operationalisation.

While some branches of academic research into trust mechanisms tease out these different aspects of what will be referred to in this thesis as ‘the trust dynamic’, in other academic enquiry, and in society in general, trust often seems to be assumed to be such a commonplace term that definitions of trust are absent (O'Neill, 2002). The term is often used inaccurately, and nuanced and composite aspects get overlooked or taken for granted. If trust has become a doxa, self-evident and without the need for explanation (Bourdieu, 1977), then those who experience trust differently, or with difficulty, may be being misunderstood. To have one’s view of the world misunderstood or devalued, according to the predominant discourse, creates the possibility of hermeneutic injustice (Fricker, 2007), where misunderstood individuals, Fricker argues, have access to the natural capacity to heal impeded. It has been posited in theoretical models (Freyd, 1996), empirical research and clinical practice (for example Herman, 1992; van der Kolk, 2014) that one such group for whom trust is difficult are survivors of Child Sex Abuse (CSA).

It has been argued that a key violation of CSA is the betrayal of trust by the perpetrator and other authority figures (Freyd, 1996; Herman, 1992; van der Kolk, 2014), and that this betrayal shapes the adult survivor into a person with impaired capacity for trust (Fonagy, Luyten and Allison, 2015). Furthermore, while not all CSA survivors are living as traumatised individuals or diagnosed with post-traumatic stress, a significant number of people diagnosed with mental health disorders disclose histories of CSA (Hailes *et al.*, 2019). This suggests that the psychological impact of trauma on trust decisions might beneficially be built into an examination of survivors' trust. The development of neuroscientific theories of the physiological and psychological impact of trauma on brain functioning and relationality offers one lens for considering trust decisions for traumatised survivors.

Traumatised survivors may turn towards mental health services for help with their distress, and the significance of trust is embodied in the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD) in the Diagnostics and Statistics Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013): "Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. 'I am bad', 'No one can be trusted', 'The world is completely dangerous')" (National Library of Medicine, 2013). While trust is not specifically named in the World Health Organization's equivalent diagnostic manual, the ICD-11 (WHO, 2019), in the more specific diagnosis for survivors of CSA of Complex Post-Traumatic Stress Disorder (CPTSD) (Rosenfield *et al.*, 2018), the wording names relational issues which allude to trust: "Persistent difficulties in sustaining relationships and in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally." (WHO, 2022a).

While many survivors, whether they are survivors of CSA or of the mental health system, reject diagnostic criteria and the medical model of mental health (Watson, 2019), other survivors call for pathways to be created for the treatment of CPTSD (Lomani, 2022).

PTSD or CPTSD are two of several diagnoses that survivors of CSA might receive (Hailes *et al.*, 2019), thereby explicitly linking CSA with developmental trauma and trust, which reinforces the validity of adopting a trauma lens in exploring survivors' lived experience of trust. And conversely, working within a Mad Studies paradigm, this author is unsettled at having to foreground the medical model to make the case for the study. While I am loath to acknowledge the power of the medical model in addressing the mental health needs of survivors, it is clear that the National Health Service (NHS) is influenced by these manuals and diagnostic criteria, and this frame cannot be ignored when stating the need for this study into trust for CSA survivors.

Important questions are raised by these diagnoses, because for mental health providers to deliver effective services, trust needs to be built between the service and survivors (Parry and Simpson, 2016): this statement is repeated often in clinical literature addressing working with survivors (for example Herman, 1992; van der Kolk, 2014). To achieve survivor trust in service providers (at individual and/or institutional levels), an understanding of how survivors navigate and evaluate service providers as trustworthy is called for. This need for trust and trustworthiness is not limited to mental health domains, but extends to all services working with and for survivors. To date, limited empirical evidence exists on this subject; Chapter Two is a literature review of the extant research of published empirical papers and survivor grey literature regarding trust and survivors of CSA. The review details the obfuscation through unclear definitions of trust, the paucity of co-produced knowledge due to an absence of participatory methodologies, and the differing emphases and foci from various paradigms and approaches used in research processes. It also identifies key concepts and findings regarding survivors' trust, but almost nothing regarding trustworthiness of trustees, or constructs of what gives rise to entrusting behaviours. This gap in the knowledge is further detailed in Chapter Two.

Research questions

To address this gap, this study asks the following research questions:

- How do survivors describe their own trusting abilities?
- What previous relational experiences inform survivors' ability and/or willingness to trust?
- How do survivors evaluate potential trustees ?
- How does trust influence disclosure?

Mad Studies

It may be helpful to note here the troublesome fact that to generate accurate knowledge about trust, it may be important for survivor-participants to trust the researcher and research methods. The possibility that previous studies have been limited in this respect is presented in Chapter Two. One way to address the issue of trust in the researcher is to locate the study within the Mad Studies paradigm, which "offers for the first time a real prospect of effective opposition to the marginalisation and oppression of people experiencing madness and distress, which is strongly philosophically […] survivor led and theoretically grounded" (Beresford and Russo, 2022, p. 1).

Mad Studies is closely aligned to the more established research paradigm of 'Survivor' and 'Service User' research (Russo and Sweeney, 2016; Sweeney, 2016), which offers knowledge from the perspective of those living with distress (Sweeney *et al.*, 2009). In this diverse field, 'survivor' can refer to survivors of sexual abuse as the term is being used in this thesis, but also survivors of other forms of abuse and neglect and survivors of what is termed 'psy' care (Beresford, 2021); 'psy' is shorthand for psychiatric, psychologists psychological and psychotherapeutic approaches (see glossary, Appendix One). Like the antecedents of feminist, disability, queer and colonial research (Beresford, 2016b), survivor research does not speak with one voice (Russo and Sweeney, 2016), but embraces a diverse yet broadly unified set of researchers (Sweeney, 2009) in the overarching mission to offer knowledge generated by those within the researched group (Sweeney, 2016). In this it is "blending intellectual reasoning with personal experience" (O'Hagan, 2009, p. i), and the approach has, in the UK, been seeking to legitimise the use of the subjective knowledge gained through what is widely termed 'Lived Experience' (Beresford and Russo, 2022) for more than 20 years (Sweeney *et al.*, 2009).

'Mad Studies' as an extension or restructuring of Service User/Survivor research has been dated to 2008 (Reville, 2013; Sweeney, 2016), and it is becoming accepted more widely as the academic branch of an activist movement that originated in Canada, where it has "provide[d] a politicized space for the activist scholarship and action emanating from mad movements" (LeFrançois, Beresford and Russo, 2016, p. 1). Its place as an academic discipline and activist movement is becoming more secure, and the UK publication of the *Routledge International Handbook of Mad Studies* (Beresford and Russo, 2022) confirms its standing. Mad Studies' interdisciplinary approach fuels its mission of fighting oppression to restore agency to those self-identifying as mad, and 'mad-positivist' (see Appendix One, glossary). Spandler and Poursanidou describe its alignment with Service User/Survivor research: "it uses Mad knowledge and subjectivity as a tool of understanding and analysis – an instrument of knowing" (Spandler and Poursanidou, 2019, p. 11).

One aim, or hope, that Mad Studies fosters is the creation of a social model of human distress, akin to the societal shift disability studies has effected (Beresford, 2021; Spandler, Anderson and Sapey, 2015), and the dropping of the "broken brain" (Sen, 2019, p. 52) agenda within the mental health system and beyond into all areas of care and society (LeFrançois, Beresford and Russo, 2016). Mad Studies epistemology seeks to address epistemic injustice (Fricker, 2007), seen repeated in the hegemony of mental health research against those deemed irrational (Beresford, 2021) or incapacitated by their histories and experiences of suffering (Sweeney *et al.*, 2009). In this way it challenges prevalent discourses suggesting those living with mental distress are without the capacity for cogent thought

(Armes, 2009; Morrigan, 2017; Beresford, 2016a; Sedgwick, (1982) 2022), and as such are "seen as separate from a rational, reasoned science and incapable of contributing to or producing their own knowledge" (Sweeney, 2009, p. 25).

It is the association between trauma giving rise to (supposed) irrationality that makes the case for this study locating in the Mad Studies paradigm. The relationship between CSA and trauma is considered more fully below, but at this point the relevant issue is the way trauma distress has been considered madness. The link between trauma and constituent behaviours considered as irrational and mad were evident in the genesis of trauma investigation; it was Charcot (1825-1893) who first advocated for the psychological origin of 'hysteria', a term previously used to pathologise the excessive emotions of women as a physical ailment. 'Studies on Hysteria' authored by Breuer and Freud (1895 (2009)) detailed the 'double consciousness' of hysterics, their dissociative tendencies and somatic expression of partial paralysis, speech difficulties, visual disturbance, and hallucinations. Janet (1859-1947) presented his traumatised patient Irène for consideration by his students, noting her irrational actions of repeatedly attempting to revive and medicate her dead mother and her persistent denial of her mother's death despite holding the corpse. Irène herself notes; "I did a lot of silly things in order to revive her…in the morning I lost my mind" (quoted in van der Kolk, 2014, p. 179). Irène is not the only survivor to note the madness of traumatic behaviours (Spring, 2019; Lejonöga and Lilja Ljung, 2019; Reese, 2021); the author has spent many hours in therapy rooms sitting under tables and punching walls, questioning her sanity while reliving the trauma of CSA.

It may be because such traumatically triggered unusual and repetitive behaviours are so frequently dislocated from their origins in traumatic events for both observer and survivor, that trauma distress was interpreted, or experienced, as madness. The current mental health diagnostic framework is predicated on previous iterations of diagnostic manuals such as the

World Health Organisation’s ICD-6 which, in 1949, listed aspects of patient symptomology such as dissociation and somatic expression as ‘disorder’ for the first time, thus informing the DSM-1 in 1952 (Horwitz, 2014) and this framing of mental, and for many, traumatic distress as disordered and contrary to the behaviours of the sane. In recent years trauma survivors have been seeking to have trauma distress reunited with its origins in traumatic events. There has been a call for diagnoses in such manuals predicated on symptoms and behaviours which ignore origins, yet which are recognised in other diagnoses as indicators as trauma, to re-examine their reluctance to include the patient’s history in the case taking (Lomani, 2022).

Is trauma madness? The tension here is palpable because for advocates of trauma as a sane reaction to the insanity of a society which turns a blind eye to child abuse, and places the consequential disturbance in the mind of the survivor (IICSA, 2022), there is an appetite within to reject this as madness. And yet, if madness has at its core a “losing touch with reality” (Ingram Richard A, 2022, p. 94) the expression of traumatic triggering, somatic re-enactments and dissociative moments would appear to fit within the Mad Studies platform in its challenge to the ignoring and repatterning of trauma in ways that hold echoes of the original abuse, and can in itself be abusive (Reddy and Spaulding, 2010).

There is a further justification; just as the Mad Studies communities make a call for epistemic justice by generating Mad knowledge, so too do trauma-survivors seek to have their first person epistemological contributions respected and heard within academic and clinical spaces (Sen, 2019; Taggart, 2022).

From the Mad Studies perspective, when those from within the field of study generate knowledge the issue of objectivity as a problem is voided (Cresswell and Spandler, 2013) and instead the knowledge of people with Lived Experience becomes a valuable asset (Webb, 2016). The paper “Epistemic Injustice” (Fricker, 2007) captures this: “The primary harm of (the central case of) testimonial injustice concerns exclusions from the pooling of knowledge owing to identity prejudice on the part of the hearer" (2007, p. 162). In this way it wields power over "knowers" with the exercising of irreducible epistemic oppression (Dotson, 2014). Mad Studies works towards addressing these power imbalances engendered in the extant system (Kinderman, 2019), advocating for radical change and disrupting the dominant discourse of mental 'illness' (LeFrançois, Menzies and Reaume, 2013). Mad Studies contributes to the overturning of oppression within research paradigms, mental health systems and society, reclaiming derogatory terms such as 'mad', and redefining "the division of authority between the researcher and the researched" (Russo, 2016, p. 62). It is here that this study finds its epistemological and ethical grounding.

In aligning with Mad Studies this study places itself in the constructionist paradigm that challenges both the positivist approach developed by Comte in the 19th century, of a world as observable and factual (Howitt and Cramer, 2005), and post-positivist researchers who, while recognising that reality could only ever be imperfectly known, still maintained that 'facts' about a studied object exist (Savin-Baden and Howell Major, 2013). The study adopts a qualitative methodology, which some say was born of a "deep scepticism and suspicion of scientific attempts to provide objective explanations of reality" (Ormston *et al.*, 2014, p. 15), and others prioritise because of their aim to add valid epistemology regarding aspects of human experience that are nebulous to quantify. Qualitative Methodological approaches have been growing since the 1960s, when they first embraced the inevitability of the subjectivity of the researcher (Savin-Baden and Howell Major, 2013). Certainly Survivor Research and Mad Studies are not the first forms of study to include recognition of the role and person of the researcher as inextricably linked to the research they are generating, and the necessity to address subjective adequacy in their study design (for example, Bruyn, 1966).

Identifying the impossibility of 'value-free' observation, due to the commonality of observer and observed engaging in interpretative and ideographic experience (Smith, Flowers and Larkin, 2009), has given rise to new methodologies. These include Interpretative Phenomenological Analysis (IPA), which is defended as an appropriate vehicle for this study in Chapter Three, Methodology, together with procedures to mitigate against bias (Rose, 2009), to justify hermeneutic claims (Finlay and Gough, 2003), and to generate trustworthy and robust data (Yardley, 2000). This is necessary because the ‘fit’ of Mad Studies with this study is not without issues; firstly I, the researcher, in conducting this study, have needed to reflect deeply on my own identity as regards my inner landscapes of distress and anguish. While I am neither a state funded service-user nor diagnosed, and thus some may say, not recognisably ‘mad’, I do own my lifelong trauma distress, my lost memory and my changeable moods. The issues around who is included in the Mad Studies project is actively explored within the field (Spandler and Poursanidou, 2019) and there are calls for it to be a broad church, with boundaries, and to include voices termed ‘mad positive’. This is someone who “does not identify as Mad but supports the goals of those who do” (Reville, 2013, p. 170); this sounds like me. Yet given my need to seek help privately, engage in lifelong self-care regimes of meditation and yoga and use academic study as a support mechanism, perhaps I might choose to see myself as “high-knowledge crazy” (*ibid*). With all these broad and inclusive titles available, I believe I ‘qualify’ to fit within the framework and I recognise the difficulty of pinning down my identity as in keeping with the fragmented experiences of self, which trauma has engendered in me and other survivors (Fisher, 2017).

The second issue troubling the use of the Mad Studies paradigm is the study’s key aim of addressing shortcomings of the current mental health system, and offering knowledge to all service providers. Some Mad Studies proponents might claim this is contrary to the mission to reject the extant system in favour of a benign, non-pathologising alternative (see Watson, 2019). The issues of co-option and collusion run through many texts on mad scholarship (Voronka and Costa, 2019; Beresford, 2021).

The tension between wanting to enable better mental health care and simultaneously dispense with an oppressive and neglectful mental health system is acute (Diamond, 2013), and not limited to this study. This is one area where Service User/Survivor research holds a less radical view (Sweeney, 2016) than some factions of Mad Studies. Those developing Trauma Informed Approaches (TIAs) (Sweeney *et al.*, 2016), for example, embrace this tension by working within the system while calling for radical change. There is also recognition that the call for radical change might be sanitised by becoming oft repeated by the mainstream (Sweeney and Taggart, 2018). This study seeks to inform emerging models of Trauma-Informed Care and the data will be taken into the arena of mental health services to inform and educate, but the author sees this as a stand against the perpetuation of the status quo within mental health care (Beresford, 2021), and is aware to avoid being co-opted. In this way I believe the study to qualify as Mad Studies scholarship, while remaining alert to the issue.

Language

One recognised method of co-option, warned against by both Mad Studies and Service User/Survivor research, is the use of language. Both also share the imperative need to pay attention to the power language has in shaping survivor experience and narratives when writing about other people: “language can hurt” (Shaw, 2019, p. 80). Burstow (2013, p. 79) points to “the strengths and weakness of our semantic choices” in the fight against the dominant discourse on distress. Choosing the word ‘distress’ rather than ‘mental health’, in relation to a survivor’s inner world, is a positionality whereby the survivor is presenting a normal aspect of lived experience, rather than entering the binary, limiting (Spandler and Poursanidou, 2019) world of mental health versus mental illness, and the precarious, constructed dividing line. Trauma distress is part of the continuum of human suffering, and as such is not a sign of mental disfunction, but a sign of resilience and the incredible capacity of the human mind-body, sometimes under life-threatening circumstances, to adapt and survive (van der Kolk, 2014).

Given this, certain semantic choices have been made by the author; this thesis resists the use of medicalised terminology, except in a critiqued manner, or when quoting a participant who actually embraced such terms. It also endeavours to empower survivors by respecting their own use of language; the findings chapters quote them verbatim both as testimony to their ability to eloquently expound their subjective experience, and as a mark of gratitude for their openness and generosity.

With regard to the power of language, the author has also chosen not to use survivors' possessive pronoun in relation to abuse: the abuse does not 'belong to' the survivor, as in "Clare's abuse". This is a politicised statement, as by making this choice the author wishes to reiterate that abuse always belongs to the abuser, even if the resultant trauma distress now 'belongs' to the survivor.

Lastly regarding language choices, this thesis is predominantly written in academic style given its role as a PhD submission, and yet as Mad Studies scholarship it could have adopted a more personalised use of language. Academic orthodoxies inform predominant use of the distancing terminology of 'the author' to place myself behind the voices of the participants, but when referring to my own experiences, for example when reflexivity is foregrounded (and above), I use the first person. The related issue of authorial hermeneutic contribution is presented in Chapter Three, Methodology.

Given these issues around language, a glossary is included (Appendix One) to facilitate shared understandings, address contested terms, and clarify definitions of trust, lived experience and other terminology (see Chapter Two, Literature Review).This thesis' specific use of the term 'survivor' was mentioned above, but needs clarification; who has been included as survivor-participants in this study? The results can only be deemed trustworthy if the sample criteria is transparent (Chapter Three, Methodology, explains recruitment and inclusion criteria), therefore CSA definitions are important. This study respects each person's right to self-identify as a survivor of CSA in line with other survivor-led movements (for example Bass, Davis and Bateman, 1994; Survivors Voices, 2022a) and so finding one ascribed-to survivor-written definition has proved impossible. Therefore this thesis adopts the inclusive UK Government definition (HM Government, 2018):

> "…forcing or enticing a child or young person [not yet 18] to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse [including via the internet] ... Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children."

This definition includes acts and ages which other definitions exclude, particularly those written in the 20th century. The absence of a universally agreed definition, or set of criteria, can make comparing research findings or accurately estimating prevalence statistics difficult (Banyard and Williams, 2007). But more importantly, shifting definitions of CSA demonstrate how non-survivors decide what constitutes a survivor. For example, Martin and Silverstone (2013) differentiate between "high impact" CSA, involving touching, attempted or achieved penetrative acts with the child's genitalia or anus, and acts of non-contact abuse as lower impact. This study rejects the premise that the proximity of an abuser's body decides the magnitude of the trauma or the trust issues, and that such delineations should shape a study on survivor trust, therefore the wider Government definition is preferred.

Prevalence and incidence

Clear definitions are important when estimating the prevalence and incidence of CSA. Incidence studies gather data of new CSA reports to child protection agencies and police from the previous 12-month period (Martin and Silverstone, 2013). However, it is widely acknowledged that this approach underestimates the extent of abuse due to the widely accepted fact of under-reporting: an NSPCC-commissioned report found that one third of children sexually abused did not disclose to an adult at the time of the abuse (Radford *et al.*, 2011). The National Association for People Abused in Childhood (NAPAC) quotes the Children's Commissioner (2015) in stating: "It is estimated that only one in eight victims of sexual abuse come to the attention of statutory authorities" (NAPAC, 2022).

Children are reported to state 'embarrassment' as the primary reason for non-disclosure (Office for National Statistics, 2019), although understanding this as 'shame' may be more helpful (NSPCC, 2019). Other barriers to disclosure include grooming, fear or removal from the home, and the child believing they gave consent (Radford *et al.*, 2011). Childline report that sexual abuse is the most common cause motivating children to seek their support (Office for National Statistics, 2019). NAPAC state that 1 in 7 adults reporting abuse to their helpline were disclosing for the first time (NAPAC, 2022), and although this was not specifically CSA it is indicative of the silence enshrouding child abuse. Reasons for this silence, and the choice of not disclosing, play an important part in justifying this study. Prevalence collates self-reported cases into an estimate of CSA, but non-comparable analysis parameters makes cross-data comparisons impossible (NSPCC, 2021). Different studies might focus on only children, or only women, current CSA or survivors recollecting experiences from their childhoods, abuse only by adults or including peer groups, and the issue of the inclusion of differing types of abuse all make statistics unreliable. One universally accepted belief is that all figures are underestimates. The final report of the Independent Inquiry into Child Sexual Abuse (IICSA) of England and Wales echoes this in stating: “the true scale of sexual abuse of children is likely to have been much higher than the actual numbers recorded” (IICSA, 2022).

Notwithstanding these issues here are some estimates of CSA: Hirakata (2009) quotes the National Clearinghouse on Family Violence (2008) as estimating 1 in 3 girls and 1 in 6 boys in the USA are sexually abused. This is significantly higher than the 1 in 20 estimated by Radford *et al.* (2011) in the UK, who surveyed children only and included both adult and peer abuse. A meta-analysis of 331 independent studies including 10 million people by Hailes *et al.* (2019) estimate a global prevalence across genders of 12%. The European Union Agency for Fundamental Rights (2014), investigating historic sexual abuse experienced before 15 years old for women only, and only perpetrated by adults reported 18% having experienced contact or non-contact abuse. Perhaps the most useful statistic in a British context, given the use of the Government definition of CSA, comes from the Crime Survey for England and Wales (CSEW), which states: “in the year ending March 2019, the CSEW estimated that approximately 3.1 million adults aged 18 to 74 years experienced sexual abuse before the age of 16 years. This is equivalent to 7.5% of the population”. This broke down to 1 in 6 girls and 1 in 20 boys. What can be gathered is that incidents of CSA are profuse, and this fact alone justifies the need for research in this field. When statistics are aligned with the effects of CSA, the need and value of such research is fortified.

The detrimental effects of CSA are well documented by survivors (see Morrigan, 2017; Reese, 2021; Sen, 2019), scholars (see Chapter Two) and clinicians (van der Kolk, 2014; Herman, 1992). However, the focus and tone of effects is dictated by the paradigm through which CSA is viewed.

IICSA England and Wales (2014-2022) conducted a literature review of the effects of CSA and reported a “clear correlation between history of childhood sexual abuse and health, health behaviours and health outcomes” (Ingrassia, 2018, p. 572). Hailes *et al.* (2019)’s ‘umbrella’ review of 19 meta-analyses, with more than 4 million individuals, identified 26 ‘outcomes’ (i.e. diagnosable conditions) associated with CSA. It states that the “strongest psychiatric associations with childhood sexual abuse were reported for conversion disorder, borderline personality disorder, anxiety, and depression” (Hailes *et al.*, 2019, p. 2), and goes on to report that survivors showed a wide array of negative psychosocial and health issues. Similarly the meta-analysis by Maniglio (2009, p. 647) reports “evidence that survivors of childhood sexual abuse are significantly at risk of a wide range of medical, psychological, behavioral, and sexual disorders. […]. Child sexual abuse should be considered as a general, nonspecific risk factor for psychopathology.”

These studies validate the need for survivors to be understood not as people with flawed mental health or a disordered personality, but as people impacted by events and circumstances of CSA. Such studies are important because they inform the care pathways in statutory services. However, previous research into CSA has predominantly fallen within the positivist and post-positivist paradigms, which make the survivor the subject of research rather than an equal participant in the generation of knowledge. This study seeks to redress this by privileging survivors’ voices. If previous studies call for services to meet survivors’ mental health needs, this study aims to show how that might best be done from the point of view of survivors, in their own words, using the interpretation of a theorist who has relevant lived experience informing the study.

Trauma

While CSA can result in mental health disorders, as these studies suggest, it is important to state that not all child victims of sexual abuse become adults with mental or physical health or anti-social issues (Herman, 1992). However, that is equally not to say that those who do not seek or get designated a diagnosis are without the after-effects of traumatic distress. Psychological trauma is both a spectrum and multi-faceted. Understanding the effects of CSA in terms of trauma, rather than as mental health disorder, is embodied in the ICD, including C-PTSD as a category for the first time in 2018 (see above). To reiterate, this study does not wish to reinforce or be co-opted into the mental health model that embraces such a diagnosis – it must be remembered that the 'D' stands for 'disorder', which can be considered by those in the Mad community as a derogatory pathologising of the rational response to extreme fear (Sen, 2019). But, as stated above, such a diagnosis makes it possible for survivors to access support services, and work towards becoming trauma-informed to meet survivor needs (Lomani, 2022). With these tensions held in mind, psychological trauma scholarship and theory offer one lens through which to consider the data, and therefore will be presented here.

Trauma is a phenomenon ubiquitous in social discourse of the 21st century (Fassin, 2009), although consensus around definitions fuels debate (Suleiman, 2008). In keeping with the privileging of survivor testimony, a survivor definition will be used as a framework from which to explore explanations and hypotheses from clinicians, researchers and theorists: "*Trauma is something that happened to you that still haunts you today…and if it doesn't still haunt you, it sure did for a long long time*" (Russo & Sweeney, 2016, p. 23).

Trauma involves an event, or events: "something happened". Trauma is personal: "it happened to you". While the traumatic event/s happened in the past, 'trauma' is still present: "still haunts you today", and it persists: "long long time". Lastly, recovery is inferred in this final section: "if it doesn't still". Please see glossary (Appendix One) regarding the word 'recovery'.

The word 'trauma' is variously used to refer to two aspects of traumatic experience: the abusive event/s themselves, and the traumatic wounding, or trauma distress, which perpetuates for the survivor (Maté & Maté, 2022). This conflation of terms obfuscates, but use of the term “a trauma” as a noun tends to refer to the traumatic event/s and “trauma” most usually refers to the perpetuating trauma distress.

The universal organising principle of traumatic event/s is the “[threat] to life or bodily integrity” (Herman, 1992, p. 33), and includes the subject witnessing events of mortal danger to someone of importance to them (van der Kolk, 2014). A traumatic event is “any experience that is stressful enough to leave us feeling helpless, frightened, overwhelmed, or profoundly unsafe” (Ogden quoted in Treleaven, 2018, p. 20). From these definitions it can be understood how CSA is a traumatic wounding, and would give rise to traumatic distress. Perhaps a different definition more relevant to this thesis is:

> “trauma and resistance to trauma can, in the human case, be understood not on the analogy of a physical force striking a more or less brittle object, nor on the lines of the invasion of an organism by hostile bacteria, but only through the transformation of elements in a person’s identity and capacity to relate to other persons and social collectives” (Sedgwick, (1982) 2022, p. 23).

This view eloquently captures how a traumatic event impacts not just the interior world of the survivor but their relationships with others too.

The theory of ‘developmental trauma’ was first advanced by Herman (1992), and eventually led to the creation of the diagnosis C-PTSD in 2018. This form of trauma is hypothesised as arising when repeated events of interpersonal harm and extreme neglect occur in developmental life stages and shape the child, thereby shaping the adult survivor (Herman, 1992; WHO, 2022a; van der Kolk, 2014). ‘Complex’ has been the preferred term diagnostically over ‘developmental’ trauma, because repeated violations for an adult can give rise to similar sequalae.

Developmental traumas include sexual and non-sexual abuse, neglect, and the observing of violence towards family members. This suite of ‘Adverse Childhood Experiences’ (ACEs) (Felitti *et al.*, 1998), the medical model tells us, results in trauma distress of diverse and complex “difficult to treat”, “hard to reach” (Fonagy, Luyten, Allison, & Campbell, 2017, p. 3) mental “illness” or “disorder” (American Psychiatric Association, 2013). These terminologies are contested by survivor organisations (Johnstone, 2018), as mentioned earlier.

CSA occurs, de facto, during the development of relationship to early attachment figures (Crittenden, 2016); theorists suggest that developmental trauma creates “attachment adversity” (Spinazzola, Van der Kolk, & Ford, 2018) which, they claim, exacerbates dysfunction in relation to trust (Fonagy, Luyten, Allison, & Campbell, 2019), thus undermining a survivor’s abilities in subsequent relationships. This pathologising of survivor ability to trust is also seen in studies focusing on other diagnoses many survivors receive, such Borderline Personality Disorder (BPD) (see Fertuck, Grinband and Stanley, 2013), now diagnosed as Emotionally Unstable Personality Disorder (EUPD) (WHO, 2022b) or on psychosis, an experience many survivors experience (Fett *et al.*, 2016). A study on trust and respect in the patient-clinician relationship (Crits-Christoph *et al.*, 2019) set out to measure patient trust and yet made no reference to the trustworthiness of the clinician. Approaches such as these link trauma and trust in ways that this study seeks to interrogate.

In addition to CSA, other traumatic experiences can exacerbate or create trauma distress for survivors: mental health provision itself is sited as an iatrogenic cause of trauma for patients within psychiatric care (LeFrançois, Menzies, & Reaume, 2013; Watson, 2019). The use of pathologising approaches to distress named in the previous paragraph can be considered (re)traumatising for some. Mainstream mental health discourse sometimes considers the re-traumatisation of patients with a PTSD or C-PTSD diagnosis to be regrettable but perhaps inevitable (Duckworth & Follette, 2012), even when attempts are made to address the issue (McGarry, 2019). But survivor groups consider such events to be under the control of psychiatric services, and therefore any event perpetrated by services caring for survivors that causes traumatic distress should be considered to be a traumatic event in its own right (Sweeney, Clement, Filson, & Kennedy, 2016), and will, in this study, be termed (re)traumatisation to signify this.

Commentators suggest that systemic injustice and oppression over gender, poverty, racism, misogyny and refugee status can also result in trauma distress (Fassin, 2009; LeFrançois *et al.*, 2013; Treleaven, 2018), and when such intersectionality comprises survivor identity, trauma distress may be intensified (Rose, 2017). Research into trauma primarily focuses on white, western populations, and survivors from within marginalised communities are often absent from the data (Rose, 2019). This study's methodology seeks to include participants from varied backgrounds.

Categories of trauma histories listed above belie the intensely personal nature of the traumatic events of abuse for the child being abused; most notably, abuse is the exercise of power over a less powerful victim (Boyle, 2020). The loss of agency, the ability to choose, consent to or stop the abuse all leave the child feeling utterly powerless and may create an internal dynamic of overwhelm or hopelessness; a collapse or denigration of self-construct as a person worthy of love (Herman, 1992). Survivors Voices is a survivor-led charity with a mission for education and activism, and their website carries a video showcasing survivor "three words" of how trauma manifests for them, for example: "never fucking leaves", "alienated lost soul" "soul destroying memories" (Survivors Voices, 2022a; Survivors Voices, 2022b).These can be counterpointed to the diagnostic manuals mentioned above that demonstrate within their diagnostic categories the persistent nature of traumatic distress. For example, NHS England lists the symptoms of C-PTSD as "feelings of shame or guilt;

difficulty controlling your emotions; periods of losing attention and concentration (dissociation), physical symptoms, such as headaches, dizziness, chest pains and stomach aches; cutting yourself off from friends and family; relationship difficulties; destructive or risky behaviour, such as self-harm, alcohol misuse or drug abuse; suicidal thoughts" (NHS, 2018).

The survivor definition above names the persistent nature of trauma ("long, long time"). One aspect of this are flashbacks, where: "sensory fragments of memory intrude into the present, where they are literally relived […] are in some ways worse than the trauma itself [and] can occur at any time" (van der Kolk, 2014, p. 66). Flashbacks and other reminders of the traumatic event can cause 'triggering', a term used by survivors and clinicians alike, where events from the past manifest into daily life. One survivor says: "triggers are like little psychic explosions that crash through avoidance and bring the dissociated, avoided trauma suddenly, unexpectedly, back into consciousness" (Spring, 2021, p. 62). Being triggered is to believe that there is a current and present threat, and the human prerogative for safety give rise to a person's stress response. A short explanation of this is included here to offer the physiological underpinnings to instinctive survival mechanisms that persist after traumatic events, and to offer a framework for the data to be compared against.

Selye's pioneering work on the autonomic nervous system (ANS) in the 20th century (Selye, 1978) and his discovery of the "stress response" became the universally accepted paradigm of the human imperative for safety. The ANS utilises opposing branches of 'sympathetic' and 'parasympathetic' nervous systems; the former engages in response to threat using fight or flight reactions, and when danger has passed the parasympathetic facilitates 'rest and restore' processes, which allow the body to re-establish homeostatic equilibrium. This model, however, could not adequately explain trauma responses or the dissociation described above (Dana, 2018), and in the early 1990s 'Polyvagal Theory'

(Porges, 2011) was developed, which offers an explanation of dissociation. Van der Kolk states: “dissociation is the essence of trauma” (van der Kolk, 2014, p. 66). Where trust is involved these key aspects of traumatic response to the detected threat of fight, flight, freeze and dissociation are important behaviours through which to consider survivor reactions when in trust-relationships. Therefore, the theoretical framework of the polyvagal system enables a view of the survivor responding appropriately to the situation as they see and somatically experience it, and that this response is an interactive mind-body instinctual system. This conceptualisation of the impact trauma has within the behavioural system of a survivor is important when considering the trust dynamic: returning to the earlier quotation, trust “represents a force that works for and through individuals, but at the same time for and through human association” (Möllering, 2001, p. 405). If the individual doing the trusting is being impacted by trauma distress, particularly as a result of a present-moment relational interaction causing a flashback and or triggering, and their physiological system responds accordingly with a reaction of fight, flight, freeze or dissociation, their abilities regarding trust will be contingent upon this. Therefore, the way in which survivors are experiencing present-moment experiences within relationship are key to the understanding of how the trustee might be intuited as safe or unsafe, trustworthy or untrustworthy by the survivor. Additionally, trauma-informed actions and reactions by service providers might be able to create encounters which facilitate trust.

Trust

Having visited trauma as a framework for survivor trust responses to trustees, the study identifies that a clear definition or conceptualisation of the term ‘trust’ is needed. The opening paragraph of this chapter remarked on the lack of clear definitions, and Chapter Two (Literature Review) interrogates current empirical research and survivor testimony regarding trust in the context of CSA, and demonstrates how the field uses the term without clear definitions. As this literature review is unable to offer such a definition, and by way of a rounding out of shared understanding of constructs of trust, this chapter will conclude with a theoretic framework of trust drawn from scholarship and research across a wide range of domains including healthcare (e.g. Dugan, Trachtenberg, & Hall, 2005), business and management (e.g. Rousseau *et al.*, 1998), romantic relationships (e.g. Gottman, 2011), refugees (e.g. Gross, 2004) and even artificial intelligence (e.g. Sebo, Krishnamurthi and Scassellati, 2019).

Seeking one definition of the word ‘trust’ “leaves the reader wanting” (Vassilev and Pilgrim, 2007; Simpson, 2007, p. 287). Many papers, even systematic reviews, note the confusion, while still failing to define trust (e.g. Magen and DeLisser, 2017; Ozawa and Sripad, 2013). Some papers “make a case for the absence of an overarching definition of trust ” (Rousseau *et al.*, 1998, p. 394), for others trust is taken to be interrelated to other aspects of relationship and can be gauged by, and move with, those other aspects (Simpson, 2007).

Beyond the lack of a unifying definition there is one abiding constant across disciplines: trust is relational (Hardin, 2002; Simpson, 2007). All manner of relationship - dyadic, multiplex, familial, institutional, or organisational - necessitates the evaluation of trustworthiness before cognitions, decisions and actions (Hardin, 2002) transpire, which involve one party becoming vulnerable (potentially at risk) in relationship to the other: “trust is the willingness to accept vulnerability based upon positive expectations about another’s behavior” (Dunn & Schweitzer, 2005, p. 736). As introduced above, CSA survivors may experience ‘vulnerability’ in a more intense or complex manner than non-abused or non-traumatised people; vulnerability may feel more acute and the spectrum of what is felt as vulnerable may be wider (Spring, 2019).

One thing is clear, trust is a ubiquitous human experience, and is phenomenological in nature (Luhmann, 1979; Rotenberg, 2010; Thomson, 2017). The a priori belief that everyone shares the same understanding (cognitive or experiential) of trust, or vulnerability, is mistaken; this may be the precise place where those seeking to serve survivors of CSA, believing they understand their client's (in)abilities to trust (if they are adopting a diagnostic lens), and their own trustworthiness, accidentally (re)traumatise, dis-serve or simply fail to comprehend what is needed to build trust (Ratcliffe, 2012).

Ratcliffe, Ruddell, and Smith (2014) present a concept of trust with three distinct forms: one-place, two-place and three-place trust. Their model equates to other theorists' conceptualisations of trust, and will be used as the framework for this study.

One-place trust is a belief in the world as a benevolent place; the trustor is trusting in a generalised sense and has "in the broadest sense […] confidence in one's expectations" (Luhmann 1979, p. 4). Other scholars use different terms such as "basic trust'" (Erikson, 1963; Herman, 1992) or "basal security" (Jones, 2004, p. 7), considered part of secure attachment in a child's development (Cole & Putnam, 1992) in (so called) "fully functional" people. One-place trust is closely aligned to "epistemic trust", defined as "trust in the authenticity and personal relevance of interpersonally transmitted information" (Fonagy & Allison, 2014, p. 372), and also seeded in adequate initial caregiving relationships, as proposed by Attachment Theory (Crittenden, 2016).

One-place trust endows a person with the "propensity" (Schoorman, Mayer, & Davis, 2007) or "predisposition" (Gill, Boies, Finegan, & McNally, 2005, p. 287) to trust. Lower levels of one-place trust leave a person suspicious, watchful or cautious (Lewicki, McAllister, & Bies, 1998).

One-place trust is said to be at risk of loss through traumatic experience (Jones, 2004), be that traumatic events in adult life (Ratcliffe, Ruddell, & Smith, 2014) or developmental trauma, which is said to interrupt the development of trusting capacity (e.g. Crittenden, 2016; Fonagy, Luyten, & Allison, 2015; Herman, 1992), leaving the survivor "disordered" and "dysfunctional" (Fonagy, Luyten, Allison, & Campbell, 2017, p. 3) according to diagnostic realms, in their capacity to trust.

One-place trust is posited to be necessary for other forms of trust to be possible (Herman, 1992; Ratcliffe *et al*., 2014; Schoorman et al., 2007). Yamagishi (2001) predicts that people who have one-place trust are better able to detect untrustworthiness in others (Gottman, 2011).

In 'two-place' trust, according to Ratcliffe *et al.* (2014, p. 3) a trustor trusts a particular individual "without reference to a specific situation or action"; this is 'relational trust'. This maps onto the 'encapsulated interest' theory proposed by Hardin (2002), where "trust exists when one party to the relation believes the other party has incentive to act in his or her interest or to take his or her interest to heart" (Cook, Hardin, & Levi, 2005, p. 2). The fundamental point being that trust is of value to both parties, not just the trustor. The trustee has a vested interest in acting in a trustworthy manner, "that is grounded in the value of maintaining the relationship into the future" (Hardin, 2002, p. 3).

'Three-place' trust conceptualises the trustor as trusting a specific person to accomplish a stipulated task. This requires the trustor to make a robust appraisal of *this* situation, and the assessment of the trustworthiness of the trustee in achieving *this* task, before trust emerges. This model declares trust as a 'cognitive notion' or 'sense' of the same ilk as "knowledge, belief, and the kind of judgement that might be called assessment" (Hardin, 2002, p. 7). This is a construct that informs a belief in a trustee's ability to engage in 'transactional trust', even in the absence of the deeper two-place trust (Reina and Reina, 2009). This is further complicated by conceptualisations of cooperation, as opposed to trust, which suggests its emergence in situations where the "risks are high, the relevant knowledge about trustworthiness unobtainable, [and] power is highly unequal" (Cook *et al*., 2005, p. 2). Cooperation emerges when all parties believe the other to have "incentive compatibility" (Cook *et al.,* 2005, p. 3) to behave consistently and reliably, and the structure of the organisation or group may include third party enforcers, using penalties and incentives. This study seeks to understand survivors' utilisations of such constructs when navigating service provision by assessing trustworthiness.

In assessing trustworthiness of trustees there is a key fact that applies in all trust-relationships: no matter how many checks of trustworthiness are made, at some point evidence fails because for every human the future is always uncertain, no matter how many guarantees are given. It is essential to note that characteristics read as trustworthy are only providing a *potentiality* of behaviour; there is always a risk that the trustee may not act out as expected or predicted (Hardin, 2002). Therefore, ultimately enacting trust depends upon the intuition, interpretation, and/or perception of the trustor to accurately evaluate the antecedent qualities of the trustee (De Mello, 1986), and "neither overestimate nor underestimate [the trustee's] competence" (Jones, 2004, p. 7) in making the decision to trust.

It is important to note the difference between a "willingness to trust", which bears no risk (Mayer *et al*., 1995) and the behavioural next step of "assuming the risk" (*ibid* p. 724), which involves the action of the trustor opening herself up to 'vulnerability' (Jones, 2004). Without the elements of risk, vulnerability and interdependence, trust is not necessary (Rousseau *et al.*, 1998): "where we have guarantees or proofs placing trust is redundant" (O'Neill, 2002, p. 6). Taking action is evidence of trust (Hardin, 2002) and action involves "strong approach-avoidant gradients" (Simpson, 2007, p. 587) to overcome the damage trauma can cause to the willingness to take such risks (Jones, 2004).

The a priori construct of "trust as good and distrust as bad" (Lewicki *et al*., 1998, p. 440) is challenged by research which shows that distrust can support helpful and constructive trust decisions (Lewicki, McAllister and Bies, 1998). The view of distrust as being unhelpful and unwanted has persisted through empirical and theoretical work on trust, whereas seeing a more nuanced view of trust and actions taken on trust, and valuing distrust, adds depth and texture to the binary suggestion of individuals either able or without the ability to trust, in both the generalised sense and specific situations.

Summary

This chapter has introduced the research questions and study aims, setting them within the context of Mad Studies, trauma and the complexity of researching trust, which is a phenomenon viewed as doxa, perhaps to the detriment of populations whose epistemic knowing differs to those who have not been subjected to CSA.

Chapter Two: Literature Review

"*I checked 'no' despite having been repeatedly sexually abused as a child"* (Austin, 2021, p. 902)

Introduction

This chapter presents and interrogates previous empirical studies which have researched survivors of CSA and have included trust as a key finding. As the chapter explains, this has proved problematic because of the paucity of studies with trust as their focus. In order to gain a full picture of the current state of knowledge, the review was extended into several areas tangential to CSA and because no previous studies of CSA and trust within a Mad Studies paradigm have been located. To include a survivor perspective, grey literature of pieces published by survivors with trust as a focus have been included. Locating such material in a way that bears scrutiny has been problematic because 'cherry picking' of material is to be avoided in scientific study, and so the rationale for inclusion is explored below.

The chapter presents how research that does include the word trust in the abstract or title has struggled to adequately define the concept or operationalisation of trust as a mechanism for survivors, and that the paradigm from within which each study was conducted has shaped the view of the survivor and conclusions reached.

Because of the need to extend search terms to locate sufficient previous investigative work, this review cannot be considered 'systematic', but has followed a rigorous and transparent method to locate the material that is presented here.

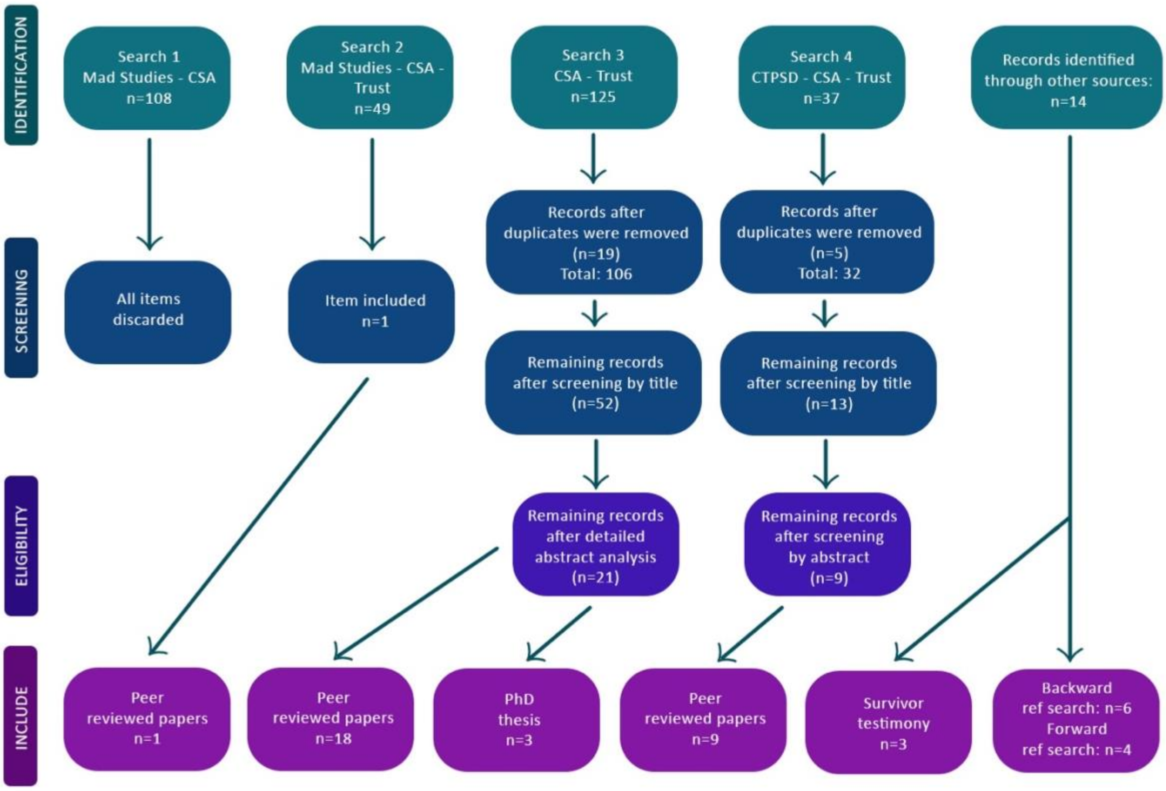
Search terms and databases

Initially a scoping literature search was conducted to examine existing Mad Studies empirical research of CSA survivors. The databases of Pubmed, Psycinfo and EBSCOHost (which searches CINHAL and Medline and PsycARTICLES) were chosen, as this doctoral study situates itself within applied psychology. The one result was a chapter in *Rose Garden* (Russo and Sweeney, 2016), a book outlining Service User/Survivor research which was referenced in the Introduction (Chapter One). When extending this search to Google Scholar (using the same Boolean string), 49 papers were generated. Skim reading of these revealed the breadth of disciplines adopting Mad scholarship to explore CSA, but only one of the pieces was an empirical study centring the survivor voice on trust. While this search legitimises the use of Mad Studies in the field of CSA, it also revealed the paucity of empirical research and scholarship drawing directly on CSA survivors' experiences as Mad scholarship.

Search terms were broadened four further times until sufficient literature from within and outside Mad Studies was captured, referring to CSA survivors and trust within the title or abstract (see Appendix Two). In brief, by searching 'trust' and 'child sexual abuse' in the originally selected databases, sufficient papers were generated to conduct the screening process and locate literature pertinent to this study. However, the exclusion rate was high, as for many papers 'trust' referred to an NHS trust, or while the word 'trust' was included, the operationalisation of trust, or trust as a concept, was not part of the study design or outcomes. To include further research that had investigated trust in the context of abuse, the search was extended to 'trust' and 'CPTSD'. People diagnosed with CPTSD will have included survivors of CSA, given the diagnostic criteria and prevalence of CSA (see Introduction, Chapter One) even if they were not the main focus of the study or the only participants. This decision was made after consultation with supervisors.

Backward and forward hand searches of reference lists during the detailed reading of the included papers yielded further papers. An adapted Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) schematic (Chart 1) shows the system for arriving at 38 peer-reviewed papers, four PhD theses published online, and three survivor testimonies. This is included not because this was a systematic review, but because the format allows for ease in seeing the process.

Chart 1: Process for inclusion/exclusion of studies in Literature Review



The grey literature of three survivor testimonies are included for their specific references to CSA experiences of trust. Including these three papers, when they were not found through systematic review methods, might be considered ‘cherry picking’: “Why three? Why these three?” are valid questions. They include CSA survivor trust as key to their commentary and it is reasoned that they add the survivor voice without repetition but with depth. Without these papers, this review would not have the survivor voice as a counterpoint to research conducted about or 'on' survivors by academics or clinicians. Since this non-empirical data from survivors is included, the balancing tool of non-empirical, peer-reviewed papers generated by the searches are also included, such as clinical and theoretical frameworks (e.g. Laddis, 2019; Coates and Gaensbauer, 2009). These papers are written by clinicians or researchers *about* survivors and trust, and thus include what can (and by Mad Studies, should) be considered 'opinion', even though the authors often present it as fact.

A final search using the same terms was carried out in the month before submission in order to include new relevant literature published since 2021 but none were located. There are 44 published documents reviewed. Four issues are important to bear in mind while reading this chapter:

- the trajectory of the author's investigation into trust
- the socio-political context at the date of publication
- author's adopted definitions of trust and CSA
- the paradigm from within which papers were written.

Trajectory of investigation

The scholarship of Finkelhor and colleagues in the 1980s (Finkelhor, 1984) informed many subsequent authors' views of 'the CSA survivor' regarding trust issues; he is referenced in 21 papers in this review. Finkelhor presented a theory of the effects of abuse, offering a "traumagenic dynamics framework" (Finkelhor, 1984), still referenced in contemporary research (e.g. Senn *et al.*, 2017), indicating the longevity of his influence. The framework is often reworded or reordered in subsequent studies with differing emphasis. Here is one example: "(a) lack of trust; (b) powerlessness and/or dominance; (c) traumatic sexualization; and (d) guilt and shame" (Senn *et al.*, 2017, p. 498). Studies included in this chapter have used both quantitative and qualitative methodologies to explore the survivors' experiences of trust that Finkelhor proposed, and shows how emphasis of these factors has changed in part according to publication date. Banyard and Williams (2007, p. 276) refer to a "third generation" of research emerging, which goes further than presenting prevalence or verification of effects as initial studies did, by exploring the nuance and ramification for survivors of the effects of CSA; for example, Ng *et al.* (2020) have studied the effect of trust in CSA survivors on inflammation.

Socio-political context

These 'generations' of research, the shift in social discourse, and a priori research parameters require that quotes used in this chapter should be considered in the context of publication date (Wright and Gabriel, 2018). For example, this comment from Zdanuk, Harris and Wisian (1987, p. 101) would in current times be met with incredulity: "in many instances, the sexual relationship between the daughter and her father may satisfy her need for physical affection and closeness." And "the incestuous relationship can be a means of expressing revenge against her mother, who psychologically abandoned her - that is, the child can excel her mother in both the kitchen and the bedroom". Similarly, Finkelhor (1984) uses the term 'partners' for child and abuser in his conceptualisation of what constitutes abuse. As mentioned above, such pieces are included for information about trust and perhaps indicate how the authors' view may be shaping their interpretation of the survivors' experiences.

Definitions

Just as the date of publication impacts the literature, so too do definitions of key terms. Trust, as discussed in Chapter One, is ill-defined and imprecise in usage, and common understandings are simply assumed. Likewise, definitions of CSA have changed over time (Robinson, 2003; Wright and Gabriel, 2018), the impact of which is identified as a limiting factor to a meta-analysis by Banyard and Williams (2007), and this, by extension, is true of the data presented in this chapter.

Implied or inferred trust raises further issues: of the five meta analyses and/or systematic reviews included, on occasion the original paper may not explicitly use the term ‘trust’, but ‘trusting’ was implied and their author then does adopt the term ‘trust’ in the review paper (e.g. Llewellyn-Beardsley *et al.*, 2019).

Paradigm

Partly assumed terminology may arise from the researchers’ paradigm, where shared understandings exist and therefore the paradigm from which authors write also influences results, discussions and conclusions. Returning to Finklehor and colleagues, the authority they are afforded this informs the voice of some subsequent researchers, who appear to make truths out of theory: for example, Senn *et al.* (2017, p. 497) state that the four dynamics (noted above) “reflect distorted perceptions of self, of relationships, and of the role of sex in relationships”, while offering no evidence of what ‘distorted’ means, and creating a disparaging view of survivors.

Terms such as ‘distorted perceptions’ are echoed through other papers written *about* survivors (Laddis, 2019; Gobin, 2012). By contrast, such language does not appear in the papers which state their aim to stay close to survivor’s voice (Harvey *et al.*, 2000; Hirakata, 2009; Brennan and McElvaney, 2020), or are co-produced with survivors (Matheson and Weightman, 2020), or are written by survivors (Morrigan, 2017). Perhaps the use of language is an indication of the underpinning attitudes and beliefs about survivors, and is also informing discussions and conclusions.

Authors’ (mis)interpretations of their findings also appear to shape extant empirical data. Quantitative studies of trust gathered self-report data (ostensibly the survivors’ voice), using tools such as ‘The Trust Inventory’, ‘Trust in Others Index’ (Hartman, 1998) and ‘Interpersonal Trust Scale’ (Leonard, 1992), and present results as statistical accounts of survivor experience. But the authors’ role as ‘meaning making’ (Wright and Gabriel, 2018) subjective agents in constructing the discussion or conclusions is evident: Gobin (2012) used quantitative tools with a control group against which other groups with a PTSD diagnosis were allotted, according to levels of traumatisation. Despite the results showing “overall participants rated each of the characteristics (loyal, dependable, sincere, honest, understanding, trustworthy, and compassionate) as desirable regardless of their trauma history” (Gobin, 2012, p. 163), the abstract makes no mention of this parity and instead chooses to privilege the finding: “preference for a partner who uses the tactic of verbal aggression was also associated with revictimization status” when the results stated they were only “marginally more tolerant” (*ibid p.165*), and are not statistically significant. In this way the study creates a view of survivors that, while not accurate to their data, fits with the paradigm it is working within.

While positivist paradigms may not acknowledge the existence or power of the author’s interpretations, other scholarship, for example, narrative studies, embrace interpretation as fact of research. Harvey *et al.* (2000, p. 297) call for authors to be “attentive to our own assumptions as we listen and try to make sense of our respondents’ ways of making sense of their experiences”.

The role of interpretation aside, the efficacy of self-report tools are drawn into question by this survivor testimony of questionnaire filling:

“I checked ‘no’ despite having been repeatedly sexually abused as a child. My primary concern was not sharing what had happened to me, but how others would react […] I felt deep shame about what had happened to me, and the fear of negative, or even neutral, responses made disclosure seem unfathomable.” (Austin, 2021, p. 902).

While this testimony does not use the word trust, it implies a lack of trust in the questionnaire and what it represented about the service. This may address an issue encountered by Mullen *et al.* (1994). After interviews, they re-assigned to the CSA group 31 participants who, at initial form filling, had self-declared as non-survivors. Perhaps more significant is the reassignment of 18 participants who declared CSA histories, when form filling but did not confirm the abuse in interviews. These 18 “were excluded from further consideration” (p. 37). The shift in participants’ CSA status was not interrogated, and indicates the need for further research regarding how to gain accurate information from survivors. If 18 self-declared survivors did not feel they could share their status in interview, perhaps it indicates something about trust in the interviewer or interview process? And perhaps the validity of the study comes under question, in terms of reliability and trustworthiness?

Silencing by failing to gain accurate information seen in the example above is exacerbated by authors’ exclusion of survivors’ testimony, as evident in Banyard and Williams (2007, p. 279) in their longitudinal mixed methods study. They decided to eliminate three women from stage four interviews because they had “evidenced very severe and long-standing psychological distress at the time of the wave 3 interview […] because of concerns that the narrative nature of the study would be overly distressing for these individuals”. Whose concerns? Were those three women asked if they wished to share their stories, despite their distress? Survivor testimony (Reese, 2021) states the need to be heard even when in distress.

Silencing of survivor views is central to Morrigan (2017, p. 61) in her paper challenging psychiatry, and is echoed by privileging of paid, professional, non-survivor opinion over survivor experience, evidenced by Blanchard-Dallaire and Hébert (2014, p. 338), who claimed a strength of their study was the teacher ratings of abused children’s abilities in social situations over children’s self-report “since it can be considered as a more objective measure”.

A similar reliance on the veracity of expert opinion over survivor experience is found in Banyard and Williams (2007, p. 288): “A strength of the current study is also that it does not rely on self-reports of child sexual abuse but uses official hospital records to identify survivors”. This demonstrates a lack of trust in survivor claims, although, as they state, it did bring forward some survivors who had forgotten their abuse until reminded of it by the researcher.

Silencing was evident not only in the data collection and interpretation, but also in the directive actions of some researchers over survivors. For example, the researchers constructing one study (Senn *et al.*, 2017, p. 505) ordered survivors in therapy groups under research not to discuss abuse experiences for fear of upsetting other group members. As the groups started to run, the researcher noted that survivors were capable of navigating this territory and when disclosures were made, “these details provided necessary context and were not upsetting to other participants”. There is ample evidence that survivors benefit from peer group support in recovery (Banyard and Williams, 2007; Roesler and Lillie, 1995; Kia-Keating, Sorsoli and Grossman, 2010), and prefer disclosing to fellow survivors (Blanchard-Dallaire and Hébert, 2014); this has implications for effective methods of data collection from survivors; they need to be able to decide what and how to share, and interviewers need to be able to be experienced as trustworthy.

In contrast other papers expressly sought to represent survivor experience “from a client’s perspective” (Wright and Gabriel, 2018, p. 665), and Hirakata (2009, p. 310) used the nuance of survivor’s spoken delivery, such as noticing “heightened intensity” to enrich her analysis.

The importance of survivors' testimony in the breaking of silence is showcased by Dominelli (1989, p. 239): "feminist work in the area of sexual abuse since the mid-1970s has challenged […] Freudian legacy by providing the space through which the abused can speak for themselves".

The value of survivor testimony in research is evidenced by Banyard and Williams (2007), who commented on the value of qualitative aspect allowing survivors' explanations as to perplexing findings from the quantitative phase. And Harvey *et al.* (2000) discuss their own career trajectory of using interviews to inform quantitative tools in early research projects, but subsequently turned to narrative methodology to gain the nuance of survivor testimony.

In an attempt to accurately portray survivor experiences, one paper engaged in participatory methodology. Matheson and Weightman (2020, p. 2) constructed a "collaboration between service users and professionals, [by] recruiting and training former patients to pilot interview questions, carry out interviews and participate in data analysis". Brennan and McElvaney (2020) in their meta-analysis identified that disclosure was more likely if the abused child knew the chosen listener had had similar experience, thus highlighting the value of survivors interviewing other survivors.

A separate issue pertains to the selection of survivor-participants. Thomas and Hall (2008, p. 149) studied "life trajectory patterns, turning points, and setbacks" for survivors (these are discussed later as pertaining to trust). This is relevant to data collection, as the point in a process of recovery will impact the data a survivor shares (Cole and Putnam, 1992; Kia-Keating, Sorsoli and Grossman, 2010; Parry and Simpson, 2016).

One paper recruited participants "doing surprisingly well" (Kia-Keating *et al.*, 2005, p. 171) to discover what these men could share about their resilience, indicating that not all survivor experience is homogenous.

Only one study adopted a longitudinal lens to study shifts in survivor recovery (Banyard and Williams, 2007), and the point was made above about survivors being excluded because of their level of distress. Banyard and Williams's (2007) study reported shifts in stability and resilience over the trajectory of the research, yet no other papers have attempted to pinpoint at what point in a recovery process the research was being conducted. None of the papers reflect on creating or understanding what conditions at the point of interview are conducive to deep sharing by a survivor. Twenty of the papers referred to the shame CSA leaves with a survivor, some refer to instability of mood (e.g. Hailes *et al.*, 2019) and depression (Maniglio, 2010), but none explicate how this might be overcome in interview. These issues indicate an area for further research.

This section has presented the power of researcher paradigm in influencing methodology, study design, interpretation and results, held in the context of the time the research was conducted, and the stage of survivor recovery. This has demonstrated the divide between researchers seeking to represent the survivors' perspective and others who adopt the role of positivist and (so-called) 'objective observer'. While survivor testimony exists, it is filtered through the researcher and thus there is a paucity of empirical evidence generated from a Mad Studies perspective, and this all indicates a gap in knowledge which a Mad Studies empirical study addressing these issue could address.

This chapter moves on to interrogate the literature regarding survivor trust, and invites the reader to hold in mind the issues exposed above.

Trust

The need for trust is stated as an imperative (Moriarty, 2017). Hirakata (2009, p. 309) captures this: "it is essential for therapists to establish a solid foundation of trust and safety". Trusting a therapist is a "very powerful and healing experience" (Chouliara *et al.*, 2011, p.

135). This is reinforced when researchers quote survivor testimony verbatim, for example: "Bill said, 'Trust is a miracle. I've never trusted anybody. And it's the biggest single by product of my therapy'" (Kia-Keating, Sorsoli and Grossman, 2010, p. 678). The meta-analysis of 20 papers over a 20-year period brought Brennan and McElvaney (2020, p. 107) to conclude: "access to someone you can trust was the most commonly identified theme in this review". Trust does not have to be with a therapist, but is also crucial to good relationships with friends, family and even pets (Kia-Keating, Sorsoli and Grossman, 2010).

Obfuscated definitions of trust pointed to above and in Chapter One abounded. For example, Parry and Simpson (2016, p. 793) use the term 'authentic trust' in the context of the relationship between the survivor and the therapist, without explaining if this is perhaps a deeper form of trust than more superficial trusting.

This section offers an interpretation of authors' meanings and usage of the term trust, with the disclaimer that this can only ever be the author of this Literature Review's understanding of the meaning of the term being used by the authors of the reviewed studies.

Mullen *et al.* (1994, p. 43) identify the effect of abuse on survivor trust, and in so doing, name different types or levels of trust. The bracketed italics are added as an interpretation of their meaning to align with the constructs given in Chapter One:

"[abuse] puts at risk the acquisition of a sense that the world is a reasonably safe and essentially benign environment *(i.e. generalised or one-place trust).* It puts at risk trust in others *(i.e. two-place trust),* particularly those on whom they are critically dependent *(i.e. relational trust*). It puts at risk children's emerging sense of themselves as active agents with some control over their world *(i.e. self-trust)*; and finally, it puts at risk their developing self-esteem."

Starting with generalised trust, Robinson (2003, p. 393) says trust is the "participant's belief in the credibility of people in the world", which seems to correlate to generalised trust or one-place trust presented in Chapter One, where there is no named other, and where there is just a sense of trust and no direct entrusting towards a shared goal. Robinson utilised the quantitative "Rotter Trust Scale", which offers the definition of trust as an "expectation that the behavior, promises, or statements of other individuals can be relied upon", thus holding trust to be something one person holds in unspecified others. Hartman (1998, p. 46) uses the term "generalized expectancy" and continues: "these generalized trust beliefs do not predict trust as it is experienced in specific relationships", and goes on to suggest that survivors "fall back" on generalised trust when in relationship with people less well known and move to a deeper inter-personal trust when in relationship with "meaningful others". This is supported by a survivor quoted in Parry and Simpson (2016, p. 798): "I see people as vicious", but the view does not hold for their participants when in specific relationships. This would suggest that generalised trust is a sort of expressed pessimism or optimism but can be adapted to specific circumstances. However, clear boundaries between generalised trust and relational trust are predominantly unexpressed in previous studies.

Senn *et al.* (2017) also appear to be making the distinction between a generalised trust in all men (as intimate partners) and the way this then impacts trust in specific men: "Women noted that their experiences of childhood sexual abuse made it difficult for them to trust men. This lack of trust, in turn, affected women's willingness to engage in committed relationships that would make them vulnerable to a partner" (Senn *et al.*, 2017, p. 499). But, as demonstrated earlier, Senn takes a positivist epistemological stance and thus the subjective survivor experience of the existence of generalised trust, or its relationship to other forms of trust, are not explored. This indicates a gap in knowledge regarding survivors' views of the interplay between generalised and relational trust.

Trust within specific relationships (that is, relational, or two- or three-point trust) is presented more frequently in the literature generated in this review than generalised trust. In one example, (Kia-Keating, Sorsoli and Grossman, 2010, p. 677) make the link between a childhood experience of relating with a trusted other and “retaining a sense of the possibility of developing trust in adult relationships.” While this statement does not mention generalised trust, could it be suggesting that for survivors, knowing the experience of trust in a specific other allows that child to develop a generalised trusting ability?

Theoretical “attachment” models are referenced in studies in this review, which state that trust in early caregiver relationships enable trusting abilities to be built upon (Klest, Tamaian and Boughner, 2019), and that trust learnt in therapeutic relationships can be transferred to subsequent ‘real life’ relationships (Kia-Keating, Sorsoli and Grossman, 2010). Nielsen *et al.* (2018) note that when intimate partners of CSA survivors offer acceptance (trust) regarding the impact of abuse on a survivor’s trust capability, this can be a doorway to trusting within the relationship. The ramifications of generalised trust seem important. Many papers in the review seems to allude to generalised trust as a necessary prerequisite for relational trust. However, further research is needed to clarify this, because another reading of current research is that having trusted a specific other as a child, an individual is then able to trust a *specific* person when in maturity. The existence of generalised and relational trust seems to be taken for granted, but the relationship between them appears unclear, apart from Robinson (2003), who explicitly makes the connection between generalised and relational trust but not in relation to survivors of CSA. Parry and Simpson (2016) conducted a systematic review of 23 qualitative studies and dedicate two sections to trust, but make no reference to generalised trust as an essential indicator of, or prerequisite for, relational trust. This leaves a gap in knowledge, which specific research questions put to survivors regarding their experience of trust could address.

Moving on to consider trust in society and institutions: Klest, Tamaian and Boughner (2019) investigated patient trust in physicians, concluding that when trust is damaged in relationship with a specific physician this extends to diminished trust in healthcare systems, and society in general, and that damaged trust in one care-giver relationship impacts trust in future, as yet unknown, medical personnel. Easton, Leone-Sheehan and O'Leary (2019), investigating clerical sexual abuse, echo this far-reaching impact onto the whole institution, and beyond to a diminished trust in God and noted it caused loss of self-identity as a person with faith. But trust in clergy and the Church can be rebuilt if there are visible efforts to root out perpetrators and repair relationships. This suggests relational trust can shape trust in future relationships and implies that generalised trust is not something imbued in early childhood and fixed for life, but is fluid and can be shaped and influenced.

That betrayal of trust, by individuals or institutions, impacts self-relationality was mooted in many studies. Hartman (1998) names a sense of betrayal survivors feel towards themselves for letting the abuse happen, as though the survivor is themselves a colluder, complicit in the abuse, and this can affect the relationship to self and self-esteem (Pyburn, 2017).

Betrayal abuse points to a ‘shaping’ of survivors’ self-identity, which was named by Mullen *et al.* (1994, p. 43): “it puts at risk the emerging sexual identity […] emerging sense of themselves as active agents with some control over their world; and finally, it puts at risk their developing self-esteem”. Easton, Leone-Sheehan and O'Leary (2019, p. 1155) spoke of the “contradiction between [survivors’] exterior self (in which they projected strength and self-confidence) and their inner self (characterized by insecurities, pain, fragility, and feelings of shame and weakness)”. Parry and Simpson (2016, p. 801) see this ‘hidden self’ as a coping mechanism, while Hirakata (2009) includes dissociation as an example of one helpful way some survivors self-care, as it provides a barrier between self and other.

The sense of self-blame arising from poorly handled disclosure is noted (Blanchard-Dallaire and Hébert, 2014), and Dominelli (1989) says the removal of the child and not the abuser from the family is sometimes a punishment for the child as much as for the abuser-parent, which can leave the child feeling responsible for the abuse.

The damage to self-relationality could be re-shaped when survivors built a trusting relationship with another, as this leads to learning to trust oneself (Harvey *et al.*, 2000; Brennan and McElvaney, 2020). (Parry and Simpson, 2016, p. 299) quote one survivor: “She wasn’t scared of me being mad…I learned a lot of self-trust in that”. Wright and Gabriel (2018) name the process in reverse, with trust in self extending to trust in others, perhaps indicating that the building of trust in any one domain (with self or relationally) flows into the other domains or with the world in general (Banyard and Williams, 2007). Understanding the intra-personal processes of self-trust, which Kia-Keating, Sorsoli and Grossman (2010) link to self-acceptance, then moves the survivor to need to find someone to disclose to (Brennan and McElvaney, 2020). This process takes the survivor into inter-personal trusting relationships, which when successful spiral back into the recovery in the intra-personal domain.

Building trust appears to impact other aspects of self-relationality. Parry and Simpson (2016, p. 798) quote survivors as having “a sense of control, choice, and direction”, having engaged in a trusting relationship, which seemed to suggest the building of self-trust. Hirakata (2009) makes a similar link about survivors knowing how to make choices with confidence, even when they come from an intuition. Harvey *et al.* (2000), conceptualise this a little differently, as a sense of a survivor becoming self-reliant, viewing her own experience as correct even when it differs from the therapist’s view. This is echoed in a different study with this statement: “Participants were also able to see how other people made choices, which helped develop their interpretation of events and ultimately trust themselves” (Parry and Simpson, 2016, p. 799).

Self-trust was closely linked or used interchangeably with self-esteem (Hartman, 1998; Chouliara *et al.*, 2011) and self-confidence (Hirakata, 2009). The opposite of self-trust was presented as self-blame, low self-worth and a sense of being “damaged goods” (Hartman, 1998, p. 34), and a broken sense of unity of the self (Cole and Putnam, 1992).

The extant knowledge of self-trust and self-relationality has predominantly been generated through the lens of the researcher and clinician as observation, and deduced in this literature review by gleaning small snippets of quotes in the published papers. This leaves a gap in the knowledge of what survivors speaking for themselves might say about their sense of self-trust when this is discussed and explored explicitly.

Trust conceptualisation

Trust manifesting in these different forms of generalised, relational (dyadic, groups or institutions) and self-trust can be enriched with what might be considered *constructs* or *conceptualisations* of trust. That is to say, trust is implied with the use of other terms, or behaviours indicative of trust: these will now be explored.

Trust as ‘safety’ is the most commonly made connection (Parry and Simpson, 2016; Hirakata, 2009; Kia-Keating, Sorsoli and Grossman, 2010; Wright and Thiara, 2019; Blanchard-Dallaire and Hébert, 2014; Bowers, 1992; Chouliara *et al.*, 2011). Banyard and Williams (2007, p. 284) state: “she described feeling safe and comfortable with him, a new feeling in a relationship”, since the authors are writing about trust it may be assume that trust is implied between the survivor and her new partner. Kia-Keating, Sorsoli and Grossman (2010) explicitly name the link between recovery and survivors expressing their experience of safety within relationships of all types.

Safety extends to survival when Hartman (1998, p. 29) quotes the child psychologist Erikson: “If the infant is not able to develop adequate trust in the caregiver relationship, growth may cease and the infant may literally not survive”, and uses the term ‘basic trust’.

Other papers use the word ‘confidence’ in the construct of trust (Hull, Corrigan and Curran, 2016; Robinson, 2003). Brennan and McElvaney (2020, p. 110) capture this idea: “within a trusting relationship, children can have confidence that their worries and concerns will be taken seriously”, and Parry and Simpson (2016, p. 794) identify ‘predictability’. Hartman (1998, p. 43) links trust to faith: “when one goes beyond an assessment of current evidence to feel secure in the likelihood of continued trustworthiness despite an uncertain future”. Finally, Dominelli (1989, p. 298) sees trust as a “tempering” aspect over power in the traditional patriarchal family, where power imbued with trust has an ethical quality; in other words fathers who are trustworthy will behave in a more ethically sound fashion in the exercising of power.

These dimensions to trust invite a question: can it be assumed that a survivor feeling safe in relationship has a de facto trust in the other person? This feels like a valid assumption to make and there is no evidence to the contrary, but this needs clarification through further research. Can the inference be extended - if safety in relationship gives rise to recovery, can it be said trust has given rise to that recovery too? These questions need to be addressed in empirical research designed to study the survivor experience of trusting and its link to recovery.

Trust as process

Trust has so far been conceptualised in terms of the survivor and the ‘other’, but many studies show trust not as a binary, but as a ‘process’ (Wright and Gabriel, 2018; Moriarty, 2017). Trust can be learnt or “re-learnt” (Kia-Keating, Sorsoli and Grossman, 2010), and takes time to be built. One empirical study states that the trust-building process may take as much a year in psychotherapy (Matheson and Weightman, 2020).

The time taken developing trust must be respected before “therapeutic interventions” are introduced (Blanchard-Dallaire and Hébert, 2014, p. 339); these opportunities for interventions are named by Hirakata (2009, p. 309) as “therapeutic windows”. A trustworthy relationship is a “mechanism” for recovery (Matheson and Weightman, 2020; Parry and Simpson, 2016), albeit “highly individualized” (Wright and Gabriel, 2018, p. 664; Moriarty, 2017). The element of trustworthiness within the therapeutic relationship needs clinical prioritisation (Easton, Leone-Sheehan and O'Leary, 2019), yet no studies exist to corroborate this where survivor voice has been centred to explore this aspect of trust.

This process of trust building, these studies suggest, is a prerequisite for disclosure (Brennan and McElvaney, 2020) and also recovery (Moriarty, 2017). Recovery begins when survivors “metabolize” the abuse (Harvey *et al.*, 2000, p. 292) in “developmental stages” (Parry and Simpson, 2016, p. 800). The stage of recognising and accepting (Banyard and Williams, 2007) the far-reaching detrimental effects on the survivor’s view of the world and themselves was a fundamental staging post before a shift in these views could begin (Wright and Gabriel, 2018). Harvey *et al.* (2000, p. 293) conceptualised “turning points” as key moments of change, accompanied by “setbacks” but also “stages by dimension”, where progress could be like a “roller-coaster” or at other times, steady. In this way the recovery process was not linear, for example: “The sense of a survivor identity also appeared to hold different amounts of value at varying stages of the participants’ healing” (Parry and Simpson, 2016, p. 802).

Trustee trustworthiness

So far the issue of survivor ability to trust has been the focus, but this review also explored the trustworthiness of the trustee. Elements that contributed to the building of trust, be it with friend, therapist, or even pet (Kia-Keating, Sorsoli and Grossman, 2010) include the qualities of the person, and their behaviours or actions.

Qualities in the trustee which imbue trust are often implicitly named. For example, in the following statement, is it acceptable to assume an inference of trust in the therapist? "She gives me unconditional acceptance and love, and all of that makes for a deeper connection, and that's when healing really happens" (Hirakata, 2009, p. 307). Chouliara *et al.* (2011, p. 136), researching talking therapies, drew similar conclusions, linking qualities such as flexibility and "not pushing things" with trustworthiness.

Hirakata (2009, p. 310) identified words used by participants regarding the qualities of the trusted other: "present, genuine, unconditional regard, love, and transparency". One survivor used the phrase: "my therapist has a way of being in the world" and another: "she's really in tune with me" (*ibid p. 306*). Other qualities include kindness (Kia-Keating, Sorsoli and Grossman, 2010; Chouliara *et al.*, 2011), "confidentiality, lack of judgement" (Chouliara *et al.*, 2011, p. 136) and being "real" and "present" (Hirakata, 2009, p. 307). Hirakata (2009, p. 305) adopts the term "being there" to show a sense of emotional availability of the trustee, which extended into a "knowing beyond words" (*ibid*).

Hartman (1998, p. 43) names more qualities: "reliability, mutuality, surrendering of control, personal safety, and willingness to risk". Here we begin to see the conflation of trust as something both the trustee and survivor do (e.g. surrendering of control) muddled into the qualities of trustworthiness the trustee offers (e.g. reliability). Some qualities are perhaps needed by both parties, but it is unclear who Hartman was referring to, for example when speaking of "willingness to risk". Is she suggesting that for one party to trust, the other party also must trust? While the blurring of clear constructs and definitions might be a criticism of the extant literature, it perhaps indicates the “mutuality’ Hartman mentions.

Trustworthy people are imbued with palpable acceptance, also named as non-judgement (Zdanuk, Harris and Wisian, 1987; Parry and Simpson, 2016; Chouliara *et al.*, 2011), and a feeling akin to friendship. Parry and Simpson (2016, p. 803) quote a participant: “we bonded in a way on a personal level so it made it easier for me to disclose a lot of really horrible things about the abuse”.

The gender of the trusted other may be relevant. Roesler and Lillie (1995, p. 81), researching therapy groups co-hosted by a male and a female lead, stated: “the least threatening place to start seems to be trust building with women. Trust in men seems to come later”.

Brennan and McElvaney (2020) concluded their meta-analysis of disclosure in childhood with an emphasis on trustees creating the “opportunity to tell”, which linked trustee availability with trustworthiness. Having heard a disclosure, a trusted person will always, and wholeheartedly, believe the child. The priority of being believed was underlined in another meta-analysis (Parry and Simpson, 2016).

The survivor may judge a trustee trustworthy because of a shared frame of reference, or feel s/he understands because of a personal experience of abuse (Brennan and McElvaney, 2020). These qualities give a sense that the trustee will be a good listener and be capable of ‘hearing’ the abuse: “even when this is not what we wish to hear or when their stories do not resemble culturally available plots or match current theories” (Harvey *et al.*, 2000, p. 308). The trustee should not be shocked (Parry and Simpson, 2016), and any pathologising may cause withdrawal (Hirakata, 2009; Hull, Corrigan and Curran, 2016). Re-labelling symptoms into “attempts to cope or ways to survive” was an act of agency and power for survivors over the pathologising of experience as “symptoms” (Roesler and Lillie, 1995, p. 6).

The normalising of experience helps build trust (Parry and Simpson, 2016), as does listening accompanied by allowing the survivor to ask questions of the trustee (Zdanuk, Harris and Wisian, 1987), and not "giving up on" or abandoning the survivor when these two requirements become challenging to the trustee (Banyard and Williams, 2007).

These qualities make the trustee "worthy enough of hearing [survivor] stories" (Parry and Simpson, 2016, p. 799), indicating that the survivor will assess the listener before disclosure will progress towards details. And in listening the trustee needed to know when the material was becoming "overwhelming or retraumatising" and help the survivor manage this without dissociating (Hirakata, 2009, p. 298).

The building of a trust depended on the ability of the trustee to create "appropriate and sensitive boundaries" (Parry and Simpson, 2016, p. 805). Boundaries and safety were seen to be "synonymous in the relationship" (*ibid*). Survivors also needed, when relevant, action to be taken as a result of their disclosure; trustworthiness was indicated by the actual 'doing' of something in the world to change things, in addition to offering support (Brennan and McElvaney, 2020).

One important action of the trustee is allow, or give "permission" (Parry and Simpson, 2016, p. 802) for agency to the survivor. The agency to make choices (Parry and Simpson, 2016; Hirakata, 2009; Banyard and Williams, 2007) is a shifting of the balance of power (Banyard and Williams, 2007). An example of being given agency was when survivors were facilitated to find their own narratives, also called "answers", within the trusting relationship (Hirakata, 2009; Wright and Gabriel, 2018; Roesler and Lillie, 1995). This did not preclude the real benefit of gaining the perspective of the trustee (Parry and Simpson, 2016), but making sense in their own way was important (Harvey *et al.*, 2000).

A relationship with a sharing of power and agency would allow survivors to experience the resolution of conflict within this safe space, and repairing ruptures in the relationship was a new, and transformational, experience for many survivors (Hirakata, 2009).

The trusting relationship can be summarised as the meeting of two people “human to human” (Hirakata, 2009, p. 310). In this meeting there is a mutuality, a parity, a “reciprocity” (Hirakata, 2009, p. 309), a feeling of equality (Parry and Simpson, 2016; Banyard and Williams, 2007), which extends to the therapist trusting the survivor (Hirakata, 2009).

Issues of trustworthiness extend to survivor trust of social or therapeutic groups. Since the process of finding a narrative is “inherently and intractably social” (Harvey *et al.*, 2000, p. 308), trusted groups offer a sense of belonging, or “connectedness” (Kia-Keating, Sorsoli and Grossman, 2010, p. 674), thereby reducing isolation (Chouliara *et al.*, 2011). Groups offered additional widening of perspectives (Parry and Simpson, 2016) and the opportunity to help others, which survivors value highly in recovery (Banyard and Williams, 2007) and indicates the transference of trust as already discussed.

In pointing to ways to become trustworthy, Brennan and McElvaney (2020) concluded that trustees need to place emphasis on relational abilities and less on “skills”, indicating the importance of ‘the person’ of the trustee. Harvey *et al.* (2000, p. 293) echo this in asking “how can we develop ways of listening to [survivors’] stories that respect their evolving understandings and their efforts to make meaning of their experiences of sexual trauma?” The call for trustees to develop abilities is evident in survivor testimony (Reese, 2021; Morrigan, 2017). Survivor testimony written by Pyburn (2017) makes suggestions as to how teachers can create an atmosphere which would have enabled her to disclose her father’s abuse. Recognition of the value of trustee qualities is in stark contrast to papers from the medical paradigm, which emphasise survivors’ need to be more trusting, and the trustworthiness of the trustee appears to be taken for granted (e.g. Hull, Corrigan and Curran, 2016; Klest, Tamaian and Boughner, 2019; Laddis, 2019).

The literature search did not generate any papers focused on the creation of trustworthiness qualities of therapists when working specifically with CSA survivors. There is, however, extensive research into the therapeutic alliance, and the importance of relationship over the modality of therapy being offered (Martin, Garske and Davis, 2000). One hypothesis for this might be that the creation of conditions conducive to trust within therapeutic relationships span all forms of clients and patients, and is not limited to survivors of CSA. Nonetheless, since these studies were not located by the search terms this review adopted, interrogating generalised trustee trustworthiness behaviours is beyond the scope of this chapter. This does, however, indicate a gap in the knowledge of trustworthiness qualities of caregivers specific to survivors of CSA.

This chapter now turns towards experiences of the destruction of trust as presented by the literature being reviewed.

The betrayal of trust

The breaking of trust simultaneously arises with the sexual abuse of a child and is documented as ‘betrayal’ in many papers (Senn *et al.*, 2017; Harvey *et al.*, 2000; Hirakata, 2009; Easton, Leone-Sheehan and O'Leary, 2019; Kia-Keating, Sorsoli and Grossman, 2010; Kelly, 1994; Barney, 1990).

Several papers make reference to distinct theoretical frameworks of “betrayal abuse”, or “betrayal trauma”, one by Finkelhor and Browne (1985), while other papers reference the more recent model by Jennifer Freyd (1996) (Klest, Tamaian and Boughner, 2019; Laddis, 2019; Gobin, 2012; Blanchard-Dallaire and Hébert, 2014). Betrayal trauma, like trust, and CSA has no one definition adhered to by all authors, but for Freyd and authors drawing on her theory, “betrayal trauma is characterized by the violation of the trust placed in persons on whom one is socially dependent” (Blanchard-Dallaire and Hébert, 2014, p. 329). Betrayal trauma includes ‘incest’, a term predominantly used by authors writing in the 20th century (e.g. Kelly, 1994; McCay, Bater and Arthur, 1985).

Dominelli (1989, p. 298) and others (e.g. Easton, Leone-Sheehan and O'Leary, 2019), link betrayal with a valid expectation of trustworthiness as a power issue: “family will be cared for and protected by its more powerful ones. Their failure to live up to this expectation becomes a betrayal of trust, or the abuse of power.”

The far-reaching impact of betrayal trauma is presented in the following quote, which is included as a demonstration of the tone adopted by those writing *about* survivors rather than sharing their words. The language used demonstrates the presenting of fact, when it is, in fact, theory:

“Betrayal traumas will be processed and remembered differently than violations perpetrated by individuals with whom victims do not have such a close connection […] victims must make cognitive adaptations in order to maintain the caregiver relationship […] failure to perceive the abuse as a betrayal is adaptive in that it assists the child, who is dependent on the caregiver, in persisting in behaviors that inspire caregiving” (Gobin, 2012, p. 158).

Thus theories posit the survivor as unable to gauge trustworthiness when the abuser was a close caregiver. Hartman (1998, p. 37) names an expectation of survivors’ “distortion of trust beliefs in order to preserve relationships”.

Gobin (2012) investigated but failed to prove the hypothesis that survivors of betrayal trauma actively undervalue qualities which signal trustworthiness, such as loyalty, compassion, dependability, sincerity, honesty, and understanding. Yet meta-analysis by Brennan and McElvaney (2020) with child survivors established that the children gauged adult trustworthiness by assessing their reactions, and *were* able to predict how disclosure would be received.

With Gobin's (2012) study being the only quantitative study (and the limitations presented above), and one qualitative meta-analysis limited to child survivors by Brennan and McElvaney (2020), the dynamic of accurately judging trustworthiness is under-researched. There is little evidence of how survivors experience 'distorted' gauging of trustworthiness of subsequent friends or partners, or repair after a breach in trust. Pyburn (2017) in her survivor testimony writes of her trust for her sexually abusive father and explains why she trusted him. She does not write of any distorted trust in subsequent relationships. However, she reports that she hinted to a trusted teacher of her fear of being sent home to her father. This attempted disclosure was not acted upon, even though the teacher later said she was concerned. Pyburn, therefore, has trusted a non-trustworthy (in terms of safeguarding) carer (the teacher); was it Pyburn who judged the trustworthiness of this teacher incorrectly? Or was the teacher at fault? This is the question Pyburn asks in her piece. Where survivors are cast as dysfunctional (e.g. Cole and Putnam, 1992; Laddis, 2019) and research is focused on addressing that dysfunction (e.g. Senn *et al.*, 2017), the issue of trustworthiness of the trustee is obscured.

Survivors may have shared their experience of gauging trustworthiness with researchers, but it has been those researchers who interpret it as 'distorted'. Laddis (2019, p. 88), a clinician presenting his theory of C-PTSD survivors, speaks of their "flawed model for the restoration of trust. […] Repetition compulsion is the patient's mode of behaving while suffering disorder in the course of ascertaining that partner's trustworthiness". The assumed trustworthiness clinicians afford themselves (e.g. Laddis, 2019), when their clients (survivors) do not see them as trustworthy, requires investigation.

There have been no Mad Studies, or direct survivor testimony studies investigating this aspect of trust, which reveals a gap in knowledge. Dominelli (1989, p. 296) indicates the role feminist studies have played in changing society's view by "exploring incest abuse in terms of what is being said by these women and children and using their accounts". If feminist studies have played a central role in shifting, in less than 30 years, the re-conceptualising of incest, perhaps survivor knowledge can inform views of survivors' abilities to discern trustworthiness.

Survivor distrust within relationship

Trust is implicit in relationship, as stated in Chapter One, and the importance of trust in survivor relationality has been demonstrated in this review. It has included survivors' experiences of difficulties within relationships and variously interrogated different types of relationship: childhood friendships (Blanchard-Dallaire and Hébert, 2014; Kia-Keating, Sorsoli and Grossman, 2010; DiLillo and Long, 1999), adult friendships (Wright and Gabriel, 2018; Barney, 1990), intimate relationships (Kia-Keating, Sorsoli and Grossman, 2010; Mullen *et al.*, 1994), and therapeutic relationships (Hirakata, 2009; Parry and Simpson, 2016; Matheson and Weightman, 2020) and group therapy (Roesler and Lillie, 1995).

Blanchard-Dallaire and Hébert (2014, p. 336) used self-report and teacher report questionnaires to investigate children at the time of the abuse, and both teachers and the children themselves confirmed "reduced interpersonal trust".

Interpersonal issues for adults were also named (Mullen *et al.*, 1994; Kia-Keating, Sorsoli and Grossman, 2010), including a sense of isolation (Kia-Keating, Sorsoli and Grossman, 2010), with avoidance of intimate relationships (Senn *et al.*, 2017; Blanchard-Dallaire and Hébert, 2014) or conversely the choosing of unreliable subsequent partners (Senn *et al.*, 2017). Gobin (2012, p. 152) suggests survivors have a "relational schema whereby abuse is perceived as normal". Even therapeutic relationships were: "not without […] difficulties" (Parry and Simpson, 2016, p. 800). Distancing may extend beyond intimate relationships to friendships (Mullen *et al.*, 1994), and Klest, Tamaian and Boughner (2019) investigated the non-adherence to medical treatment and effects on trusting doctors (see above). Survivors can prefer to be self-reliant (Kia-Keating, Sorsoli and Grossman, 2010, p. 672) with the building of a “protective shell”, which Blanchard-Dallaire and Hébert (2014, p. 337) call an “emotional detachment”. (Parry and Simpson, 2016) link this to silence around disclosure.

Certainly this review has presented the magnitude and far-reaching effects of breaches of trust for survivors. However, Mullen *et al.* (1994, p. 44) offer an important counter-balance: “It should not be overlooked, however, that in many of those who recalled CSA we could not document adverse adult outcomes. CSA is correlated with a range of sexual, interpersonal and social difficulties but these problems are not an inevitable outcome of such abuse.” While incest and betrayal trust are presented and infer particularly detrimental effects on the survivor, so too does the severity of the abuse (Blanchard-Dallaire and Hébert, 2014) or the longevity of the abuse (Mullen *et al.*, 1994).

Summary

This review has gathered the extant literature regarding the many dimensions of survivors’ trust and equally has revealed the many gaps in knowledge, most particularly from a Mad Studies angle.

Constructs and definitions of trust presented in this review leave the reader having to intuit meanings. It appears that damaged basic trust is an inability to trust which has been established in early childhood, and generalised trust is a belief that unspecified others (usually in a group) are (un)trustworthy but that relational trust is possible in certain situations, although this has not been related explicitly to the ‘trustworthiness’ of the trustee, only to certain aspects and abilities of trustees. Breaches of trust and betrayals are to be expected but can sometimes be repaired. There is a clear evidence gap in how survivors express their experience of trust, trustworthiness, breaches of trust, betrayals and under what circumstances repair is possible.

The thesis will now turn towards the construct of a methodology able to address these epistemological gaps.

Chapter Three: Methodology

"If I trust you you'll get it all out of me, so obviously I must trust you" *Chloe*

Introduction

The Literature Review (Chapter Two) revealed a gap in knowledge due to a lack of focused empirical research into CSA survivors' perceptions and experiences of trust, trusting, and trustworthiness. In particular, the paucity of research generated from within the Mad Studies paradigm motivates this study and informs the methodology and use of phenomenology. Firstly, by adopting a Mad Studies lens with the imperative of foregrounding the testimony of survivors, testimonial injustice of "deflated level[s] of credibility" (Fricker, 2007, p. 17) is redressed. Secondly, by using the lived experience of CSA of the researcher, hermeneutic injustice (Fricker, 2007) - that is, the failure to understand the meaning being made by the participant - is to some degree addressed. The shared abuse histories between participant and researcher make open and trusting co-constructed data collection interviews possible (Oakley, 2005; Dominelli, 1989). Thirdly, phenomenology offers an advantageous philosophical foundation for the study because phenomenology's heritage, from its first proponent, Husserl (1859-1938), onwards, is one of constructive challenge to existing scientific approaches (Leslie, 2000, p. 24).

This chapter explores relevant aspects of phenomenology's history and constructs, to argue its relevance as a philosophical underpinning as a way of seeing 'reality' because it allows for the ideographic experience of survivors to become 'of worth'. The chapter then considers Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009), a form of applied phenomenology, as the specific methodological vehicle for the study. By recognising and addressing IPA's contested validity, shortcomings are addressed and adaptations to its methods are presented to meet this study's specific needs (Chamberlain, 2011).

Phenomenology: epistemology and ontology

Phenomenology as philosophy has always found scholars of the approach contesting the validity of each other's viewpoints (Käufer and Chemero, 2015), and applied phenomenology is equally rife with dissenting (Burch, 2021). Yet the entire field has a primary core to which all proponents adhere (Langdridge, 2007): that is, "the study of meaning and its conditions of possibility by means of a reflective method that relies strictly on evidence from first-person experience" (Burch, 2021, p. 285). It is this that makes phenomenology an advantageous paradigm for this study. Taking survivor testimony as valid 'first person evidence' negates the undermining of credibility that can arise when survivors are researched from within a mental health paradigm, which oftentimes links trauma distress 'symptoms' to mental health diagnoses. The 'madness' inherent in diagnoses, using the label of disorder, can confer a status of "less reliable epistemic knowers" (Taggart, 2022, p. 155), due to the assumed deficit in reason (Crichton, Carel and Kidd, 2017). The scholarship of Foucault (2003) is often invoked in the determination of those named 'mad' to have the discreditation of madness reversed, and no longer be discounted as irrational or without the capacity for reason. Ratcliffe (2012, p. 473) advocates the use of a phenomenological "radical empathy" to see the world as those with psychiatric illness see it, which is to see everything with fresh eyes, and this invitation might be beneficial when considering the world view traumatised survivors report.

Phenomenology's oft-quoted statement, "go[ing] back to the things themselves" (Smith, Flowers and Larkin, 2009, p. 12), steps aside from such pre-formed ideas and encapsulates the phenomenological endeavour espoused by Husserl (1859-1938) of seeing with fresh eyes. This study seeks to do this by addressing the investigation to the subjects (survivors of CSA) who are trusting or not, in different ways and contexts, rather than clinicians or academics commenting on survivors' abilities to trust, which is the predominant approach adopted by studies in the Literature Review. When clinicians or academics speak of survivor (in)ability to trust, they become secondary observers who, according to phenomenology, are 'seeing' through their own subjective view.

Zahavi (2018b) notes that under a phenomenological gaze, ontology and epistemology lose their usual divide and merge, as the nature of 'reality' is not distinct from the knower. This offers this "first person ontology" (Gallagher and Zahavi, 2012, p. 100). King *et al.* (2008, p. 81) underscore this: "what is distinctive about the phenomenological approach, however, is the strictness with which *all reference to reality is set aside"* (author's italics).

Choosing to drop off the subject-object view and embrace "being-in-the-world" (Zahavi, 2018a, p. 24), or 'Dasein' (a term adopted by Heidegger), is to step into the phenomenological paradigm with no fixed reality (Frechette *et al.*, 2020). Reality is only as each person experiences it, so a phenomenological view recognises that trust is experienced individually in the survivor and the trustee. One part of the dyad cannot speak entirely accurately of the experience of the other, even when they are co-creating a relationship where trust is central to that relationship.

When applied to the study of specific aspects of ideographic experience (such as CSA), phenomenology focuses on the perception and the meaning being made by the subject (Langdridge, 2007), and underpins the value of "dependable ways of describing conscious experience" (Gallagher, 2012, p. 5). Polkinghorne (1989, p. 41) clarifies:

> "Experience involves the operation of active processes that encompass and constitute the various contents that become present to awareness. These contents include not only the contents of perception but also those of memory, imagination and feeling".

Thus, phenomenology explicitly allows for the understanding of traumatic present-moment experience to include memory of past events, imagined possible futures, emergent sensations and affect. For this study, phenomenology privileges the perception and meaning survivors are making of whether the trustee is trustworthy by recognising their sense of trustworthiness of, and trust in, the trustee as their own reality. By taking this approach the study restores epistemic trust in survivors' testimonies, and the proposition that survivors have impaired trusting capacity (see Chapter One) can be challenged by setting aside preconceived ideas and by using phenomenology's "disciplined naivete" (Finlay, 2009, p. 476).

The use of phenomenology as a relevant and capable approach to research diverse fields of study is well recognised (Dahlberg and Dahlberg, 2020; Finlay, 2009; Frechette *et al.*, 2020) and IPA is a research methodology drawn from phenomenology's focus on the *meaning* made of experience ideographically. This focus separates it from other qualitative methods and aligns it with the aims of this study (Smith, Flowers and Larkin, 2009). Grounded Theory (Charmaz, 2014), while respected for its aptitude for scrutiny, focuses on the formulation of theory arising from data (Gordon-Finlayson, 2010), but this study addresses the epistemological gap of the meaning made of experiences of trust within trust-relationships, not a theory of trust per se.

Narrative Approaches (NA) (Clandinin and Caine, 2013), like phenomenological approaches, interrogate experience and meaning-making, but NA allows, or invites, the participant to direct the interview towards their own priorities by engaging in 'story-telling' (Savin-Baden and Howell Major, 2013). This made NA less suitable for this study, compared to IPA's prerogative of focusing on a specific aspect of experience chosen by the researcher.

Thematic Analysis (TA) (Braun and Clarke, 2006) thematises aspects of experience but does not tend to include language or metaphor investigation (Nowell *et al.*, 2017) and by avoiding an epistemological stance (Braun and Clarke, 2006), it falls short of the epistemological coherence that a phenomenological focus offers. Compared to GT, NA and TA, IPA is a methodology capable of offering "not an explanatory enterprise but rather a clarificatory one. Instead of enabling understanding, it pursues 'constitutive understanding'", (Burch, 2021, p. 286) and with its interpretative lens it adds richness and depth to the Mad Studies knowledge this study seeks to generate.

Interpretative Phenomenological Analysis (IPA)

IPA was developed to interrogate the meaning made by participants in health psychology (Smith, 2018). IPA's use has extended into a diverse range of disciplines (Eatough and Smith, 2017), adding to its credibility as a robust tool for interrogating experience (Brocki and Wearden, 2006). *Interpretative Phenomenological Analysis, Theory, Method and Research* is known as the IPA handbook (Smith, Flowers and Larkin, 2009), and has been supplemented by ongoing debate in peer-reviewed journals challenging and defending efficacy (for example van Manen, 2017a; van Manen, 2019; Zahavi, 2019; Smith, 2018). Peer review of papers published in journals has also scrutinised its effectiveness (Brocki and Wearden, 2006; Chamberlain, 2011; Finlay, 2012), and indicates areas where adaptations to the methods can ensure the effective use of IPA to meet specific study needs (Chamberlain, 2011).

IPA explicitly differs from pure phenomenology precisely because it is not attempting to offer insight in general *about* a phenomenon in a Husserlian approach (Laverty, 2003), and is instead "concerned with the detailed examination of personal lived experience" (Eatough and Smith, 2017, p. 193). The difficult interface between survivors and those caring for them due to discredited survivor testimony reinforces the value of IPA in interrogating the complexity of emotionally charged experience, as Smith (2011, p. 9) states, IPA “is most commonly used to examine experience which is of existential import to the participant”.

By focusing attention onto the inductive epistemic, and turning to the participant to uncover “bottom-up” data, IPA differs from those seeking to validate a pre-formulated theory (Flowers and Dickinson, 2018). IPA is ideographic, this is stated as one of its three foundational principles, together with phenomenology and interpretation (Smith, Flowers and Larkin, 2009). The exploring of experience at the level of the individual aligns it with Heideggerian phenomenology (Frechette *et al.*, 2020). To do this it uses the phenomenological core attribute of seeking “the essence” of the experience to challenge “traditional” or established thinking by returning to a view unshaped by taken-for-granted attitudes (Smith, Flowers and Larkin, 2009).

In IPA this is achieved via the Husserlian-aligned ‘époche’ of ‘bracketing’ (Laverty, 2003) where the ‘common sense’ notion of how things are is recognised as possible bias to the deeper meaning for the participant. The “suspension or reduction of the common sense thesis that an independent reality ‘explains’ experience” (Polkinghorne, 1989, p. 41) enables the clear(er) seeing of how the respondent is expressing their unique experience of how things are *for them*. This ‘fresh seeing’ needs to be repeated during analysis, as the researcher’s previously unseen pre-suppositions emerge (Smith, Flowers and Larkin, 2009) (see Chapter Six).

While this aspect of Husserl’s construct of phenomenology is important in operationalising IPA as a method, IPA more fundamentally aligns with Heideggerian phenomenology because of the ‘Dasein’ aspect of experience. Heidegger adopted this previously unused term to express that “our very being is to be located in and involved with the world” (Zahavi, 2018b, p. 24). This was a radical shift from Husserl’s construct of the ‘subject-object’, to exploring instead the ‘subject-world’ (Käufer and Chemero, 2015). Dasein makes explicit that all things are interacting; all experience is relational. The participant is “in the world” and the co-arising of experience from the interaction is shaping each moment (Smith, Flowers and Larkin, 2009). There is no reality separate from the participant’s experience of it (King *et al.*, 2008). Reality is not a ‘thing’ in the world as positivist views have it (Frechette *et al.*, 2020); ‘reality’ is personally owned, and is constructed by the Dasein nature of experience. Thus IPA offers a radical rejection of subject-object dualism, which underpins positivist scientific research (Käufer and Chemero, 2015), and the medical model of mental health, which enshrines the Cartesian dualism of subject (psy-doctor or academic researcher) and object (survivor), the former a non-biased observer of the latter.

While this study focuses on survivors’ experiences of trusting, it must be noted that this approach holds that the trustees will also be having their own ideographic experience of the same relationship. By allowing for the dyad to be having equally valid yet different understandings from the same interactive moment, the two become of equal importance (Zahavi, 2018b). This then rejects the critical realist stance that there is a ‘truth’ or ‘facts’ about an interaction between survivor and trustee, and only the trustee is in a position to know, or name, the reality. This becomes significant, and is interrogated as a key finding in the discussion and conclusion to this thesis.

In this respect IPA aligns with the supposition that trust can be effectively understood through this lens of relationality. By positing “reality as the product of the mind” (Savin-Baden and Howell Major, 2013) and not separate from the person perceiving it, events - such as a relational interaction between carer and survivor - can be understood as interpretative experiences for both members of the dyad. Käufer and Chemero (2015, p. 29) use the term “infallible evidence” to underline the phenomenological view that experience of an event cannot be incorrect, because it is the experience that we are examining, not some idea of any reality separate from that person’s experience. IPA makes no attempt to verify the truth or facts of the events (King *et al.*, 2008), and participant statements are valued for their ideographic contribution to the field of knowledge of what is experienced, rather than some idea of what actually happened as a reality.

As the Introduction outlined, this study uses a trauma lens to engage with survivor experience and IPA’s hermeneutic stance allows for a richly informed analysis of this difficult-to-understand aspect of traumatic response. Hermeneutics is the endeavour to understand (Zimmermann, 2015), and it was Heidegger working with Husserl in the development of phenomenology that postulated the entwinning of hermeneutics through phenomenological method (Caputo, 2018). The value of hermeneutics in research was advocated strongly by Smith (2007) in his construct of IPA as a way of interrogating participant meaning-making using bracketing, which sets aside assumptions and doxastic truths, thus allowing ideographic material to be firstly brought forward and secondly valued.

Of equal importance is the use of hermeneutics in the deep interrogation of participants’ use of language and metaphor, and its capacity to reveal the complexity of the hidden aspects of meaning (Hearn, Finlay and Fine, 2016). Also, the use of the ‘hermeneutic circle’, “a back-and-forth movement from part to the whole” (Frechette *et al.*, 2020, p. 9), is an essential interrogative tool in analysis and takes the researcher between levels of data, for example from a participant’s word in relation to the entire transcript, from one participant to the whole data, from the data to the societal context. This dialectic facilitates the emerging of hidden meanings (Smith, Flowers and Larkin, 2009).

In addition to this there is the meaning the researcher is making *of* the meaning participants have made of their experience. This is called the ‘double hermeneutic’ within the analysis process. One must also recognise that the reader interprets the written word and thus is also making her own meaning of the thesis, thereby adding the triple hermeneutic. Given these hermeneutic layers, the trustworthiness of interpretations is now explored.

The use of interpretation necessitates an understanding of how meaning is made by ‘pre-supposition’, also known as ‘pre-reflective’ awareness (Zahavi, 2018b). The issue centres on the nature of awareness, and at what moment the participant becomes aware of their experience, or in other words is reflecting on a specific experience and thus making meaning from it (Laverty, 2003). Gallagher and Zahavi (2012, p. 52) note the unity of the phenomenologists in “defending the view that a minimal form of self-consciousness is a constant structural feature of conscious experience”, and this makes the experience ‘belong’ to the individual. Smith, Flowers and Larkin (2009, p. 189) then add three layers of reflection in terms of intentionality to this first fundamental layer: the “glance” at the pre-reflective experience (layer two) , the “attentive reflection on the pre-reflective”(layer three), and the “deliberate controlled reflection” (layer four). For survivors this may prove to be a particularly useful lens to use, because trauma causes fast reactions (van der Kolk, 2014) and possibly the ‘pre-reflective yet mine’ nature of experience may be what generates actions. The fawn, fight, flight, freeze/flop aspect of trauma is an important part of this first layer in theory, and is something for the study to investigate. This first layer is also important in the double hermeneutic of the researcher, because pre-suppositions can never be bracketed (Frechette *et al.*, 2020).

Over longer time frames levels two, three and four become possible. In the interview there is an invitation to engage in levels two and three, maybe even four (Smith, Flowers and Larkin, 2009). But the hermeneutic of the researcher is to be aware of all three levels and fully engage during the analysis in level four. When the researcher is also a survivor, awareness of level one is essential so as not to be lost in un-reflexive and un-reflective awareness in the interpretations being made - not be stuck in the “natural attitude”, but carefully using bracketing to generate trustworthy data.

The role of time on meaning-making is recognised by the phenomenological aspect of IPA. Events are “temporally and experientially unified […] we encounter the present on the basis of the past, and with plans and expectations for the future” (Zahavi, 2018b, p. 61). Trauma (see Chapter One) makes specific significance of past events shaping the survivor’s current moment and predicted futures; sexual abuse may have happened in childhood but flashbacks, intrusive memories, triggering and nightmares bring trauma distress into the present moment (van der Kolk, 2014) and thus shape the meaning being made here and now. IPA’s capacity to embrace the mental construction of perceived futures aligns it with the ontology of this study, with the nuanced expectation that the data collected is ‘of the moment’ when it was gathered, and is set within social, political, cultural and economic contexts (Brocki and Wearden, 2006). Because of this, this study does not claim a generalisability to all survivors, or to any fixed proof of a reality beyond what was co-created in the interview room at the time of the data collection. This is true of all IPA and, arguably, all qualitative studies, because the expectation that findings might be horizontally generalisable (Yardley, 2000) across similar populations is not the objective. Instead this study seeks to generate data which Yardley (2000) terms vertically generalisable, that is, of relevance in expanding understanding about the phenomenon and “to link the particular to the abstract” (Yardley, 2000, p. 220). In this way the study seeks to inform people working with survivors about the possibility that what these participants spoke of might inform their own work in their engagement with survivors.

Finally, the role of the body in phenomenology is embraced by IPA (Smith, Flowers and Larkin, 2009), and this is crucial because trauma distress plays out as physiological sensation within the body (van der Kolk, 2014). Merleau-Ponty extended the role phenomenology affords the body (Gallagher, 2005), and embraces meanings made from “the body one *is* rather than the body one *has*” (Romanyshyn, 2011, p. 41). This epistemology of the body’s central role in symbolic gesture as sensation and thought, and the relation between the two, which is shaping what the survivor knows of her world (Romdenh-Romluc, 2010). This engagement with embodiment adds to the rationale for using a phenomenological lens, because trauma experience is both cognitive and embodied (van der Kolk, 2014) and survivors draw on their physiological, visceral feelings to gauge their sense of safety when formulating meaning from relational moments. The body as a phenomenological lens is operationalised in the method section below, considering it to be a “sentient being” (Frechette *et al.*, 2020, p. 5).

Heidegger’s initial consideration of the contribution of the body in phenomenological ontology rested on the inter-subjectivity of experience between object and subject. This contact-point of inter-subjectivity can be understood as empathy (Finlay, 2005). Empathy as a hermeneutic tool (Smith, Flowers and Larkin, 2009) is important to this study, as it is the capacity to empathise through shared experience which underpins the participatory and survivor-researcher stance. Ratcliffe (2012, p. 473) expands on this in his call for the adoption of “radical empathy”: “in the absence of radical empathy, certain changes in the structure of experience that occur in psychiatric illness and also in a range of other contexts are either misinterpreted or altogether resist interpretation”. Ratcliffe claims that experiences outside ‘normal’ might be misunderstood and thus marginalised and/or mis-treated unless the researcher is able to engage in form of phenomenological empathy that allows access to previously misunderstood, confusing or unclear elements of experience by the participant and/or researcher. In this way radical empathy goes some way to reversing hermeneutic injustice pointed to above.

To conclude, Heidegger’s contributions to, and construct of, phenomenology and hermeneutics are undeniable. IPA draws heavily on the rationale and freedom it offers to research. Yet for this study, placing his work centrally brings an ethical squirm when contemplating his allegiance to the evils of Nazism. Caputo (2018, p. 30) notes that the researcher must focus “not on [Heidegger’s] authorial subjectivity but the author’s subject matter. You ignore Heidegger at your peril”. This study aligns with Levinas and Arendt (Arendt, 1970; Thomson, 2017; Stokes, 2020) in their call for ethics that demand censuring the man while embracing the approach to epistemological discovery, and this is built into the ethics outlined below.

IPA and rigorous research

Having laid out phenomenology as an appropriate paradigm, and presented IPA as a methodology with utility to address the specific aims of this study, it is also important to note that the credibility and suitability of IPA, as it has been constructed by Smith in the handbook, has faced criticism (fuller analysis of this is given as background in Appendix Three). IPA’s effectiveness has been evaluated by detractors (Chamberlain, 2011) and Smith himself (Smith, 2011) through the examination of peer-reviewed studies, where IPA was the adopted methodology. It is clearly problematic to claim IPA is an unsatisfactory methodology when it is researchers who have failed to deploy it in accordance with its underpinning philosophy and stated methods. IPA cannot be held responsible when it is misused. In brief, Smith (2011) both defends and expands the construct of IPA in response to critical thinkers, and verifies earlier claims to IPA as a methodology which provides boundaries to maintain adherence to Phenomenological and Hermeneutic principles. The ‘scaffolding’ it provides guards against faulty application, yet it is important to acknowledge that IPA is “not a fixed thing itself" (Smith, Flowers and Larkin, 2009, p. 4), as the handbook explicitly states. Eatough and Smith (2017 quote Shaw and Frost, 2015: 2):

> "Human experience is multidimensional and multi-ontological, that its exploration can be better served by combining methods to address the research question in many ways, and that embracing the differences that different paradigms bring can help us better understand the complexities of human experience and interaction".

Burch addresses critics of IPA (and other AP methodologies) by suggesting an "intrinsically interdisciplinary research program that integrates the method of [core phenomenology] with the method and/or findings of some other discipline(s) to solve a problem for which no monodisciplinary solution will suffice" (Burch, 2021, p. 277) .

Chamberlain (2011) offers this option specifically to IPA by noting the opportunity it affords to adapt research protocol. Chapter One pointed to potential benefits from the shared CSA histories between researcher and participants. This might be considered one adaptation to the method, which then draws on IPA's stated need of the necessity of strong reflexivity (Etherington, 2004) to address concerns or cynical dismissal by readers, face up to epistemic oppression (Dotson, 2014), and deliver the benefits available from the positionality of the researcher (Beresford, 2016b).

Critical analyses of IPA mentioned above afford this author the opportunity to include in study design essential elements to shape and deliver robust, trustworthy and transparent findings. IPA does not differ from other qualitative research in the need to deliver reliable data, yet given its ideographic nature and the contextual issues (Todorova, 2011) that make it non-replicable, other ways to offer rigor to findings must be considered (Yardley, 2000). Lincoln and Guba (1985, quoted in Nowell *et al.*, 2017) offer a well-respected checklist of trustworthiness, credibility, transferability, dependability, and confirmability. Nowell *et al.* (2017, p. 1) succinctly names the task: "to be accepted as trustworthy, qualitative researchers must demonstrate that data analysis has been conducted in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible”. Nizza, Farr and Smith (2021, p. 369) have identified a checklist of four qualities that comprise a robust IPA study: “constructing a compelling, unfolding narrative; developing a vigorous experiential and/or existential account; close analytic reading of participants' words; attending to convergence and divergence”. This chapter now presents the methods adopted to deliver a study with these credentials. Firstly, an exploration of the ethical framework of the study.

Methods

The University of Essex granted ethics approval for this study (Appendix Four). As a study of trust with people whose early-years care had been violated by authority figures, the study was shaped to embody trustworthiness throughout and minimise power differentials (see below). Critics of previous IPA studies suggest that robust studies need to be “sensitive to their context” (Yardley, 2000, p. 219) and adapt the methods to meet specific needs (Chamberlain, 2011; Burch, 2021). To this end this study has been shaped to ensure the safety and care of participants and researcher by seeking guidance from a CSA survivor with 26 years’ professional experience supporting survivors and educating service providers. Seeking such guidance is also in keeping with participatory ideology proposed by Mad Studies proponents (Beresford and Russo, 2022).

Inclusion criteria

Adults self-identifying as survivors of CSA were invited to participate, and no proof was required other than the survivor’s word. Seeking validation of abuse histories might have signalled non-trust, which could have been (re)traumatising, and would have undermined the creation of an atmosphere of trust between researcher and participant.

Recruitment

Participants were found using a ‘snowballing’ procedure (Gilbert and Stoneman, 2016). The researcher contacted seven people known to her through her work in the field: the survivor-advisor, six survivors and one therapist working with survivors. Of the six survivors, four participated and a question at the end of each interview invited that participant to tell other survivors of the study. If these survivors were interested in becoming participants they could contact the researcher. Several of these ‘secondary’ participants went on to nominate further participants. The therapist generated one participant, and the latter recruited a friend. In this way the study used the trustworthiness of the recommending participant to signify safety to other potential participants. There were three survivors who received the participant information sheets but declined interview. Concerns prior to recruitment that this method would yield insufficient participants proved unfounded and so previously planned recruitment methods (social media, posters on noticeboards) were not needed.

Completion of Recruitment

The study design planned 12 to 16 interviews based on discussions within IPA forums, literature (Smith, Flowers and Larkin, 2009), and peer-reviewed papers examining ‘sufficient’ reach (Guest, Bunce and Johnson, 2006). Mason supports the widely held qualitative view that a pre-ordained ‘right’ number of interviews disregards the rationale for qualitative research over quantitative research and its ability to “build a convincing analytical narrative based on ‘richness, complexity and detail’, rather than on statistical logic” (Baker and Edwards, 2012, p. 5). This allowed for flexibility in target numbers at the start of the study. A study by Guest, Bunce and Johnson (2006) concluded 12 interviews as a mean number needed sufficient repetition of themes to become evident, with main themes evident after six interviews, thus indicating a suitable moment to terminate recruitment and interviewing. The argument for using saturation is alluring, but Saunders *et al.* (2018) note the difficulty of listening alone to find the saturation point accurately, and prefer analysis of each transcript before progressing to the next interview to confirm repetition. But, in line with IPA's protocol, this solution was rejected in favour of the rationale that immersion in the re-listening, transcribing and uninterrupted inductive "back-and forth" analysis between all transcripts would better aid developing a comprehensive hermeneutic of both individual-level and combined data. Therefore, once recruitment and interviewing commenced the researcher kept track using a journal of her sense of repetition of emerging themes, but no decision to cease occurred because after 12 interviews, new participants were still offering to contribute. Not wishing to silence or reject survivors, as this might mimic poor disclosure experiences and have been (re)traumatising, 16 interviews were conducted. All 16 had been analysed, and coding was well under way, when a 17th survivor, ardent to contribute, contacted the researcher. The data from this participant confirmed that although ideographically excellent data was gleaned, the narrative fell within the bounds of the codes and themes thus far elicited. No further survivors came forward and interviewing came to an end with a total of 17 participants.

Demographics

Homogeneity of the sample (as demanded by IPA) was located in the shared history of CSA. The timeline of abuse and recovery was not explicitly sought. Since the abuse occurred in childhood and all participants were adults, the abuse was non-recent CSA. Specific demographics regarding age, gender or race were outside the scope of this study, as there was no intention to compare trust pertaining to social categories, although it is reasonable to assume that social factors might play a role in how different participants understood and talked about trust. Social data is provided in Table 1.

Table 1: Social demographics of study participants

	Pseudonym	Gender			Race		Nationality		Sexual Orientation		NeuroD	Age				
		Female	Male	Non-B	White	Black	British	Non-British	Heterosexual	LGBTQ+		20-29	30-39	40-49	50-59	60+
Participant																
1	Jake		x		x		x		x						x	
2	Betty	x			x		x		x							x
3	Milla	x			x		x		x				x			
4	Jo	x			x		x		x							x
5	Ruby	x			x			x		x				x		
6	Caroline	x			x		x		x					x		
7	Helen	x			x		x			x					x	
8	Chloe	x			x		x		x					x		
9	Stella	x			x		x		x						x	
10	Rachel	x				x	x			x					x	
11	Tessa	x			x		x		x						x	
12	Julie	x			x		x		x		x	x				
13	Frank		x		x			x	x						x	
14	Will		x		x		x		x						x	
15	Patrick		x			x	x			x					x	
16	Yasmin	x			x			x	x					x		
17	Anna	x			x		x		x				x			

The option of studying women only was discussed with the advisor, who maintained, from their experience, that abuse and trust experiences share broad commonalities across gender as well as some differences. In the absence of previous empirical research into the differences in CSA effect between genders and because the Literature Review for this study did not yield evidence regarding gendered experiences of trust, a mixed-gender study was chosen. Gendered and socio-economic category-focused studies of trust are an area for further research.

The participants in this study shared certain characteristics which make the data generated specific to this group; specifically the Findings (Chapter Four and Five) indicate that they had all been able to build trust-relationships, and their reflections on trust were predicated on having moved through the stages of building trust when in relationship with a trustworthy person. In this way the data in this study has been shaped to some degree by the ability of these particular participants to reflect back on their many and varied experiences of trust and the trustworthiness of trustees. No one was recruited who had not had trust relationships. This may be because such individuals did not want to reveal their vulnerability by taking part in a research study. Therefore, the study was not able to capture the data from participants who did not feel sufficient trust in the researcher to join the study and this is a limitation of the study design, and one that is considered below in alternative methods of data collection. It may be significant that the age of the participants in the study is skewed towards middle age; possibly younger participants might have had fewer trust-relationships and might have offered different complexion on their present day experiences of trust and trustworthiness. Possibly older survivors had learnt how to build trust; this is considered in the Findings Chapters (Four and Five) and Discussion (Chapter Seven) because many participants expressed that in the present day they could feel mistrust when encountering someone deemed untrustworthy just as they had in earlier years. The limitation that data is specific to the sample is shared by all qualitative research in that data gathered can only pertain to the specificity of study participants; different participants will always generate different data (Smith, Flowers and Larkin, 2009; Savin-Baden and Howell Major, 2013)

Interviews

Interview venues were chosen by each participant. This was to address ethical considerations of participants feeling safe and knowing they had input and control through the interview process. Participant choice in elements such as the venue affords “credibility [to] the research process (Lincoln & Guba, 1985)” (quoted in Chouliara *et al.*, 2011, p. 132).

To keep the researcher safe, and to meet ethics committee requirements, all venues were in close proximity to other people. Options included the University campus, therapy centre, café or online video platform. Four participants chose the online video option. Online video may have offered this cohort an advantageous sense of safety by avoiding in-person contact, and venues which could be triggering (Hanna, 2012). Online interviews are reported in studies to be as effective as in-person interviews, with a similar number of topics discussed although with fewer detailed statements (Krouwel, Jolly and Greenfield, 2019). In this study while one video-interview was shorter than the in-person interviews, the other three were of similar lengths, the wi-fi connection did not falter, was not pixellated, and rich data was gleaned verbally and from the subtext of tone and delivery. However, video-interviewing did possibly inhibit the reading of body-language cues (Seitz, 2015).

The issue of safety may have been relevant for the two participants who chose café venues, which possibly caused a reduction in the level of detail being revealed. It cannot be known what they might have shared in other contexts, but this is true of all interviews given their contextual nature (Mann, 2016). Background café noise made transcribing one interview difficult, but sound-enhancing technology left only three words unintelligible.

The study could not assume the level of trauma distress being experienced by interview participants in the totality of their life, or on the day of the interview, or if triggered by moments during the interview. Therefore the study was designed to offer a safe (enough) container to investigate experiences of trust and a discussion around the possibility of material in the interview causing (re)traumatisation. To this end information sheets were sent to participants ahead of the interview, and points raised in these were explicitly discussed at the start of the interview. Informed consent (Davies, 2008) was attained (Appendix Five).

Using the term ‘enough’ safety signals that for people living with trauma, safety is not an ‘absolute’ concept, but a continuum, and requires “both people [participant and interviewer] defining what this means and negotiating it relationally. This extends to physical, psychological, emotional, social, gender and cultural safety” (Sweeney *et al.*, 2018, pp. 319-333). Safety is recognised in ethical contexts when working with human participants according to the overarching Belmont Report (Favaretto *et al.*, 2020), and the undertaking to do no harm (Vanclay, Baines and Taylor, 2013). Other scholars state that research participants should be exposed to as little risk as possible (Piotrowski, 2019), but this presented an ethical dilemma for this study as it specifically invited the remembering of painful and possibly abusive experiences with trustees, even if the study was not inviting discussion around the CSA itself. And although not an investigation of the CSA, no silencing would take place within the interview and the original abuse experience could be discussed, as participants wished. The benefit rationale for this study to provide survivor knowledge was strong, rather than the second-hand knowledge from clinician experiences of survivor experiences, but had to be balanced with the risk that retrieval of such knowledge might be (re)traumatising.

The ethics application and execution included measures to ensure participant safety in several ways. Recruitment and interview issues have been discussed above. Other measures were firstly, assurances of the researcher's ability to offer care in the event of triggering. The researcher is a longstanding mindfulness teacher and works therapeutically with traumatised clients.

Secondly, participants' psychological support frameworks, including existing supportive non-therapeutic relationships, were established during the signing of the consent form. Information regarding other support organisations was provided with the participant information sheet (see Appendix Five). The concluding question in the interview was an enquiry as to how the participant was feeling now; what, if any, support they might seek during the rest of the day; and to check they knew how to reach the researcher if they wanted support or signposts to other help.

Thirdly, the ceding of control to the participant was explicitly discussed at the start of the interview and in the participant information sheet. The participant was at liberty to terminate the interview, decline to answer questions, and could change direction of the narrative.

In actuality, no (re)traumatisation was reported by participants. The researcher checked this during and at the end of the interview. All participants spoke of either not feeling in need of support following the interview or said they would be using established methods of support, for example, Milla said: *"I might go home and write my journal and start reflecting".* Twenty-four hours post-interview, an email was sent to check the wellbeing of participants, and everyone confirmed they did not need any help.

While no participant reported triggering, emotional moments were not absent and led the author to ask participants' wishes: continue, shift topic, or terminate. Many participants appreciated being heard, and being able to help other survivors through the medium of this study. A full exploration of this is presented in Findings Two (Chapter Five).

The researcher's wellbeing was safeguarded with frequent supervision from both her primary and secondary supervisor, and she maintained regular contact with her personal counsellor throughout the period of the study. Periods of reflexivity during the recruitment process and after each interview allowed for issues to be noticed and support sought where necessary (Mann, 2016; Davies, 2008). By way of example, one male respondent ceased to respond to the text message exchange arranging a venue: he had wanted to conduct the interview in his home, which breached ethics approval. The researcher wondered if her polite decline may have inferred he was untrustworthy, or might abuse her when in his home. This participant had been nominated by another participant previously unknown to the researcher, and thus with no mechanism of a third party to reach out and check his wellbeing, after two texts were sent asking if he was alright, contact was terminated. The option to ask his friend who had put him in contact with the study would have breached confidentiality regarding this sudden silence. This man had named time constraints due to workloads and deadlines, and this may have been the reason for him ceasing contact, but thoughts for his wellbeing sat heavily with the researcher. Journalling, supervision and counselling helped to hold her concerns that she may have done harm sensitively in context.

Ethics approval included issues of confidentiality, and given the silencing characteristic of CSA the crucial issue of anonymity "as a vehicle by which confidentiality is operationalised" (Wiles *et al.*, 2008, p. 52) was addressed (see Appendix Five). The anonymisation process followed existing University of Essex protocols by divorcing participants' names from their transcripts directly after interview, thereafter using pseudonym names during analysis, and in this thesis. The consent forms and the list linking the names to pseudonyms remain in a locked cabinet and will be destroyed once this study is completed.

Data collection

Moving from ethical structure to interview content, semi-structured interviews were conducted, lasting approximately one hour to match therapy session timespans, as a familiar format for participants. A draft interview schedule was trialled in a pre-pilot interview (Gillham, 2005) with the study advisor, allowing the researcher an authentic interview experience with a member of the cohort and the opportunity post-interview to reflect together and evaluate the interaction. Considerations included the schedule versus time dynamic, effective open questions and prompts, and the need for balance between pre-planned topics and alternate directions brought by participants. The researcher received feedback from the advisor on her technique, personal manner, and capacity to manage the interview in terms of time, emotional safety, handling sensitive moments empathically, and maintaining her own stability. 'Active listening' as a reflexive behaviour (Ezzy, 2010) was intentionally used during subsequent interviews. This is listening to understand rather than to answer back, and listening to the researcher's own internal process while interviewing. This pilot created a sense of confidence going forwards with the refined interview schedule (Silverman, 2014), and an understanding of the value of flexibility, responsiveness and attentiveness to follow-up questions as an opportunity to "shin[e] a light on something that was implicit (hidden and ambiguous), and making it explicit (expressive of a strong emotional reaction)" (Frechette *et al.*, 2020, p. 7).

The pilot interview was transcribed and included in the results. Appreciating IPA's invitation to shape the study according to its needs, the researcher took further steps to improve her interviewing abilities. Firstly, she asked her personal counsellor to conduct an interview using the schedule with her as the participant. This allowed the researcher to experience the phrasing and order of questions, and the depth they seemed to be seeking and give her a first-hand experience of the tension between too much and too little guidance (Chapter Six includes data from this interview). Secondly, interview training workshops enabled her to practice and notice when subtle or unconscious directing was arising.

Participant comments during the interviews point to the success of this approach. Chloe said: *"I can talk to you and, like I say, I'm quite who I am, if I trust you you'll get it all out of me, so obviously I must trust you".*

Even with this, and similar statements in other interviews, it is acknowledged that the level of trust it was possible to build is open to critical reflection. Chapter one indicated trust as process and trustworthiness as a feature of the trustee which is gauged by the participant and which fluctuates during encounters, and with it entrusting fluctuates also. This has implications for the data collection process. The decision to use discrete one hour interviews may have curtailed a deeper entrusting which might have been possible in a series of meetings, a video diary or written follow-up questions. Balancing the time and emotional demands of being a research participant with the specific needs of survivors informed the choice of the discreet encounter even with the consequential need to acknowledge that richer data may have been gleaned had a deeper, longer term relationship been established between researcher and participants.

In the initial planning stages a focus group to consider the key themes had been considered; this was to include all participants and follow the first stage of data analysis. However, as recruitment continued this became problematic because the researcher was aware of certain relational difficulties between several of the participants (the snow-balling recruitment method resulted in some participants knowing each other). Tensions between participants would have made creating safety difficult, and risked the anonymity for participants if data they had shared in interviews was identifiable by members of the group. The focus group was believed to have the potential for (re)traumatisation. Participant well-being was central to the ethical structure of the study and also influenced the decision to use one hour interviews. This population needs specific and sufficient support to mitigate against, and act in, instances of trauma triggering; while follow-up support via email (and telephone/video-call meeting if needed) post single interview was manageable for the researcher, if the group of 17 had met this would have been too large a number to provide psychological containment both during and post session. Adequate support would have required a counsellor or similar support worker and because the study was unfunded such provision was beyond its scope.

Finally, the option of gathering data from survivor groups where trust was already established could have been an alternate route, however the introduction of a researcher (or any new person) into such a group would have disrupted the trust-bonds of the group thus creating new and emergent trust and trustworthiness dynamics. Data gathering from such a group by written question and answer or by interrogating existing survivor discourse on trust were additional options but may have missed nuance and breadth which evolved organically in interviews, and offered the possibility to adapt questions according to the flow of the dialogue. IPA advocates for one to one interviews specifically to maximise the possibility of follow-on questions delving deeper into issues the participant has deemed important to bring in response to initial questions. It is through the dialogue between interviewer and participant that richer, more nuanced data is sought.

The issue of trust between interviewer and participant is relevant to every study as without trust participants may not reveal sensitive, or nuanced data; in this study with its focus on trust the need for trust is acutely felt. Findings Two (Chapter Five) presents a section titled ‘relational trust and the interview process’ which advances evidence as to the trust built by the methods chosen, with the acknowledgement that trust with the researcher may not have been felt by other participants who did not voice their sense of entrusting during their interview, and that further, deeper trust may have been possible in a relationship established over time. The Discussion (Chapter Seven) considers the interview as a trust relationship in the light of previous scholarship.

Moving on to consider how interviews were shaped to build trust with regard to the interview schedule, the tensions around the balance between directive and non-directive questioning was ever-present. The ethics application and participant information sheets stated the intention that the interviews be ‘co-constructed’ to explicitly defuse any sense of power imbalance between researcher and participant. This was to benefit from an interaction between two survivors with the hope that the explicit knowledge of shared histories would mitigate survivors’ silence, known to exist in other more power-based relationships (McElvaney, 2015; Morrison, Bruce and Wilson, 2018). But the term ‘co-constructed’ was perhaps insufficient to encapsulate the endeavour, as the term is open to multiple interpretations and is a topic whose legitimacy in generating reliable data is contested (Davies, 2008). Mann (2016) summarises the emergent academic view that all interviews are co-constructed, and data gathered can never be replicated in other interviews, even between the same dyad. After the first three interviews, the researcher reflexively explored the implications and choices around co-construction and identity, for while CSA was a shared identity, this did not nullify other forms of ‘power-over’ possibilities as a result of different identities, such as academic researcher versus participant, or gender, age and race. Although survivor identity is a ‘leveller’, other identities could have been creating a power dynamic giving the researcher control of the interview. Transcripts capture moments where mention was made of commonalities and differences, signalling that participants were also, at times, aware of these identities. With these issues in mind, feminist epistemology was drawn upon. With its proximal relevance in situations where two members of the cohort explore sensitive topics pertaining to identity and oppression (Oakley, 2005), feminist scholarship and autoethnography offer “critical reflection”, “strong reflexivity” and “transparent reflexivity” as tools to ensure robust and trustworthy data (Mann, 2016; Doucet and Mauthner, 2008; McWade, 2019; Ellis, 2004).

Having offered equality to the participants in the term ‘co-construction’, the researcher strove to honour that by sharing the space as equals, but this did not infer equal sharing of airtime. To allow the majority of the dialogue to rest with the participant, reflexive noticing during interviews repeatedly pulled the researcher towards brevity in sharing her own experiences. Daley (2010, p. 69) adopts Schön’s defining of this reflexivity as “reflecting *in* action”, and the post-interview scrutiny (to inform future interviews and data analysis) as “reflecting *on* action”, both of which the researcher adopted.

Scholarship on reflexivity points to pre-conceptions and actions or choices for researchers as nuanced, sometimes submerged or obscured and that they may appear at any point in the research process (Daley, 2010; Dean, 2017; Finlay, Wiley and Gough, 2003; Smith, 2007).

The role of emotion in the research process and researcher choices reading data is an issue for every researcher (Loughran and Mannay, 2018), but when the research topic is so close to the heart of the researcher, as in this study, sensitive and careful weighing of values and responses proved necessary. Chapter Six presents instances that demanded a repeated process of reflecting on participant testimony, and the operationalisation of reflexivity, including exploring researcher meaning making while working with the data. Reflexivity in this sense is the operationalisation of the ‘bracketing’ spoken of above, which phenomenological approaches make explicitly necessary for study to be trustworthy. The researcher sets into brackets their own meaning to privilege the meaning being made by the participant (Eatough and Smith, 2017).

Data analysis

Turning now to the analytic process, this followed a series of stages inspired by Thematic Analysis method (Braun and Clarke, 2006), and blended with the hermeneutic prerogative of IPA. Firstly, note-taking and reflective and reflexive journalling in the hour post-interview, followed by a re-listening to the recording of the interview, helped the researcher capture her thoughts and feelings. It also enabled adaptations to the interview schedule for subsequent interviews (Smith, 2007) to address missed opportunities or areas to develop the data.

Transcription was conducted by the researcher, with further journalling and note making. Lapadat and Lindsay (1999, p. 65) challenge the notion that “transcriptions are transparent, directly reflecting in text the ‘hard reality’ of the actual interaction as captured on audio”, and argue the importance of transcription as a methodological consideration. Capturing meaning from and beyond language (Forrester, 2010), and capturing prosody (Smith, Flowers and Larkin, 2009), contributed to redressing survivor silence and silencing, by privileging the use of all aspects of communication and acknowledges the ‘unspoken’ aspects of survivor experience. To this end, notes regarding non-verbal cues, such as intonation, affect, intensity, emphasis and pauses arising within and around words, were added to transcriptions to enrich the data (McLellan, MacQueen and Neidig, 2003). The consideration of the meaning of silences (by the survivors and researcher) was also contemplated during this phase (Poland and Pederson, 1998).

Body language was named by several participants. Caroline said: *"no I couldn't say anything, [...] I just sat on my hands"*. Body language's silent communication was captured during interviews by the researcher naming out loud (therefore recording on the audio) moments when the survivor was gesturing to supplement or replace verbal communication. One such example:

> "*Caroline: it's like decompartmentalise that, get on with it, like*
>
> Researcher*: put it over there, I can see from the way you're using your hands, it's so clever, you're putting it over there and get on with what's in front of you*"

This naming of the gesture additionally allowed the participant to clarify or reiterate the meaning *for them* of the gesture.

Transcripts were re-read as coding commenced using the software package Nvivo. Double-checking previous interpretations of muffled words, and the sense of the underlying meanings, brought a sense for the researcher of being very close to each participant. This phase unfolded during the first Covid pandemic lockdown, and the voices of the participants began to feel like familiar colleagues. With few distractions from engaging in the data, the second hermeneutic of the meaning made by the researcher began to emerge. Many questions started to arise as to possible meanings, both as the researcher's understanding of participant's meaning-making and the researcher's interpretation of participant's meaning-making. This is when reflexive journalling was at its zenith.

Once initial coding was completed, a process of stepping back to view the codes and going deeper into metaphor and language began, and in particular, the recurrent sense of survivors' experience of "they made me feel". The dynamic, iterative, "back-and forth" between analysis of individual transcripts and analysis of the data set of all transcripts using the hermeneutic circle (Frechette *et al.*, 2020) followed the inductive process (Smith, 2007) and generated initial themes. By sifting, re-reading, comparing, and amalgamating initial themes, gradually more coherent, robustly "defined" (Nowell *et al.*, 2017) themes emerged.

Following the critiques of IPA which problematise previous studies for remaining at thematic presentation, the researcher took a bold approach to interpretation by organising the material into process and shaping the writing of the findings in a sequential manner (Chapter Four).

Chapter Five, Findings Two, presents certain central themes that emerged from within this process. Both findings chapters include longer quotes than in many qualitative studies for several reasons. Silverman (2014, p. 114) points to the importance of 'sequencing', and suggests to present a quote out of the context of the preceding utterances makes meaning devoid of context and "unreliable [...without] some attention to how the former shapes the latter". Secondly, IPA methodology recommends the double hermeneutic be justified and substantiated by the use of quotes. Furthermore Nowell *et al.* (2017), in seeking to offer credibility to qualitative findings, suggests quotes needs to be recognisable as underpinning the interpretation being made. When the point being made in this study is at odds with extant beliefs about carer trustworthiness versus survivor pathology, evidence needs to be provided in the form of longer quotes. Lastly, as a Mad Studies thesis, the survivors' voices are valued and prioritised by including as many as possible.

Summary

This chapter has presented the rationale for adopting a phenomenological paradigm for this study, as phenomenology's heritage as a challenger to extant scientific and positivist paradigms is well matched to the study aims. Phenomenology fits within the Mad Studies prerogative to foreground lived experience as valid epistemology. IPA has been defended as a suitable and capable methodology and been adapted to meet the specific and sensitive needs of this study. The methods section has laid out ways in which the participants and researcher bring to the study certain idiosyncratic sensitivities and needs, and it has demonstrated how these have been both catered for, and made advantage of, to generate rich and trustworthy findings. It is to these findings that this thesis now turns.

Chapter Four: Findings One, The Process of Relational Trust

Introduction: *"It's a process" Milla*

Chapter Three presented Interpretative Phenomenological Analysis (IPA) as a methodology equipped to analyse survivors' lived experiences of trust and trustworthiness. IPA operationalises the researcher sense-making participant's ideographic experience, facilitates the gathering of this into themes, and grants the researcher privileges in deductions and interpretations insofar as these are supported with a data audit trail and reflexivity. IPA aligns with Mad Studies in centring survivor testimony as paramount, and the two findings chapters (Chapters Four and Five) include survivor statements to evidence claims and interpretations by the author. This first findings chapter also includes the less conventional option of supplementary survivor testimony (Appendix Six). While the chapter stands alone without the appendix, this inclusion is justified as it provides a more thorough audit trail against claims of researcher bias, and is a mark of respect to participants' generous contributions.

The Mad Studies paradigm has informed the use of the hermeneutic prerogative of the author to interpret the words and actions of the participants with the sanity of the 'rational madness' of responding as they do to situations which are experienced as a pattern repeat of the original CSA experience. In this way actions and words that may seem mad to non-traumatised readers are given their place as reality and sanity for these participants.

This first findings chapter presents survivor trust not as theme but as process: the Introduction (Chapter One) postulated relational trust as an enacted decision made by the trustor (survivor) when in relationship with a trustee and working together around a shared task. The Literature Review (Chapter Two) supported this working model with implicit comments on the building of trust, albeit in the absence of explicit research on the construct of survivor trust. The difference between feeling trust in someone and operationalising that with ‘enactment’ is supported by the findings presented here. In making the decision to enact trust, survivors travel through a series of steps or zones to establish the trustworthiness of a specific trustee, giving the rationale for presenting these survivor experiences as process rather than by theme. Further justification for the presentation of findings as process becomes evident as the chapter unfolds. The second findings chapter (Chapter Five) presents generalised trust juxtaposed to relational trust and other aspects of survivor trust.

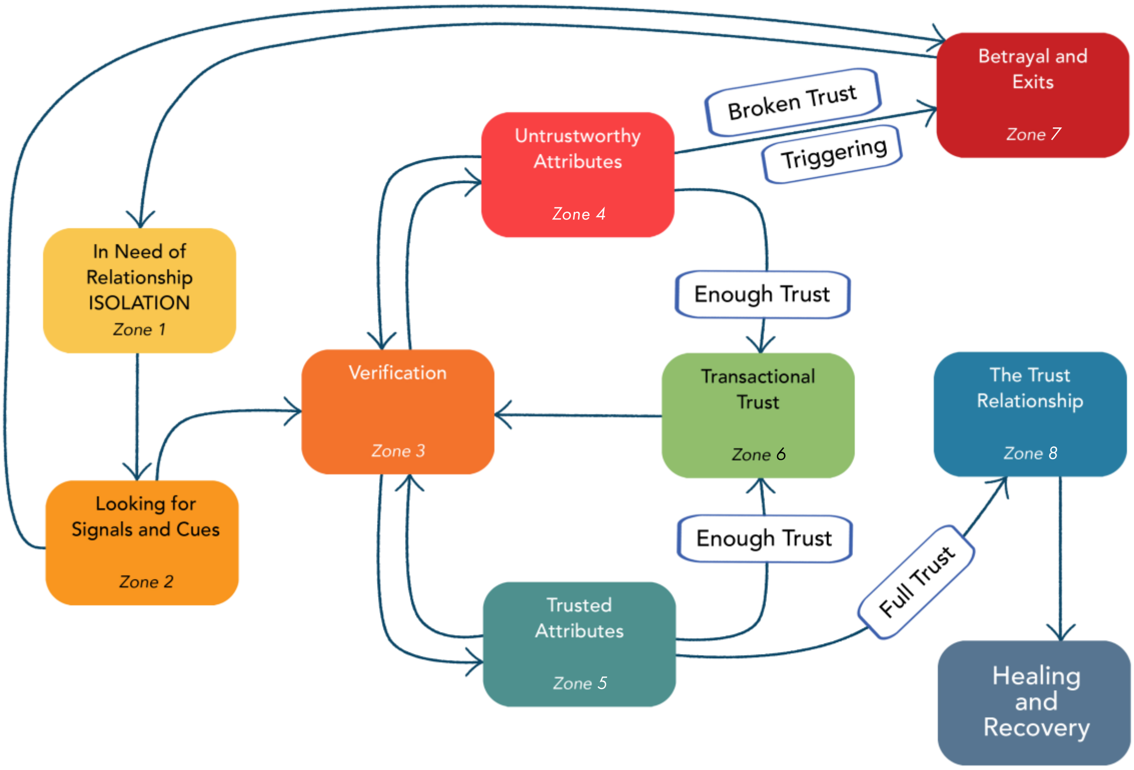
Enacting trust: zones

Survivors spoke about how both the attributes and actions of a trustee impact their choices to deepen or downregulate trust *in this trustee*. An overview is proposed in the trust enactment model process flow chart below (Figure 1). This process holds for all forms of relationship discussed in the data: familial, romantic, therapeutic, task-focused (for example, dental treatment), or in engagement with institutions such as the social care or justice system. Zone 1 presents survivor experience of isolation and the need for relationship. Before their first disclosure this stage, perhaps more accurately this “state of being”, extends to most relationships. However, as the survivor starts to have experiences of relational trust their confidence in reading trustworthiness increases. It is also possible for a survivor to be in Zone 1 in terms of one type of trusting relationship and yet at the same time be in a different zone with a different trustee addressing a different task. For example, a survivor might be in Zone 1 with regard to finding a trustee to specifically address the original CSA and consequent trauma distress, and yet be engaged in a trust-relationship (Zone 5) with a dentist having root canal. These different layers or levels of enacting trust become evident as the zones are presented.

Within each zone of relational experience the survivor is also experiencing relationship with self and relationship to the abuse, and these aspects are presented in the second findings chapter (Chapter Five).

As a relational process, trust is built through a series of zones. Different words were considered to symbolise these differentiated experiences, such as ‘stages’, ‘steps’ or ‘phases’, but these were rejected as they all have an implicit sense of the sequential whereas ‘zones’ is more commonly used to denote differentiated areas. Even the term ‘zones’ is problematic in that the differentiation between zones in the written word appears to be a clear or hard line, whereas in real life there are less recognisable boundaries between zones. The movement between zones was oftentimes complicated and confusing for participants, and involved looping back or jumping forward in a non-linear way. The length of time spent in a zone was entirely personal. The linearity of a written chapter fails to capture the fluidity and non-binary directional movement between and through experiences, and the way in which a present-moment of relational exchange results in the internal experience of meaning-making in relation to the other, be that a person, institution, society, or the self, past and future. Arrows on the flow chart attempt to capture this fluidity. The reader will notice that the order in which this data is presented in the written word does not follow the sequential order captured pictorially; the decision to label the zones according to their content as shown in Figure 1, rather than the order in which they are presented in this chapter, has been a difficult one but in some ways can be seen to capture or demonstrate the non-linear nature of the process, and some of the confusion experienced within it.

Figure 1. Trust enactment model flow chart



Zone 1: Isolation and the need for relationship: *"it was intruding into my daily life" Jo*

Survivors spoke of a time before they sought help with a task that necessitated trust:

> *"There was a long period of time when I didn't share any information [concerning CSA] with anyone and I was 37 before I ever shared anything with anyone"* Stella

This was a period of isolation and self-reliance Betty described as:

> *"[I] just get on with it you know and so um yeah that's been my way of coping"* Betty

Being isolated and coping alone was familiar, and learnt from the abuse:

> *"I thought bloody hell you know um, there's no way out of this, you know, what can you do and so from then on I suppose he (the abuser) had the upper hand and he*

> *knew that my parents were supporting him [...]so from that age is when I'm by myself really" Will*

The length of time a survivor might stay in this isolated state varied dependent on the magnitude of need for help or the emergence of the knowledge[1] that CSA was driving the distress (see footnotes in Appendix Six):

> *"It's that secrecy that's known, [...] it's totally repressed, totally down low, it never happened, mine didn't happen until last year, 12 months ago when the dammed tsunami in my head erupted and it all came out, "Oh OK, that's what happened" "*
>
> *Rachel*

The memory-loss Rachel is pointing to was common[2], and considered by some as a subconscious self-protective mechanism:

> *"...but there's lots of things you don't even think yourself that you are hiding" Chloe*

Similarly, dissociation was experienced as a coping mechanism even when it included threads of self-doubt and confusion[3]:

> *"Disassociating, in a way, as a coping mechanism and it's still in the back of your head still, because I did that for a long time, it was in the back of my head, but you just push it back because you don't really want to acknowledge it" Ruby*

Other coping mechanisms, such as work[4] or relationships[5], also kept survivors distanced from distress, and in safe isolation. Some felt unable to access help due to circumstances:

> *"There was no way I could ever raise this as an issue um you know or even think about going to the police or anything like that, when my mum was alive, it would have destroyed her, so I couldn't do it" Will*

But often the dynamic of holding silence was driven by fear[6] from groomed beliefs[7]:

> *"The person who abused me kept telling me people won't believe you" Jake*

> *"It's always there, kind of at the back of my head, what might happen if I told someone and I worry about, and I know, that's the crazy thing is, I know it's completely irrational"* Anna

For others the thought of having disclosure rejected, or the consequences of disclosing, held them in isolation:

> *"The terror of saying what had happened and not being believed or you know her [mother] being angry or us being thrown out of the house that we were living in was immense"* Betty

Additionally, survivors held back from seeking help due to internal environments of suffering, that is, self-distrust or self-blame, driving isolation:

> "*I thought actually it was something wrong with me, that I was mad or had some illness that caused me all this anxiety, I felt it was not something that had happened to me it was more that it was something wrong with me"* Frank

Lastly, some survivors named an overriding caution, a generalised distrust of people as their reason for self-isolation:

> *"It was when I was 6 that I really realised my capacity to lie, my um, ability to see how adults lie um, and that's when I think I learned that nobody can be trusted" Ruby*

Data regarding survivor experience of feeling a generalised distrust of all people, groups of people or society as a whole are presented in Findings Two (Chapter Five).

This sense of people as untrustworthy fostered a tendency towards suspicion[8] of others, a need for control and a guarding of self:

> *"It's just being guarded and being, it's controlled that's what it comes down to, that's the word, it's control, I need to be in control of the situation"* Will

The term 'guarded' was used repeatedly and while some survivors saw this as their own suspicious nature[9] [10] linked to their history of CSA, some survivors saw it differently:

> *"I'm very guarded, extremely guarded, but I don't know if that's just say like, would it be my personality or is that with people in general, as I've got older I've become more guarded, yeah, only due to, I would say, I don't want to say historical things happening, not* <u>*that*</u> *historical thing [CSA] more current things happening" Patrick (his emphasis)*

Certainly many saw themselves struggling with trusting, which is subtly, but importantly, different from not trusting a specific other, and data regarding this is presented in Findings Two (Chapter Five).

Suspicions of potential trustees extended to being unsure of people's motives[11]; inconsistency of the behaviours of early caregivers created perplexity for survivors regarding other people[12], and some survivors were careful not to take trustee behaviours at face-value [13]:

> *"When people say nice things I struggle to believe that's true, I think what the hell do you know, […] yeah, so I go through the world not being able to accept compliments and always keeping back, cool, protected, certain" Rachel*

> *"I struggle with people being nice to me […] yeah, it's not allowed, I think it's harder than people being horrid because I'm used, I kind of expect that, well I'm trained for that" Tessa*

These generalised non-trusting statements were added to by specific examples of untrustworthy behaviours from individuals, institutions, the media [14,15] and society[16] (see Zones 4, 6 and 7), and after an experience of relational betrayal or a breach of trust, generalised trust beliefs were reinforced. These experiences fed back into reasons for survivors choosing to return to isolation (Zone 1):

> *"I've been left to pick up the pieces myself because nobody will help" Caroline*

Losing a trusted other and returning to the isolation of Zone 1 was experienced as a bereavement:

> *"Now she's [the dentist] left and I've actually had her for five years and she's only just not long found out and I've felt like I've built up this trust with her and she really understands and now she's gone and that makes me nervous about going back because I feel like I'm starting all over again and you might not necessarily get people who think you are sympathetic" Milla*

In this way Zone 1 for survivors in this study is both a set of memories about how life and trust was before the *first* "trust-relationship", and a place where a survivor will 'begin again' when betrayed, after a trust-relationship has ended or when seeking a trustee for a different task. After betrayals or the first trust-relationship, survivors are drawing on a different set of conditions upon which subsequent relationships will be founded. Thus, past experience of both the abuse, and previous contact with trustees, informs survivors' behaviours and process when entering relationships. Instances of having trust breached or betrayed by specific people could be extrapolated to a genus of people[17], for example, all psychiatrists[18].

These many interwoven reasons and experiences kept or returned survivors to isolation, and for most it was the building of tension and distress and the failing of coping mechanisms that would culminate in a turning point, sometimes expressed as 'breakdown', where the need for help became paramount, outweighing everything else. This could be experienced physically, including involving self-harm, or mental-emotionally:

> *"I can push it all down and not experience it necessarily like but yeah my body will let me know, or like I get hives as well, they'll come out all over me and I'm like 'no I'm not stressed, I'm not stressed' (funny voice) but I've got lumps all over me which are saying 'you are'" Caroline*

> *"When I first started kind of accepting and facing that I had had quite a lot of experience of abuse that I needed to do something about, […] where previously I had suppressed it all and um but it got to the point where it was intruding into my daily life and my mental health such that I knew I needed to do something um I was quite depressed, I had suicidal ideation" Jo*

The realisation that help must be sought was, sometimes, a process of realisation:

> *"I felt it had built up to two years before I disclosed to a health professional […] um, and I think so, but then I needed to be heard" Jake*

Thus survivors were propelling towards the need for trustee. Yet, the freedom to choose[19] and the agency to engage with help was important:

> *"I think it's just something that I know is going to be like taxing so I've just got to make sure that I'm in the best frame of mind to do it" Julie*

Sometimes the choice was supported or encouraged by others, but the actual step to engage belonged to the survivor:

> *"I was sort of forced because I disclosed to my sister, […]and I remember when I walked into the police station he [police officer] was like you don't have to do this you could just turn around right now and not come back and I was just like (pause) [she actioned her complaint]" Milla*

Taking the step to approach a potential trustee took courage:

> *"I went to the GP hoping that I could get some support and, […] I mean it took a huge lot of courage to go and say anything to her" Jo*

At this point survivors move to Zone 2, the careful observation of the trustee.

Zone 2: Signals and clues: *"she just had that kind of feel about her" Anna*

Compelled by Zone 1 experiences, and with a 'task' which can no longer be ignored, survivors spoke of seeking out a trustee, either an individual or an institution. However, finding a trustworthy person was challenging because of a paucity of suitable people[20]:

> *"I think it's extremely hard to find a therapist, at least it was for me to find a therapist that is really able to help you"* *Frank*

Therefore finding a trustworthy other relied on survivors' abilities to select the right person. In this quest, survivors believed themselves competent:

> *"I actually think most survivors have an innate ability to know if somebody's trustworthy or not, and sometimes it's saying 'I just don't feel easy with that person' and maybe not being able to put their finger on why"* *Jake*

When seeking a trustworthy other, survivors drew on templates from previous relationships to gauge trustworthiness, and despite the statements of Zone 1 regarding generalised distrust, all but one participant had had trusting relationships in childhood, often these were with a close relative or teacher[21]:

> "*I don't hide anything from my mum because that's the only person I can trust, [...], but that's the only person I can tell everything to [...] yeah, she's my go-to"* *Patrick*

Anna has tattoos in dedication to her beloved grandmother:

> *"and the flowers are all just for my nan because my nan was incredible"* *Anna*

Milla, brought up in care, trusted one teacher and:

> *"a key worker always fought for me [...]it's these sort of relationships that I really am grateful for"* *Milla*

One survivor insisted on trusting no one, yet felt she understood trust as an experience in her relationship to swimming:

"I have a real affinity with water, I have all my thoughts, my dreams, not premonitions, [...], yeah, huge relationship with water, [...] it's about that thing, about trust isn't it" Rachel

These early trust-relationships informed survivors' confidence in knowing what trust feels like[22], and include a felt-sense, embodied[23] beyond the cognitive:

"When it's someone you really trust ...um ... that's interesting I think it definitely is a feeling, it's a holistic feeling, so um it's a feeling of warmth towards the other person, of kind of attraction, mutual attraction, [...] and you're both pulled into a kind of shared space" Jo

Trusting is recognised by the way it facilitates a 'shift'[24] within the survivor (see below):

"Um it's definitely it's a sense I can let my guard down [...] it's a definite feeling like somebody's got my back, I don't have to um be on that constant alert, I probably still am on some level but it's a noticeable shift I can just really feel like I can really be myself I can be authentic" Betty

This confidence informed a self-trust in intuitive, sometimes immediate, decisions to trust some trustees:

"I think it was intuition actually, I don't think it was a plan, or maybe it was love"

Yasmin

"I think I instantly trusted her actually, she didn't ever give me any reason why I shouldn't, um, she was just instantly warm and friendly and she just had that kind of feel about her, that this is a good one" Anna

Survivors spoke of developing an ability to detect signals and clues of trustworthiness in the attributes and behaviours of the other, using this embodied knowing of trust:

"I think my antennae can be highly tuned sometimes with that sort of vigilance really [...] and I do notice if people aren't listening you know" Betty

> *"I like to think that people are good people, but I'm usually very on guard for any kind of reason why, why they shouldn't be trusted" Anna*

Frank linked this to the CSA:

> *"I must say I'm pretty good to get a feeling of what people I can talk to and people I that cannot talk to, I think it has to do with the ability that I developed when I was a kid, to see, to start with I was able to sense, will it happen tonight, the abuses so I, I read the, I mean, the how should I put it, I was like a radar system, I sensed what, how are they feeling today, would they come tonight are they angry, not angry and then I tried to avoid them, er, in order not to be abused, and I think that ability I have used going forward as well to see ok, can I trust this person, can I talk to this person" Frank*

Abuse was unsafe, making signals and clues of safety evidence of trustworthiness; safety was equated to being accepted[25]:

> *"You're not always safe to talk because they don't, you can feel they don't want to know" Tessa*

Disclosing CSA brought huge feelings of vulnerability:

> *"Telling my story publicly made me really like paranoid people looking at me like because of that and I have had people judge me or say oh look at the girl that was abused things like that which ain't nice" Milla*

This was understood to necessitate finding within relationship the feeling of safety, which could be generated by care, comfort and protection from danger, physical[26] or psychological[27]. Thus safety is a self-protection mechanism and was recognised to be nuanced, with gradations of safe-ness:

> *"Safer with, not actually safe with you because you're white but safer with you, that sounds terrible doesn't it" Patrick*

Evaluating safeness and trustworthiness was non-binary and goes beyond the cognitive or calculated. It includes an innate felt-sense of 'reading' people using signals and clues, which means that gauging trustworthiness can, for some survivors, with some trustees, be complex:

> *"If you are given false messages and false understandings about what trust actually is then that's the foundation that you go on to build" Jake*

So, while some survivors felt able to read signals and cues, not all the participants were as confident in their abilities. Survivor statements regarding difficulties assessing trustworthiness emanated from confusion around kindness, and acts of generosity:

> *"If someone is horrible it's great, I can deal with, but if somebody is nice well what else is going on there" Will*

> *"(receiving a compliment) hurts at the same time as it's nice, but it hurts more than it's nice, something in me can't handle it, I'm not very good at people being kind" Tessa*

Jake understood the source of his confusion:

> *"When I was being abused he would ask me 'are you enjoying this' and I would say 'no' and he would say 'yes you do', so the other messages were I was getting was that don't trust what you think is good for you".*

This dilemma of what the truth is, or reality of a situation, and the trustworthiness of the other person, is especially pertinent to the assessment of the trustworthiness of sexual partners. Two survivors in this study noted their caution in choosing partners given previous bad experiences:

> *"I've had quite a few relationships, two marriages, I felt for a long time I don't think I can have a relationship with a man because they really send me over the edge, they can be as nice as anything but I can't handle it [...] so then I think to myself am I gay, and it's not like I go out looking at women and think phwoar, it's a connection that, that emotional, I don't know, so that is another ongoing battle of not being able to trust men, because I don't believe I am gay but I can't have a relationship with a man, I really really can't"* Helen

Helen's words show the magnitude of distress that difficulties in reading trustworthiness can cause, and the extent to which she is prepared to flex aspects of who she is to find a trusting relationship.

Lastly, there was recognition by some that there may be some incorrect assumptions of non-trustworthiness when in a triggered state and experiencing trauma distress. This was recognised as sometimes arising because of signals from the trustee reminiscent of the abuser (see Zone Six), and, as Jo says:

> *"When I'm triggered by something that obviously is a, someone's behaving or speaking or in a context that reminds me of one of my abusers, then, then I can react in a way that isn't, then I cannot have the normal sense, the good sense of this is a trustworthy person?"* Jo

The combined effect of these elements, both before coming into relationship (Zone 1) and in the first moments of relationship (Zone 2) make survivors tentative in enacting trust, even with a person they have assessed to be trustworthy on first meeting. This was felt to have led to the development of strategies to verify the trustworthiness of a potential trustees before revealing vulnerabilities: Zone 3.

Zone 3: Verification: *“Testing the water” Milla*

Having read the initial clues and signals, survivors who decided to continue in relationship with a potential trustee engaged in a verification process, and the caution described in Zone 1 continued:

> *“I think because I had such horrific experiences when I disclosed the abuse I became very very cautious about letting anyone in, in fact for many years I wouldn’t let anyone, although I’ve been with my wife for 30 years, even then” Jake*

This quote shows how being in a long-term relationship (for Jack with his wife), and “letting them in” have nuanced and important differences. The process of ‘letting someone in’ is operationalised through a series of small ‘testing’ moments to observe trustee responses:

> *“It’s like a process, it’s like you give things in dribs and drabs you give them something, test the water see how they react and yeah they’re alright, do you know what I mean and that’s definitely how I’ve always done it” Milla*

By not showing vulnerability in initial stages the survivor could continue to ‘guard’ against hurt or rejection, and used *“minimising” (Jake and Betty)* as a strategy[28]:

> *“She said do you think, her actual words were ‘do you think it’s affected you?’ so I said ‘oh no not really’ so she said ‘well, just forget it’” Jake*

(What Jake actually needed is presented in Zone 4).

Survivors described a way of staying hidden while testing the trustee, using a mask or façade of happiness or self-confidence:

> “*For most of my life I have, I’ve had people telling me, how are you always so happy all the time, you’re always so, laughing and happy, and I think ‘you have no idea’”*
>
> *Ruby*

> *“Nobody sees the child inside fighting away” Rachel*

This ‘mask’ was learnt for some as part of the grooming process:

> *"If anybody asked me anything about you know what we did together it was like '(child voice) we were looking for rabbits in the sand hills' and um it was always, and I learned to lie and make up stories and I could make them up so well that it was almost like it had happened" Ruby*

And the need for the 'mask' was felt to be reinforced by society and previous painful betrayal experiences:

> *"Everyone's worried about how people are going to respond, I'm pretty sure that I probably meet survivors everywhere but I don't know about them because no one goes around openly telling others […]I feel like it really needs to be more transparent, I think it's hard but I think it also depends on what it is because you know I was sexually abused by my father so that's, that, that's really taboo, it's incest, I hate that word, it's, it's really taboo" Milla*

Holding the silence, even when knowing *'it is not my fault', Julie,29*, was also recognised as part of the grooming process:

> *"I suppose you just have, I have to be able to get on with it, again I think it's something we learnt through childhood abuse as well isn't it" Caroline*

This ability to self-protect by concealing aspects of self is recognised by Chloe as common to non-abused people too, but for survivors the part that is concealed is very vulnerable:

> *"I think you have a few hats, don't you, have work hat, you have mum hat, you have friends hat, you have, then you also have your little child hat" Chloe*

The silence, testing and 'masking' was more than just self-protection, it was also developed through experiencing recipients insufficiently resilient to receive disclosure who had been damaged by revelations:

> *"They couldn't listen any more, they couldn't take on, take in what I was telling them, really so I needed to limit what I could tell them" Frank*

> *"At first you're very cautious because first what you're going to tell this woman is going to blow her mind" Patrick*

This was a choice not to disclose and was to protect the listener:

> *"I think some of it is quite, if I think about it now it's quite horrific, you know, some of the stuff that went on and like I say, some of the emotional stuff that went on, I think you know, if I told someone I think I could traumatise them, I think I worry about them" Chloe*

For some survivors caring for others was a trait learnt in childhood, and part of the CSA:

> *"I used to sleep on my mum's floor because I was worried to be away from her [...] yeah, I had to be near her, I had to know that if anything happened I would hear it, I would wake up and I would be there and it was me, I had to keep her safe" Anna*

Survivors actively avoided vicariously harming trustees with narratives of the abuse that had harmed them:

> *"At that stage I wasn't that sensible how much I could tell to different people and I talked a lot and was very open with it and after a while I understood that people couldn't receive that really, so after that I've been more sensitive to see how much I can tell people and how much they are able to receive so that's developed over time"*
>
> *Frank*

In this way survivors temper their disclosures as much for the other as for themselves, and this also contributes to the iterative process of disclosing a little, watching, assessing, perhaps backing off, or opening up a little more:

> *"So I thought I'm just going to t.t.t.tell this woman that I've been sexually abused by my dad [...]so I sat her down and I went to tell her and then I suddenly thought no I don't trust her because my dad made sure like I was worried about breaking up all*

> *the family and brrr brrr brr brr brr (guttural sound suggesting delay in speaking) and I didn't trust her she wouldn't tell anyone else so I made up some story that someone else had sexually assaulted me"* Milla

Partial revelations are indicative of trust developing but do not signify total transparency or total trust by the survivor at this stage:

> *"She asked me if I was feeling suicidal..... the million dollar question, whenever I'm asked this, my mind goes through a series of thoughts, do I tell the truth and risk them thinking I'll do something and they'll cart me off to the place with the bouncy wallpaper or do I say 'no' and risk them thinking I don't need their help and can wait. I told them a truth and a half truth, Yes, I was, I had the thoughts, but I said that I could control them because my family needed me"* Anna

Such small revelations were an act of trust because they place the survivor in an uncomfortable position of vulnerability:

> *"Initially I would be like, I would say something, and I'd be really sort of like annoyed with myself, thinking right you know, you've got all this stuff on me"* Helen

To summarise, for self-protection and care of potential trustees, survivors use caution, a mask, and minimising to gradually assess trustworthiness and during this verification phase (Zone 3), survivors were looking for a range of actions, choices and behaviours which confirmed untrustworthiness or trustworthiness. Their testimony of these elements by which trustworthiness is gauged is presented in two parts (zones 4 and 5), for even though some of the actions of trustworthiness are simply the opposite in a non-trusted other, by keeping the survivor statements true - either trustworthiness or untrustworthiness - their words saliently paint a picture of the *person* of a trusted or non-trusted other.

Zone 4: Untrustworthy qualities and behaviours: "*I felt quite stamped on really" Helen*

Turning now to survivors' experiences of down-regulating trust in response to those trustees they deemed to be untrustworthy. Both the attributes and actions of potential trustees could be read as untrustworthy. 'Attributes' refers to aspects of the personhood of the potential trustee, such as their perceived character, the silent communication body language and appearance, their *'vibe'* (*Tessa*). 'Actions' have been thematised as *non-comprehension, inappropriate responses*, *insufficient resources* and their compounding effect of *igniting untenable feelings* necessitating self-protection. Appendix Eight shows these elements alongside the trustworthy themes.

It is important to reiterate that the data in this section pertains to the survivors in this study and because of the ideographic nature of abuse, experiences of very specific triggers and personal likes and dislikes of individual service providers is reflected in the data.

Attributes

Zone 2 presented data that suggests that previous trusting relationships create a template for future relationships. Similarly, the survivors' narratives indicate that abusers, untrustworthy initial care givers and previous interactions that have left them feeling hurt or harmed create a template by which to gauge the non-trustworthiness of trustees. Attributes, such as eyes[30,31] or hands [32]which were similar to the abuser, often triggered a rejection of this person as a potential trustee, or triggered the stress response:

> *"With some people you go "I don't even want to be near you", laughter, sometimes I can't always place why, sometimes it's obvious they remind you of your dad"* Tessa

Arrogance was not trusted:

> *"I was already sort of apprehensive kind of walking in and it was just his whole body language as well, he just had that pose about him that it was just, 'I am the doctor',*

and […] it was like a full-on flashy suit, and the whole thing um, […] he just had this arrogance about him , it was instant, it hit me instantly" Anna

Gender, for some, sent warning signals:

> *"I was abused as a child and I was groomed and raped at 19. Both of them male (list of further male abusers).That's not to say all males are bad people who are set out to hurt me… but it has made me very wary and guarded around them. My senses go into overdrive and scream at me to run, get away, as fast as you can and hide…"* Anna

Anna's language shows the strength of the 'flight' response generated in the presence of an untrusted person, but she did have trust-relationships with several men, and she commented on the fact that gender was not an insurmountable trust issue: trusting a man was dependent on the personality and attributes of that specific man.

Attributes reminiscent of those who facilitated the abuse could also be associated with untrustworthiness:

> *"She (mother) failed me, I was abused because she failed her duty as a parent (finger tapping) and also she was just a horrible person so I never trusted women, there was my biggest issue"* Caroline

Turning to actions, and the first theme of non-comprehension:

Zone 4: Theme 1: Actions: Non-comprehension

The survivors stated a deeply held wish to be understood:

> *"I wish people could be in my skin for a day and just understand"* Tessa

> *"I think people just don't know what to do, you disclose child abuse and they go 'oh dear', it's too enormous"* Jake

Survivors experienced many trustees not understanding CSA. Because of the traumatic imprint left by CSA, Milla, and many of the survivors, had a liv*ing* experience that small moments in everyday life could be very triggering and that the effect of these has been hard for previous potential trustees to comprehend, and this has made it less likely to trust future trustees. This failure to understand CSA has ramifications:

> *"I think it would help in some situations for me to just say something like to my boss or whatever, because you know there are things that would trigger me all the time and I might get a bit emotional, but to others they'll think well she's a bit emotionally unhinged, but if they had a bit of understanding a bit of context it might be better but then that makes me wary" Milla*

This difference between the events of CSA which happened in the past and the present-moment reality of how that plays out had not been understood by many of the people survivors had turned to for help:

> *"There's just no understanding, you can just see they don't understand any of it" Chloe*

Survivors could appreciate that it is difficult to understand, but felt that this should not result in the further non-trustworthy actions:

> *"Yeah, even if they don't get it, just listen, maybe that's asking too much" Tessa*

The ability to listen was a crucial aspect to understanding; the mechanism or conduit by which comprehension could begin. Without listening, which was felt to be the conduit for understanding (see Zone 5, survivors spoke of difficult feelings arising within themselves (explored below) and when a disclosure is met with a lack of understanding survivors paused trust. An absence of understanding[33] , '*comprehension' (Betty)*[34], or the *'ignorance' (Milla)*[35] of the magnitude of abuse[36,37], the lived experience of trauma distress[38] or the present moment reality of past traumatic experience[39,40] cause survivors to withdraw:

> *"They don't understand, it's sometimes it's the tiniest, littlest sort of subtle things that are the most painful, I was sexually abused for 6 years but it was that moment when*

> *my dad didn't trust me that was hardest, again, but if you're a clinician you'd go but yeah, surely it's the six years of trauma, not necessarily"* Jake

Non-comprehension extended into all forms of relationships:

> *"He's (ex-partner) just like 'oh leave it in the past what are you jacking it up for, it's just going to be all emotional around the kids, it's going to affect the kids', but he weren't, he weren't supportive in any way"* Milla

An attitude of *"oh, it was years ago, move on"* (*Julie)* renders the survivor isolated having reached out for support. Some survivors expressed a sense that their trauma has specific lived-experience characteristics which only survivors can truly *'get' (Chloe*):

> *"I think there is a massive lack of awareness of the enormity of what child abuse does to you subtly as well as overtly with the depression or with the chronic long-term mental health problems, the subtle things it does to you about your self-esteem and confidence how you appraise the world"* Jake

But when this results in trustees who are insufficiently educated[41] and the needs of a survivor are not met empathically, trust is deeply impacted. At the very least some survivors expressed not wanting pitying or *"patronising" (Chloe)* behaviours:

> *"As long as somebody says, 'oh poor you' (pity voice), it gets on my wick [...] I want understanding, of like why I'm ticking, like the way I tick"* Helen

When a trustee fails to comprehend their responses can be experienced as inappropriate responses (Theme 2).

Zone 4, Theme 2: Actions: Inappropriate responses

The moment of disclosure is crucial, and more than any other aspect of non-trustworthy behaviour, when met inappropriately profound negative consequences follow, both within this relationship (zones 6 and 7) and in future relationships (zones 1, 2 and 3):

> *"I hadn't barely spoken to anybody about it, the first person I ever told when I was 12 […] she was so, like, flabbergasted that I didn't really go into it and any time I spoke to people they'd either cry or (pause) and I felt like I was um just I didn't feel like people could handle it"* Ruby

Being met with silence[42] in response to disclosure was detrimental:

> *"I did have a counsellor in the past who just sat there and listened and I felt like I was just talking into a hole in the wall you know […] I did tell the guy (about CSA) because I thought, I think I must have thought 'oh maybe that's what he needs to know', I thought that would get things moving but nothing seemed to be moving and I didn't know what, I didn't have a narrative around it particularly then […] that just felt like "oh so it's not really such a big deal" yeah (pause) […] it just sort of felt like a cul de sac really"* Betty

Betty's image of the cul de sac, portrays the end of the road, nowhere to go, powerfully capturing both the sense of hopelessness of a dead-end when a potential trustee cannot be trusted, and the need to turn around and travel back into the road one has come down, for Betty that was silence and coping alone (Zone 1).

One of the most damaging responses to trust was when disclosure (a sign that a certain level of trust had been reached) was challenged or disbelieved:

> *"A psychiatrist […] said to me last year when I was having whatever they were, body memories, flashbacks whatever they were, she said I am creating them […] so I was pretty angry […] um and I felt quite stamped on really, […]so that really did have an impact on me"* Helen

Chloe disclosed CSA as a child to her family's GP, the man who had delivered her at her birth:

> *"I don't think he believed me which set me back, which then closed me up for quite a few more years before I reopened it again, so yeah, [...] yeah, he sort of 'are you sure?' was the vocal words, have you mistrued (sic) this, misread it, and he just didn't seem, I didn't feel like the trust was there so I just closed down and left and walked out" Chloe*

Chloe's decision to trust her GP was predicated on an expectation of trustworthiness, but also that he would trust, that is, believe, her, as her statement shows. A disbelieving, untrusting, trustee profoundly impacted survivor trust in both this person and fed into generalised distrust (see Chapter Five) and was difficult, usually impossible, to repair (Zone 7):

> *"I said dad, look this is what's happened to me and he said no you must be wrong and I think that was the hardest moment because everything the abuser had said up to that moment led to one thing, you've got to protect your family they won't understand our love as he put it , and when I told him (dad) and he said you must be wrong, my world fell apart and it was only for a minute or two minutes before my dad said no I believe you. But in that moment...*
>
> *S: He said I do believe you*
>
> *J : He said I do believe you, but in that moment it destroyed that relationship till his death bed [...]and we never recovered our relationship" Jake*

This sense of "not being heard" repeated the childhood pattern:

> *"...and it's also about not being heard which we were as a child [...] not being heard so anything where somebody is not hearing what I'm saying will make me mad and totally lose any trust" Helen*

Experiences of not being heard, believed, or being dismissed were compounded when survivors' stress responses, often activated by untrusted trustee behaviours, are pathologised. Demonstrations of anger in order to receive needed services[43] when used as diagnostic indicators of borderline personality disorder, for example, makes trusting the pathologising trustee difficult[44]. And when a trustee makes assumptions about survivor behaviours based not on fact or evidence, but on a diagnosis, trust is compromised. Caroline had her children removed not because of any wrongdoing on her part, as the court stated when they were returned to her, but because of a diagnosis social services were working from:

> *"…on the grounds that I'm a borderline and obviously borderlines hurt their children and they neglect their children" Caroline*

For Anna, and others, it is an inappropriate response for a trustee to break a promise, neglect or betray a duty of care by not honouring a commitment:

> *"She (therapist) kind of reassured me that she wasn't going anywhere and that I would still be able to keep in touch kind of thing and we'd emailed a few times and stuff but towards the end she kind of changed um she didn't reply to my emails […]and she kind of sent me this really really blunt email, really straight to the point of "I am not your counsellor any more, I did say we could still keep in touch but um, kind of I'm not your support now", kind of thing and it was absolutely soul destroying Anna*

When a trustee fails to help, protect, or shield a survivor, or when the survivor has a sense that the institutional systems have fallen short in a duty of care[45], a sense of hopelessness or overwhelm can result. Milla gave up on pursuing justice against her abuser with the police:

> *"I just mentioned it to them that this happened and blah blah blah and he went his response to me was … 'BUT it's historical' that was his response … so why the word 'but'? It's like it's less important because it happened ages ago it's not that long ago it was twelve years ago when it stopped, it's not that long ago … he's(abuser) still working, he's got a child who would have been the same, is nearly the same age as I*

> *would have been when the abuse first started and so, I don't know … and from then on I thought, I didn't, there's no point pursuing it, it happened ages ago" Milla*

Trustees' inappropriate use of power emanating from their role[46] or authority[47] within the relationship was untrusted: authority was already something survivors were vigilant to, having understood the effect of being without power in the original abuse[48]:

> *"It's very hard to trust anyone isn't it, especially anyone who has any authority about them at all" Will*

Authority was felt to be like being abused when used to conceal facts from survivors:

> *"They diagnosed me with borderline personality disorder but didn't tell me, they just put it on my file so then every contact with professionals after that they're dealing with a borderline but a borderline that doesn't know she's a borderline" Caroline*

Secrecy and abuse of authority extends to duplicitous behaviours by trustees:

> *"I found out later on when I was in my teens that she (mother who had received disclosure) didn't tell anybody, … I was very angry, I did feel betrayed that she hadn't stood up for me and I felt you know that justice could have been done if she had been stronger or braver" Betty*

Betty's mother died without the trust between them ever being repaired[49].

In instances when authority, and trustee control, was felt to be used to exclude important parts of survivor experience from the relationship or conversation it became more difficult to trust the trustee. Yasmin experienced a panic attack while having her legs lifted into stirrups for an internal procedure, and while screaming, was administered the planned general anesthetic, and after:

> *"The doctor came and said, 'we found three different things, there's no alarm, maybe we will have to blah blah blah', but it was only about the medical stuff, nothing about*

> *this happened (her screaming), and how are you, and […] do you know where to go, do you have help?” Yasmin*

Similarly when the totality of case history, especially the traumatic distress, was ignored, it became more difficult to trust the trustee:

> *“I was talking about one of my medications that was causing weight gain and he (psychiatrist) said um ‘oh well actually medications don’t cause weight gain, you just have to watch what you eat, um can you watch what you eat’. I was like, I have an eating disorder, that’s kind of what I do, it was a terrible thing to say to somebody that’s literally, I might not be crazily underweight at the moment but I’m definitely not healthy with my eating habits and er, it was awful thing to say and um, he must have known because he must have read some of my records before I went in because he brought up when I was in er the psychiatric unit […], so he must have known”* Anna

Survivors often knew what they needed and to have this knowledge and lived experience overridden caused huge suffering, and a withdrawal of trust. A number of examples of instances were shared were trustees ignored[50], rejected[51], contradicted[52] and dismissed [53,54] survivor narratives and disclosures. Just two examples are given here to represent the many shared in the data:

> *“He (GP) said, ‘well, why are you depressed’ and I said ‘because’ I said, ‘because I was sexually abused’ and then he said ‘oh, how long ago was that?’ I said ‘well, since I was 9, 14 it finished’, ‘well you’re 16 now you should be over it’” Jake*

In the 1960s Betty’s mother had turned to her priest for help regarding the CSA (a fact Betty only learned several years after her mother’s death):

> *“It turned out afterwards that that’s the same priest who not only did not report it further up the chain he actively went to my mum’s sister and said your sister is spreading malicious rumors about your husband so that was a knock-out blow” Betty*

Acting against survivor wishes extended to issues regarding bodily proximity, and respecting the survivors' personal space. CSA had, for some, sensitised the need for distance[55]. Physical boundaries needed to be respected because survivors knew they could be triggering:

> *"I was not happy with EMDR, I think it was too close and she was having to touch me and um I was falling down holes a lot and she said she was trying to keep me here but I couldn't, I was going somewhere terrible" Tessa*

Requests could be totally overridden:

> *"Suddenly, despite my earlier second mouse-like plea to the charge nurse about needing a female doctor... the curtains flew open and in came the male specialist with his male junior doctor, a couple of female ward nurses and another female specialist nurse, all suddenly surrounded my bedside" Anna*

This lack of respect for survivor needs was spoken of frequently. Chloe, working as a mental health nurse, saw colleagues shouting at trauma-survivor patients:

> *"The lack of knowledge of speaking to, even speaking to people [...] that's not there and there's no, they are very much in your face 'why are you doing this?'" Chloe*

Anna's experience of her two psychiatrists, one trustworthy and the other not (quoted in Zone 5), made her incredulous that her NHS trust could employ two utterly different people in the same role[56].

These examples of poor responses to survivor experience negatively impacted survivor trust, but it was recognised that such responses may have been contingent on insufficient resources, a theme which theme three explicates now.

Zone 4, Theme 3: Actions: Insufficient resources

Addressing the effects of CSA demands resource, as Jake states:

> *"It's a resources heavy issue to deal with, and[…], when they're short of resources, it's much better to close people down than to open them up"*

The meaning made of being given time in a flexible and urgency-sensitive manner will be explored below as a facet generating trust (Zone 5), and the institutional aspects of availability in Findings Two (Chapter Five), but 'insufficient resources' also includes the inner resources that trustees need for their work with survivors:

> *"That was the problem with the other therapists they were, they were scared I would say […] I could see that and um it didn't work um, because they weren't willing, they were willing but they didn't, they weren't brave enough to follow me on that road I think" Frank*

Chloe, and others, recognised that this was due to paucity of training and that this was often beyond the control of the trustee:

> "*When you're younger you think your doctor knows everything […]they have all like this medical knowledge and lots of it but I don't think, even now I don't think, you know, there's not enough, they don't get enough training on this psychiatric stuff or anything and they certainly don't get any training in I think in abuse"*

Even while knowing of the scarcity of inner or outer resources, inappropriate care made many survivors cautious about trusting:

> *"They (dentists) just want to get on with their job and if anything you're just an inconvenience if you don't act like everyone else" Milla*

Survivors recognised that sometimes the refusal to engage, to give time or attention, was due to factors outside the trustee's control, such as a lack of appropriate practical resources, predominant in situations where the umbrella institution or organisation controlled time frames, or the choice of therapist:

> *“(National Mental Health Charity) are the only ones that did help, but again, ‘oh we can give her ten sessions’, but after the second session the therapist has left and then was a three-month wait for the next therapist to come in then it’s a male so she won’t speak to that person anyway”* Caroline

But trust takes time to establish:

> *“By the time I got round to trusting her we were at the end of the therapy so it’s taken a while, [mumble] and it’s only 5 months [...] apparently some people get 6 weeks” Rachel*

This lack of time or resource would close survivors down:

> *“They never give you, there’s never enough time, you’re hurried out the door, like therapy lasts this long, and a doctor lasts that long and dentists last that long and you’d think it’s going to take me longer than that to even be able to let go enough to even find words or let you in my mouth [of dentists], I just ask for time” Tessa*

Not being given time was experienced as not being given respect:

> *“I think they, people* (trustees) *forget that for that person* (survivor) *that’s their assessment and that’s, you need help, whereas if you are the health professional you will have done that hundreds and thousands of times so it’s completely standard for you and if you treat that person in front of you as just another person then you’re not actually respecting them”* Jake

In addition to a lack of respect, when the time frame is insufficient there was a shared feeling of abandonment by many participants:

> *“There was so much more to do, the transition from seeing her and then not and talking and then not... I wasn’t ready for it* and it really hurt... *still” Anna*

When resources are limited survivors experienced being passed on to yet another service[57] as rejection, when Jo made her first attempt to find help by speaking to ger GP “*she said ‘oh this* *is the phone number of the Samaritans'".* Oftentimes survivors found the subsequent service equally ill-equipped to cope:

> *"Their response to me constantly, because I had been referred a couple of times actually for therapy and every time it was 'oh your story's too complex', but then there was never another referral after that ... every single time over seven years of nothing but struggle" Milla*

These institutional issues are presented in Findings Two (Chapter Five).

The effects of these three themes - non-comprehension, inappropriate responses and insufficient resources - left survivors feeling isolated and desperate, and with a sense of a repeat of childhood experiences:

> *"A scared little child who used to lock herself in her room um in her bedroom, I never used to come out of my bedroom, um, and , ere r er how do I put it I used to sit in my room I remember up to probably till I had the children, working out ways how I could run away, run away from this world, or kill myself, even from very young age, even from like seven, eight years old I was trying to work out the best way to do things, you know if I jump out this window..." Chloe*

This isolation triggered some survivors into distress in addition to the trauma they already carried and these 'untenable feelings' are Theme 4.

Zone 4, Theme 4: Actions: Igniting untenable feelings

Survivors spoke of feelings and distress that were hard to contain and which drove their actions and choice in regard to either leaving relationships or if they stayed in the relationship they downregulated their level of trusting (see Zone 6, transactional trust). Caroline said being *"treated like a disorder literally all of the time"* was shaming, and when added to pre-existing shame it reduced further the possibility of trusting the trustee:

> *"You say something to your doctor and there's that thing of internal embarrassment that you are responsible for the actions of these people even though I'm highly intellectual and there's a difference between what you know and what you feel, so there's a sense of shame" Rachel*

Shame and disgust may maintain the boundary between the dyad, even when other issues are being addressed. Ruby stayed in therapy for months:

> *"She was this older woman and I didn't feel like I could tell her these things (the abuse) because it felt dirty I couldn't be honest with her" Ruby*

Some survivors spoke of feeling blamed:

> *"He [police officer] would just say things like, basically if I didn't say 'no' then that's, then I've given consent but I was a child, so I couldn't […] and he also said to the other one, um, he was 'but oh were you a virgin at that time'" Julie*

The feeling of being undermined, or demeaned was experienced when a supposed trustee questioned their account:

> *"(psychiatrist) queried everything I said and questioned whether I was fit to be a mother and if my children were safe and my nurse was shocked by him and had to intervene and tell him she's been to my house and met my lovely happy loved children and there's no concerns from her or others who have been to see me at home" Anna*

When a trustee rejects survivor testimony, survivors experienced self-doubt:

> *"I tell you what it makes you feel like, one that you's making it all up, and two well no that's it yeah you've fabricated everything, you're doing this for some other incentive" Will*

Not respecting survivors' epistemic worth triggered feelings of being devalued and demeaned:

> *"He was awful in every possible way, he was just, every (pause) everything he said felt like it was him saying 'I'm a doctor, I know best, you're the patient, you're dumb, you're whatever', it just felt (deep in-breath) completely degrading, completely soul destroyingly degrading" Anna*

> *"Ohhhhhh, last time I went to a GP he just was rude and I was too traumatised to have a cervical smear, […] so it said in the letter 'you haven't come for your smear, […] if you can't come for your smear you've got to come in and tell us why', so I thought 'well that's treating me like a child', so I went in and saw the only, male, doctor there I think and he said, 'you do know what a smear is for don't you?', I said 'yes', 'tell me what a smear is for' (condescending voice) like that and I thought 'what the f***' […]. He said 'so you know you should have it', I said 'I don't want it and I'm traumatised' and he said yeah, look at the size, look at the size of your files, I couldn't read all of that, as if, oh, (sigh), 'thank you'" Tessa*

This section has shown many examples of survivors encountering trustees who act and behave in ways that make survivors downregulate their trust in this person, (see Appendix Eight). Some survivors were able to maintain sufficient trust to stay in the relationship in pursuit of the orienting task. This is called transactional trust and is presented in Zone 6. Because such experiences impacted trust they drove decisions about next steps, such as retreating behind the self-protection of the mask, minimisation and silence presented in Zone 3; this was necessary for the survivor to be able to remain in the relationship. This was particularly true in instances where the relationship had been imposed by the structures of an institution so the survivor had no choice; in such cases survivors had to remain in the relationship oftentimes unable to address the issue of the untrustworthiness they were experiencing. In other instances survivors spoke of being unable to remain in relationships where they felt a trustee had responded in the ways described in this section and the magnitude of the trustee's untrustworthiness was experienced as 'betrayal'. In these instances survivors usually terminated the relationship using a variety of mechanisms. These are presented now.

Zone 7: Betrayal: "*when I feel betrayed … they're dead to me*" *Betty*

This section presents survivor testimony of non-trustworthy trustee behaviours experienced as betrayal because of the level of (re)traumatising survivors suffered. The magnitude of this suffering drove relational endings:

> "*I had a really good, in inverted commas, strategy that I could cut people off, so if someone broke my trust I just cut them off*" *Jake*

Such betrayal experiences could be any of those explicated in Zone 4, but usually it is a blend of the type of person (attributes), their actions, the survivor-perceived degree of untrustworthiness, and the consequential untenable feelings (including triggering) within the survivor that result in a sense of betrayal. The betrayal experience differs from the 'untrustworthy' experience in that it pushes the survivor past a point where even transactional trust (see below) can continue and this caused the breakdown of relationships.

Gut reaction

Betrayal was an experience all participants spoke of and for some the powerful feelings of betrayal were visceral, and signalled the unequivocal need for an ending*:*

> *"When I feel betrayed that's horrible, it just feels, there's a definite, you know, well if I bring that to mind I get a real lurch in my stomach. Like say they're dead to me […] what's the point in maintaining your relationship with them? […] I have been betrayed" Betty*

Jake also speaks of his gut's reaction:

> *"I think it was the sheer disbelief, to have my experience so, brushed aside, I felt almost physically sick, I felt I it had built up to two years before I disclosed to a health professional [...] um, and I think so, but then I needed to be heard" Jake*

Routes to termination were varied and are presented as themes of: *exit, confront, freeze, and collapse.*

Exit: "I think I did two sessions and I was like whussssssssh" Caroline

When betrayed, escape was most commonly enacted by exiting the relationship. Chloe's testimony regarding her GP (given above) is repeated here for emphasis of the action untrustworthy behaviours drive:

> *"I didn't feel like the trust was there so I just closed down and left and walked out" Chloe*

Anna visualised (perhaps wished) to enact a dramatic exit:

> *"I left my appointment with him (psychiatrist) feeling like I hadn't been listened to, feeling judged, feeling worthless, feeling like he thinks I'm a failure of a person, a terrible mother and that I'll probably end up with a knock at the door from social services to check on my children because he's wrongly assumed that I'm a drug addict and I only go to my appointments to sponge more drugs out of the NHS, [...] I got back to my car and sat in the car park with visions of myself driving my car into a tree and it bursting into flames" Anna*

Regrettably many survivors followed through with the ultimate exit strategy:

> *"I tell you I tried to disclose to teachers, um, it was brushed under the carpet. I was told I was making too much of it and I was referred to an educational psychologist who again didn't want to hear what I had to say and then when I was 16 I sort of disclosed officially to um a doctor whose reaction was that it happened in my childhood um and that I needed to pull my socks up. [...] When I was 18 because of*

> *the depression and anxiety and my OCD I was referred to a psychiatrist who after I had been seeing her for a few months I then disclosed again to her and her reaction was just to forget about it and move on and then I tried to kill myself" Jake*

Jake was not alone in reaching the breaking point before help was finally found[58]:

> *"It took me to having mental breakdown to get any therapy" Milla*

These examples evidence the impact of interacting with a trustee who does not handle CSA in what is experienced as a trustworthy manner and that this is arguably traumatising rather than retraumatising.

Freeze

A different reaction to betrayal is a triggering into a 'freeze state":

> *"One dentist used to put the mat over my chest and be grappling but his wife was in the room, and I thought his touching was inappropriate, but because of what happened as a child, I froze, so I just sat there frozen, and it meant that I stopped seeing that dentist as soon as I could" Rachel*

Not all testimony explicitly stated that 'freeze' was being experienced but it is indicated in Ruby's reaction, as it can be seen in her sense of the futility of attempting to fight against this abusive doctor both in the moment, and afterwards:

> *"I was given a physical by a male doctor who I felt was utterly inappropriate [...] he examined me vaginally and was looking into my eyes the whole time to see my expression, I couldn't believe he had done that [...] I just thought who are you going to tell that to, and even in the grand scheme of things him doing that was nothing compared to what my grandfather (abuser) did so to me it was like whatever, he's a creep" Ruby*

Being (re)traumatised into freezing included being prompted to return to the childlike state[59] at the time of the abuse. During the police investigation of Jo's allegations against her father she was triggered by their use of the word 'paedophile' to describe her father:

> *"I couldn't say, so I had to say in the break, and I couldn't say when we were in the thing, and she (police officer) said well 'why didn't you just say?' (small child voice) because I was a little child, couldn't"* Jo

Jo's struggling to speak is indicative of a freeze re-enactment of the silence at the time of the abuse and since.

Collapse

Instances of freeze extended into total shutting down for Anna because CSA has left her with a tendency to be triggered when she is expected to expose her skin[60]. Even exposing her skin to her husband is an issue, therefore when her wishes were comprehensively overruled she was triggered into dissociation:

> *"I surprised myself and managed to find my voice, before he sat down I said quickly, 'sorry, can I please have a female chaperone please just umm I have PTSD and don't want to risk dissociating and trauma". [...] he said 'Oh, don't worry, I'm only doing an abdominal examination!' Grinning and practically laughing, "Oh yes but I still need one please thank you", this time, he made a very loud sigh as he turned around and walked off to find a nurse who seemed quite bemused and didn't say anything just stood there [...] 'Can you pull your shirt up and trousers down please?' As he stands impatiently staring and waiting and the nurse doing the same. The silence in the room was hellish. This was too much now I'd had enough, I curled myself up in a foetal position like ball and couldn't speak in any more than one word whispered and mumbled sentences, as the world slowly began to drift away from me"* Anna

Milla and Will (see Findings Two, Chapter Five) both chose to abandon their fight for legal justice after betrayals by police and Church respectively, and this had implications beyond their own sense of betrayal, as it left Milla's abuser at large and Will believed it left the Church able to act with impunity against victims of abuse within Church auspices.

When exiting a relationship, survivors were choosing to return to Zone 1 to cope alone and yet when betrayal necessitated this, it was felt to be safer than staying in relationship with this untrustworthy other:

> *"I honestly give up trying to get help from the NHS with my mental health... I'll go it alone thank you!" Anna*

The term 'betrayal' is used by survivors when in relationship with a person or institution they experience as utterly un-trustworthy, and who causes fear and (re)traumatisation. The discussion will consider whether this is due to survivors misreading the trustworthiness of their trustee, or actual wrongdoing by trustees; certainly participants in this study shared experiences that would be hard to consider anything but (re)traumatising and abusive from people they had tried to trust to find help from. Ruby's example of sexual assault by a professional was not isolated; Rachel and Stella also spoke of health professionals sexually abusing them. Allied with Jake's attempted suicide and Anna and Ruby considering suicide following (re)traumatising encounters with professional the magnitude of betrayal as a feature of relationality for these survivors is evident.

Zone 6: Transactional Trust: *"if it's something minor I can just get through it" Jake*

Experiencing trustees as untrustworthy did not necessarily result in feeling betrayed or in exiting the relationship, as presented above. But during initial contact (Zone 2) and the verification process (Zone 3), all survivors in this study had interacted with trustees who they felt could not be trusted with their trauma distress in its fullness. Despite this often they had chosen to remain, and/or felt no choice but to remain in the relationship in order to achieve the task the relationship was organised around. Often quoted examples were for physical health issues, within the criminal justice system, or with psychiatric services, because the trustee had been nominated to them by a triage or designation process:

> *"I had about 30 seconds warning, my psychiatric nurse came out and said, [...] 'Oh, by the way it's Dr Nx, she's (regular and trusted psychiatrist) off work today so you'll be seeing a different psychiatrist' 'Oh, ah,' she said 'and it's a man'. I was like 'ah' so I was already sort of apprehensive kind of walking in" Anna*

If these instances happened in situations where survivors needed the orienting task to be attained, sometimes they could remain within the relationship without full trust:

> *"Erm, I think sometimes, yeah, if it's something minor I can just get through it, that's not a problem, if it's something major I wouldn't engage with them unless I could trust them" Jake*

Such relationships draw on what is, in other disciplines, called 'transactional trust', meaning that the survivor draws on an ability to trust 'enough' or 'sufficiently' to remain in the relationship to attain the orienting task. Frank's need for a colonoscopy helped outweigh his sense of the doctor being untrustworthy with his trauma:

> *"Then I told the doctor that would be performing that investigation that I had been subject to sexual abuse, 'so it's a little bit sensitive to me how you make it when you start with the instrument' and she said 'Ok', and then she started [...], I mean she was very good at it but um I didn't feel that, I mean, nothing like trust because I didn't get any response really" Frank*

It was possible to stay because of the survivors' abilities and inner resources: one skill was to be in relationship while holding something of one's self separate[61]:

> *"I will keep myself out, separate that deeper self, separate […] it just feels like that's my protective way, I don't know how else to be"* Ruby

While the relationship could continue, the level of vulnerability was downregulated through a withdrawal of information, or a retreat behind the 'mask' or the use of minimisation presented in Zone 3:

> *"I felt like he* (police officer) *was being really judgmental and at first I couldn't tell him that I'd been raped so I just told him that I'd been sexually abused"* Milla

> *"I can't just walk in* [to her therapist] *and go blah because then it's my weird thing about feeling guilty that I feel like I'm just putting myself on people even though I'm paying for the bloody session, like it makes no sense, I still do it, I don't like to burden, I don't like to be a downer […] I pull back"* Ruby

However, the ability to stay in such transactional relationships was dependent on not being triggered into trauma distress, and this was seen by survivors to be more because of their own resilience to manage triggers and reminders of the abuse, than the untrusted trustee not causing triggering. Jo needed to have dental treatment:

> *"I thought well this is stupid I need to be pragmatic about this so I just disassociated, I just switch off my emotions so I don't feel anything and think of it as a perfectly pragmatic thing and I go in and say 'I need to do this, oh by the way I am an abuse survivor, I find it very triggering please be very careful'. And then I'll sit there going 'I'm not feeling anything', you know, it's not happening to me, I'm not here, just don't (mumble), I'm just a lump of meat"* Jo

Yasmin has stayed with her dentist but finds the relationship difficult:

> *"I, I've I, er it's like her hands or dentist's hands, the ones that I have had in my face, they remind me of, they have the same kind of hardness of holding, it's not like gentle,*

> *it's like 'crechhhh' more, it's like pushing and more like [...], so it reminds me of my grandfather's hands [her abuser] which I have always remembered his, I have have always remembered the touch of his hands [...] he was so, he was so hard with us, with touching us because he was also a doctor" Yasmin*

But transactional trust and the need for the survivor to self-resource would come at a cost:

> *"It took a big toll on my health and things like that and so did the trial because you know it would be the night before the trial and you'd been waiting months and months for that date and then you'd get a phone call from the police saying 'sorry, it's been postponed for another six months', and that happened two or three times so that was really really hard because it's like months and months of sleepless nights, you'd prepared yourself for it" Milla*

When the survivor chose to remain in a transactional trust-relationship they knew they would gain some benefit in that the 'task' may be achieved, but the deeper trauma was not healed, and could compound suffering with secondary traumas, as Milla shows in this last quote.

This section has presented survivor experiences of transactional trust. The danger with trustees not providing a relationship where a fuller trust can emerge is that information important to achieving the task gets lost, to the detriment of the survivor:

> *"Everything on my records is really outdated and it's sort of written by people I've never actually opened up to because I haven't trusted them enough" Anna*

> *"I also felt like the counsellors wanted me to be better sooner than later, so I also gave them what they wanted to hear" Ruby*

To conclude, transactional trust is an important ability survivors knew they had and used when it was needed, but also knew that this was not a full or deeper trust. For such a trust to evolve something more was needed from the trustee.

Zone 5: Trusted qualities and behaviours: *"I knew what I needed" Tessa*

Just as in Zone 4 where survivor testimony on their reading of untrustworthiness was presented, it is both the immediacy of survivors' felt sense of the type of person this particular trustee is, as well as their choices, actions and behaviours which contribute to the building of a belief in their trustworthiness.

Trusted attributes

Certain personal attributes were echoed throughout testimony: *"friendly and accessible" (Betty), "gentle" (Jo), "true" (Tessa),* and these point to a key component of trustworthiness as something the trustee *is* rather than something they *do*:

> *"She's just lovely and she imbues trust, you know, I really do trust her" Stella*

> *"It's her personal manner, I think just her body language and her voice, it's very soft, yeah, it just feels very gentle" Betty*

These attributes are embodied can be 'read' via body language[62] or physical characteristics:

> *"Straight away as soon as I saw [therapist], kind eyes [...] just so kind, and that's a massive thing about my sort of like attachment to her" Helen*

> *"Um, there's something about his voice [...], but I don't know, I'm a lot for voices. I liked the way he was talking when I was talking to him on the phone" Chloe*

In addition to the 'personhood' of a trusted other, survivors described trustworthy actions and behaviours, presented now as four themes: *skills, transparency, authenticity* and *availability*.

Trusted skills

‘Skills’ refers to a set of abilities in engaging with a traumatised person during the disclosure (partial or full) of abuse: for non-therapeutic trustees this might be a simple verbalisation of choice and permission:

> *“He (surgeon) said just tell me what you need to tell me, you don’t have to disclose anything to me that you don’t want to” Chloe*

In therapeutic relationships, trustee ‘skills’ referred to managing full disclosure and effectively processing traumatic material:

> *“I was dissociated, so, I mean, she started talking to ‘us’ rather than talking to me, she said ‘I understand that there are many of you here today and and and I’m talking to all of you’ and then she started to build the trust with all these small persons within me” Frank*

This capacity to create an environment where sufficient disclosure could be shared and allowing survivors control over pace and extent of revelations by respecting the ‘testing’ of Zone 3 necessitated displaying patience and acceptance:

> *“She (psychiatrist) doesn’t fire questions at me or anything, we just chat and she seems to figure out what she needs to know just by my waffle” Anna*

To achieve this the trustee needed skills in empathic connection, and ability to ‘read’ the survivor and respond appropriately:

> *“I just gave very brief headline um of my experience um and he (peer-group member) was saying ‘Oh that’s terrible, that must be very difficult, he was empathic, […]in a way that was really touching” Betty*

Empathy included the ability to pay attention to the detail of what was being said, as well as what the survivor was holding back[63] and know when to probe for more and when to allow space[64]. Many survivors wanted the trustee to see what else was here[65]:

> *"I needed her to actually feel what I was saying underneath what I was presenting"*
>
> *Jake*

And some needed help to speak:

> *"She just, she didn't ask questions, like I need you to kind of help me, pull this out of me like 'cos I can't just walk in and go blah [...] I'd say to her, you know, I find this very difficult when I come here that I'm supposed to just start talking"* Ruby

There were instances when survivors needed the trustee to see what was needed and offer flexibility. For example, Chloe sought a therapist who would allow her husband to attend:

> *"I had to have J__ [husband] with me initially to trust, to get the trust [...] yeah and I think the second or the third time J__ didn't come any more, I think I just needed support for the first two times and then I could sort of slightly trust this person (therapist)"* Chloe

Survivors knew when a trustee was paying empathic attention by appraising their listening skills[66]:

> *"Trust for me is somebody needs to listen, that's a massive part [...] if I'm not being heard [...] because you can listen with your ears but if you don't listen with your heart there's no point"* Helen

Listening included embodied engagement:

> *"How can you trust, how can you trust someone who don't look in your face?"* Helen

And when listening, a trustworthy other is not preparing their response: listening not just to use the survivor words to springboard into their opinion or view. Staying with the survivor in their narrative was important. For Chloe her trusted therapist:

> "*…didn't try to put their two pence in all the time" Chloe*

This metaphor suggests that Chloe appreciates her words being valued, and the trustee not valuing their own words more than hers. This valuing appears in Jo's statement too:

> *"Listening um, about taking seriously what someone else is saying, not only thinking about your own self and your own response but really listening to the other person" Jo*

> *"Just feeling that somebody is listening actually, taking it in and not just filing it away" Anna*

Not 'filing it away' suggests the listening is engaged and the words are not being dismissed, as in filed away, but also not being added to her medical notes or files. Her words are valued as live and relevant, not as indicators of disorder. In this way these survivors found listening indicative of being given worth. This skill of listening is sensitive without being pitying[67], and embodies acceptance in verbal and embodied responses which, crucially, must include the trustee believing the survivor:

> *"I think that the relief of being able to tell someone and being believed diffused a lot of that agitation and fear and everything" Betty*

By believing, the trustee holds no blame for the survivor, and thus triggers no shame, creating a non-judging[68] atmosphere where the survivor can relax and drop their guard, thus allowing the trust-relationship to develop (Zone 5).

> *"I think it's because he didn't disbelieve me and he didn't put any blame on me" Julie*

Sometimes the survivor also needed the trustee to have the skills to know what need to be done, and the ability to take control of the situation, Anna needed to feel her nurse knew what to do:

> *"[The] Mental Health nurse literally said she didn't know what to do for me and said 'I'm at a loss' repeatedly... Well lady, I came to you in crisis 'at a loss' and you're the one paid to know what to do!!! So if you don't know what to do, then how am I?" Anna*

This includes the skill of knowing when the survivor needs control and choice and when they need to feel that their trustee is holding them safely because of the choices being made on their behalf.

Trusted transparency

Survivors are able to ‘read’ these abilities in the trustee because the latter acts ‘transparently, that is, willingly revealing something of themselves within the relationship:

> *“I hate people that you think, what aren’t you saying, so trust is a big thing about that” Tessa*

Transparency meant not hiding any ‘side’, not wanting something from the survivor and not acting in a hidden malicious manner:

> *“I trust them, they’re* (GPs and dentists) *fine [...] (pause), they’ve got nothing to get from me, have they? What they got to gain from me? They’re there to do their job” Patrick*

When trustees allowed access to personal details, a sense of ‘something shared’[69] was fostered. Jo thought her therapist was a survivor of CSA:

> *“It certainly contributed for me, I think, it made her more effective, I think, because you know she really understands, you know, because of how she reacts and what she says and her insights” Jo*

> *“We (partner) were two peas in a pod, she had had trauma as well but of a different kind and so I think we were able to really trust in each other” Ruby*

Commonality was imperative for some:

> *“Yeah, and I think it helps that they’re both women and they’re both black so in fact all three of my therapists are female and all three of my therapists are black and that makes me feel comfortable because there’s a cultural understanding” Rachel*

Transparency allowed survivors to ‘see’ the trustee, which enabled a developing sense of ‘fit’, even when aspects of therapist disclosure were not necessarily in line with codes of conduct and ethical practice therapists work to:

> *“She’s (counsellor) very loving, she’s, ‘Oh, I love you, I’ve missed you’, and people say ‘Well, that shouldn’t be a* counsellor*’, but she is, that’s my type of* counsellor*” Helen*

Trusted authenticity

When trustees were transparent, the survivor could verify the trustee as ‘authentic’:

> *“Survivors sense if they can trust [the trustee] or not and that’s hard to quantify but I think lot of it, […] a lot it is about being authentic as a person” Jake*

Authenticity enabled safety, even eccentricity if it fitted the whole picture of the trustee, and was welcomed:

> *“She cooked chickpeas, she worked in that wholefood shop across the road, you know, she had that old hand-knitted, you know.” Patrick*
>
> *(Susanna) “And that didn’t put you off?*
>
> *(Patrick) It was safe”*

Trusted availability

Lastly, trustworthiness was proven though actions, which underlined a level of availability aligned with reliability:

> *“She (GP) said ‘I’ll ring you up in two weeks’ time’ and she did, you know” Betty*

Honouring promises offered a necessary continuity, which instils safety:

> *“A lot of it comes down to things being predictable and routine” Milla*

A flexibility with appointment times, and session lengths and longevity of relationship was also seen as trustworthy in that it underpinned a valuing of the survivor:

> *"He (therapist) said, "I'll be with you as long as you need" Jake*

'Testing out' takes time, and not being under pressure through enforced time frames allows the space to say what needs to be said:

> *"We (referring to partner) were both able to really um investigate and speak to what had happened to us, um yeah, we both just really gave each other time to be able to talk" Ruby*

The combined effect of skills, availability, authenticity and transparency synergistically create an engaged attitude of empathic kindliness and created a sense of being valued70 in the eyes of the trustee:

> *"I really, I believe they genuinely care and they genuinely like the personality, the person" (referring to herself) Rachel*

When survivors judge a trustee trustworthy, they allow the relationship to develop and trust to deepen further into Zone 8, the 'trust-relationship'.

Zone 8: The trust-relationship: "*we're tuning our strings […], we're vibrating at the same tone" Jo*

In 'verification' (Zone 3), survivors tested out potential trustees using an iterative process of discovery, gradually revealing more in response to trustee trustworthiness. In the flourishing of a trust-relationships this process allowed the two individuals to *"gel"*71 *(Tessa)* or come into harmony:

> *"I think there's a kind of sense of being in tune, you know that whole thing of, I don't know if you're a musician, but I play in, I'm an amateur musician,[...] and you know that thing when everyone's tuning up at the beginning, when you're all trying to play G and you (aggggg) and you're gradually tuning up, and it feels like that, it feels like we're tuning our strings until we're on the same, we're vibrating at the same tone"*
>
> *Jo*

The fruition of a deeper trust heralded for many survivors a shift to a form of relationality where the exploration of more sensitive material, and the approaching of more challenging tasks, became possible. This then gave rise to better outcomes; healing became possible from the trauma distress. When in a trust-relationship not therapeutically focused, the orienting task was often achieved and in addition sometimes the healing of aspects of trauma distress also occurred. In this zone the process of building relational trust has flourished into a full form of trust for the survivor. The facets of such a relationship are less about the attributes or choices of the trustee and more about the facets of the relationship itself. Because this relational trust is so very different from the generalised distrust touched on in Zone 1, these two forms of trust are explored more fully in the Chapter Five. Additionally, aspects of trust beyond the process of building trust are also presented: trust in institutions, trust in group and self-trust.

Summary

Survivors described the decision to engage in relationships necessitating trust as a process of discovery; initially self-discovery with the transition from the abuse being unacknowledged towards recognition, followed by the discovery of the need for help (Zone 1). The process proceeded to the discovery of a potentially trustworthy person, and the establishing through experiential steps the level of trust that could be placed in that person. Zone 3 demonstrated the safe exploration of the characteristics and behaviours of potential trustees, and this iterative process of discovery was to ‘check out’ through small revelations and reveal the trustworthiness (Zone 5) or untrustworthiness (Zone 6) of the other person. It is emphasised that these are not statements of reality regarding trustees; this study is focused on the perceptions, the meaning being made, and hence the opinions of the particular survivors this study engaged with. For these participants trustworthiness had, on occasion, opened into deeper levels of trusting (Zone 8), which facilitated the healing of the original trauma.

Equally survivors shared narratives of relationships which had been ruptured and ended (Zone 7), or where trust was downregulated and yet still sufficient to engage to attain the orienting task (Zone 6).

By exploring how survivors build and lose trust, the myth that trust is an on/off mechanism, an ability or propensity lodged solely within the psych of the survivor without reference to the trustee has been dispelled by these findings and the implications of this are explored in Chapter Seven, Discussion.

Chapter Five: Findings Two, Trust In Its Many Forms

"I can trust myself but can I trust others?" Will

Introduction

The previous chapter, Findings One, explored the zones through which survivors in this study moved in a process of building relational trust. This scoped the reasons for seeking a trustee, initial moments of contact with a potential trustee, the verifying of (un)trustworthiness, transactional trusting and routes post-rupture. All of this data pertained to the survivor within a dyad with a specific trustee. In this second findings chapter, the experience of what is called a 'trust-relationship' with a known trustee once trust is established is counterpointed to statements regarding generalised trust. This is included to address the gap in knowledge presented in the Literature Review regarding the conflation of types of trust in extant studies. The data in this chapter demonstrates the clear differences for these participants between types of trust and the interrelationship between them; in addition this chapter presents data regarding relational and generalised trust in the context of institutions and groups. Such data was not present in the Literature Review and is a major contribution to the knowledge gap.

The chapter moves on to present the way survivors spoke of self-trust, and other forms of self-relationality, as impacted by relational trust. In a few instances testimony presented in the previous chapter appears again in this chapter. This occurs when it is relevant to points being made in the last chapter and the point it pertains to here. Sometimes the quote has been interpreted with a different slant and in this the approach takes advantage of the invitation and freedom IPA offers to use a radical hermeneutic lens. Oftentimes statements had multiple implications or meanings for both the speaker and the listener, and the hermeneutic endeavour is predicated on that freedom. Such re-readings add depth, nuance and richness to the study, as was called for by critiques of IPA in Chapter Three: Methodology.

The chapter starts by presenting data on survivors generalised sense of not trusting.

Generalised trust

Survivors knew that trust was important, as Anna said in the previous chapter:

> *"Everything on my records is really outdated and it's sort of written by people I've never actually opened up to because I haven't trusted them enough" Anna*

Many of the survivors shared Anna's distrust and expressed this as sense of generalised distrust towards 'all people', Ruby said: *"I think I learned that nobody can be trusted"* and Helen said:" *a lot of people will groom you with all your stuff and then they'll use it against you"*. For some, this distrust extended to the whole of society or 'the world':

> *"If you want to ask me about trust and the world, I am the least, I don't trust anything, society, […] society is my biggest thing […] society doesn't give a toss" Tessa*

Will realised it was the abuse that shaped his view of the world and his cautious behaviour around children and voiced his belief that he could not trust other people not to suspect him of being a paedophile:

> *"Another person may see it as a normal thing to do with a child, laugh with a child, you tickle a child, you play football you do, you know, with me you don't do that with children unless you're up to something, again it's that trust thing again you know it's not, I can trust myself but can I trust others to think that I'm not up to no good […] and now you really over-compensate because that's your view of the world" Will*

For Will the world is a place where he cannot trust that people think his intentions are genuine.

Origins of generalised distrust

The survivors had differing opinions about the origins of their belief in the untrustworthiness of people. Jo felt that this was due to the abuse itself:

> *"So I think sometimes for me the damage of the abuse is that I'm not always good at managing trust"* *Jo*

But Jake and Anna attributed their caution to groomed beliefs about the danger of trusting people with disclosure: *"the person who abused me kept telling me people won't believe you"*. Anna's abuser had used fear to instil in her the danger of trusting others:

> *"He (abuser) well basically told me if you tell you're going to lose everyone, you're going to you know, lose your parents, lose your mum" Anna*

Will recognised the transfer of his generalised trust from the abuser (a priest) to others in similar powerful positions*:*

> *"It's very hard to trust anyone, isn't it? Especially anyone who has any authority about them at all, and I went all the way through school, you know, not doing so well at school was because of that"* *Will*

Caroline's generalised distrust arose not from the abuser but from her mother who had failed in her duty as a parent-protector, who was "*basically renting me out [to a paedophile] for the alcohol".* Caroline understood how this had created a gendered and a generalised distrust*:*

> *"I never trusted women, there was my biggest issue, I trust men over women, which then led me to be abused by strangers because as my mum would say all men are potential rapists, I've never trusted, I couldn't trust men because they're all gonna rape you, yet you can't trust women because my mum was an alcoholic".*

Caroline's comment also indicates that caution with entrusting is not just dependent on the abuse, but intersects with other aspects of abuse and neglect in participants' childhoods and later life. Caroline's extrapolation of the behaviour of one type of person (a woman) towards entire groups of people (all women) was similar to others. For example, Stella said: "*I have this theory that all psychiatrists are tied to drug companies"*. For Chloe*: "I just don't trust professionals [medical health workers]"*. Chloe's distrust had arisen through experiences of such professionals:

> *"I think you always think if you go to your doctor you can trust your doctor*, *they know everything, and they don't. It's only now that I've worked within* the sort of area *I work I've worked in in mental health, [...] and it's only now I've realised they don't have training, they don't have what we think everyone does"*

Chloe's first rejected disclosure was to a GP (see previous chapter). It is important to recognise that it is difficult or negative experiences of trusting, or believing in the trustworthiness of certain groups of people, that have resulted in or exacerbated a generalised distrust, and not just the abuse or grooming. Similarly when disclosure had left a survivor feeling silenced, ignored rejected or betrayed, and this had returned them to isolation (Zone 1 in Chapter Four, Findings One) to cope with their trauma alone, this impacted generalised distrust not just relational distrust.

Sometimes as the survivor was maturing from childhood to adulthood, the questioning of trustworthiness of society and institutions was exacerbated when CSA trauma intersected with other traumas. Patrick is a Black, gay CSA survivor and said:

> *"I was very mistrusting, it's, this sounds, ah, this sounds terrible because I was feeling like I was in no-man's land, because growing up as a mixed-race child…"*

Intersectional trauma was not limited to the past, as many survivors spoke of experiencing present-moment traumatic distress from CSA being compounded by other present-moment stressors and traumatic events. These present-moment traumatic experiences included racism (Rachel), homophobia (Patrick), poverty (Tessa), physical health issues (Tessa and Stella) and the detrimental harm caused by mental health services (Jake, Helen and Caroline), or the civil (Will) or criminal justice system (Julie, Milla and Caroline). For Tessa it was the experience of homelessness that intersected with being a CSA survivor:

> *"When we were homeless [...] we were treated so appallingly in that we had no voice, we were treated like just low, like unimportant, um your concerns were pushed aside" Tessa*

The intersection of these many stressful and traumatic events contributed to trust in society and institutions being impacted. This was then held in the context of the media's response to CSA. Some participants experienced the media as being against them, not supportive of their courage and fortitude in speaking out. Betty spoke of her feelings after the social and mainstream media response to a Michael Jackson exposé documentary:

> *"The impact it's had on those two men [...], it's just so brave to, you know, open yourself up to openly, say what happened and to say it was wrong and yet they got such a vilification and abuse from all the fans, the Michael Jackson fans and that made me so angry [...] because [...] they don't want their idol to be tainted but it is something about, we should be able to stop a child abuser shouldn't we and nobody stopped it" Betty*

Rachel spoke of seeing the wives and children of abusers protecting and supporting those abusers and challenging the testimonies of fellow survivors, which she feels sends a signal that survivors' pain is not important:

> *"If you look at what Rolf Harris did, he was in bed, his daughter's friend, was in bed with her, she was only a child, she was eight or nine and the daughter goes into court, as does his wife, holding this man up, as if the poor thing wouldn't do that, but he did and we spend our lives saying that children are liars, they're not," Rachel*

For Rachel this distrust extends to politicians, speaking of Boris Johnson she said:

> *"So we have a prime minister living with a woman who's in her 30s who was called for domestic abuse to the house and it was all put under the carpet"*

These examples problematise the idea that generalised distrust arises purely from abusive experiences in childhood, instead showing how the world a survivor encounters in response to their experiences can be (re)traumatising. When society demonstrates denial of and distrust in other survivors' testimony, participants felt triggered into anger and fear which compounded or reinforced their existing trauma distress.

Generalised distrust dislocated from relational trust

Generalised declarations of distrust seem unrelated to memories of relational trust in survivors' pasts, in particular their childhoods. All but one participant spoke of childhood relationships which encompassed trust such as with grandparents, teachers, or care workers as presented in Zone 2 (Chapter Four). Tessa trusted her grandfather:

> *"My grandparents, my dad's, my horrible dad, his dad was absolutely lovely to me, he encouraged me and he was funny, and he shared laughs with me, and he was just normal and he taught me things, he really taught me things,[…], he was just warm and funny, so that was my grandad"*

Yet Tessa is quoted at the start of this chapter saying, *"I don't trust anything".* Tessa is capturing an important difference between trusting any*thing* and her ability to trust a specific other. Similarly Ruby (*"I learnt nobody can be trusted"*) spoke at length about her trust for her partner, and a therapist. Patrick said "*I don't hide anything from my mum because that's the only person I can trust*", which suggests a blanket distrust of everyone but his mother, yet he did name groups or types of people who he did trust, he said of doctors and dentists: *"I trust them, they're fine […] (pause), they've got nothing to get from me".*

This discrepancy between relational trusting experiences and generalised distrust statements suggest that survivors knew the feeling of trust (Jo: *"I think it definitely is a* *feeling, it's a holistic feeling"*) and had previously trusted, and yet this did not change their view of people when spoken of as a whole.

Furthermore, generalised distrust was not universal across all the participants, for example Rachel said:

> *"It's not a distrust of everything and everyone, it's an intimate distrust, if I'm in a relationship you're not going to know that I've got a stash of money tucked away, what culturally we call vex money"*

Indicating that relational trust is the place she is cautious, Anna said: *"I like to think that people are good people, but I'm usually very on guard for any kind of reason why, why they shouldn't be trusted"*, demonstrating a willingness to trust generally, but relationally trust will be dependent on a particular trustee.

Etymological implications

The word 'trust' is being used in all of these different contexts, and these variations and anomalies suggest that in different situations the actuality of what trust looks like is variable; that trust and entrusting are nuanced, related to the person and situational, and that generalised distrust does not disqualify relational trust. The word 'trust' has more than one meaning for these participants.

The process of building relational trust was presented in the last chapter, and the way in which testing out and taking time to establish trustworthiness, if successful, moved the survivor-trustee dyad into what has been termed the 'trust-relationship' (Zone 8). This terminology has been adopted to indicate the shift from 'enough trust' to stay and work at the orienting task, but insufficient trust to begin a process of resolving the trauma distress. It is to the trust-relationship that this chapter now turns.

Relational trust

Findings One (Chapter Four) presented survivor experiences of building relational trust as a step-wise process. Zones 4 and 5 considered the many attributes and actions which survivors assessed as indicators of trustworthiness or untrustworthiness. The process of validating and assessing continued while at this stage in these relationships. In this way trust was understood not as a binary of "I trust / I do not trust", as communicated when speaking of generalised trust, but rather a fluid ebbing and flowing of relationality in the specific relationship with a named and known trustee. This trust was utilised in addressing the orienting task as it was being worked on together, because transactional trust, that is 'enough trust', was present for the survivor to remain in the relationship.

The process of testing and verifying could take varying amounts of time, depending on both the trustee and the survivor and the interactions, but for some dyads the relationship developed sufficiently for a more durable trusting to emerge and flourish. Jo's quote showed when the two have moved into a trust-relationship "*there's a kind of sense of being in tune […] we're vibrating at the same tone"*. When this harmony is experienced, a deeper trust ensues. This deeper trust was described by several survivors as an 'opening':

> *"He said there's nothing in your records to say you've suffered child abuse, you know, is that something that you need to talk about, to deal with? So he opened the door" Jake*

> *"There was something about him I knew I could trust, […] we started talking and I opened up, I didn't tell him everything that day, it took me a little bit of time but he knows absolutely everything now, but then we started from there and there was a process" Chloe*

The ‘opening’ image speaks to the revealing of something previously closed, or hidden, and indicates the trust-relationship as a place in contrast to the secrecy of the abuse. As Ruby said, she was groomed to keep silent: *“I learned to lie and make up stories”,* trusting her therapist in a trust-relationship enabled her recovery:

> *“She was an art therapist, and she was amazing , […] and I was able to talk to her […] she’s very kind, just natured, in her whole nature, she’s very kind, um she’s quiet, she seems understanding, she just like, everything about her, […] it seemed like, I just felt comfortable with her”*

Yet in a previous therapeutic relationship, where there was trust, but not this deeper level of trust, Ruby could not speak: *“She was this older woman and I didn’t feel like I could tell her these things (the abuse) because it felt dirty I couldn’t be honest with her” Ruby*

Others spoke of this new-found place of a deeper trust allowed previously silenced experiences to be shared as honesty:

> *“We both just laid it out on the table what we were both looking for in a relationship and it was the most honest I’ve ever, I think, been with somebody” Ruby*

> *“I would say I am being honest with you B (therapist) because I trust you, you know, because if I don’t trust people I might not be able to be honest with them” Tessa*

This moment marks a shift from two individuals working around a shared goal, to a deeply connected relationality:

> *“We’ve (referring to partner) both been what I call the rock and the barnacle to each other, […] why does the barnacle need the rock, for something to hang onto and why does the rock need the barnacle for company and so we all, like there’s always been the sort of alternating of the rock and the barnacle” Ruby*

When a trust-relationship flourishes, survivors experience something different from the relationality that is tranactionally based, and the dynamics of the CSA and wounds of traumatic distress start to heal. Survivors knew this was what they yearned for:

"No one cares for me, properly, but I know I'm looking for (pause) *what I didn't get (in childhood)" Tessa*

In trust-relationships built on honesty and openness, it is the *relationship*, not just the trustee, that holds five hallmarks. These signify a journey of healing, and are co-create by the survivor and the trustee: *vulnerability, resilience, esteem, shared responsibility, and the repair of ruptures.* This section includes references to the original abuse, to evidence the healing the trust-relationship facilitates.

Vulnerability

Firstly vulnerability: survivors were prepared to show more of their vulnerability (to 'open' as stated above) when the trustee showed their own vulnerability. This was predicated on the transparency of Zone 5 (trusted attributes):

> *"It's a gradual process of being vulnerable with each other to a point where you feel there's safety and a checking out of that goes along so it's almost like we're all like the onion thing, we're all onions and we're peeling off layers and layers to the point where we're not hiding behind any more layers, we're being really real with each other" Jo*

Demonstrable evidence of the vulnerability of the trustee[72] was actively sought, and was a confirmation of their humanity[73]:

> *"She was shocked but she was also sad, she had tears in her eyes, you could see that she was, um, quite upset, not for herself" Chloe*

If the trustee is not vulnerable the relationship is not equal:

> *“ It’s just me having to, pause, […] expose what’s happened to me but there’s no level playing field” Ruby*

Trusting each other with one’s vulnerability allowed for this deeper and deeper opening[74] to the pain[75] of CSA:

> *“I was actually I was considering lying about the memory loss thing because I am so afraid of not being believed, (pause) so at one point I was like, maybe I won’t tell him* (cousin), *maybe I’ll tell him I knew* (about grandfather abusing her) *but I didn’t tell him* (cousin), *but I’m not, I’m going to tell him* (cousin) *the full story, I’m going to tell him everything the way it is in my memory and how it’s been so, I think he’ll understand” Yasmin*

Allowing for vulnerability created a space for acceptance and the dropping of punitive reactions other therapists might adopt in response to challenging behaviours. Jo attended some sessions drunk:

> *“She* (therapist) *was just so good the way she handles it, so I know other therapists would have handled it really harshly and she did say after the first couple of times, when I was coming and saying ‘I know I want to feel this, I want to feel this here, and I want to explore what I’m feeling here and I can’t, I can’t let myself feel’ and that’s why I started doing it* (drinking before sessions) *and I hadn’t said what I was doing but she obviously smelt it and she sort of said, ‘you know, Jo, I know what you’re doing and I think I know why but maybe you’d like to tell me about it’, isn’t that wise and kind?” Jo*

Trusting relationships make it safe to be vulnerable, and allowed survivors to experience care that was lacking in childhood:

> *"I think she was mothering me, like re-mothering me, because everything was like, it's OK, it's fine she never lectured me or or or tried to dig in a way that was, that I got defensive"* *Yasmin*

> *"The sister (nurse) came over […] and she said 'would you like me to wash you?' and she just washed my hands and arms for no reason whatsoever, but it was so she could touch me […] it was mothering, I wasn't mothered, I wasn't mothered, she was being mothering, I was surprised"* *Tessa*

Such experiences were in sharp contrast to the original abuse, where extreme vulnerability had resulted in needing to be vigilant to danger, and protective to those who were responsible for the survivor. In such instances survivors had become the protector-parent that the trust-relationship was counterpointing:

> *"I used to sleep on my mum's floor because I was worried to be away from her because if something happened to her, (pause) and then I had to take 8 teddy bears at a time, it was so stupid, the number thing and I just felt I had to have everyone with me, and that just stayed with me, […] yeah, I had to be near her, I had to know that if anything happened I would hear it, I would wake up and I would be there and it was me, I had to keep her safe"* *Anna*

Experiencing the vulnerability of the trustee was, for some, also a counterpoint to the experience of the abuser who was harsh. Yasmin wished for her dentist to be gentle, and shared about her grandfather's abuser's hand in the last chapter:

> *"The touch of his hands […] he was so, he was so hard with us, with touching us"*

Resilience

The quality of vulnerability needed to be in alliance with demonstrable qualities of resilience, the second hallmark of trust-relationships. In Zone 3 (verification) survivors spoke of protecting trustees from the damage of listening to abuse narratives. In a trust-relationship the survivor witnesses the resilience of the trustee and, to repeat Chloe's statement above: *"he knows absolutely everything now"*; nothing need be held back. But survivors needed proof, through experience, of trustees being resilient enough to hear abuse narratives, witness trauma distress, or even stay alongside the survivor when engaged in 'fight'[76]:

> *"Then met a lady called C__ (counsellor) absolutely fantastic, straight to the point , that's what I like [...]no bullshit, no sort of like fluffing it up and all that" and "you get somebody like S__ and J__ (therapists), who are real real people and have got the knowledge alongside their experience and the empathy and sort of like, you know, a bit of brutality sometimes which is good" Helen*

Unless the survivor has experienced this resilience, they cannot open up and go further into the process of revealing:

> *"I can't just walk in and go blah because then it's my weird thing about feeling guilty that I, feeling like I'm just putting myself on people even though I'm paying for the bloody session, like it makes no sense, I still do it, I don't like to burden, I don't like to be a downer [...] I pull back" Ruby*

Resilience is palpable:

> *"There's something very direct about German people,[...] you felt that they were honest [...] yeah in a kindly, in a, not in a rude way, not blunt, but it was, it just, maybe that's not a true thing to say, but the four or five German people I've known I've thought wow, I believe you, you are somehow open and true"*

Resilience includes a willingness by survivors to take risks and be brave in approaching and working with difficult material[77], naming what they saw[78], which manifested in this positive *"honesty" (Tessa)* presented above. Helen recounted an exchange when her therapist challenged her by calling out her anger and saying "*you've got the hump*". Helen was hurt and angry because the therapist had been off sick, and Helen felt abandoned. This statement by the therapist dramatically changed the situation by allowing Helen to voice her anger. Helen says of this healing of the rupture within their relationship:

> *"It's about taking a risk sometimes because if she* (therapist) *hadn't have took that risk I would probably have been like that (angry) for over two weeks and that would have not done me any good and I would have made myself more angry so because she took the risk I sort of like, the top come off"*

The strength of the relationship allowed Helen's persistent anger to emerge, and she found they were both resilient enough to endure it, which facilitating a healing, in that she moved to an anger-free state and experienced appreciation and gratitude for her therapist, emotions she has struggled with in other relationships.

> *"Part of me wants to punch her (therapist) and part of me wants to say thanks very much, I owe you, so yeah, (laughter)" Helen*

In this way, when the trustee is resilient, the survivor can be resilient and face material that has not dared be spoken before:

> *"She [therapist] never lectured me or or or tried to dig in a way that was, that I got defensive, she was very listening and listening and listening and finally I decided, and also I told her I think there's something wrong with me, I think something is really really really wrong with me, either I'm bi-polar or I'm a borderline person or something is wrong with me, something is majorly wrong with this, and she was like, what is this, what is this? where does it come from? and she was always asking me and this when I realised that maybe this is what everything is about"*

Yasmin's testimony demonstrates the weaving of elements presented separately in this section, and Findings One (Chapter Four), where she can, for the first time, voice her fears of being someone with a mental health disorder, and this then opens to the revelation that her behaviour may be stemming from the CSA all those years ago, a link she had not made before. Perhaps Yasmin had become resilient enough to turn towards this new knowledge. In the trust-relationship Jo also found the strength to go deeper:

> *"She made things safe and um I wanted to, […] I was prepared to work really hard at it" Jo*

Findings One (Chapter Four) presented data regarding survivors choosing to protect trustees from the detail of the abuse they had suffered and this was seen as an important choice on their part. This suggests that resilience to hear traumatic material is not always a feature of every trust-relationship. For example, Anna said of her husband:

> *"I just don't want to put that in his head, I don't want him to think about it, it's enough that it's in my head um but yeah, he knows the kinds of, the general idea, and that just feels enough, I don't want things to be kind of a secret to him I don't want to hide things from him, I just think full details aren't always needed" Anna*

Held in esteem

Thirdly, in trust-relationships each holds the other in high esteem. Being esteemed is to be valued, to have your suffering validated and acknowledged both by individuals and institutions. Of her much-loved psychiatrist, Anna said:

> *"I feel less like I'm a just nothing, I don't know, been a bit more valued or something"*

This is in stark contrast to Anna's sense of invalidation when a different person who took over in the same NHS role:

> *"I left my appointment with him (psychiatrist) feeling like I hadn't been listened to, feeling judged, feeling worthless, feeling like he thinks I'm a failure of a person"*

When experiencing being held in esteem Anna held the first psychiatrist in esteem too, saying:

> *"[She] is the most incredible psychiatrist I have ever met... and goodness, during 25 years of needing psychiatric care, there has been many of them. She listens. She really listens. She remembers things I've told her from months ago without having to stare at her computer screen or notes to re-read past sessions. She smiles at the right times and frowns when frowning is needed" Anna*

Survivors in trust-relationships found a voice to *ask* for acknowledgement:

> *" I wanted someone to say, yes, it was important" Jake*

Thus breaking the silence of Zone 1 (isolation):

> *"I [had an] overwhelming sort of need to say 'I've been through something, please acknowledge it'" Milla*

Helen eloquently projects the need for relational-esteem onto toys in this extract from her poem:

They could not tell you what happened
Because they could not speak
But I would give them comfort
As it was what these toys did seek
Someone who would love them
For what they were inside
To see past that tattered look
And hold them up with pride

Being esteemed was experienced in different ways, for some as a sense of being 'seen'[79,80], for others the acknowledgement of their journey to survive[81] and flourish, and for others esteem was experienced through trustee choices, such as being valued enough to be given time[82] outside of boundaried appointments, and of being more than 'work'[83]. What emerges is a sense of being respected for their lived experience[84] as a survivor:

> *"She (psychiatrist) knows that while she was at university learning about mental health, I was out there living it... so instead of arrogantly barking orders, we just talk, we share ideas and we make plans that I feel comfortable with" Anna*

Respect was expressed as a key need by several survivors, with the recognition of when it had not been present. As Jake and Caroline point out, respect includes the experience of being seen as a unique individual, good enough and worthy as they are:

> *"If you treat that person in front of you as just another person, then you're not actually respecting them" Jake*

> *"I have to sort of fake the middle class, [...] and demand or command some respect in these meetings whereas when I was just being me that's not good enough" Caroline*

Shared responsibility: choice and control

The fourth theme is the mutuality of sharing responsibility, as Anna said three quotes above, of the survivor being given choice, and of trust-relationships being ones with a flattening of power hierarchies where control is shared or negotiated. There is joint ownership of the direction the relationship takes, bringing a mutuality or equality in achieving the tasks or goals of the relationship. This allows the survivor choice and control:

> *"she (dentist) said well we can give you a sedative and all that stuff, I thought I actually want to be in control and alright, it's going to be uncomfortable, scary, traumatic, because there's something out my mouth coming out, [...], I'm always in full control with her and that's the thing, always in full control, and she'll say put your hand up and stop" Helen*

When the process, or treatment, involves traumatic material managing choices together was empowering[85]:

> *"I have a GP now who I have a discussion with about my mental health rather than being told what is good for me and that's making all the difference [...]um so we manage my mental health together" Jake*

This sharing of decision making extended to the trustee trusting the survivor:

> *"'it sounds like you've got it in hand and you know what you want' and she (GP) just completely trusted me to, with the course that I was taking" Betty*

> *"she (therapist) trusted my "NO", she didn't say "but this is therapy blah blah blah", [...] my "NO" worked" Tessa*

This was not the case in every situation however; Zone 5 (trusted attributes) spoke of instances when the survivor needed to see that the trustee had the skills to know how to care for the survivor in some situations, to summarise Anna's full quoted in the last chapter "*Well lady, I came to you in crisis "at a loss" and you're the one paid to know what to do!!!"* . Therefore, this issue of choice and control is nuanced; in trust-relationships the survivor has the choice to ask the trustee to make decisions for them, and trusts in the trustee and their decisions.

This bi-directional trust sometimes included the trustee trusting the survivor with aspects of the trustee's own experience, or private life, and this was valued as it further confirmed the worth of the survivor in the eyes of the trustee. This is taking transparency one step further:

> *"I think what really helped me there as well is that she told me bits about her as well, so I know that she's got a son and we've talked a bit about her kind of family and things um" Anna*

When the trustee holds no authority over the survivor, issues can be aired with no fear of reprisals:

> *"I can challenge her and she's willing to challenge me [...] the fact that I could take the mick and she could take the mick and it was comfortably done and that actually helped " Rachel*

Being in relationship was recognised as valuable, and rewarded with what survivors saw as a mutual willingness to fully commit to the process of overcoming trauma distress[86]. The effect of shared power was especially valued when the survivor knew the choice was outside of the usual remit as it demonstrated the trustee seeing the survivor as an individual with specific needs. Examples included bringing a spouse to the first few sessions[87], being allowed to lie on one's side for a dental treatment, taking the necessary time [88,89], discussing the way to sensitively handle the passing on of disclosure[90], and getting comfortable with a dental treatment room before being asked to sit in the chair, and before being asked to open the mouth for a check-up[91]. All of these are examples of the trustee being willing to override 'rules' or norms if the survivor is expressing a need that the trustee is able to meet by being flexible[92].

Mutuality in therapy included being allowed to control what was being explored [93], respecting the individuality of what helps[94], and the pace at which the work was going:

> *"...and one of the interesting things that she did, I think, that's it's totally at your pace so she's not pushing the pace forward at all" Jo*

When mutuality is experienced it is in contrast the sense of having no -power or choice which some survivors showed was so much part of the original abuse experience[95]:

> *"He (grandfather-abuser) was a master manipulator and he would manipulate the entire family [...] he loved that power and that control [...] it was easier for me to just do whatever he wanted and then everyone was happy and everything was easier if I just did it because when I didn't he would take it out and show me with his looks and everything that I had made that happen so it was so manipulative" Ruby*

Rupture and repair

Trust-relationships were not without moments of rupture, yet the dyad in the trust-relationships often had the means to address and repair these. Rupture and repair is the fifth hallmark of trust-relationships. Rachel and her trustee found a way back into relationship after the trustee caused a rupture by asking for details about the abuse and abuser:

> *"She actually asked about the actual experience and I came away totally rocked, that this is what she wanted to hear about, what! so I was actually going to leave the following week , and instead I shewed (sic) for her and 'I didn't know we did that', and from there and she accepted what I said and it started to move forward" Rachel*

Oftentimes having a trustee apologise or see a mutually experienced moment from the point of view of the other, or share their own point of view (see Risk, above) enabled deeper connection and opening to emerge. When a police officer apologised for calling Jo's father (her abuser) a paedophile, the breach of trust was resolved:

> *"Yes they named it [their mistake]and um apologised, it means something, not to say that they thought they were wrong in using that word, but apologised that that had, had, that, and it had come out of the blue for me, that that was a difficult reaction for me, [...] I think they still felt they were justified to use the word but they didn't use it again" Jo*

Repair also worked to deepen relationship when it was the survivor who had caused the rupture. Patrick had tried to terminate long-term therapy with a letter, because he was struggling with the intensity of the work:

> *"She [therapist] [said she] would like to think I had the integrity to end the relationship we had, before we had, in a one to one, face to face [...] as opposed to by a letter, so I was like, oh , I was like shit, yeah I suppose she's right, that's was the*

> *least I could do, so she thought I could at least do that, so, I've gone back there and it's perfectly fine"*

This therapeutic relationship continued for many months more.

It would be incorrect to say that all trust-relationships deepened post-breach, for while repair was possible, it was not always immediate[96] or complete, and could return survivors to Zone 3 (verification):

> *"We (colleague) have come back to a close, not as close as it was originally, not like completely restored"* Jo

To sum up this section on relational trust, when a deeply trusting relationship is established, survivors were able to access vulnerable material in a way which was deeply healing. This was not peculiar to therapeutic relationships and many survivors gave examples of this in other relationships. For Helen the trust-relationship with her dentist played a significant part in healing her trauma:

> *"It was a such a relief of um this whole trauma of my mouth which still goes on psychologically but it was like I was nurturing the part that was [affected by the abuse]"* Helen

For some, this deep relational trust was experienced in a group setting, which is explored below, but first this chapter explores survivor testimony regarding the trust that was emerging during the interview process by way of illustration of the value of Mad Studies as well as an example of relational trust in operation.

Relational trust and the interview process

Findings One (Chapter Four) presented data framing relational trust as process, with the conceptualisation of zones, and some consideration has been given to the speed at which a survivor might move through these stages. Given this data, it is important to recognise that the research interview is itself a relationship where such a process of evaluation by the survivor of the researcher will have been unfolding. Statements regarding trust in the researcher are presented here, to both bolster and validate the data presented so far and as a reflective piece by the author of her ability to present herself as trustworthy, thereby validating the use of the Mad Studies paradigm.

Many survivors stated that they trusted the researcher:

> *"I can talk to you and, like I say, I'm quite who I am, if I trust you you'll get it all out of me, so obviously I must trust you"* Chloe

The shared history of CSA was remarked upon as enabling relational trust. This reinforces the theme of mutuality as an important aspect within a trust-relationship:

> *"I feel it's also easier for me to talk to you because you have experienced something, like, we have a level playing field"* Ruby

Tessa reiterates Ruby's sense of the value of the shared CSA history with the researcher facilitating trust, by linking this to the importance of feeling safe:

> *"I feel safe, I feel safe, I know you* (author) *do this stuff and I know it's happened to you"* Tessa

Tessa went on to point to the importance of trustworthy attributes and transparency, mentioning nothing being hidden, and also that the researcher holds no power to harm her:

> *"You've just got a nice vibe to me so, you know, so it's fine, I don't expect you to do anything terrible, (laughter), I don't think you've got a hidden agenda [...] I don't need a house from you, I don't need anything from you"* Tessa

The interview for Tessa was also described by her as a safe place to be vulnerable and display trauma distress without feeling judged or shut down, and she valued having the power to choose to continue and not have control over the interview taken away from her. Tessa was getting tearful and was asked if she wished to continue. She said she very much wanted to:

> *"I'm so used to it"; "I cry all the time, I try not to because you can't speak and cry, I just cry all the time*" *Tessa*

At the end of the interview she said:

> "*This is no worse than every day, it's just I had to get it out (the story/her words) and this happens when I go to therapy because it comes out (the story), it's whenever it comes out, so it's fine absolutely, I promise you this is no worse than any other day*" *Tessa*

Tessa's wish to be heard and share her experiences was echoed by Yasmin:

> *"I'm grateful for being asked to participate in this, so thank you for listening and thank you for sharing also your personal stuff and also for meeting me exactly where I am, and not, that's also very big, to just being able to jump around things and being distant or this or that, just to blaaaaaah and babble on about it, so thank you" Yasmin*

Anna expressed the desire to make a difference for other survivors as a result of this research:

> "*It just feels like there is a lot that could help*".

While Milla shared her appreciation of the interview perhaps differing from the normal power dynamic of researcher, participant:

> *"It didn't feel like an interview, it felt more like a conversation, I think maybe that's how it should be"*

These many elements - mutuality, transparency, equality, safety, feeling valued and of worth - have been presented as key issues in the relational trust section above and demonstrate that survivors who have been in trust-relationships have developed the ability to judge trustworthiness and enact trust speedily. For 14 of the 17 participants the interview was the first time they had met the researcher. Two of the 17 had met her once before, while only one had a previous working relationship with her. Further implications regarding this are presented in the discussion.

Relational trust and the group

In this chapter and the previous one, relational trust data has been in dyadic relationships. This section presents data regarding the building and experiencing of trust for some of the participants in groups.

When Anna's 16 sessions of one-to-one therapy ended, she was offered a space in a peer group. This was not for therapy. In Anna's words:

> *"They assured me that the group is there for ever and it needs to be because those ladies are absolutely awesome [...] we don't talk about our problems, nobody knows why anyone is there, that's not what it's about, we just drink tea and chat and we make crafty stuff but it feels, we don't need to know why they're there we take comfort feeling that we're just kind of around people that know, they just get it and there are times when someone gets upset just gets triggered off by something and they need to take a few minutes [...], I love them to pieces, I absolutely do, they're just so lovely, I've never felt somewhere, found anywhere I can just be me, completely me, and not have to be acting to kind of fit in or anything"*

This description speaks of important elements found in a one-to-one trust-relationship manifesting in the group: availability (*"there for ever"*), acceptance (*"I can just be me"),* choice (*"we don't talk about our problems")*, respecting the other person's choice (*"we don't need to know why they're there"),* listening and sharing *("we just chat")*, understanding *("they just get it"),* mutuality (*"people that know").* Anna respects her trustees (*"I love them to pieces").*

The experience of the group holding the facets of a trust-relationship was echoed by others who had been (or were still) part of groups organised around abuse histories, even if they were not therapeutic. Betty was part of a mental health support group at her workplace, and had not intended to speak of her CSA history, but something about the group and the person she was paired with at one point led to her disclosure:

> *"Recently I opened up to the mental health champions group at work and it wasn't planned really, […], he is empathic but he doesn't show it but I was able to tell him for some reason ,[…] I told him but I couldn't look at him, I was looking down I was saying 'I really struggled with that session last week because', and then I just gave very brief headline um of my experience um and he was saying oh that's terrible that must be very difficult, he was empathic, he was […]in a way that was really touching that he was so solid you know"*

This testimony demonstrates how the trust to disclose can emerge when someone in a group setting is listening, empathising and responding appropriately with kindness. In this way the boundary between group and individual overlap, or possibly the group dynamic offers something similar yet different which facilitates disclosures.

These qualities were also spoken of by survivors who had attended group therapy. Helen joined a group that she felt was cliquey, but when the main protagonists moved on she said:

> *"What was left was a very trusting group, because these three had been a bit controlling and bullying and people had struggled to be themselves because of the way these three cliquey people were, but yeah yeah it was after them three had left we were a really close knit group […] yeah it's the first thing that I regularly attended and it's the very first thing that I ever finished"*

Trust between the remaining group members facilitated Helen and two of her peers to make significant recoveries, with one studying for a PhD, one having had a book published and one running an exercise company:

> *"So us three have done really well, we've come out of that group and done really well in our lives and we've stayed in contact obviously and we pat each other on the back now and again and say 'look at us, look how well we're doing' , laugh, but yeah I'd say the group turned all three of us around I'd say, so that's good"*

This study also indicates that mental health-focused groups were not the only route to recovery. Will (who had not engaged in therapy) exemplified such an alternative route to recovery:

> *"I joined the fire service when I was 21, 22 and all of a sudden there was a team of people invested in you, just someone who was out there who was actually investing in you and I knew you know, when I joined the fire service they were hairy-arsed fire fighters in those days, it wasn't very PC you know, they weren't out there to get me at all, they weren't interested in me, in that fashion [...] a sexual fashion, no of course they're not, they were out there to have a laugh [...] that turned my life around as well only because, it enabled me"*.

These testimonies share common features with those whose recovery was facilitated through one-to-one trust-relationships. In groups, colleagues listened, respected and valued them, there was an equality and shared interests, a sense of belonging and a normalising of trauma distress. These groups were all part of institutions, and this chapter now considers survivor testimony of their trust in such institutions.

Trusting and institutions

Survivors shared many examples of turning to institutions to access services. This is a blurred area to interrogate, because while oftentimes it was an individual the survivors were interacting with, the meaning being made by survivors pointed to issues located in the structures or ethos of the institution. In these instances testimony was given as though the survivor was not interacting with a person, but with the institution itself:

> *"It took me to having mental breakdown to get any therapy [...], it fucks me in half, to be exactly honest because I know I'm not, their response to me constantly, because I had been referred a couple of times actually for therapy and every time it was 'oh, your story's too complex', but then there was never another referral after that, it was 'your story is too complex' that was the end of that, every single time over seven years of nothing but struggle"* Milla

The institution not only failed to help Milla but exacerbated her suffering. This might be considered a primary traumatisation, rather than a retraumatisation. Experiences of seeking services and being denied the support and help survivors needed was spoken of frequently. Lack of resources was presented in Findings One in Zone 4, and the examples here present data from when the survivors were specifically locating the problem or cause within the institution, rather than the individual they were engaging with.

Trust in institutions was lost when survivors were repeatedly referred. Milla's example above is echoed by Helen:

> *"She [psychiatrist]put me on more medication and discharged me but I was meant to see a, what is it, a STEPS group [...] and do intensive psychotherapy, never got onto the STEPS group because I was too complicated [...] so that made it more interesting, so [she] referred me to [charity] a special mental health team and I had a CPN come round and because I appeared to be, pause, 'normal' I was meant to have a psychological assessment at [charity] but I got nothing [...] because basically she went back to the psychiatrist and the psychotherapist or whoever it was and the woman said 'she doesn't need to see me' because basically the history of what the psychiatrist said she didn't need to see me but the psychiatrist and psychotherapist were completely different"* Helen

Relationships could be terminated when the trauma distress being triggered was not adequately held by the process or structure of the therapeutic holding. Caroline was a pre-teen, living in a care home and being sent on public transport for once-a-week therapy:

> *"You open up all your wounds and then you walk out and get on a bus and go home to your care home and be on your own for a whole all week with these thoughts of self-harming because they've raised these issues for you to go back the next week …no ….no" Caroline*

Caroline felt that the institutions (psychiatry) and her care home were at fault because the arrangement was insufficient, which left her feeling as isolated as before the therapy began, but in addition more helpless and hopeless after starting and leaving therapy, as she was having to manage her trauma distress alone. Instances like these gave rise to the statements of generalised distrust in section one of this chapter, where Stella stated not trusting psychiatrists and Chloe not trusting professionals in the health service.

Experiences of being unsupported, ignored, rejected, deemed too difficult and "*too complex"* (Milla, Caroline, Helen) to receive services held the survivor both in Zone 1 of isolation and needing relationship, while also causing caution and hesitancy in seeking help again from services. Once trust had been broken in these ways, survivors reported that it was more difficult for their attitude to potential individual trustees to be repaired, in addition to a greater distrusting of the whole institution. Julie had had several unsatisfactory interactions when making a formal report to the police about her abuser, and then had a better interaction but said:

> *"I think structurally there's a major issue in the police in the sense […] so even when I did have a really good policeman I still distrust the actual police force if you see what I mean" Julie*

Will, who was abused by the family priest, lost trust in the entire Church and the civil court system through the process of seeking an apology:

> *"The Church, oh god, because the lawyer we wanted on my side, the church nabbed him from the top […] and you think, you fuckers, and this is before they had any, they would not acknowledge anything at all, I tell you what it makes you feel like, one that you's making it all up, and two well no, that's it, yeah, you've fabricated everything, you're doing this for some other incentive, […] and what they threw back at you, this is supposed to be a caring Church and that's the thing that fucked my mind up, this is the Church […] it really really did and that's one of the reasons I didn't want to go to court because they said it would be really difficult to win against him, they've got the top lawyer in the country" Will*

Will gave up pursuing his claim through the courts, and Milla decided not to try to get a conviction against one of her abusers:

> "*Look, I can't handle another trial, I've been through it, how traumatising it is, I can't even if that means I'm selfish I'm not doing it" Milla*

The incongruence of a supposedly responsible and/or 'caring' institution abusing survivors by in some way 'enabling' CSA, by neither preventing CSA nor punishing the perpetrators, results in confusion and isolation. It left survivors questioning both the individual and the institution's commitment to the way a perceived duty of care was expected to be operationalised. Trust in the whole institution was impacted when the department responsible did not make amends by holding themselves or their employee accountable:

> *"I didn't want any finance, I didn't want any awards or anything like that at all, I just wanted the Church to acknowledge that they are accountable for the people they employ" Will*

When mistakes were made, either in treatment by individuals or within institutional settings, survivors wanted acknowledgement of wrongdoing and an apology from the institution. If this was not forthcoming, survivors felt distrusting of further interactions:

> *"I've never had any help, I've never had any justice for any of the abuse, I didn't get justice for having my children taken off me either" Caroline*

In these situations it is possible to see the flow between relational trust and generalised trust: a series of interactions where the survivor feels betrayed or ignored, or any of the other issues presented in Zone 4 (untrusted attributes) are then extrapolated onto the institution.

Self-relationality and healing

Findings One (Chapter Four) presented data on transactional trust where survivors had sufficient trust in the trustee to enact trusting behaviours around the orienting task, but it was only in the deeper trust-relationships that recovery from trauma distress seemed possible. In the process of trust-building, testimony showing the sense of 'opening' up to the distress and the events was presented. In that healing process other metaphors and images were also used regarding the 'removal' of the abuse and or distress; Ruby said: "*I need you to kind of help me, pull this out of me*". The sense of needing to have something removed was evident for Chloe too, who said of her therapist that he *"let me get it all out".* Milla says of her journal, "*it's just like the emptying my thoughts down*", as a form of *"*getting stuff out". These images evoke the visceral image of having the abuse, the trauma, or perhaps the abuser pulled out of them. In a previous quote Ruby said, speaking about the abuse, it "*felt dirty"* when working with her less trusted therapist. Jake, using a similar dirt metaphor, spoke of having his abuse *"brushed under the carpet"* and of he himself being *"brushed aside",* also invoking an image of dirt, or maybe secrecy. Other survivors spoke explicitly of shame. Patrick recognised the secrecy element of the abuse, but stated unequivocally of his abuse history "*it's not my dirty secret*", confirming that it is dirty, but that it's not his. Successful recovery was a process of 'cleaning' and 'removing', and revealing. Now a considerable distance into his recovery, Jake said:

> *"I think because I've been able to put those places, that guilt, that shame, that blame and there is shame there is guilt there is blame around abuse but it's never the victim's it's the perpetrators, and I think because I've been able to give that squarely back to the person who did this to me, so it has no power over me" Jake*

Being able to free oneself of responsibility for the abuse was a key step that trust processes enabled:

> *"[what] happened to me in my childhood, (stutter) I'm not accountable for that, it's taken a while to realise that" Will*

The trust-relationship facilitates both finding the trauma, 'getting it out' and placing it where it belongs. For Patrick it was a sense of repair:

> *I realised what an impact she [therapist] had on my life […]um, (pause), [I] try and put myself a bit more forward, value myself […] not, not feel like I was,* um, (pause) *damaged" Patrick*

This removal or repair then seemed for many, to give rise to a change or shift in their relationship to themselves. Yasmin spoke of self-forgiveness:

> *"Just to say the words and understand why I've been like this, why I am like this, why these things are normal to me, and not normal to me, it makes it easier for me to forgive myself for being like that" Yasmin*

Milla's positive experience of group therapy, even though initially difficult, brought self-acceptance and integration:

> *"I don't know, I felt like I could just be more accepting of myself in a way and because they didn't judge me in fact when they did know about my story they were*

> *really sympathetic in fact a couple of grown men sat there and cried" "I feel like through group therapy and by becoming more whole less split if you like I can acknowledge that"*

Yasmin also felt a newfound authorship of her life, and ownership of her body:

> *"I have very very recently come to a place where I can feel that I have a say or that I have a wish or that I have a body or that I have longing and I have, erm, that I'm not just there for somebody else [...] so fresh that I'm almost only at 'wow', I have, I am me" Yasmin*

When esteem or respect is experienced, it changes a survivor's relationship with themselves in a profound[97] way. It started to grow a sense of self-worth:

> *"So she's(GP) 'oh you've done really well' and somehow her saying it just made it feel like 'oh my god yeah', I hadn't realised that I've survived it and I've done OK, you know" Betty*

These experiences demonstrate a shift from the sense-of-self survivors remember feeling entwined with the original devaluing of the CSA:

> *"I was groomed by a paedophile from aged 8 to 10 who would buy my mum alcohol, take me off for the weekend, tell me that my mum's basically renting me out for the alcohol" Caroline*

This sense of discovering a new or different 'self', of becoming a person who is more than a CSA survivor, was embraced with wonder and excitement:

> *"Well because we are survivors but that's the base line, anything else you can create whatever you want, I am a survivor but I'm also creative and a person in my own right I can, I'm a healer, I'm more than just one word, I'm a writer, I'm a nutter you know, in a good way I've got a good sense of humour, so I put the survivor in the middle and do a spider-gram*

> *Susanna: So it's something about you and it's not everything*
>
> *Helen: Nope it's definitely not everything"* *Helen*

Chloe also expressed her excitement and joy at discovering herself:

> *"I think, when I finally [became] who I am, it's like, ooo I am a person. I am me. I am, and it's a bit like that Pinocchio story, isn't it, I am real, I am a real person, and I think for years you don't believe you're a real person you're just this little, quiet shallow thing"* *Chloe*

These statements demonstrate how the building of relational trust impacts self-relationality, both in the building of self-trust and in many other dimensions too.

Summary

This chapter has presented survivor testimony regarding generalised trust, demonstrating experiences of individuals, institutions and society who have been deemed (un)trustworthy. This has shown that while the original abuse may have shaped a sense of distrust, it was not this alone. As survivors moved into adulthood, attempts to find help and care brought new and painful experiences which left them isolated in their distress and with their sense of the unsafeness of people and the world reinforced. However, despite this, all of the 17 survivors who participated in this study had been able to engage in dyadic relationships involving trust. The data in Chapter Four, Findings One, showed the development of relational trust as process. In this chapter, 'deepened' or 'developed' trust, conceptualised as the 'trust-relationship', has been presented and juxtaposed to generalised distrust to demonstrate the disparity between survivors' experiences of not trusting and trusting. Testimony demonstrated how the research interview and a variety of different groups were both arenas where relational trust was possible.

The next chapter interrogates these findings in the context of previous research and considers areas for further studies to be conducted.

Chapter Six: Autoethnography as Reflexive Inquiry

"Then I feel I can open up into my sadness, my raw places" Susanna

Introduction

It's December 1st 2022, it's 7.43 am and I am walking back from the beach with the little dog. We set off in the first gloaming light of the day; we set off at this time most days and the beach is at the end of the road from our house, so this routine is, well, routine. The sun wasn't over the horizon but there was enough light to make out the marshes in all of their grey and watery hues. Gradually the sun lit up the underneath of the high cloud base and the day started to come alive, with the geese taking flight from their sleeping quarters on the marsh. They began their conversation of shrieks and craws and as they caught my eye the Mary Oliver poem came to mind: "You do not need to crawl on your belly for a thousand miles across…you only need to love what you love"… why do I always forget those middle words? And then, boom, like a bolt of lightning, or more accurately a bolt of light, the full blast of bright sunshine shot out its brilliance across the fields in the distance and the marsh all around me. Suddenly the grass, which hitherto had not made any impression on my consciousness, was the most vivid, stunning, resonant, intense green. A green I am not sure I've ever seen before. I must have seen it, my mind spoke back to me, I've been living here, and walking here, for more than 20 years. But still. It was captivating. Enchanting. Arresting. And then it was gone. The sun rose higher and behind a cloud and the grey returned.

What colour green is grass? There can never be an accurate answer to this, as colour is always dependent on the amount of light falling on it and the eyes viewing it. There is no objective reality of grass - a core phenomenological viewpoint (Sokolowski, 2000). Because I realised again on that morning, and throughout this thesis, that the part my eyes and mind are playing is making a massive difference to what I am seeing and then saying (Gallagher and Zahavi, 2012). But what colour is grass? What is the truth of the words I write? How much does what *I* notice shape my analysis and interpretation? (Smith, Flowers and Larkin, 2009) How much is still authentically representing what I have been told in the co-constructed interviews? Is there a reality to grass or survivor experiences? How do I break out of routinely seeing (Ratcliffe, 2012)?

In this chapter I discuss the task I have attempted to execute honestly and vigilantly, using reflexivity and reflective practice (Etherington, 2004; Davies, 2008) to deliver the words of my participants in a way that is true to them, and myself. My task has been to convey their meaning while using my own analytical and interpretative skills, yet every sentence I have constructed has been subject to my own lens, in the light of my way of looking, and my experience as a survivor of CSA. On the one hand I do understand the horror of abuse and its legacy. On the other, does this blind me to difference? Critics of Mad Studies, of IPA and of qualitative research raise the question of bias and objectivity, and those issues demand robust answers (Yardley, 2000; van Manen, 2017a; Zahavi, 2019).

I am saying that I have not taken lightly my role as my participants' interlocutor, and that in the translation I know I will have made a difference to their original meaning. The double hermeneutic (Caputo, 2018), spoken of the Chapter Three, recognises that this is unavoidable. But it has never been my intention to co-opt the participants' words (Russo and Sweeney, 2016; Beresford and Russo, 2022). It has always sat uncomfortably with me that their generosity, if I am not careful, will simply be a mechanism for me to aggrandise myself with the title Doctor (if I am lucky, and have worked diligently). This is not my objective (as nice as that might be). I want this Mad Studies project to make an impact on service provision for survivors (LeFrançois, Menzies and Reaume, 2013). Therefore I include this chapter as evidence of the way in which I have operationalised IPA's imperative to use reflexivity and reflective practice to ensure trustworthy and robust analysis (Eatough and Smith, 2017; Smith, Flowers and Larkin, 2009; Smith, 2011). This chapter will consider the ways in which I have operationalised these tools to stay true to this goal.

Transcript Three: Susanna

After the pilot and first interview, I found I was uncertain about the amount of time my own voice was taking up of the one hour allotted. I realised that I had a lot to say of my own experiences of trust and trusting, and this was stealing valuable airtime from my participants. I reflected that I could perhaps gather this information a different way, because while I wanted to have myself in the research in a way that authentically represented my journey as a survivor, I also needed a reflexive practice to see where my experience aligned with, or differed from, that of the participants. This gave rise to the recording interview conducted with me by my person-centred therapist, using my own interview schedule. This recording remained unlistened to until after the first draft of the findings. I decided not to include my words as data in order to keep my distance from the findings, but instead I have used it to reflexively critique when (and whether) my views have shaped my interpretations of individual moments within transcripts and when amalgamating the data into final chapters.

When I did listen to myself speaking, shocked is not too strong a word for what I felt; almost everything I said echoed and mirrored the findings, but at the time I recorded it I had no notion that my experiences fitted the shape of the process flow chart trust enactment model, or the relationship between generalised and relational trust. I had no idea that my rough-hewn definition of trust would match the other participants' personal construct of trust (see Conclusion). I remember during the interview feeling that I was rambling around the subject, tangentially answering the questions, and said at the end that I feared I hadn't been able to give any valuable data and didn't have a clear overview of my own trust abilities or experiences. This statement was actually echoed by Anna at the end of her interview! I had even used some phrases other participants used in interviews recorded after my own. For example, I said I wanted a “level playing field” with my clinical psychologist both in our entire relationship and particularly when he was using EMDR (Eye Movement Desensitisation Regime), a procedure which felt to me like I was subjected to the use of his power over me. Unless he showed his vulnerability I could not show mine. I also spoke of “dropping into the water” small pieces of information to see how the trustee reacted.

In one way this reassured me that my experiences qualify me to speak on behalf of the participants. On the other hand it made me extra vigilant in my final analysis, and re-writes, to ensure I could validate the claims I was making by using participant quotes, hence the number and length of quotations included in Chapters Four and Five, and also Appendix Six as additional corroboration of my interpretations.

The need for corroboration

This need to validate claims is enshrined in qualitative methodologies (Watts, 2014; Norman K. Denzin, 2000), but I suspect my vigilance on this point also rests on my fear of being ‘called out’ on my interpretations. This arises for two reasons. Firstly, as a survivor of CSA I am ever cautious of ‘getting things wrong’, or of being ‘the wrong sort of person’, especially in matters of a moral nature. I know for much of my early life I had a deeply instilled belief (shared by many survivors) that I was morally bankrupt, caused damage to others, and was the author of my own abuse and thus I was an untrustworthy person. I am glad that these beliefs no longer grip me as they did. However, their imprint remains with me. This especially caused me to pause and reflect before making the claim that protecting others from narratives of distress (Chapter Five) was a sign of thoughtful trauma-informed conduct and not a psychopathology, which the belief ‘I am bad’ evidences in some forms of psychotherapy and diagnosis (National Library of Medicine, 2013; van der Kolk, 2014). My supervisor invited me to reflect that Anna’s statement about not telling her husband all the abuse details could be seen as such, but I wanted to honour Anna's own view of why she holds her silence. To me, it makes sense and she says she is protecting her husband. I do not want to use her words against her - and this is noted as important when conducting IPA studies, that the aim is not to put the participant on the witness stand or use their narrative to condemn them (Smith, Flowers and Larkin, 2009).

Secondly, I feel the need to corroborate because of my concern regarding the close match between my interview and those of the participants. I reflexively inquired if it was possible I might have blinded myself to places where my narrative diverged from theirs? Was I not seeing their experience? Just like not previously seeing the grass the way I did that December morning? So I looked again at the transcripts and picked out areas where we did not share experiences, and stood back from my initial interpretations to check the meaning they were making and I was making too. One area was around diagnosis, another was the issue of over-trusting romantic partners and I explore these separately.

Diagnosis and fury

One example of transcripts varying from my experience was regarding diagnosis. For me diagnosis has been terrifying, but re-reading I discovered that while for Caroline diagnosis had been a pathway to the removal of her children, for Jake and Helen diagnosis had been helpful ways to understand their experience. For them and others, notably Anna, diagnosis had been the route to gain access to services they wanted help from.

On reflection I saw that Caroline's story of ending up with a list of diagnoses, and particularly the withholding of her BPD diagnosis from her, enflamed my sense of outrage and righteous indignation at the way diagnosis caused iatrogenic harm (Watson, 2019; Timimi, 2021). The first draft of the Introduction was shaped as a missile aimed at the medical model of mental health and the DSM in particular. I had read literature to inform myself regarding Mad Studies and Service User Research, including activist literature such as

Drop the Disorder (Watson, 2019) and the many survivor blogs. This literature, and working within the charity Survivors Voices, had fuelled my rage at the system. Supervision helped me look again at my own bias in this respect, and my transcript helped me see the extent to which, as a younger woman, I had avoided any form of formalised health provision in response to the grooming and abuse. My experiences shaped my unwillingness to place myself in the hands of people with power.

By looking again I was freed to report the experiences of those who have found help from within the system. This helped to temper the previous focus of vitriol towards it. The findings also showed me that this thesis has a much bigger story to tell than just a rebuttal of DSM-V claims of survivor inability to trust, in that it can inform potential trustees about how to be trustworthy, rather than simply proving that survivors are able to trust. Since trustees work within many service provider institutions (and independently), by focusing beyond mental health diagnosis I feel the study has more potential for change and this is important to me.

Over-trusting

Another area where my experience has not matched my participants and which has needed scrutiny of my hermeneutic responses is my own repeated willingness to over-trust romantic partners. One paper gave me difficulties when critiquing it for the Literature Review. It speaks of "repetition compulsion" and survivors' "flawed model for the restoration of trust. […] Repetition compulsion is the patient's mode of behaving while suffering disorder in the course of ascertaining that partner's trustworthiness" Laddis (2019, p. 88). While reading this paper I would find myself falling asleep, getting distracted, getting angry, becoming faint with ringing ears and displaying many traits I have recently come to see as silent or gentle dissociation. I sought supervision, and now believe that my repeated choosing of partners who would betray and abandon me was less about mis-reading trustworthiness (although this would be a part of the picture), but rather a repeating action that some part of me feels compelled to re-enact. It feels shameful to admit it in this chapter and to myself. However, taking this on board has contributed to a marked shift in this behaviour in my private life. Insofar as it impacts the thesis, understanding this as a trauma dynamic and matching it to other participants who spoke of difficulties in romantic relationships (Milla, Helen and Will) informed the emphasis the pattern and issue was given within the findings chapters.

The part parts play

Reflexive journalling, supervision and therapy helped me to see that my outrage at a medical model that places disorder in the psyche of the survivor was to some degree a form of self-defence. This took quite a lot of sifting and reflecting, because I stand by the claim that the system is wrong in doing so when that further harms survivors as a consequence of (supposed) care. Through that lens I see a society which seemingly either doesn’t care to or can’t stop the abuse of children. It does not help adult survivors get reparations, and actively adds to the harm by disbelieving narratives of abuse. But my outrage is also arising, to some degree, from the need not to see myself as damaged or shaped by the abuse I suffered: to not be diagnosable (which I am…I have an extreme form of amnesia). For my own self-worth, and sense of being a decent person, I have split off the experiences of some child parts of me behind a wall of forgotten memories and silenced emotions (Fisher, 2017; Schwartz and Sweezy, 2019). If society sees survivors as damaged, then seeing myself as damaged would confirm that I am survivor - coming to terms with this in the eight years since 2014 when I discovered I was sexually abused from a very young age has been very extremely challenging. My outrage around survivors being pathologised, to some extent, is the fight reflex of my autonomic stress response: the same fight that kept me alive through crushing abuse, and so is also a good thing, as it has been my self-defence.

This is all so complicated, because the part of me conducting the thesis is a capable, intelligent woman, but the lost parts are deeply wounded. Reflexively I have had to navigate these more quiet and unintegrated parts very carefully to neither disavow the damage CSA causes, nor fall into the pit of despair at the magnitude of the damage done. This balancing act has then needed to be translated into words on the page. At times the balance has been lost - notably when analysing transcripts in Covid lockdowns in 2020. I was felled like a tree when my body yielded to shingles. My illness necessitated more sensitively seeing the way in which the abuse I suffered has indeed shaped me, and in owning this I was better able to enter a more helpful relationship with diagnosis, both for myself and the structuring of this thesis in terms of participants' views of diagnosis. Furthermore, knowledge of my own parts led directly to me being able to recognise the parts of the participants, even when they were not explicitly naming their different responses as coming from parts. Again, I was sensitive not to put words in their mouth, but to substantiate claims I was making using quotations. I additionally showed how seeing their experience through the lens of parts offered a different and contradictory view to a more diagnostic use of parts as indicators of disorder (e.g. Fonagy and Bateman, 2008). Parts can protect, and that was an important message from the participants, and from me, that I have presented in this study (Fisher, 2017; Schwartz and Sweezy, 2019; van der Kolk, 2014).

By rewriting the Findings chapters three times I feel I have used my reflexive and reflective skills to find the balance that I feel happy to own. I was making sure which part of me appeared on the page, and how this impacted the way I was interpreting the participants' meaning-making. I used my lived experience to translate their meaning regarding parts into the study. The final result has been encouraged and supported by my supervisors, and using their feedback I feel the thesis portrays the messages clearly with respectful and careful holding of the tensions of my parts and their story that I am sharing in this chapter.

I don’t understand

There was one aspect of participants’ testimony that I struggled initially to understand and, with some irony, this was about not being understood. Journalling, and many long dog walks to the beach, were helpful in seeing clearly the emotional charge for one participant in particular around the statement “I understand” when spoken by someone who hasn’t experienced CSA. It infuriated her. I found I needed to consider carefully the meaning-making that was shaping the participant’s experience and set aside my own indifference when someone says that to me. I feel I have used her experience in keeping with her own feelings, and linked it to hermeneutic injustice and oppression, which is central to the thesis (Fricker, 2007; Dotson, 2014). Thinking through how one person understands another person’s subjective experience widened from this one comment into attending a phenomenology module at University, and seeking tutorials with the tutor. In the end my not understanding her fury at the words “I understand” facilitated my grasp on what phenomenology is really driving at regarding subjective experience.

Reformist or revolutionary?

Stepping back from anger towards those in power brought me to a part of the reflexive journey which necessitated a decision about my positionality: am I reformist or a revolutionary? To honour the direction of travel that Mad Studies is taking, this question needed careful consideration. The answer became complicated. For myself I am a revolutionary: the system is broken. It is not just using a defunct physical health model to triage people towards mental health services, but also that mental health provision is underfunded and constructed around a faulty view of human consciousness. In this I fall in with other thinkers who question the parameters of current mental health provision: Sedgwick, Drop the Disorder, PTM Framework authors, and other survivor activists. But this thesis is being issued from within the Health and Social Care department at the University of

Essex and is an academic endeavour and an empirical research study. It is designed to inform and improve the existing system. Therefore, I made the decision to background my desire to overthrow the system (as if I could anyway with a PhD thesis!) and use this document to work towards adding to the discourse in a way that might improve services, by shaping them to help survivors access care that meets their needs.

Guidance and help

I return to my first question…what colour is grass? How can I avoid ‘routinely’ not seeing? Phenomenology has both freed me and made me beholden to the need to take nothing for granted. Not my participants’ words, or time, most certainly not my own vulnerability and ardent desire to help other CSA survivors and not the support mechanism that has enabled the use of IPA as methodology.

Supervision, counselling and my longstanding meditation and mindfulness practices have been a route to both reflexive and reflective analysis. Together they have facilitated the use of bracketing of my own views and helped me see the part I have been playing within the conceptualisation and manifestation of this thesis. This process has taken time. Reflecting and reflexivity are retrospective acts of casting an eye over what has recently emerged onto the page from my mind via the fingertips. These tools have enabled the adoption of various vantage points throughout the research process. While I can see the irony, I also know the benefit of how my own trauma-induced dissociative, parts-based psyche has been necessary in my operationalisation of ‘different vantage points’. I have spent many years working to understand why I have such radically different aspects to my personality (business woman, healing-arts practitioner, academic, teacher, Buddhist, conventional mother, and more), and while many times this has been to resolve the conflicts that these parts create within me and my life, they also allow for the looking at ‘life’ or ‘reality’ through different lenses. The Buddhist approach of emptiness practices (Burbea, 2014), of which I am a passionate scholar, is closely aligned to phenomenology in this respect and again this link has helped me to step back and see the way in which each moment of experience is contrasted through dependency on previous moments of experience.

Summary

In this chapter I have presented the more prominent and noteworthy moments of ‘looking again’ that have contributed to the decision-making process and the construction of the final thesis. Undoubtedly my own experience as a CSA survivor has influenced these final decisions, and this is most perhaps evident in my presentation of ‘protecting the other’ and ‘the part parts play’ as both (to use some Buddhist words) ‘wholesome’ and ‘skilful’ for the participants in this study.

I believe that my lived experience has played an important part in breaking through the hermeneutic injustice (Fricker, 2007) of non-survivor views of things like repetition compulsion, dissociation, façading, protecting and even cautiously non-trusting until the ‘proof is in’ of trustworthiness. These aspects of survivor psyche have too often been seen from outside as indicators of disorder, rather than as the way the survivor (sometimes) sees them: that is, as adopted ways to survive the abuse and the inescapable distress (Herman, 1992; van der Kolk, 2014). Expressly because I understand, I have been able to ‘translate’ this into the language of empirical research, and I hope I have been able to validate my translation using the tools of reflexivity and reflective practice.

Chapter Seven: Discussion

“I’ve been through something, please acknowledge it” *Milla*

Introduction

This chapter considers the findings from the previous two Findings chapters and places them in the context of previous research (Chapter Two) and theoretical frameworks relevant to trust and trauma presented in Chapter One. The chapter also explores shortcomings of the study and suggests directions for future research.

Clarifying the term ‘trust’

Chapter One presented a critical overview of the literature regarding the concept of trust, drawing on various disciplines as a starting point for considering the specificity of a CSA survivor’s experiences of trust. It stressed the importance of a clear understanding of the different uses of the word ‘trust’. These different uses include ‘trust decisions’ - the enactment of trust through actions between a trustor and trustee as relational trust (named in Chapter One as three-point trust) and separate from ‘generalised trusting’, that is, a sense of the trustworthiness of others in a non-specific way, be it groups, factions, organisations, types of people or society as a whole. Both relational and generalised trust are different from ‘basic trust’ (Herman, 1992) and ‘epistemic trust’ (Fonagy *et al.*, 2019) and different again from the ‘propensity to trust’, which points to an ability in the trustor. This chapter will argue that the single word ‘trust’ is often used when the implications in terms of survivor behaviours are different. The conflation of these elements was evident in the Literature Review, which presented how existing trust research has blurred the definitions. One example is Mullen *et* *al.* (1994). Others offered no evidence other than empirically unproven suggestions of a relationship between generalised and relational trust (Hartman, 1998). A systematic review of 23 qualitative studies (Parry and Simpson, 2016) makes no explicit mention of generalised, basic or relational trust, just using the word ‘trust’ for all three. This obfuscates the difference and interrelationship (if any) between the different types of trust, and the implications for survivors when enacting trust. This chapter explores these themes in relation to previous scholarship to identify contributions to knowledge.

The importance of trust

Although survivors in this study did not explicitly separate out these elements of trust, they considered it essential, as Findings One (Chapter Four) illustrated. This concurs with the Literature Review (Hirakata, 2009; Kia-Keating, Sorsoli and Grossman, 2010; Blanchard-Dallaire and Hébert, 2014), and with Brennan and McElvaney (2020) who, researching children, identified finding a trustworthy recipient to be *the* most important factor in disclosure.

When survivors were asked how they knew they were feeling trust or trusting someone, they spoke of a sense of safety, a felt-sense of connection, comfort and bodily relaxation; trusting someone meant you knew they were *“not going to harm [you*]*”* (Tessa). While the survivor quotes do not comprise a pristine definition, they encapsulate important elements of trust regarding risking vulnerability and the need for protection and security. Survivors’ heightened need for a sense of safety is not surprising, considering the enormity of vulnerability they spoke of in terms of shame, fear, anxiety, triggering and isolation. The pain survivors had suffered at the hands of others through vilification (for example, in the media or by being rejected by people they trusted enough to disclose to) added to the sense of being unsafe. In addition, for some the abuser’s grooming techniques to instil silence and the horrors of the abuse itself led to feeling vulnerable. While it is a natural human prerogative to need safety and protect vulnerability, survivors of CSA have been bequeathed this need in extraordinary proportions.

This sense of survivors "knowing" what is trustworthy, and the parameters of trustworthiness being idiomatic, was a key finding of this study would indicate an opportunity for further research. Indeed, it challenged some studies in the Literature Review, which suggested that survivors have a great deal of difficulty accurately reading trustworthiness (e.g. Senn, Carey and Coury-Doniger, 2011; Laddis, 2019), and indicates an opportunity for further research. And yet some survivors in this study did express reticence in assessing trustworthiness, suggesting variability amongst survivors. This is, of course, to be expected as no qualitative sample can ever capture a pristine picture of a population as diverse as survivors of CSA.

Issues regarding trust are further explored below and presented here in terms of this study contributing to a defining of trust. The data shows that in the absence of trust, or with limited or transactional trust, survivors withheld important information and declined to enter vulnerable states. Many of the survivors indicated that it was only when a deeper trust unfolded between the dyad that recovery was facilitated. This reinforces the centrality of trustees being trustworthy in the eyes of their survivor client/patient, and offering sufficient transparency for the survivor to judge their trustworthiness. When these elements were in place, survivors were more likely to gain the services they needed, and begin a process of recovery.

Generalised trust

Participants in this study expressed generalised distrust often, voiced as feeling 'suspicious' and 'guarded'. Ruby captures this: *"I think I learned that nobody can be trusted".* This generalised distrust was expressed widely within the sample, and fits with extant empirical data of CSA survivors' predisposition to distrust as presented in a meta-analysis of survivors' experiences of talking therapies (Parry and Simpson, 2016), where it was attributed predominantly to the abuse itself. It also aligns with the view held by the medical model of mental health that trauma (when diagnosed as PTSD or CPTSD) will include issues of trust, as Chapter One presented. One diagnostic category for PTSD includes the statement of patient beliefs that "No one can be trusted" and "The world is completely dangerous" (American Psychiatric Association, 2013).

The finding of generalised distrust also fits with theories of the effects of CSA (Finkelhor and Browne, 1985; Freyd, 1996), which the Literature Review found cited in the design of studies (e.g. Senn *et al.*, 2017; Gobin, 2012). Such studies researched CSA survivors, but none focused specifically on trust. Trust was ancillary and tended to appear in these studies as a comment in their abstract and findings. Such comments confirm the importance of trust but these studies did not offer further information about trust as a construct or the detail of survivor entrusting. So, while the issue of difficulties with 'trust' (whatever the study is taking that to mean) for survivors is known and voiced in previous research and in services, and the survivor testimony in this study appears to corroborate this, but this discussion will argue that this is a starting point only, and that 'trust' and 'entrusting' are different.

This study adds important detail regarding generalised distrust to these previous findings, and argues that generalised and basic trust are different, as presented in Findings Two (Chapter Five). Issues of generalised distrust will be explored in detail now, and basic trust later.

As already stated, many participants in this study voiced their belief that the world is untrustworthy. Some (Tessa and Will) named the whole of society as untrustworthy, but for other participants it was specific named groups of people that were untrustworthy. For Chloe it was health professionals; for Stella, psychiatrists. For others a specific gender or skin colour was less trusted (see below).

Participants linked distrust of specific groups to previous experiences with members of that group. This resonates with a previous study by Klest, Tamaian and Boughner (2019) when researching the link between betrayal trauma and health outcomes. They identified that breaches of trust experienced with one physician will impact the trust the survivor feels for subsequent heath providers, that is, individual physicians, but also similar healthcare departments. But Klest *et al.*'s study, using online self-report questionnaires, did not interrogate the 'what happened next' of specific relationships, just the overall sense of non-trusting. It investigated generalised feelings of trust and not relational trust, but concludes that survivors' lack of trust was directionally linked to poor health. This study challenges the Klest *et al.* finding, exposing the problematic assumption that generalised distrust as a result of previous experience means a survivor will be unable to enact trust with a similar person in the future, even if they do feel a heightened sense of distrust on first encounter. This study offers both a more nuanced and hopeful perspective on the impacts of previous poor healthcare experiences on future encounters for CSA survivors; distrust may be present but a poor outcome is not predetermined.

Survivor transferral of beliefs about the (non)trustworthiness of institutions, depending on interactions with individuals who work within these institutions, was also reported in previous studies (Klest, Tamaian and Boughner, 2019; Easton, Leone-Sheehan and O'Leary, 2019). This study supports this.

While this study confirms previous research in this respect, it also shows the opposite can also be true: good experiences with specific groups makes trusting this 'type' of person possible, and a study by Hirakata (2009) found the same. Distrusting one group did not preclude trusting other groups. Patrick, a Black gay man, for example, held no distrust of certain groups and yet he did hold distrust of white men in a therapy role.

This study adds weight to the link between past experiences informing the trustworthiness decisions of both individuals and institutions, and may have implications for future dyadic relationships. One clinical implication of this study is that explicit discussion about previous experiences of the institution or service a service provider is working within may help mitigate negative expectations for survivors as to the trustworthiness of this new specific trustee.

When ‘types of person’ extends to sex, gender or race, this study yielded less clear findings. The research questions did not investigate in detail the impact of survivor and trustee identity on trust. It indicates that further research in these areas is necessary. However, some initial points have been raised. A study by Roesler and Lillie (1995) set out to investigate sex as an issue in trusting therapists in group therapy and found that trust in women group leaders came more easily for female survivors than in the male co-host. The present study is more equivocal on sex as relevant to trust, as while some survivors did express sex preferences and some linked this to the abuse, this was not universal. For example, Caroline (whose mother had exchanged her with a paedophile for alcohol) commented on finding trust with women difficult. Anna named her struggle to trust men in general, even though she did name several men she had trusted; once again Anna’s testimony points to the difference between a generalised distrust of unnamed men as a group, and her ability to trust specific men with whom she has built relational trust. This level of detail was absent from previous research.

This research offers no comments on non-binary gendered trustees shaping relational or generalised trust for the survivors in this sample, and because no non-cis-gendered participants were included, there is no data on how these identities might impact trust experiences. No questions broached the issue of sex versus gender, and so the statements above referring to ‘sex’ rather than ‘gender’ have been intuited by the researcher and may be in error. Neither did the Literature Review yield any previous research studies on survivors’ gender (versus sex) and trust. As an important emerging arena in societal discourse, this necessitates further research.

In this study, trust dependent on or precluded by race appeared to suggest clear links to previous experience, with the one Black female survivor (Rachel) expressing a distinct preference for Black therapists, and the one Black male survivor expressing his willingness to trust the author expressly because she was white *“like my mum”* (Patrick), and he trusted his mum, yet (above) we heard that he would not trust a white male therapist. No previous study has interrogated the effect of race on either generalised or relational trust, and this is an area for future research, perhaps by a researcher with a shared racial identity of study participants, as called for by race-specific groups within Mad Studies (Essien, 2009). This might elucidate links between survivor identity and preferences according to trustee identity and might make the provision of care more effective, although possibly be a challenge in that it may involve discrimination according to protected characteristics.

One final point regarding generalised distrust centres on the use of language in discourse around survivors. Generalised distrust describes what a survivor is doing, especially if it is considered ‘generalised distrust*ing*’. However, if this terminology implies the survivor has a ‘low propensity to trust’ or problems trusting, this becomes part of their identity - the inability is lodged in the survivor’s psyche alone, and the role of the trustee’s trustworthiness is not considered. In this scenario relational trust has been excluded from the construct of the survivor’s ability to trust. This view is included in the diagnostic categories mentioned earlier for mental health disorders associated with trauma, where no reference to the trustworthiness of the trustee is made. This is important because such diagnoses reach beyond mental health service provision; for example, the justice system and social services consider diagnosis in their provision of care. When a survivor has been given an identity as someone with a low propensity to trust, it may shape how the service provider sees, and responds, to them. This study cannot explore in detail the work of Hacking and the theory of language "making people up" (Hacking and Hacking, 1999), but this might be the starting point for a further study exploring the interface between survivor testimony and clinical diagnosis regarding trust. Comparison of perspectives by survivor and clinician in therapeutic relationship may further detail the implications of the views and beliefs each hold of the other in shaping trust, and the 'reality' of trustworthiness, safety and propensity to trust as identities, rather than responses to moment-to-moment experience. This point is reiterated when the chapter considers relational trust.

Basic trust

As mentioned above, some previous scholarship uses the term 'basic trust' (Herman, 1992; Hartman, 1998). Evidence for a construct that a person's ability to trust is based on an innate or congenital ability or propensity to trust has not been substantiated in this study. Survivors shared richly the way in which their experiences of trust, both relational and generalised, were constantly being impacted and shaped by moment-to-moment experience. Trust was malleable, and so no fixed ability to trust existed, even though a feeling of not trusting generally might be stated. Nothing further can be added by this study to the idea of basic trust.

The concept of epistemic trust is also beyond the scope of this study because the search terms did not draw previous scholarship on epistemic trust into the Literature Review, since no study has been conducted with CSA survivors or CPTSD diagnosed patients.

However, in brief, it feels important to point towards any findings from this study that might ignite interest in further Mad Studies research with regard to CSA survivors and epistemic trust. This study has shown that entrusting is built in the relationship between two people; while feeling distrust of unspecified others is common, once in relationship trusting involves both parties. Epistemic trust involves the subject internalising information from another person and thus would be a form of ‘entrusting’ within relationship. Therefore, the premise epistemic trust advances (that adults with damaged attachment styles have an inability to accept knowledge from an epistemically accurately informed other) does not fit with the findings of this research unless that ‘other’ is measured against, or proved to be, behaving in a way that the specific survivor finds to be trustworthy. Epistemic trust would be better considered ‘epistemically entrusting’ and would be relational and not generalised. This then is a clear area for further research and also has implications for a range of clinical interventions that operationalise epistemic trust, e.g. mentalisation based therapies (Fonagy and Allison, 2014). It is important that clinicians are educated in the nuances of the trust dynamic to avoid the pitfall of assuming any problems in relational trust with a client are due to their deficit, or making broader assumptions about their own inherent trustworthiness, the treatment being offered, the institution or service context.

The intersection between generalised and relational trust

As discussed above, relational experiences with previous trustees shaped participants’ statements of generalised distrust, which then shaped their subsequent relational encounters and resulted in heightened caution when assessing a new trustee. Entrusting a new trustee in a similar role was not (just) dependent on the survivor’s *abilities* to trust, but on the trustee’s abilities to convey trustworthiness. The demonstration of trustworthiness by the trustee, and the reading of these signals by the survivor, enabled the dyad to navigate together the establishing of sufficient trust. This point conveys an important new contribution to knowledge about survivors and the dynamic between generalised and relational trusting that has not been conveyed in previous research in this field, although it has been advanced in trust research in other disciplines (Hardin, 2002; Mayer, Davis and Schoorman, 1995; Schoorman, Mayer and Davis, 2007).

This study provides abundant examples of generalised distrust arising from relational betrayal (see Findings One, Zones 4 and 7), whether the orienting task centred on trauma distress or not. In particular, poorly handled disclosure by previous trustees caused retraction to Zone 1 (isolation), with the added pain and distress caused by trustee rejection. In these instances the trustee had been trusted *enough* by the survivor for the disclosure and/or request for help to be made: disclosure indicates some level of trust. Survivor trust in a disclosure recipient was noted as essential in previous research (Brennan and McElvaney, 2020) and also that the absence of trust prohibited disclosure (Austin, 2021). Disclosure is evidence of transactional trust. To risk repetition from findings, but to use the data to make this point, Jake's experiences are particularly salient; he tried to disclose to five different professionals: teacher, educational psychologist, minister, GP and psychiatrist. Later in his transcript, Jake said*: "I think because I had such horrific experiences when I disclosed the abuse I became very very cautious about letting anyone in".* This quote shows that relational breaches of trust influenced Jake's generalised sense of caution, resulting in carefulness in subsequent relational trust situations.

When survivors had tried to get help unsuccessfully, it resulted in a sense of hopelessness in a world where abuse was enabled by people in positions of authority. Generalised distrust is built on relational moments of attempts to seek help being met with disregard or rejection, and it circled back to a distrust in other authority figures and gave rise to caution in new encounters. This strongly suggests betrayal by trustees trusted 'enough' for disclosure (relational trust), or to ask for help, is informing subsequent generalised distrust. No measurement can be made from this qualitative study as to the strength of subsequent breaches of trust compared to the shaping of trust by the initial abuse or grooming experiences, but from this study it appears to be significant.

At this point the author finds a tension in the adoption of the 'meaning making' aspect of IPA as any form of supreme truth: did Will *feel* the world was an unsafe place, or is there an actuality in his experience? While he did make meaning, he didn't *just* make meaning of his parents' words: his parents' ignoring of his wishes left him unprotected by those who were responsible for his safety. This failure to protect the child is the foundation of Betrayal Trauma Theory (Freyd, 1996) and this view of the world sits more comfortably within a critical realist paradigm than a phenomenological one. The issue of the validity of phenomenology is discussed in the conclusion, but this tension needs to be named here when discussing generalised trust.

Ontological issues

Generalised distrust is being informed not only by previous experience of abuse, grooming, intersectional issues and broken trust by similar groups and society, but also by survivor experience that they are living in a dangerous world. Findings Two (Chapter Five) presented data regarding survivor experience of the world as a place where bad things happen to survivors. Rachel and Betty cited the media and social media's responses to disclosures of abuse being rejected and vilified. In the Literature Review (Chapter Two), several studies invalidated survivor experience of a dangerous world, instead suggesting that survivors are misreading situations because of their trauma distress (Senn *et al.*, 2017; Gobin, 2012). When the researcher takes the ontological position that survivors' view of the world as trustworthy and safe is an incorrect view and/or that they themselves as therapist are trustworthy and therefore safe (e.g. Laddis, 2019), they present a 'fact' of themselves and the world as 'real'. Can this be taken as fact? Or does it belie a fundamental and incontrovertible distortion of the fact of the existence and validity of subjectivity as held in the phenomenological paradigm?

Burstow (2003) challenges the view of the world as a safe place by pointing to these two false assumptions:

> "1. The world is essentially benign and safe, and so general trust is appropriate, and
>
> 2. people who have been traumatized have a less realistic picture of the world than others" (Burstow, 2003, p. 1279).

Burstow maintains that people who have been subjected to abuse know of an equally real world: they have, and are, the evidence that the world is not a safe place. The proposition that survivors see the world incorrectly, and making efforts to persuade them of this when it contravenes their own experience, could be very destabilising (Calef and Weinshel, 1981). It could cause the survivor to lose faith in their own experiential grasp on *their* reality, leading them to experience (or reinforce an existing) ontological insecurity (Laing, 2010). This was explicated by Helen after her memories returned and her disclosure was rejected by a therapist. How can a survivor feel a sense of trust in the world when their version of the world is not be validated by a person they have turned to for help? This speaks to testimonial and hermeneutic injustice which cause the (further) isolation of subjects whose epistemic worth is dismissed (Fricker, 2007).

The need for survivors to gain personal understanding through talking therapies was noted in previous research by Parry and Simpson (2016), and this study offers abundant evidence to support this need for understanding, listening, and what Ratcliffe (2012), writing from a phenomenological perspective on trauma, calls 'radical empathy'. Engaging with radical empathy, the trustee steps outside of their usual view of the world to encounter the world as the trustor encounters it. By meeting in this place, known to the trustor and new to the trustee, an equality and mutuality is located together, the importance of which is explored below. It was a paper by Ratcliffe, Ruddell and Smith (2014) that made a valuable contribution to the theoretical framework of trust in Chapter One, and that paper also adopted a phenomenological lens to survivors of traumatic distress. Add to this is use of the phenomenological lens which suggests the utility of “radical empathy” (Ratcliffe, 2012) as an approach to facilitate recovery and epistemic justice for survivors. This underscores the relevance of phenomenology when seeking to understand survivor experiences of trust.

The inability to privilege the meaning survivors’ make of their world is evident in studies pathologising the survivor, organised around mental health diagnosis (Laddis, 2019; Hailes *et al.*, 2019). This foregrounds survivor deficit and backgrounds social issues and wider contexts of survivors’ lives. It falls under the trauma-uninformed way of foregrounding ‘what’s wrong with you?’, ignoring the trauma-informed need to instead ask ‘what happened/is happening to you?’. The context of survivors’ lives oftentimes exacerbates traumatic distress (LeFrançois, Menzies and Reaume, 2013). The experience of additional aspects of trauma within the lives of participants in this study supported this; Patrick and Rachel were managing not just traumatic distress from the CSA, but also the trauma of racial oppression. Tessa had had a period of homelessness, which made her anxiety and distress much worse. These are intersectional traumas and also complex social and material contextual factors (Essien, 2009), which were then exacerbated for survivors when they attempted to get help, for example, when Tessa was having a smear test and the behaviour of the GP tipped her into heightened distress at a time she was struggling with the pressures of homelessness. The GP’s behaviour might be called a retraumatisation given Tessa’s trauma history, but this can be seen as a primary trauma in its own right; either way it reinforced Tessa’s generalised distrust and left her isolated.

Taking a person’s mental health out of the context of their life is to rob the distress of its validity as a sane response to abuse (Burstow, 2003). The Mad Studies epistemology of this study lends validity to the survivor’s lived experience. Therefore, when relationally damaging events returned survivors to Zone 1 (isolation), it is because of the reality the survivor is experiencing of the safeness or danger of interacting with world or other. In this way generalised distrust is arising from the actions of trusted-enough trustees who were in roles incumbent with acting in a trustworthy manner for those who they serve. It creates a world, an ontology, that is real for the survivor.

This section has interrogated the data from this study in the context of previous research to show the interrelation between generalised and relational trust. These points suggest that generalised statements of survivor trust/distrust hide multiplicities of complex trust beliefs. Especially important is the fact that blanket, generalised distrust statements appeared unrelated to memories of relational trust in survivors' pasts, in particular their childhoods as presented in Chapter Five. This matches findings in previous research of survivors "retaining a sense of the possibility of developing trust in adult relationships" (Kia-Keating, Sorsoli and Grossman, 2010, p. 677). This suggests that having trust-relationships with specific people in formative years, while not mitigating against generalised distrust, did play a part in enabling trusting relationships with specific others, as it facilitated the "knowing" of a felt sense (Gendlin, 1991) of trust. The ability to engage in relational trust will be presented now.

Relational trust

The concept of relational trust speaks to the action of 'entrusting' for a specific survivor with a specific trustee, who join to work around an orienting task (Hardin, 2002); in the absence of the task Chapter One presented this as 'two-point' trust and when the task is the unifying feature this is 'three-point' trust (Ratcliffe, Ruddell and Smith, 2014). One key feature of relational entrusting is the vulnerability involved in trusting as presented in Findings One (Chapter Four): *"it's a gradual process of being vulnerable" Jo*. Entrusting is a process.

The relevance of process is inferred in Chapter Two (Literature Review), but none of the papers specifically interrogated mechanisms that facilitated trust. Previous studies have noted that trust was important, that when trust was present recovery was possible, and that survivors were engaged in process. For example, Parry and Simpson (2016), in their systematic review of 23 qualitative studies investigating CSA survivors' experiences of talking therapies, concluded 'process' as key for survivors. However, that study focused on the "therapeutic process" and talked of "developmental stages" as important for recovery, rather than trust as process.

Matheson and Weightman (2020) and Wright and Gabriel (2018) also concluded that trust facilitates recovery and said that this takes time, implying that it is a process. But the present study goes further by focusing specifically on facets within the relationship and the trustee, as well as survivor thoughts, feelings and choices, that together inform the stages of building trust.

Although this study only researched survivor experience, and did not include data gathered from trustees, it has pointed to the enormity of the role of the relational 'other' (their specific trustee) in survivor willingness to trust. By viewing the process of trust-building as reliant on the trustee and not just the survivor, the impetus is placed on the dyad in establishing a relationality with trust at its core, rather than focusing on the survivor and their process. In this way, this study extends previous scholarship.

The focus on stages of trust-building and entrusting as process are captured in the trust enactment model flow chart (Figure 1), which proposes not only that trust is built over time and through interactive moments, but that it can be damaged, causing withdrawals or a stepping back. Sometimes damage was terminal, while in other relationships ruptures were repaired. In this way the model gives a comprehensive overview of not just building trust but also the converse. Zones are the author's attempt to present the messiness, paradoxical nature and complexity of human experience in a way that can be grasped by someone outside of that experience. The survivor organisation ‘Survivors Leading Essential Education and Change’ has captured this previously (SLEEC, 2022) – see Figure 2:

Figure 2: Perception vs experience of recovery from trauma

The sense of recovery from trauma as akin to a “ rollercoaster ride” was noted by (Harvey *et al.*, 2000, p. 293), and is supported by the findings of this study. Therefore the presentation of zones is not to create a simple or smooth reality out of ideographic moments, but to offer a phenomenological conceptualisation aiming to give the reader a feel for the various ‘flavours’ of meaning being made of trustees who perceived trustworthiness differently. Such a model is a new contribution to the understanding of relational trust for CSA survivors, and because issues of trust are grouped into a process flow chart of a trust enactment model, it shows more clearly the links between perceived trustee behaviours, and consequential survivor choice and healing.

Many of the elements presented in Findings One (Chapter Four) appear in previous research but as isolated themes or moments of survivor experience (Chouliara *et al.*, 2011; Blanchard-Dallaire and Hébert, 2014; Brennan and McElvaney, 2020; Hirakata, 2009; Mullen *et al.*, 1994), rather than process-influencing decision points. These themes will be interrogated now in the context of the trust enactment model flow chart.

Isolation

The experience of aloneness was presented as a starting point (Zone 1), as all of the participants described times in their lives when they had been (or chose to remain) isolated and coping alone. Such isolation has been noted in previous research (Senn *et al.*, 2017; Mullen *et al.*, 1994; Kia-Keating, Sorsoli and Grossman, 2010). Kia-Keating *et al.* (2005), working with men, reported isolation as a form of self-reliance. Data in this study goes beyond previous research in showing how isolation can be to self-protect but that it also can become a driver in a process of finding help with an issue requiring a trusted other, be that trauma-specific (in the case of clinical care) or trauma-sensitive (with a police office, dentist, or social worker, for example).

Testimony indicated that it is when the magnitude for the need for help outweighs the need for the safety of isolation that survivors began the search for a trustee; perhaps the magnitude of need helps push past the generalised distrust named above.

Caution and carefulness

When the survivor’s need for help escalated and precipitated the move towards a potential trustee, the initial stages of assessing for trustworthiness commenced. This is conceptualised in Findings One as ‘signals and clues’ (Zone 2). Generalised trust did not rule out the possibility of building relational trust if the trustee could demonstrate trustworthiness. There was some commonality among survivors as to qualities and behaviours that demonstrated trustworthiness, such as gentleness and kindness (discussed below), but in this study there were also some idiosyncratic requirements specific to the survivor and their own unique experiences. This is related to generalised distrust of certain types of people explored above. For example, Helen spoke of being cautious of people with eyes like her father's. The way in which past experiences of specific trustees shapes present expectation and/or meaning-making of trustworthiness in individuals is one indication of the possible nuances. Senn *et al.* (2017) and Mullen *et al.* (1994) both noted that survivors experience a vulnerability when entering a relationship with a specific trustee reminiscent of past abusers. Therefore caution was an important self-protection mechanism while gathering information on the potential trustee.

Survivor cautiousness when in relationship was noted in previous studies (Harvey *et al.*, 2000; Banyard and Williams, 2007; Cole and Putnam, 1992), but these did not detail the steps involved or the survivor rationale for caution before entrusting.

This caution has important clinical implications because it is the specifics of the trustee, and not only survivor ability or willingness to trust, which facilitates or negates the development of trust for a survivor. When linked to the data discussed above about generalised distrust/trust being associated with the trustee's specific characteristics and/or identity such as race, gender etc, it suggests that these aspects may need to be explicitly discussed for a dyad to progress towards trust. Previous studies simply concluded that survivors in their studies had issues trusting (Senn *et al.*, 2017; Mullen *et al.*, 1994).

Additionally it is important to consider the language being used to describe survivors' initial 'caution', this word suggests possible danger and hypervigilance in non-dangerous situations (in the eyes of the trustee). But if the word 'carefulness' is substituted instead, it implies a sense of wisely avoiding harm. If trust has previously been damaged, 'carefulness' may validate a survivor's choices at this stage of trustee-checking. However, some survivors used the word cautious themselves. Patrick said: *"At first you're very cautious because first what you're going to tell this woman is going to blow her mind"* and so this study honours their use of that word, while adding to the discourse of the way language usage creates "realities" (Burstow, 2013; Shaw, 2019; Orwell, 2018; Hacking and Hacking, 1999; Russo and Sweeney, 2016).

Process of discovering trustworthiness

Caution and carefulness allowed time to gain initial readings of trustworthiness and when favourable the survivors spoke of beginning to substantiate through finding further evidence. This 'testing' strategy involved revealing small pieces of information and gauging trustee responses. This stage is conceptualised as 'verification' in Findings One, Chapter Four (Zone 3).

In both Zones 2 and 3, the survivor is assessing for trustworthiness, but this can also be seen to be a process of checking for safety when revealing small aspects of their history or distress. In the Literature Review trusting was closely linked to feeling safe (Parry and Simpson, 2016; Hirakata, 2009; Wright and Thiara, 2019; Blanchard-Dallaire and Hébert, 2014; Bowers, 1992; Banyard, Williams and Siegel, 2001; Kia-Keating, Sorsoli and Grossman, 2010). This is reinforced in this study by survivors' statements expressing the need to establish that the trustee would not hurt them: *"I believe, I believe that they're not going to hurt me" Tessa*.

Gradations of trust and recovery

The verification process of testing for evidence of trustworthiness took time. Survivors spoke of the point in the relationships when having established *enough* trustworthiness they made an initial disclosure. More time was needed to reveal further details of abuse histories, vulnerabilities and distress at a pace that felt safe. It is not that having established trust everything is revealed at once. This process of disclosure appears to be at odds with the study by Brennan and McElvaney (2020), investigating child disclosure, which reported that once a recipient is deemed trustworthy a child will disclose, which resonates with studies of adult disclosures (Alaggia, Collin-Vézina and Lateef, 2019). Survivor testimony by Pyburn (2017) also states that trust will facilitate disclosure. However, the word ‘disclosure’ in the studies cited above refers only to the binary of silence versus speaking: the act of making an initial statement divulging the abuse. In contrast, this study adds important knowledge and nuance regarding the levels or stages of disclosure rather than simply the binary of initial disclosure.

Earlier the recognition of ‘stages’ in relationship was discussed (Wright and Gabriel, 2018; Banyard and Williams, 2007; Harvey *et al.*, 2000; Parry and Simpson, 2016), but this study more closely links such step-wise movement to deeper places of vulnerability as moments of greater entrusting, dependent upon deepening relational trust. For survivors in this study, “I trust you” does not necessarily mean “I give you access to all of the aspects of my trauma-distress”. Each small piece of disclosure is a moment of vulnerability and in that moment the survivor needed the trustee to behave in a trustworthy manner. This results in the ‘looping’ through the zones (see arrows on Figure 1); the dyad are held in this loop with each moment of revelation resulting in entrusting or holding back and re-checking (breaches of trust at this stage are discussed below). For many dyads, the relationship does not go beyond this stage, but the orienting task may be achieved and the relationship may end satisfactorily. This is called ‘transactional trust’ (Zone 6) in scholarship from other disciplines such as Risk and Management (Colquitt, Scott and LePine, 2007; Reina and Reina, 2009).

Being able to achieve orienting tasks is significant and the value of transactional trust should be appreciated. This aspect of survivor ability to trust is absent from the diagnostic constructs of PTSD and CPTSD given in Chapter One, and not mentioned in previous scholarship in the Literature Review. This is possibly because previous studies focused predominantly on therapeutic relationships and thus did not draw in trust in other service provider relationships. Identifying survivor transactional trust is a key finding of this study. Transactional trust enabled survivors to achieve or attain important aspects of care, such as getting dental treatment (Chloe, Helen, Jo and Ruby) or a colonoscopy (Frank). Many other examples were given, but if part of the orienting task is to resolve trauma distress, transactional trust alone is not sufficient, because it precludes the sharing of vulnerability and important information pertinent to healing. To become vulnerable enough to work on the more sensitive trauma issues, a deeper level of trust was needed. The findings demonstrate that the dyad need to be able to move beyond transactional trust together and form a relationship based on mutuality to create a full trust-relationship (Zone 8). Without this deeper trust even therapeutic relationships could get stuck in the transactional trust loop. As Ruby said of her first therapist, *"she was this older woman and I didn't feel like I could tell her these things (the abuse)"*. Yet in relationship with her art therapist a deeper trust emerged and Ruby's trauma distress started to be accessed and resolved. In this way it becomes evident that the recovery spoken of in the Literature Review (Parry and Simpson, 2016; Harvey *et al.*, 2000) is dependent on trust being built together by both members of the trust-dyad, which takes patience and time.

Time and availability

The process of building deeper levels of trust indicated the importance of time in trust-building, as noted in studies by Matheson and Weightman (2020) and Wright and Gabriel (2018). But participants in this study spoke of the paucity of provision both therapeutically and from other service providers; survivors felt they simply were not given enough time to feel comfortable through the verification process.

An insufficient number of sessions, or the ending of sessions in the middle of sensitive work, could cause a down-regulation in trusting for survivors, but institutional limitations on therapist availability, or the length of time a health appointment is restricted to, may be beyond the control of the individual trustee. This has implications for services which support survivors, because it places the trustee in a difficult position in the eyes of the survivor while s/he is in the process of trust building. Survivors expressed that when there is insufficient time in a session, too much time between sessions, no in-between session support, or if the attitude of the trustee projects a sense of rush, survivors can feel abandoned. For some this can trigger crisis: Caroline illustrated this when one session a week meant she felt *"on [her] own for a whole all week with these thoughts of self-harming".*

One outcome from this intersection between institutional limitations and dyadic trust might be for trustees to explicitly discuss expectations and limitations during the verification process of building trust. For example, survivors appreciated it when trustees did not make undeliverable promises, were transparent regarding time frames (which survivors call for in Zone 5) and worked with them to prepare endings.

The skill of knowing

Survivors' belief in their ability to assess trustworthiness is a key finding of this study. Frank was confident in his vigilance to manage the abuse when it was happening, he called it a "*radar system".* This is an important contribution to knowledge regarding survivor ability to trust, because survivors' skills in reading others' trustworthiness, and having this level of vigilance, kept them safe both at the time of the abuse and in the present when choosing trustees. Survivors valued these skills of vigilance as essential self-protection mechanisms. However, in diagnostic terms, 'hyper-vigilance' is included as indicative of disorder in diagnoses of PTSD and CPTSD (WHO, 2019; American Psychiatric Association, 2013; Hailes *et al.*, 2019). This mismatch of beliefs echoes the section above about language framing reality and whose view is accurate when safety is concerned. This study makes explicit the utility of vigilance where trust is concerned both to ensure protection for self and others before revealing CSA histories.

Protection of self and others

While performing checks on trustworthiness, survivors were protecting themselves from groomed expectation of detrimental reactions to disclosure. Caution due to this and from the abuse itself is detailed in Findings One, Chapter Four (Zone 4), but this study has presented additional data showing caution also arising from experiences with previous trustees as detailed above. This learnt cautiousness/carefulness due to previous trustee behaviour is not mentioned elsewhere in the Literature Review, and thus this is a valuable new finding. A meta-analysis by Brennan and McElvaney (2020) on disclosure by children reported on features of good disclosure experience, and was motivated by previous studies noting the detrimental effect of poorly facilitated disclosure. But that study made no link between previous disclosure experience and its impact on future choices regarding disclosure. Nor has exploration of bad trustee reactions to disclosure been linked to trust in this trustee or future trustees previously.

In addition to self-protection, several participants expressed a need to protect others. For example, Anna explained why she did not fully disclose the abuse to her husband (Chapter Four). The Literature Review suggests that survivors have a heightened sense of disordered responsibility for others because of grooming (Laddis, 2019). This clinical view may firstly fail to recognise the complexity of reasons for not wishing to disclose, and secondly may be pathologising a natural human choice. This issue is like the one presented above regarding the ‘truth’ of the need for vigilance, and the ‘reality’ of danger. Survivor choice not to disclose as an act of care and kindness towards others would benefit from further research, because vicarious trauma arising for recipients of traumatic material from clients is a burgeoning field of study (McNeillie and Rose, 2021). Perhaps it is no surprise that survivors, experts by experience in the detrimental effects of trauma on wellbeing, might wish to protect loved ones by actively choosing to ‘hold’ silence around the stories of abuse. Mad Studies provides a forum for survivors to share their wisdom on safely disclosing to trusted trustees and the best way to navigate disclosure. The mechanisms used of “*giv[ing] things in dribs and drabs, you give them something, test the water see how they react” (Milla*) may be a valid model for trauma education.

Façading and ‘parts’

While utilising testing-out behaviours in Zone 3 ahead of disclosures, survivors spoke of self-protecting using a front or façade. This ability was also noted in previous research by Blanchard-Dallaire and Hébert (2014). Façading was spoken of by several survivors as a choice to hold back aspects of vulnerability according to the situation. For Ruby it was keeping her fears hidden behind laughter. This capacity to self-protect by keeping more vulnerable parts out of view and showing a capable exterior was reported in a study by Easton, Leone-Sheehan and O'Leary (2019). Façading was also a helpful coping mechanism, as discussed by Parry and Simpson (2016). This challenges previous research that suggests holding back disclosure is an inability to trust appropriately (Laddis, 2019). Façading and the use of chosen dissociation (as opposed to triggered dissociation) may have close links when navigating trust. Two participants spoke of using dissociation as a coping mechanism when having dental treatment. Hirakata (2009), in a study focused on dissociation, also reported its use as a coping mechanism and Roesler and Lillie (1995) concluded that survivors appreciated having their coping mechanism respected as valid and helpful in facilitating recovery, which testimony from this study echoes.

For some, façading extended into recognition of knowing oneself to have ‘versions of self’ or ways of being. Having ‘versions of self’, or choosing not to show aspects of self, was generally not spoken of as problematic by participants, possibly with the exception of Tessa, who spoke of becoming passive.

In previous research using a diagnostic lens, such as papers in the Literature Review focusing on CPTSD (Coates and Gaensbauer, 2009; Hailes *et al.*, 2019; Klest, Tamaian and Boughner, 2019; Laddis, 2019), these shifting self-states map onto ideas of fragmented selves (Fisher, 2017), a theory which is emerging to encompass the already well researched connection between abuse and dissociation presented in the Literature Review (Laddis, 2019; Hirakata, 2009). But Polyvagal Theory (Porges, 2007) and 'Parts Based' therapies, such as Internal Family Systems (Schwartz and Sweezy, 2019), advance the theory of 'parts' as a phylogenically developed survival mechanism demonstrating not disorder, but the opposite. While Mad Studies privileges survivor testimony, this more mainstream scientific-based view of the physiological basis for a survivor having different parts may be a helpful adjunct. If being able to split off aspects of self that hold memories of extreme fear is considered an 'ordered' physiological response to extreme threat, this stands against the pathologising of such behaviours. In these theories, if death does not prevail, the subject's psyche maintains this split as he/she moves forward through life, and any subsequent encounters reminiscent of the near-death experience may trigger the subject to 'shift gear', sometimes beyond conscious control, into a 'part' or dissociated aspect of self to draw on the survival mode that was successful last time such an event took place (van der Kolk, 1994). This leaves the survivor with 'parts' of personality between which they might move according to situations. What this study offers in addition is that some participants were choosing to use those parts in the operationalisation of entrusting. This is a significant contribution of the study, bringing together survivor testimony and trauma-informed approaches by giving survivors esteem as knowers. From Mad Studies and phenomenological perspectives, if the survivor finds such mechanisms helpful then it demands respect. Having said this, the interviews in this study were not focused on an investigation of parts or self-states, and consequently data on this area, especially regarding the difficulties or downsides of moving between parts, was not forthcoming. Further research from a survivor perspective of the operationalisation and utility of parts in building (or precluding) trust is essential to understand how these fit into recovery and entrusting. It would also be important to interrogate and compare survivor experiences of parts in contrast to clinicians' views of such mechanisms when enacting trust. Additional research to compare survivor experiences of parts to non-traumatised adults' conceptualisations of themselves and their parts when enacting trust would also be of benefit, since parts-based view of human consciousness is not limited to traumatised people; it is advanced that all people have self-states (Schwartz and Sweezy, 2019).

Untrustworthy attributes and behaviours

The process of testing out potential trustees yielded many examples of untrustworthiness by potential trustees. Just as transactional trust is enacted when a trustee is trustworthy enough, so too being deemed untrustworthy involves a continuum, rather than a binary decision, until a tipping point is reached of untrustworthiness and then the survivor might exit the relationship. If a trustee is evaluated as not being very trustworthy (or not trustworthy enough), this meant that the survivors limited the extent of vulnerable information they shared with this person. The Literature Review of previous empirical research offered no interrogation of ways in which trustees might be or behave in untrustworthy ways which would cause the survivor to feel unable to entrust their vulnerability to them. Given the paucity of previous research in this respect, this discussion will predominantly reference previous research regarding the positive qualities that have facilitated survivor trust and consider that the opposite is being implied as untrustworthy in those studies. Therefore when untrusted aspects of trustee behaviour presented by this study in Findings One (Chapter Four, Zone 4) are substantiated, it is only grey literature in the review that can be referenced: that is, previous scholarship offering survivor testimony pointing to untrustworthy behaviours and ways of being. Studies exploring disclosure (Brennan and McElvaney, 2020; Parry and Simpson, 2016) have focused on what survivors need for disclosure and have not addressed behaviours and ways of being considered by survivors to be poor reactions by recipients of disclosure.

Trustworthiness

This study has generated rich data regarding survivor experiences of trustees who engender trust in them and the way in which this facilitates attaining services and resolving trauma distress. The Literature Review also offered many examples of trustworthiness, in particular a study by Hirakata (2009) into the treatment of dissociation, and a systematic review of the way adult survivors experience formal talking therapies by Parry and Simpson (2016). These two studies will be referenced repeatedly, as the details of trustworthiness this study has presented are discussed. References to trustworthiness made by other studies in the review are moderate and sometimes only implied, but they are also included.

Initial impressions

Survivors spoke of the immediacy of knowing if this trustee was trustworthy. One of the first things that survivors noticed and evaluated were the 'attributes' of trustees. This refers to a "*personal manner"* (Betty): for example, warmth, softness, gentleness, friendliness, kindness. This echoes the findings of Hirakata (2009). The term '*real'*, used by some participants, (Tessa) also appeared in previous research (Kia-Keating, Sorsoli and Grossman, 2010), alluding to the authentic presentation of the person as genuinely being themselves. Survivors needed a trustee who fitted them and their specific needs. For example, Helen liked that her counsellor "*kicks arse, […] that's my type of counsellor*". Conversely, as mentioned above, attributes that reminded the survivor of an abuser signalled non-trustworthiness.

Taken together, these factors indicate that trustworthiness is specific to the dyad of survivor and trustee. This aspect of specificity in building trust has not been presented in previous studies.

Attributes in this study are not an identity embodied in title or status or training. Several survivors spoke of early disclosure being made to trustees they had expected to be trustworthy because of their title or job role (Chloe, her GP; Jake with many different mental health workers and a minster; Will, his parents, Milla, a police officer), only to have been (re)traumatised by the rejection they had received, and as a result had "*closed down*" (Chloe). Chloe went onto say: *"I think you always think if you go to your doctor you can trust your doctor they know everything, and they don't".* Chloe's stage of recovery at interview and her discovering what is trustworthy through her subsequent trust-relationship with a therapist and second husband means she can share back her learning of what may have looked trustworthy as a younger woman but wasn't, and what she experiences as trustworthy now. The temporal nature of evaluating trustworthiness is considered below.

Intuiting and sensitivity

Participants spoke of needing the trustee to have sensitivity to their needs; to know when a survivor needed them to be silent so they could take control of the flow of the dialogue without "*try[ing] to put their two pence in all the time"* said Chloe. Conversely the ability for trustees to know when survivors "*need [therapist] to kind of help me, pull this out of me"* (Ruby). This might be considered a form of intuiting. Hirakata (2009, p. 305) refers to this as "knowing beyond words", but this study adds detail to how survivors value that as a sign of trustworthiness.

Skills

Findings One (Chapter Four) captured a list of proficiencies survivors named as important for trust to develop (itemised in Appendix 8). These might be taken together as trustees' actions, behaviours and skills. Knowing and demonstrating appropriate skills in managing trauma reactivity, skill in listening, engaging, believing, valuing, non-judging, empathising and comprehending had all been reported in previous studies (Hirakata, 2009; Parry and Simpson, 2016; Harvey *et al.*, 2000; Chouliara *et al.*, 2011). Specifically trauma requires therapists skilled in trauma treatment (Parry and Simpson, 2016; Chouliara *et al.*, 2011) and preventing dissociation when recounting traumatic events (Hirakata, 2009). One of the central skills is listening.

Listening

Survivors in this study indicate they experience listening as an embodied demonstration of trustee engagement. Listening was noted as a core component of positive survivor experience of talking therapy by Parry and Simpson (2016), but the present study offers a greater depth of analysis to the nuance of listening. Some survivor testimony is repeated below to illustrate this.

Listening is woven through many of the zones, and at different stages it had different implications with survivors making different meanings of it. Listening is a central cue of trustworthiness in a potential trustee (Zone 2, signals and cues). In Zone 5 (trusted attributes) listening is used as proof, or verification, of trustworthiness: as Helen says: *"trust for me is somebody needs to listen"*, adding that in trust-relationships (Zone 8) listening was supplemented by heartfelt response*: "you can listen with your ears but if you don't listen with your heart there's no point".* This fits with recognition of the difference between listening and hearing noted by Brennan and McElvaney (2020). For Jo respectful listening facilitated repairing a breach in a trust-relationship with a work colleague. For Anna listening is part of the process of appreciation and validation by her trusted psychiatrist*: "just feeling that somebody is listening actually, taking it in and not just filing it away".* Anna is making meaning in that listening feels like her distress is being 'taken in', perhaps ingested and processed, rather than remaining immutable; listening *is* the healing. Harvey *et al.* (2000, p. 292) in their narrative study of recovery trajectories also noted the "metabolisation" of abuse in the process of removing its powerful grip. These statements identify different types of listening.

These examples of trustworthy listening are in stark contrast to Anna's sense of worthlessness when her untrusted psychiatrist didn't listen to her: *"I left my appointment with him (psychiatrist) feeling like I hadn't been listened to, feeling judged, feeling worthless, feeling like he thinks I'm a failure of a person, […] I [had] visions of myself driving my car into a tree and it bursting into flames"*. The ramification of his inability (or unwillingness) to listen incited Anna's suicidal ideation. From the data of this study it is impossible to know how this psychiatrist would characterise his part in the exchange, but Mad Studies privileges Anna's experience as a valid claim to the need to be listened to. His non-listening caused her further suffering, and the trusted psychiatrist's listening (cited above) was felt as a validation. No previous studies have given evidence such as this as to why survivors down-regulate their trust.

Listening goes beyond inter-relationality to impact intra-relationality, and adds to the discourse of self-relationality. Yasmin, in a trust-relationship (Zone 8), found the listening therapist facilitating self-listening and the discovery of her own deepest fears and self-doubt, which shifted her relationship to herself and the abuse: *"she was very listening and listening and listening and finally I decided, and also I told her I think there's something wrong with me"*.

These examples illustrate that when trustees don't listen, listen without respect, or listen to judge, this impacted both survivors' willingness to trust the trustee but also their self-relationality. Harvey *et al.* (2000, p. 297) recognised the default mode for recipients of survivor testimony to be listening yet making their own meanings while listening, and warns to be “attentive to our own assumptions as we listen”. This points to a very real difference between a trustee listening for their own interpretation (Hailes *et al.*, 2019; Senn *et al.*, 2017) , or, for example, to diagnose (Laddis, 2019) or to decide as to the “truth”, or “reality” of the survivor experience (Senn *et al.*, 2017). Listening, even in a research setting, Harvey *et al.* (2000) reported, can instead become a vehicle to facilitate the survivor’s own evolving understanding, and to allow the survivor to find their own meaning, which resonates with Helen’s plea to be “*heard [...] with the heart*”, and matches the value of coming to understand one’s self through talking therapies (Parry and Simpson, 2016). It also speaks to the call for the restoration of hermeneutic justice to disenfranchised epistemic knowers (Fricker, 2007).

In Zone 6 Tessa, in response to being blanked by her GP, makes the plea to listen: *“yeah, even if they don’t get it, just listen, maybe that’s asking too much”.* Tessa recognised poor or absent listening may not be due to unskilled behaviours, but limitations imposed by institutions, as discussed above regarding time. In this there is the clash between survivor needs and what institutions and individuals are able to offer. Trust in institutions is presented below.

This section has presented the fact that listening has different levels, or ‘tones’ at different stages of recovery and possibly places survivors’ stated need for listening beyond that of non-traumatised clients. A further study could examine the difference between listening efficacy for abused versus non abused adults. This study suggests that listening and the need to be listened to goes beyond simply stating the need for trustees to listen, as is often given in CSA literature (e.g. Hull, Corrigan and Curran, 2016).

Engaging with disclosure

While listening, trustees needed to respond appropriately. Examples of inappropriate trustee responses, as these participants had experienced them, are given in Findings One (Chapter

Four, Zone 4) and in Appendix Eight. These responses include lack of respect, ignoring, dismissing, pathologising, breaking boundaries around personal space, or outright sexual abuse and assault; this list is not exhaustive. Previous research has not offered insight into any of these experiences, which were very common for the participants. One aspect of inappropriate (and at times illegal, in the case of assault) response was the inability of some trustees to believe the survivor, and a sense of not being believed arose from the survivor being questioned, challenged or contradicted. Believing was essential for deepening trust and this resonates with previous studies, which have strongly asserted believing as a central need (Brennan and McElvaney, 2020; Parry and Simpson, 2016; Harvey *et al.*, 2000; Chouliara *et al.*, 2011).

Being believed was only one aspect of a trustworthy response to disclosure in this study. Survivors voiced their understanding of why sometimes disclosure was not handled well; for example, Frank referred to his GP as “Doctor Asperger”, and this GP’s skills precluded Frank trusting him. Data pertaining to this was fully presented in Findings One (Chapter Four), and falls under the ‘inappropriate response’ heading. There is nothing to add from the Literature Review.

It is an ability in a trusted trustee to feel comfortable and demonstrate their confidence with CSA disclosure that is crucial. In this, disclosure needs to be received without a sense that it had shocked or traumatised the listener and this calls for a degree of resilience in the trustee, so that the survivor is not having to protect the person they have turned to for help, as stated above. Previous research also notes the importance of trustee’s resiliency when receiving difficult narratives (Parry and Simpson, 2016; Harvey *et al.*, 2000), and survivors in this study substantiate the importance of this aspect of trustee skill. Survivors needed to experience that their trustee was able to manage, for example, disgust and other challenging aspects of working with CSA, such as when fight or avoidance was triggered.

The Literature Review mentions nothing about the difference between a survivor in a steady, stable mind state and a triggered one, apart from a study by Chouliara *et al.* (2011) into therapeutic interventions. Survivors in this study indicated that it is to be expected that they would become triggered when talking about their CSA history or distress. Previous research has not interrogated the difference between being stable or triggered and any part the trustee or their institution may be playing in causing this, or a sense of being unsafe. Findings One (Chapter Four) of this study showed how a stable survivor might be triggered into disarray by trustee behaviours, as happened for Helen in the quote given earlier: *"[she - therapist] nearly took me over the edge".*

Survivors needed trustees to comprehend "*the enormity*" (Jake) of the damage abuse causes, especially if what is shared with the trustee is only a shard or fragment of the full abuse narrative, which was often the case when verifying if it was safe to say more. This was mentioned in previous research in passing (Hull, Corrigan and Curran, 2016), but not highlighted as a major need.

Predictability reliability dependability flexibility

Aligned with appropriate responses was trustee predictability and reliability. Honouring promises and not going back on previously implicit or explicit arrangements was important. Dependability, a 'not giving up' by the listener, was noted as an important quality in the study by Banyard, Williams and Siegel (2001), and they noted that staying alongside a survivor though vulnerable moments was particularly important. This is allied to resilience in the section above: can the trustee remain predictable when the unexpected arises by a survivor being triggered for example? Or if they are acting in ways that may challenge boundaries? Jo, when arriving at therapy drunk, and Helen when angry with her psychiatrist for being left in the waiting room, were both instances when trustworthy trustees made allowances for these behaviours and trust in the relationships deepened as a result. Previous research has not highlighted the need for such dependability, which is related to flexibility and an ability or willingness to meet the needs of the survivor, such as Chloe's dentist letting her lie on her side. This is another example of the specificity of needs for the unique nature of the dyad when working together. Flexibility was noted as an important trustee characteristic by Chouliara *et al.* (2011).

Creating the opportunity to tell

The trustee being the right kind of person with the right skills, as discussed so far, perhaps facilitated what Brennan and McElvaney (2020) foregrounded as the "opportunity to tell". This ability to create 'opportunity' was noted as a key role of the trustee, which concurs with their need to be flexible and responsive to the survivor needs with regards to going deeper into vulnerability. This implicitly locates control of the process in the hands of the survivor, with trustee support, and was noted in previous research (Parry and Simpson, 2016).

Choice control and agency

Trustees sharing power within the relationship by affording choice and agency to the survivor was noted as important in previous research (Banyard, Williams and Siegel, 2001; Parry and Simpson, 2016; Hirakata, 2009; Chouliara *et al.*, 2011). Control was stated as key in the meta-analysis in talking therapies (Parry and Simpson, 2016) and by Chouliara *et al.* (2011), but could only be operationalised if the survivor had been explicitly told of the choices.

In this study Ruby wished for a *"level playing field".* This was not asking for the boundaries to be eroded, but for equity in shaping the direction therapy and other services were taking. Several participants named needing control during dental treatments if they were becoming overwhelmed. The need for control was not universal to all situations, however, as others some wanted the health professionals to be in control to keep them safe, as seen in Anna's statement: *"I came to you in crisis [...] if you don't know what to do…".* The need for choice and control and to exercise agency was specific to the situation and the dyad, and again indicates the need for clear communication between survivor and trustee to navigate shifting needs or changes of requirements sensitively.

Mutuality

The sharing of the power enables survivor choice in many respects, but especially in directing the unfolding of moments within the relationship, so that they are not trustee-directed, although previous research indicated that trustee directivity was acceptable once trust was established (Parry and Simpson, 2016). When survivor and trustee can work together around the direction of relational travel, this was expressed as “mutuality”. Mutuality or ‘equality’ was seen as important in creating an environment in trust relationships for revealing more vulnerable material, and thus facilitated trauma distress healing. The Literature Review touched on this, with Brennan and McElvaney (2020) stating the value of the mutuality of shared frames of reference in building relationship, and Zdanuk, Harris and Wisian (1987) noted the benefit of trustees allowing the survivor to ask them questions, possibly also a sign of a relational equality. The value for survivors of hearing trustees’ experiences and opinions was noted by Parry and Simpson (2016). The mutuality of sharing wounded and difficult feelings was central to the continuation of the relationship (see below) and demonstrates the equality of the power dynamic also reported by Banyard, Williams and Siegel (2001). The dyad working together was noted by Hartman (1998). Hirakata (2009) chose the term “reciprocity” in the sharing of trust, which echoes the equality between the dyad and the importance of mutual trusting in this study.

Jake named mutuality as a shared *“humanity”*, and several survivors appreciated when trustees shared information about their own lives and showed their own vulnerabilities, and this was also noted by Hirakata (2009). It allowed the survivor access to the person of the trustee behind their professional persona.

‘Mutuality’ and ‘humanity’ were linked to survivors feeling that they were being valued, and in return they valued their trustee. This two-way flow of such qualities became the hallmark of relationships which had the capacity to endure rupture (discussed below). The survivor felt respected as a whole person: as Helen said, she is more than her abuse, she is in the middle of a “*spider-gram*” of all the many things she is and does. Previous research has rarely identified these elements of the trust relationship, particularly respect, in as much nuanced detail as this study. However, Roesler and Lillie (1995, p. 14) in their study exploring the gender of the facilitators in group therapy did conclude the necessity of groups to “place great emphasis on their working relationship, showing mutual respect for one another”.

Interestingly Senn *et al.* (2017, p. 499) quote a study participant who recognises the need for respect:

> *“I was molested as a child. I would never let another man take advantage of me like that. I am no longer a helpless little 5-year-old. So it’s either my way or the highway. So if you don’t respect what I’m saying, if you can’t deal with it, there’s the door”*

Yet such a response is then used as evidence for an interpretation that this is a “monopolizing [of] control in intimate relationships, potentially as a way to reclaim the power and control that they lost as children” (*ibid*). In contradiction, Gobin (2012) in her conclusions recommends that survivors receive education to be able to recognise and demand respect within romantic relationships. Nelson (2016) explicitly notes survivors’ need for respect, linking it to acceptance and belief, calling for it as part of a new, more effective approach by clinicians to CSA. Gottman (2011) in his work on trust in intimate relationships also notes the central role of respect and sees it as the antithesis to contempt. This fits well with survivors who spoke of the contempt they experienced from some trustees and the meaning they made of this in terms of withdrawing trust, for example, when Anna was unable to expose her tummy for a consultant gynaecologist. Respect sits comfortably alongside non-judgement, which was reported as a necessary quality in trusted trustees by Zdanuk, Harris and Wisian (1987) and Parry and Simpson (2016).

Jo spoke of this aspect of sharing the space with mutuality in terms of musicians coming into tune together, which evokes the word 'resonance': "*we're tuning our strings until we're on the same, we're vibrating at the same tone"*. Resonance is not a word used in the Literature Review, but it is a commonly used term in therapeutic relationship literature (for example Watkins, 1978).

Having made the case for mutuality, it may raise issues about the location of boundaries in trust relationships.

Safe boundaries

Choice and agency and the mutuality of power sharing could be drawn upon in moments of breaches of trust between the dyad to facilitate repair, but safe boundaries are important, as noted in previous studies (Parry and Simpson, 2016). 'Mutuality' might suggest an unsafe boundary, according to some ethical underpinnings to service provision in many fields, where personal distance and therapist anonymity is the usual approach to service provision (Heitzler, 2013) and which may embody a power differential.

Betrayal in therapeutic relationships is avoided through the careful use of boundaries, and betrayal trauma literature points to the need for safe boundaries to be applied to repair damage done in childhood when abuse breached boundaries (Gobin and Freyd, 2009; Finkelhor and Browne, 1985). Testimony in this study pointed to incidents of unequivocal boundary breaking: Ruby, Stella and Rachel were all sexually assaulted by health professionals, which caused (re)traumatisation. Ruby was sexually assaulted by a psychiatrist and felt unable to report it. It is of note that no further action was taken by these survivors.

So while survivors and previous research (Hirakata, 2009; Banyard and Williams, 2007; Parry and Simpson, 2016) recognise boundaries as essential for safety and for building trust, these safe boundaries may be different for survivors and service providers . Survivors' calls for mutuality may need boundaries to be considered differently. Therefore, the issue of boundaries and mutuality is complex and ideographic.

This study found boundaried care characterised by, and woven through with, warmth empathy and kindness, also a key finding in a study by Nelson (2016). Further research is indicated regarding boundaries of personal disclosure by the trustee, or boundaries around trustees' trust in survivor. Morrigan (2017), a survivor-researcher, makes a case for survivor involvement in all psychiatric decisions and this challenges boundaries. Mad Studies, like disability studies, makes the explicit demand of "nothing about us without us" (Beresford and Rose, 2009), which also challenges traditional boundaries made purely by service providers with no recourse to survivors. This is a complicated area because the data from this study suggests trust and boundaries are interwoven. Further research might validate the need for choice and control in building trust, but how that meets the need for containment and care through boundaries needs elucidation. Comparing survivor constructs of safe boundaries with those of service providers at an institutional and individual level would both generate knowledge, clarify current confusion and provide a road map for building trustworthy care in respect of this issue.

Rupture and repair

Survivors in this study spoke of how repair was possible in relationships with an established level of trust, and even in relationships of transactional trust (Zone 6), which a relationship in verification stage (Zone 3) might not weather. But in the early stages of relationship, untrustworthy behaviours could cause exit by the survivor from the dyad. There is a tipping point when a rupture is considered beyond repair, which is seen as ‘betrayal’ or that a trustee is considered too untrustworthy for the relationship to continue.

‘Betrayal’ is a very personal experience, and yet the examples given in Findings One (Chapter Four) were betrayals by the survivor, and reading (or hearing, for the researcher) the narratives it is difficult not to also feel them as betrayals. How can an onlooker determine what is a betrayal? Maybe this is a quintessentially phenomenological judgement for every human, abused and non-abused, as it will always be constituent on previous experience and context. But if a survivor turns to a service provider for help and then encounters behaviours that cause further distress and/or (re)traumatisation, undermining trust in generalised groups of people, distrust and caution in subsequent relationships, diminishes their self-worth and reduces self-trust, this author suggests it *is* betrayal, and that service providers need to recognise their part in how such betrayals arise, and mitigate against them.

Betrayal as a keynote of survivor experience is emphasised in existing scholarship (Blanchard-Dallaire and Hébert, 2014; Gobin, 2012; Hartman, 1998; Klest, Tamaian and Boughner, 2019) and often attributed to a repeating experience located in the original betrayal of abuse or neglect in early attachment relationships, and thus located in the psyche of the survivor. Usually this view draws from theoretical models of Betrayal Trauma Theory (Freyd, 1996) and the Traumagenic Dynamics Model (Finkelhor and Browne, 1985; Finkelhor, 1984). In extant literature, it is expected that survivors will experience rupture or betrayal in relationships because it is a hallmark of CSA abuse. The possibility for repair is only mentioned once in the Literature Review (Hirakata, 2009). Little detail is provided about how survivors experience the difference between rupture and betrayal, or about the subsequent actions by the survivor and/or trustee following betrayal, or the trustee’s role in causing a sense of betrayal or the breach of trust.

This study adds a wealth of data to these issues: examples of rupture/repair seemed most prevalent in therapeutic relationships and possibly this is facilitated by therapeutic skills; certainly it seems dependent upon the trust threshold having been met ahead of the rupture. Repairs in other forms of relationship were rarely spoken of, although the existence of transactional trust (Zone 6) suggests that survivors can maintain relationships where ‘enough’ trust exists, in contradiction to the idea that all relationships are in jeopardy due to survivor trust-instability and a constant vigilance to breaches being regarded as betrayals.

For some survivors, repair following rupture facilitated a deepening of trusted relationality, which may seem counterintuitive, but for Rachel the repair process demonstrated the therapist’s willingness to listen to her point of view and value her comments and evidenced his trustworthiness. Rachel’s trust in a new therapist also deepened because she had help from a different therapist in managing this breach. This resonates with how trusting is transferable between relationships, noted previously by Kia-Keating, Sorsoli and Grossman (2010). Helen recalls a rupture when her therapist took a risk and challenged her: *“I said ‘you made me really angry’, and she said ‘good, I’m glad’”*, which facilitated a process of exploration that aided her understanding and recovery around this recurrent emotion. At the time of the interview Helen was still working with this therapist. Helen’s example was one of many from survivors whose narratives of repair centred on *both* members of the dyad finding ways to communicate explanations of their actions and strong or difficult feelings, speaking again to mutuality. The sense of having one’s objections accepted, heard, and responded to in a positive way is integral to the continuation of many ruptured relationships.

One form of rupture and/or betrayal is the receiving of disclosure badly, as stated above, and this study has richly demonstrated the profound implications for survivors and the dyad. But this nor previous research has detailed the cost to trustees when relationships involving trust are not navigated well. Trustees who work with survivors may be invested in the relationships and care deeply for survivor wellbeing. Is there a cost to the trustee in terms of professional disappointment, frustration or perhaps vicarious trauma when broken trust results in orientating tasks not being achieved? This is beyond the scope of this study. Therefore, further research into the implications of broken trust for trustees is important to draw attention to its cost, both for trustee welfare but also to inform and motivate better trustee engagement in building trust.

Following rupture and betrayal there are also implications for institutions in terms of the cost of repeating treatments, further care and support for survivors. If a dyad can establish a trust-relationship and recovery ensues, everyone (survivor, trustee and institution) benefit. This study provides initial data in this area and indicates the value of further investigation into (i) the thresholds for non-repair, (ii) antecedents to repair, (iii) possibility (or impossibility) that relationships might achieve the orientating-task once trust has been down-regulated by survivor and/or trustee.

Accurately assessing threat

‘Difficulties with trusting’ for CSA survivors was noted above as a diagnostic category of disorder, but this raises the question: whose assessment of the threat of betrayal is accurate, the survivor or the trustee’s? Should the survivor’s avoidance of harm through self-protection and caution in revealing vulnerable information be seen as dysfunctional? The argument here must rest on interpretations of threat; the Literature Review showcased empirical research (Gobin, 2012), peer-reviewed clinical comment (Laddis, 2019) and betrayal theory (Freyd, 1996; Finkelhor and Browne, 1985), pointing to CSA survivors’ inability to accurately judge trustworthiness, seeing threat where none exists. This study did not set out to prove whether it was the survivor or the trustee who was reading the situation ‘correctly’. Yet survivors generated abundant examples of trustees’ inabilities and failings in offering trustworthy care as they experienced it. It is impossible to know from the data gained only from one half of a dyad, the survivor. It cannot be known how trustees might explain their actions or have a different interpretation of what happened and why. But, from a phenomenological point of view, this would still not find ‘fact’ in right or wrongdoing: if the survivor feels the trustee to be non-trustworthy, then to provide care *that* trustee would need to be able to interact, listen and learn from the needs of *this* survivor to create (or attempt to create) the trustworthy environment prerequisite for the healing process to unfold.

Parameters of trustworthiness

This study reveals an important area for future research: an exploration and comparison of survivors’ evaluations of trustworthiness with trustees’ understandings of their demonstrations of trustworthiness. This might focus on comparing trustee personal attributes and actions and survivor experience of these and an interrogation of the space in between them. Differences between indicators of trustworthiness in the eyes of trustee and survivor may explain the mismatch between the findings of this study and previous research, which suggests survivors misjudge the trustworthiness of trustworthy clinicians (Laddis, 2019; Campbell *et al.*, 2021). Such studies do not present their understood or defined parameters or frameworks of trustworthiness. Just as trust is rarely defined, so too trustworthiness is perhaps taken at face value or considered to be a given aspect of job role. In the absence of agreed conceptualisations of trustworthiness, and with no empirical literature to evidence good practice of trustworthiness in the *eyes of survivors*, how can a survivor be evaluated in terms of their ability to correctly assess trustworthiness? Italics are included to point to this essential point. Survivors have rarely been included in the discourse around trustworthiness. While ethical codes of conduct exist for service providers within their professional bodies, as do complaint procedures, these have rarely been created with participatory ideologies at their heart (Beresford, 2021). There are documents promoting codes of conduct when working with survivors which recommend various ethical behaviours (e.g. Nelson and Hampson, 2008; Rouf *et al.*, 2016), including survivor-researchers. The Power Threat Meaning Framework (PTMF) also foregrounds the importance of the trustworthiness of service providers. The PTMF was published in 2018, re-conceptualising mental illness from being located solely in the psyche of the patient to incorporate power structures and the way a person makes meaning from experiences where power and threat have been at play (Johnstone and Boyle, 2018). But documents such as these, and the discourses they foster, can be siloed and embraced by those already in agreement about the need for the service-user participation (Pilgrim, 2020). To find a more universally accepted understanding of trustworthiness explicitly for survivors of CSA, but possibly for all traumatised people, requires a dialogue to enable a shared construct of trustworthiness where the ability to assess it could be considered or possibly measured. This would mitigate the belief that misjudging trustworthiness is a part of the survivor's disordered psyche, and reposition trust and trustworthiness as foundational elements of relational practice and therefore beholden to both parties.

Relational trust in group settings

Findings Two (Chapter Five) presented data regarding survivors' trust experiences of groups as an extension of their experiences of dyadic trust, where they exercise the same testing out and caution in a process of gradually revealing more vulnerability. The chapter showed how trusted groups had made significant contributions to healing trauma distress. This matches findings from previous studies, as Harvey *et al.* (2000) reported: groups create a social setting, and the finding of narrative, a key facilitator of healing, is essentially a social process. Groups allow for a normalising of trauma distress, and work against the isolation of Zone 1, which is so central to CSA. The ability to listen to others' views was noted as a valuable aspect of both dyadic and group trust (Parry and Simpson, 2016), even if it was very challenging at times.

Several of the participants in this study worked in group settings to help other survivors, and previous research has also noted that altruistic actions for other survivors can be an important aspect of recovery (Banyard and Williams, 2007).

To sum up, this section of the chapter has considered relational trust in the context of previous research. One example of relational trust is the research interview, and given the history of CSA, the researcher shares with the participants the issue of researcher bias. The need for robust and transparent analysis and interpretation bears consideration. Issues arising from the interview interactions, as well as the interview, as an example of a trust-relationship will now be considered.

The research interview as a trust relationship

Methods in Chapter Three presented the rationale for the research interviews being constructed to build trust between participant and researcher. This need was not mentioned or explored in previous scholarship. When surveys were used (e.g. Gobin, 2012) it is not possible to know whether participants trusted the researcher or their approach. Austin (2021), a survivor-researcher, writes that she answered questionnaires inaccurately because she did not know how the data would reflect on or impact her at a later date. Findings Two (Chapter Five) demonstrated that participants trusted the researcher in this study, and were able to build trust with someone not previously known perhaps because most were at a stage in their recovery where they could reflect back with self-awareness and non-triggered reflections of ‘how things were’. The relevance of the stage in recovery at the time of interviewing was noted in previous CSA studies (Cole and Putnam, 1992; Parry and Simpson, 2016; Banyard and Williams, 2007; Kia-Keating, Sorsoli and Grossman, 2010). However, such scholarship considered the survivor *as a person* to be ‘stable’ enough (Kia-Keating, Sorsoli and

Grossman, 2010), rather than noticing that certain events might, in the moment, cause a trauma triggering that might disrupt that stability. Understanding the impact of the trustee (clinician or author) on survivor stability is an important contribution of this study. The same observation was made in the Literature Review when studies concerned therapeutic relationship (Chouliara *et al.*, 2011), but no link was made between such triggering and the down-regulation of enacting trust, and how this might shape data collection interviews, and ultimately the conclusions of the entire study.

Participants in this study appreciated the opportunity to speak, despite the difficulties of sharing painful narratives. The longitudinal study by Banyard, Williams and Siegel (2001, p. 279) chose to eliminate three women from the fourth wave of interviews "because of concerns that the narrative nature of the study would be overly distressing for these individuals". The issue of survivors becoming distressed during interviews, and protocols to address this, were included in the University of Essex Ethics Approval. During interviews only one survivor became distressed to the extent that the researcher needed to help her return to stability through focusing and grounding practices. This desire to be heard even through tears, and through the distress of sharing difficult or shaming issues, painful memories and the frustrations of betrayal after previous disclosure, is testimony to the value of Mad Studies not perpetuating the silencing by researchers in other paradigms (Sweeney, 2009; LeFrançois, Menzies and Reaume, 2013; Beresford and Russo, 2022). Silverio *et al.* (2020) support the need for CSA survivors to be given the chance to speak without the silencing of ethics committees or well-wishing researchers wanting to save them pain. Perhaps it is the pain the trustee is experiencing when hearing testimony that drives the silencing, as was noted in previous studies (Chouliara *et al.*, 2011; Harvey *et al.*, 2000)?

With these issues in mind, yet in keeping with all qualitative research, the data generated 'is of the moment' and specific to these participants (Oakley, 2005). Therefore it is not generalisable in the way quantitative data is sometimes portrayed, although this too is arguably not possible (Gilbert and Stoneman, 2016). Other survivor-participants may have experienced trustees or the author's trustworthiness differently. However, the propositions the data points to and the trust enactment model process flow chart of building trust are transferable, and relevant in informing service providers of survivor needs regarding trust. As with all qualitative research, this study is specific to the interaction between participant and author, thus replicability is impossible (Higginbottom, 2004), but it is a foundation on which further research might build. While replication is not even desirable in qualitative studies (Stenfors, Kajamaa and Bennett, 2020), it would be beneficial to repeat the study to see if the similar meanings are made pertaining to trust by a different set of survivor-participants and under the analysis of a different researcher (Sweeney *et al.*, 2013). This might add weight to the findings, since they are radically in contention with some of the extant research presented in the Literature Review.

The transferability of the study and gathering of data into zones was also made possible by the homogeneity of the sample, an important prerequisite for IPA (Eatough and Smith, 2017). Fifteen of the 17 participants were survivors of long-term, early years CSA with the perpetrator either a close family member, or the abuse enabled by a parent (even if the parent was ignorant of their complicit actions), even though no attempt was made to target this population. They might be seen as a sub-set of CSA, which includes many forms of early sexual abuse, as presented in the Introduction (Chapter One). Fourteen of these participants had undergone significant amounts of therapy, which may explain both their willingness and ability to speak to (and thus trust) the author, a white woman in her mid-fifties, who most had never met before. Having moved beyond the silence of Zone 1, participants were able to share memories of it, which the author could compare with their experiences of subsequent moments of interaction and the impact of trusting and not-trusting within a variety of relationships.

Fifteen participants felt they had come to (better) terms with their histories and had learnt skills to manage trauma distress. While for sixteen participants this was a function of having had trust-relationships, it could also be attributed to their age. Only one participant was in her 20s, one in her 30s and the rest were more than 40 years of age, so the distance from the abuse allowed reflection and life experience, which perhaps coloured earlier views of the meaning of the abuse. Similarly, the relevance of time and life stage on recovery was noted by Banyard and Williams (2007).

The point of time at data collection is important, as while participants can reflect on childhood trusting abilities and tell us that they did trust some people, it is impossible to know from interviews with adults how they felt as a child; one can only hear how adults remember feeling about trusting as a child. This was understood and voiced by Milla: "*it's not who I am, it's someone who I once was".* This is not to undermine or disbelieve the testimony, but points to an opportunity for further research with children: the Literature Review included two studies with children (Brennan and McElvaney, 2020; Blanchard-Dallaire and Hébert, 2014) and both spoke of the need for trust relationships in childhood. Testimony from this study concurs that trust is important from early in the life course. This would indicate the benefit of a longitudinal study from childhood through adulthood to explore changes in trusting over the life course. Banyard and Williams (2007) conducted the only longitudinal study in the Literature Review, but their focus was recovery and resilience and not changes in trusting capabilities. Their study did yield valuable data for this study and Google Scholar reports it has been cited 235 times (at date of submission of this thesis), evidencing the usefulness of longitudinal studies as a valuable method to evaluate changing trusting capabilities.

There may be additional benefits from a different researcher conducting a secondary analysis of the rich and extensive data collected in this study. Another researcher's interpretation could yield yet more valuable information (Sweeney *et al.*, 2013), particularly if the researcher were not a survivor of CSA. It might confirm the trustworthiness of the new, sometimes radical nature, of the data this study has yielded. This could then reinforce the value of the Mad Studies paradigm, as it finds its standing as a valid epistemological paradigm (Beresford and Russo, 2022). This statement is not to undermine the value of Mad Studies, or the work of a Mad-positive researcher, but to realistically foreshadow the rejection or dismissal of such radical results when they come into contention with more traditional views of survivors' abilities to trust.

Lastly, applying this study's methodology to other traumatised groups may reveal the transferability of the recommendations to wider traumatised populations, such as survivors of (non-sexual) inter-personal abuse and neglect, especially children, since the trauma they have suffered will also have happened during the early formation of relational patterns involving trust. Initial reading, although beyond the scope of this study, suggests that traumatised survivors of domestic violence experience trust in similar ways (Roddy and Gabriel, 2019).

Self-relationality

Having interrogated the generalised and relational trust mechanisms, their interrelation and implications for institutions, this chapter moves to explore how trust-relationships impact survivor self-relationality and recovery.

Shame arising from CSA was often expressed in this study indirectly rather than explicitly, with survivors using metaphors alluding to the unclean; Ruby: "*it felt dirty*" Jake: "*it (disclosure) was brushed under the carpet*" , or servile "*we were treated like just low*" (Tess) bringing an image of servility, or subjugation. The sense of a damaged self, dirty or defiled by abuse is voiced in the Literature Review (e.g. Hartman, 1998), and this study corresponded, with some survivors expressing *"a sense of shame"* (Rachel). Possibly the façading of Zone 2 as self-protection is also constituted on this part of survivor identity – certainly previous studies have interpreted the time taken to build trust as due to survivor reticence to disclose because of shame (Wright and Gabriel, 2018; Matheson and Weightman, 2020; Easton, Leone-Sheehan and O'Leary, 2019).

Understanding shame as a self-identity or self-relationality is meaningful when such identities intersect with self-trust. This echoes previous research: "The first stage of healing […] appeared to be a process of recognizing the impact of CSA on their sense of self" (Parry and Simpson, 2016, p. 801).

Cole and Putnam (1992) drew attention to aspects of self-relationality which were damaged by incest, while Hartman (1998) and Pyburn (2017) focus on survivors' beliefs of having colluded with abusers, which can damage self-respect and self-esteem. Other studies noted self-acceptance (Kia-Keating, Sorsoli and Grossman, 2010), self-esteem (Hartman, 1998), self-confidence (Hirakata, 2009) and self-reliance (Harvey *et al.*, 2000) as key facets of self-relationality important to recovery. All of these are echoed in this study. Yasmin said earlier, *"it makes it easier for me to forgive myself for being like that"*. Will spoke of his self-respect since succeeding in his career; Jake similarly in his work with survivors, and Helen as a poet. Trust relationships had facilitated healing in relationship to self, which shifted the survivor's life course. Anna said: "*with lots of practise though, I've learned to trust my body"*.

Improved self-trusting (Hirakata, 2009; Brennan and McElvaney, 2020) and survivor self-confidence reportedly improved when in trust-relationships (Harvey *et al.*, 2000; Parry and Simpson, 2016) as an important aspect of recovery. Survivors in this study reinforce the value of positive self-relationality as part of recovery. Will said, *"I think um I think I've learnt to live with um my thoughts"*.

Summary

This chapter has argued that conceptualisation of survivor trust as presented previously in empirical research has been limited, flawed and has lacked clear constructs and definitions. Using a Mad Studies approach, survivors in this study have been able to offer a significant amount of detail and depth to the understanding of how trust is considered by them, and how they build trust when in relationship with trustees, even when they consider aspects of the world to be generally untrustworthy. The Mad paradigm facilitates and underpins the claims of this study that while some traumatically triggered behaviours may appear mad, they are in step with an understandable and justified response given the relational experience with the trustee and the playing out of relationality within the dyad. By demonstrating survivor ability to engage in transactional trust, and that trustees also need to demonstrate trustworthiness, the study has brought new epistemological insight to this field.

The study has differentiated between generalised trust and relational trust, and in so doing has challenged the belief that survivor ability to trust is dysfunctional. These conclusions will be considered in more depth in the final chapter.

Chapter Eight: Conclusion

> *"She (psychiatrist) knows that while she was at university learning about mental health, I was out there living it... so instead of arrogantly barking orders, we just talk, we share ideas and we make plans that I feel comfortable with"* Anna

Child sexual abuse has been hidden from sight for generations (Herman, 1992). Feminists in the 1970s prised open the hermetically sealed can of silence (Lorde, 2017) that so many institutions have colluded to keep shut (IICSA, 2022). These pioneers were brave enough to release the metaphorical worms of the magnitude and depravity of the actions of child abusers, and we now know the magnitude of their effect on their victim-survivors (Maniglio, 2009; Hailes *et al.*, 2019; Wennell, 2022; Herman, 1992; van der Kolk, 2014). But it has, in the UK, taken another 50 years before the commissioning of a seven-year inquiry into this indictment of society (IICSA, 2022).

Statistics of the enormity of CSA are always inaccurate. The IICSA report, published in 2022, concluded that "the true scale of sexual abuse of children is likely to have been much higher than the actual numbers recorded, and this continues to be the case with current methods of data-gathering" (IICSA, 2022). Therefore, knowing that significantly more than 1 in 6 women and 1 in 20 men have been subjected to unwanted sexual contact before the age of 18 (Office for National Statistics, 2019) makes the scale even more overwhelming.

That the IICSA report has been published at all is a cause for cautious optimism, as it signals that some in society are listening. Among its comments is one noting that "[survivors] might need practical support about how to report abuse and obtain medical assistance, advocacy support and therapeutic support such as counselling and psychotherapy” (K7: IICSA, 2022). The report makes a recommendation for a “guarantee of specialist therapeutic support for child victims of sexual abuse” (*ibid).* This study has shown that for survivors to obtain such support, service providers will need to be able to behave in a way that survivors experience as trustworthy. Trust is essential for survivors to access the services they need. Furthermore, this study has contributed data that suggests that survivors’ definitions, and constructs of what pertains to trustworthiness, may differ from how service providers see their own trustworthiness. This is an area for further research. This study was not intended to explore this gap, as no trustees were interviewed, but designed to hear survivor testimony as an opening for discourse around this issue.

While codes of conduct may stipulate ethical actions and procedures for trustees which would point to trustworthy behaviour, these may not entirely fit with survivor definitions of trustworthiness. Chapters Four and Five explored in detail what trustworthiness, and its opposite, look like for the survivors in this study. One key theme emerged: that of trustee-survivor equality, or mutuality, and the need for a survivor to experience the trustee’s humanity. This both echoes and substantiates the call for virtuous abilities in those who receive testimony from marginalised groups (Fricker, 2003; Fricker, 2007) and that such virtues bring about hermeneutic justice, which negates epistemic injustice. In this there was a question about the location of boundaries, and the boundaries appreciated by survivors, such as Anna who valued her trusted psychiatrist sharing news of her family during appointments. There was a need for survivors to ‘see’ the trustee in order to evaluate and verify their kindness, humanity and resilience before first transactional and then relational trust started to grow. There was a need for flexibility, including a flexible boundary according to the specific needs of a specific survivor in a specific moment of interaction. This boundary may be at variance with some modalities governing service providers, according to their professional boundaries. But even if, in theory, trustees ascribe to such codes of conduct, the many examples of breaches of ethical behaviour, and at times outright betrayals, presented in this study suggest that boundaries are an issue for survivors and trustees alike.

The 17 survivors who contributed to the study have given an abundance of examples of ways in which they were treated that resulted in the down-regulation, and oftentimes removal, of trust. When trust was broken, the survivors spoke of being denied access to services to meet their fundamental needs. Firstly, they gave examples of not being able to access services pertaining to the orienting task (that is, the need that brought them into the relationship); they left without receiving help from doctors, police officers, the criminal justice system, teachers, parents, social workers, dentists, therapists and many more. Secondly, survivors who exited relationships where they felt vulnerable, unsafe and in danger of being (re)traumatised, spoke of being denied epistemic worth. When their testimony was not believed, challenged, rejected or ignored, they felt (or were) further marginalised. This compounded their confusion and sense of isolation. Thirdly, there were instances of hermeneutic injustice. Some trustees simply did not understand CSA and the scars it leaves, nor did they understand the traumatic distress and trauma-triggering which is so often inevitable and yet an important, and for some an essential, coping mechanism. Trustees discounting such mechanisms as signs of disorder left many survivors feeling pathologised and judged. Lastly, breaches of trust and betrayals had (re)traumatised or caused iatrogenic harm to many of the survivors in this study. Three of the participants (Jake, Anna and Ruby) spoke of considering committing suicide and one of them (Jake) made a suicide attempt driven by trustee reactions to their pleas for help. All participants had left relationships deemed untrustworthy and returned to isolation still in need of help, and all except one had to wait a long time before finding people they trusted enough to work on their trauma distress. The ‘one’ was in her 20s and still did not feel strong enough to go to therapy and open up the wounds again, but hoped she would at some point. Not providing trustworthy care for survivors has been foregrounded by this study as of major concern to survivors. It signals the need for both further research to verify and substantiate these findings, but also to galvanise activist calls for change to the system.

When trust cannot be built between the trustee and the survivor, it is not only the survivor who loses out; the trustee too may suffer. Oftentimes staff in caring roles come into their chosen profession because of a desire to help (Baguley *et al.*, 2020) and when a trustor (survivor) removes their trust, potentially the trustee has failed, or at the very least, the dyad has failed. This may be dispiriting and/or demoralising to the trustee, or even a source of vicarious trauma (Chouliara, Hutchison and Karatzias, 2009). It may be (re)traumatising for the trustee because of their own history of trauma. There are indications that service providers have a higher than average number of ACEs themselves (Esaki and Larkin, 2013), and so this study points to the importance of operationalising survivor trust as an issue for trustees.

The effect of broken trust does not end with survivors and trustees. There is a cost to the institutions in terms of the need for repeat and additional care as a result of unsuccessful client-service provider, client-therapist, or patient-doctor appointments. And ultimately there is a cost to society, as the IICSA report states[1].

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[1] A study by the National Society for the Prevention of Cruelty to Children (NSPCC) calculated that CSA costs the UK around £3 billion a year (2012/13 prices).[2] Of this total estimated cost, by far the greatest part – around £2.7 billion – was linked to lost labour market productivity due to higher unemployment and lower incomes among victims and survivors. The remainder of this total – around £424 million – was primarily made up of costs to the public purse resulting from the provision of health, criminal justice and child social services. IICSA (2022) *The Report of the Independent Inquiry into Child Sexual Abuse: Executive Summary*.

All of this indicates that understanding trust and operationalising it is important, perhaps essential, if the outcomes in terms of survivors care are to improve, as both this study and the Literature Review underlined. This study has extended the research around the importance of trust for survivors. Previous studies had flagged the role of trust in their findings but this was not fully explored or explained within their conclusions. This study has also added to the knowledge base in demonstrating the complexity of the relationship between generalised and relational trust. It suggests that 'basic trust' as a form of trust that is learnt in childhood and then immutable is ill founded. If basic trust does not exist, this might indicate that epistemic trust as a concept is also questionable. Epistemic trust is in its essence relational, but this study suggests that the absence of measurable parameters of trustworthiness for the trustee *in the eyes of their trustor* makes untenable the concept of epistemic trust deficiency solely lodged in the survivor. This study perhaps offers helpful information for proponents of basic and epistemic trust to consider in structuring further research.

Turning to consider relational trust, this study has provided data to fill the epistemic gap regarding this aspect of service utilisation. The findings have identified the intricacy and subtlety of the formation of a dyadic relationship, wherein survivors feel sufficiently sure of their trustee to open to vulnerability of current distress and the narratives of the abuse they suffered as children. The trust enactment model flow chart of relationship formation and the conceptualisation of zones (Figure 1) makes clear the steps and stages survivors move through in building trust. The study has also generated an overview (Appendix Eight) of the attributes and actions that have been experienced as trustworthy and untrustworthy by the

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Available at: https://www.iicsa.org.uk/reports-recommendations/publications/inquiry/final-report/executive-summary (Accessed: November 30th 2022).

participants of this study. These two charts are a starting point for further research to verify or validate the propositions they make.

Findings Two (Chapter Five) presented the data that populated these charts with the examples participants shared of where they had trusted people enough to result in the beneficial outcomes of achieving the orienting tasks. This had included invasive treatments such as colonoscopies, gynaecological procedures and difficult dental treatment, all aspects of care that only an ability to trust had made possible. Developing trust had also enabled several participants to navigate the legal system, social services and charities for homelessness and many more. These are examples of transactional trust, and the study's presentation of this form of trust is new to CSA care as both concept and behaviour. This conceptualisation might be usefully adopted in shaping trustworthy-enough care in services. By understanding how to build and operationalise transactional trust, services might better meet the needs of survivors when full disclosure is not necessary and yet a trauma-informed approach allows for sufficient disclosure to move into a situation where tasks can be achieved.

The deeper strata of trust called 'trust-relationships' was explored in Findings Two. This level of trust allowed the dyad to address trauma distress and resulted in substantial improvements for many participants in their mental and emotional wellbeing and their relationship to themselves. Understanding the difference between enough trust and deep trust, and the way this facilitates trauma recovery, links to previous research and thus reinforces the value of and necessity for trust. Yet this study has added detail and nuance to previous findings.

Many findings in this study offer nuanced and rich data in the domain of CSA to add to previous empirical research. Therefore a systematic review of trust in the wider context of trauma, other traumatised groups, all diagnoses survivors receive or mental health in general, would be helpful to locate this study in the context of the wider picture for service users. Nonetheless this study offers a foundation from which to start.

The testimonies presented demonstrate that the survivors in this study had been able to both trust ‘enough’ to engage in transactional trust relationship, and to trust fully to engage in relationships where they revealed vulnerability to such an extent that healing became possible. The data in this study suggests that statements within documents such as the DSM and the ICD, which suggest that people living with PTSD and CPTSD have difficulties trusting, might bear reconsideration in the light of the trustworthiness of the trustee. Although the survivors in this study agreed that trust and trusting has been difficult for them, it is not the simplistic fact so often associated with CSA survivors. The discussion explored the way in which the use of language and binaries form archetypes and identities, which tend to mask the complexity and sensitivity of entrusting for survivors. It is beyond the scope of this study to comment on the way in which survivors are portrayed in the wider arena of service provision when the medical model of mental health care is adopted by other agencies. However, the diagnostic imperative of asking ‘what’s wrong with you’, rather than the trauma-informed approach of asking ‘what happened to you?’ had, for many survivors in this study, prevented disclosing necessary information, and because of this silencing was perpetuated and impeded their recovery. The study has given indications that the making of an identity for CSA survivors is an area for further research, because portraying a survivor as someone who struggles to trust may be creating expectations in service providers who are potential trustees. Perhaps survivors’ identities create a prejudice, coloured by diagnostic statements like “hard to reach” which goes on to contribute to the shaping of the relationship (for example Fertuck, Grinband and Stanley, 2013). In contrast survivors shared that they see themselves as people beyond their trauma: Helen spoke of all the ways she is more than her abuse. The survivors' call to be valued and of use also attested to the need for services to broaden the lens though which they see their clients/patients.

The presentation of isolation before seeking help explicated survivor testimony detailing both the difficulties *and the reasons* for their difficulties in entrusting, but went on to detail how trust can be built in the right environments. In sharing these testimonies, a picture was constructed which proposes that while survivors' needs around entrusting may be specific and necessitate some special conditions, the task of building trust falls equally on the trustee to demonstrate their trustworthiness.

Trustworthy of what? The Literature Review (Chapter Two) discussed the problem with current research and other published papers and literature, which has inadequately defined or conceptualised what is meant by the term 'trust'. The study has identified a hermeneutical lacunae around untrustworthiness. Equally, 'trustworthiness' remains clinically undefined. Chapter One proposed the word 'trust' as a doxa. This study has aspired to use the experience of survivors to portray a construct of trust that might be a starting point for future studies. It has provided evidence that being able to recognise generalised, basic and relational trust and the difference between them might facilitate the operationalisation of better trust-based relationality when working with survivors. This study took as its starting point conceptualisations of trust used in other disciplines as a framework against which to compare survivor testimony. But in conclusion it feels essential to end with a working definition, one that subsequent research might use as a starting point. The discussion named aspects of trust that survivors in this study pointed to: the need for safety being the main one because of the magnitude of vulnerability CSA had bequeathed them. A definition of trust, and equally one answer to the question 'trustworthy of what?', might best be served by a survivor quote, in keeping with the rest of this study, placing the power back into the words of the participants:

> *"being able to trust […] I feel like I can put myself in your [trustee's] hands, somebody who shows that they're human and they get that this is really hard, then I feel a bit safer to cry, to not be that resentful angry nasty [survivor] who levels it by being shocking. Then I feel I can open up into my sadness, my raw places, […] that they care, that they're not going to hurt me, I think that's it, it's something about knowing that they're not going to take advantage of me or hurt me or ignore me, that they're actually paying attention to my pain". Susanna*

This is a quote from transcript three: my interview with my therapist. I include testimony from myself in this concluding chapter to underline the part I have played in constructing this Mad Studies thesis. Chapters Three (Methodology) and Six (Autoethnography as Reflexivity) presented the thought process behind keeping myself distanced from the findings and analysis as a primary data contributor, so that my role as interlocutor and interpretative agent, and the choices I have made, could be clearly delineated and explained in a data audit, using quotes and my reflexive explanations. This role has been held in tension with my own shared history, as it constantly informed my perceptions of what I was hearing in the interviews, and while analysing and formulating data into the findings and discussion. As the quote above shows, before I had even heard from 15 of the participants, I shared so many of the elements that have been extrapolated into this thesis. I hope the structure of the thesis and the inclusion of lengthy and additional quotes provides the means for the reader to see that I have not used my own view to bias the data, but I have used it to translate and compile the 17 transcripts into one thesis. This approach meets the criteria for robust and trustworthy research in the methodology (Chapter Three), particularly the requirement of: "constructing a compelling, unfolding narrative; developing a vigorous experiential and/or existential account; close analytic reading of participants' words; attending to convergence and divergence" (Nizza, Farr and Smith, 2021, p. 369). In this way

I hope I have adequately justified the approach and vindicated the Mad Studies imperative to use lived experience as sharp academic tool "strongly philosophically and intellectually grounded" (Beresford and Russo, 2022, p. 1). If the opening paragraph of this conclusion alluded to feminists employing a can opener, perhaps Mad Studies might be considered some form of 21st century incendiary device?

To that end this study has contributed to an evidence base of Mad Studies as a research paradigm equipped to challenge the current social and mental health service provision and offer guidance from which reform can be effected, maybe even the revolution so many yearn for. By drawing the 'rational madness' of trauma distress into the Mad Studies fold, justifying the sibling nature of trauma and madness, and their shared ambition of advancing survivor knowledge as not only valid but long overdue epistemology to those who seek to support and help survivors, this thesis makes a nuanced contribution to the field.

The need for change in the systems of service provision is becoming more evident: in the areas to which this study addresses itself further research has recently been called for. A crowd-funded study by Sexual Violence Priority Setting Partnership (James Lind Alliance, 2022) has named 10 top priorities for research, of which this study has made a significant contribution to five, and an initial contribution to three. Table 2 (Appendix Seven) outlines these. The James Lind Alliance offers a further seven crucial areas for research. It is notable that no.11 is: "What factors influence if survivors of sexual violence / abuse feel able to disclose, report and seek support?" This study speaks directly to this call for empirical research.

It is noteworthy that this priority-setting does not single out the role institutions play in survivors' recovery from sexual violence. One of the key findings of this study is the strain that survivors identified on trustees from having to work within institutional constraints, particularly around the amount of time available. Time constraints, both in session length and in the number of sessions available, meant the survivors could not deepen into trusting, yet this was beyond the control of the individual trustee. These constraints did not just apply to therapists but included GPs, consultants, dentists and the police. Therefore the need for further research regarding institutional structures that enable trusting relationships between their employees and the clients has also been indicated.

In using a Mad Studies paradigm this study has been able to restore epistemic worth to the participants and the researcher; additionally the valuing of lived experience has conferred hermeneutic worth. Ratcliffe (2012) in his paper entitled ‘Phenomenology as a Form of Empathy’ spoke of the radical empathy needed when a person’s experience is outside of societal norms. Trauma changes a person’s view of the world, as Chapter One argued. That chapter presented the theoretical framework of trauma, finding that triggering and fight, flight, freeze and dissociative responses were credible as normal for, and helpful to, survivors. Many times these responses had been utilised as coping and self-protection strategies; it was only in trust-relationships that they could (mostly) be discarded in the safety of full trust. The reality of what is safe, and through whose eyes we should evaluate safety, has been a key theme and finding of this study. Phenomenology as a vehicle of exploration has been advantageous because of the credence it lends to seeing ideographic experience as of worth. The justification of phenomenology as the relevant methodology was presented in Chapter Three, and the Findings Chapters demonstrate the survivors’ experience of trust fitting within a phenomenological world-view in that their experiences of ‘reality’ are oftentimes at variance with what might be considered, under a critical realist gaze, dissonant from ‘normal’ or expected reactions. For example, when Anna is asked by a gynaecology consultant to lift her clothes so he can examine her stomach, the request sent her into dissociation, yet such a request, in a hospital, by a consultant, in response to symptoms would be considered by most non-traumatised people as quite reasonable. To understand and interpret why such a request is considered a betrayal, untrustworthy and causes such an extreme response, one needs to adopt a way of looking which gives authority to Anna’s interpretation as of equal worth to the mainstream view of such a situation. Such “pre-verbal taking-for-granted” (Bourdieu, 1990, p. 68) constructs of so-called normal reactions is of considerable importance in the marginalisation of survivors of CSA. Survivors’ triggered reactions so often seem to engender hermeneutic injustice in service providers, who, the testimony of the survivors in this study suggests, do not always (or often) understand traumatic response. Mad Studies and phenomenology, in this respect, make a comfortable alliance. However, the alliance is not without tension because the claim of a reality constructed subjectively could lead to the dismissal of survivor experience. Anna, in the example given above, could be viewed as seeing a reality (that the consultant is untrustworthy) in error because her mental health diagnoses left her unable to judge safety correctly. That view holds with an objective reality against which subjective experience is judged, and in that paradigm the honesty of the testimony shared in this study might be abused, by being used to pathologise the participants. Therefore this study fills the researcher with a protective urge that the survivors’ words should not be twisted when viewed through other lenses. Equally the views expressed by the participants should hesitantly be generalised to all survivors of CSA, because while the participants in this study shared one aspect of themselves (their CSA history), in many other ways they were a diverse population - not just in protected characteristics, but in how they like to spend their Sunday afternoons, for example. This is something the study shares with all qualitative studies. And yet the author believes in the transferability of the findings to many other CSA survivors and other groups traumatised by sexual violence.

To conclude, during the five years this study has been conducted, society has undergone a major shift in the discourse around sexual violence. At times CSA has been the central focus and at times a part of the wider discussion. The social media movement #MeToo went viral in 2017, and this was followed by the building revelations of CSA within football culminating in the Sheldon Report (2021). These mainstream media and social media events were forerunners to the #Everyone's Invited platform, which showcased the extent to which rape culture has been prevalent, and ignored, in schools and wider society. As these events unfolded, IICSA was working towards the final publication of its seven-year inquiry into a diverse array of institutions where CSA has, again, been prevalent and over decades, ignored (IICSA, 2022). This moving of previously silenced behaviours into mainstream discourse was accompanied by other shifts: the publication of the Power, Threat, Meaning Framework (Johnstone, 2018); and the opening of a workspace within the NHS Collaboration platform called The Trauma-informed Community of Action (TiCA), launched in 2020 (NHS, 2020) and expanded to a website called "Open Narrative System" (Trauma Informed Community of Action, 2022). While the APA refused to include complex or developmental trauma in its fifth edition of the DSM, the WHO did include CPTSD as a new diagnosis in 2018 and extended the diagnostic criteria in 2022 (WHO, 2022a). Lastly, Routledge recognised the significance of Mad Studies as a research paradigm gaining traction in the publication of the International Handbook of Mad Studies (Beresford and Russo, 2022). While this list is not exhaustive it does illustrate the many ways in which this study is situated within the groundswell of change. This thesis started with a quote from Judith Herman and perhaps it is fitting to finish with a further piece from her: "The study of psychological trauma has a curious history – one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion" (Herman, 1992, p. 7). By foregrounding Mad Studies in this study, and the study culminating in the midst of this shift of CSA and sexual violence into the mainstream, the author hopes that it too will play a part in maintaining the pressure on services to adapt and develop to better serve survivors in their quest for recovery. Using trust, and its operationalisation, as a lens to view relationality with service providers adds depth to existing approaches for working with CSA survivors. While much has been researched and discussed regarding CSA disclosure (for example Alaggia, Collin-Vézina and Lateef, 2019), trust seems to be included as important without being fully understood or central to the discourse. Similarly, research focused on therapeutic alliance but not specific to CSA (for example Martin, Garske and Davis, 2000) mentions the importance of trust, again without foregrounding the mechanisms that facilitate dyadic trust. In these respects this study has broken new ground, and by bringing the focus onto the work of the dyad points to an exciting area for future work both for researchers and service providers to maximise the benefits offered, as survivors have shown in this study. When trust is built, healing and recovery ensue.

Appendix One: Glossary

CSA: Child Sexual Abuse

CPTSD: Complex Post Traumatic Stress Disorder (see below)

Complex-PTSD: Complex-PTSD has been embraced by some survivors as an alternate route to trauma-informed care within the existing medical model and as a welcome alternative to diagnoses of personality disorders (Lomani, 2022).

DSM: The Diagnostic and Statistical Manual of Mental Disorders (DSM) was first compiled in 1952 by the American Psychiatric Association (APA), and has been through four further iterations (1968, 1980, 1994 and 2013). Modifications and additions to inclusions provoke significant debate. The latest iteration, DSM-V (American Psychiatric Association, 2013), is relevant due to its influence over the socially constructed nature of traumatic distress; the rewriting of its diagnostic criteria for Post-Traumatic Stress Disorder (PTSD) in each edition point to this fact. The predominant purpose of the DSM in the US is to manage the allocation of funds by medical insurance providers to patients for their medical care (Caplan, 1995).

EUPD: Emotionally Unstable Personality Disorder

Experience: “The fact or state of having been affected by or gained knowledge through direct observation or participation” (Merriam-Webster, 2022). The word ‘experience’ is, like trust, doxa and subject to contentious discussion in Mad Studies and Lived Experience contexts. In this thesis the word ‘experience’ denotes that the subject (the survivor) has participated in or observed an event, and that this has created within their conscious mind a set of thoughts, emotions (affect), and body sensations. However, given the framework of trauma, some of the meaning being made of that event may also have had an effect within the subconscious, as the autonomic nervous system may have been triggered into the stress response, including the dissociative reflex of collapse. The meaning being made by the entirety of this event (which includes trauma distress arising in the present moment) is, using a phenomenological lens, co-arising with and in relationship to the 'world' of the event. This phenomenological aspect is captured in Heidegger's construct of Dasein, which is explained in Chapter Three, Methodology.

ICD-11: The World Health Organization publishes the International Classification of Diseases ICD); in 2018 (updated in 2022) the 11th edition included the new diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD). The UK National Health Service (NHS) adheres to this manual under NICE (National Institute for Healthcare Excellence) guidelines (NHS, 2022). The ICD is a global standardised framework of diagnosed diseases to facilitate measurement and tracking.

IICSA: Independent Inquiry into Child Sexual Abuse of England and Wales

Lived Experience: "Knowledge that is generated from people with direct experience of the social issue under investigation" (Taggart, 2022, pp. 154-155). In this thesis the subjects with Lived Experience are survivors of CSA. Some commentators point to the tautology: how can experience be anything other than 'lived'? It has been proposed that a useful term would be "Liv*ing* Experience", since the effects of trauma are still playing out in survivors' lives (Waddington, 2022). Lived Experience can be a useful shorthand mnemonic to signal survivor identity in professional environments.

NAPAC: National Association for People Abused in Childhood

NHS: National Health Service

Non-Recent CSA: The word 'historic' has commonly been used to denote the survivor as an adult and, by definition, the abuse took place in their childhood, thus 'historically'. The Lived Experience Survivor Panel at IICSA rejected the term 'historic' for its associations with being so long ago it was no longer relevant. The term 'non-recent' has been suggested instead (Taggart, private communication).

NSPCC: National Society for the Prevention of Cruelty to Children

ONS: Office for National Statistics

PTSD: Post Traumatic Stress Disorder. A diagnostic category in the DSM-V and ICD-11.

PTS: The non-diagnostic term 'post-traumatic stress' (PTS) is rejected, as its use implicitly infers the time-sensitive nature of distress becoming disorder; when a stipulated number of weeks, arbitrarily chosen (Caplan, 1995), is exceeded, the same 'symptoms' become a 'disordered' state of mind, and the patient receives the diagnosis Post Traumatic Stress Disorder (PTSD).

Psy: A term adopted to denote the multiple agencies influenced by and adopting the biological psychiatric paradigm beyond psychiatry (Diamond, 2013).

(Re)Traumatising: The use of parenthesis around 're' denotes the Lived Experience view that the term 'retraumatisation', as used in psy discourse, may be obfuscating the primary traumas of psy care (Sweeney *et al.*, 2016). The use of the word in this way invites the reader to consider if what is being presented represents a primary trauma or a retraumatisation.

Recovery: The use of the word recovery in no way suggests that any survivor of CSA should or will recover from the events of their childhood. Some survivors express their experience that this word has been co-opted in some scholarship to undermine the enormity of the effects of abuse, and suggest that survivors might recover (Watson, 2019), as in "get over it" and stop making demands on the NHS. This thesis reclaims this word to signify a healing of, or lessening in, traumatic distress because participants in this study expressed their experience of this, not because it has been expected of them.

Survivor: In this thesis 'survivor' refers to adults who were sexually abused in childhood, with recognition that the term is widely used within Mad Studies to refer to people who have survived the harmful effects of psychiatric care from the wide range of psy disciplines, mental health services and other institutions to whom they turned for care. Many survivors of

CSA are simultaneously survivors under this wider definition. In this thesis survivors, when engaged in trusting relationships, become the 'trustor'.

Symptom: The term 'symptom' is rejected for the suggestion that distress is indicative of an underlying illness, rather than the 'symptom' being an experience of distress, a coping strategy or a survival mechanism (Roesler and Lillie, 1995; Johnstone, 2019).

Triggering: One survivor definition is: "triggers are like little psychic explosions that crash through avoidance and bring the dissociated, avoided trauma suddenly, unexpectedly, back into consciousness" (Spring, 2021, p. 62). One scientific explanation is that traumatic experience has an end but the trauma is perpetuated within the psyche and body of the survivor, because fragments of the traumatic experience are believed to be located as dissociated memories beyond conscious control within the stress response centres of the brain. When a survivor encounters something in present-moment experience reminiscent (to the subconscious) of any aspect of the original trauma, the stress response is reactivated and the fawn, fight, flight, freeze or flop reaction is triggered. This causes the survivor to have a flashback, nightmare, feel overwhelmed, dissociated or any other aspect of their own individual response to their own experience of trauma (van der Kolk, 2014).

Trust Dynamic: All aspects of trust: trustor, trustee, evaluations of trustworthiness, the subsequent feeling of trust in another person, the inherent need for vulnerability and the possibility of betrayal.

Trust-relationship: The trustor and trustee engaged around the orienting task and reaching a deeper level of trust.

Trustee: Any person the survivor engages with around an orienting task with uncertainty regarding their propensity to deliver their part in the attainment of that task (Hardin, 2002). In this study trustees include romantic partners, family members, psychiatric and psychotherapeutic services, all medical professionals (including dentists), the Police, Judiciary, social services, teachers.

Trustor: A person who seeks a trustee. In this thesis this is the survivor.

Appendix Two Literature Review - Search Terms and Details

Literature search terms

Scoping search

Existing empirical research into CSA survivors' experiences through a Mad Studies lens. On June 14th 2021 the following Boolean string was used.

"Mad Studies" AND ("child sexual abuse" OR "childhood sexual abuse " OR incest). The initial inclusion of terms "historic* sexual abuse" and "historic* sex abuse" were removed, following search engine rejection. This string was generated using the app '2D Search.com', developed at the University of Essex, with guidance from the designers and adapted to each data base: Pubmed, Psycinfo and EBSCOHost which searches CINHAL and Medline and PsycARTICLES.

Search 1

Extending the same search terms to Google Scholar yielded 108 results. Skim analysis indicated the reach of Mad Studies, with scholarship, papers, chapters and grey literature about CSA spanning education, sport, literature, film, the justice system, intersectionality, gender studies and social work. Published predominantly in Canada, the USA and the UK, these items made reference to CSA impacting trust, but none specifically addressed the concept of trust for survivors or the forming, or breaking, of trust in caring relationships. Results included chapters from the prevalent Mad Studies and Survivor Researcher, and Survivor Activist literature referenced in Chapter One.

Search 2

Narrowing the search in Google Scholar by including "trust" in the Boolean string ("Mad Studies" AND trust AND ("child sexual abuse" OR "childhood sexual abuse " OR incest)), conducted on June 24th 2021, yielded 49 results, of which one was relevant. This is a systematic review of the narratives of CSA survivors; a backward reference search generated three further papers.

Search 3

To locate further relevant literature, on June 16th 2021, the search was extended beyond Mad Studies by utilising the Boolean string in the original databases:

> “trust[tiab] AND ("child sexual abuse" OR "childhood sexual abuse " OR incest)”.

Pubmed yielded 76 results. Psycinfo added 13 and EBSCOHost 36; of this latter, 5 were PhD theses and the relevant sections regarding trust were read in detail. Screening reduced the included number to 24.

Search 4

To capture further empirical research involving survivors and trust, the diagnosis CPTSD was searched. This diagnosis references CSA as an inclusion criteria (see Chapter One), so while the results will include non-survivors of CSA, the data regarding trust may be relevant. On July 13th 2021 the same databases were searched using the Boolean string (trust[tiab] AND (“developmental PTSD” OR “complex PTSD” or “CPTSD”). This yielded 17 papers in Pubmed, 7 in Psycinfo, and 13 in EBSCOHost. After removal of duplicates and screening, 9 were included.

Additional inclusions

One additional PhD thesis was located using the library search engine. Grey literature of survivor-published works was located through blog reading of survivor forums and through discussion in survivor networks, of which the author is a member. Backward and forward reference searches generated 6 and 4 studies respectively.

Exclusions

Discarded papers include duplicates; those where “trust” was in reference to an NHS ‘Trust’; those making reference to survivors’ difficulties with trust a priori, as a fact, but with no explicit focus on this; and papers where the term ‘trusting relationship’ in the abstract had pulled the paper into the search but the study was not explicitly investigating trust.

Inclusion was extended to pieces which could be considered historic, dating back to the 1980s. This is justified by both a wish to speak to shifts in discourse around CSA, but also to glean details of trust dynamics which are not era-specific.

Appendix Three: “The Phenomenology Wars”

Philosophical phenomenology is not one “thing” (Käufer and Chemero, 2015) but is multi-layered, with contested standpoints. This began with Heidegger’s dissent from Husserl’s initial construct, thus taking it in a divergent directions, inventing terminology and extending its reach, melding it with hermeneutics and Gadamer’s philosophy (Zimmermann, 2015). Subsequent philosophers continued (and continue) to adapt and develop the phenomenological approach (Gallagher and Zahavi, 2012). Some scholars see this as constituting a progression (Eatough and Smith, 2017), for others it has given rise to the schisms and heated debates both within Pure Phenomenology (PP) (Gallagher and Zahavi, 2012) and Applied Phenomenology (AP) (Burch, 2021). Burch (2021), in attempting to un-muddle the burgeoning ‘phenomenologically inspired’ approaches from more traditionally aligned AP and PP approaches, names eight distinct AP methodologies and interrogates their validity, finding only one approach to AP which addresses the many criticisms, that being one which operationalises flexibility and allows the dropping of dogmatic restrictions to meet specific circumstances of the population being researched. This solution has been adopted in this thesis to imbue robustness.

Motivated to understand divergence and convergence between different phenomenological approaches, King *et al.* (2008) constructed a study of mistrust using one interview transcript analysed by three research dyads, each using a different AP methodology. Analysis by these dyads generated different themes and meanings, but during the discussion consensus was reached, forming a coherent overview of the interviewee’s experience of mistrust. This suggests that while different phenomenological research lenses generate different meanings, there is overarching coherence which is made possible through discussion.

What does this divided, complex and parrying field mean for a scholar choosing a phenomenological methodology (Dahlberg and Dahlberg, 2020)? The onus becomes to demonstrate that phenomenological claims can be validated (van Manen, 2017a; Zahavi, 2019), including defining allegiance to either Husserlian descriptive phenomenology or Heideggerian Interpretative Phenomenology. This applies to the methodology of IPA, but also to the ways in which this study operationalises IPA's principles by explicitly disclosing chosen methods in the final report (Smith, 2011), and explains why IPA has been selected above other phenomenological methodologies.

For a participant, or indeed every person, discerning 'what happened' involves making meaning out of (interpreting) events and experiences. Heidegger placed interpretation, 'hermeneutics', at the heart of phenomenology to reach into the "essence" of the experience (Finlay, 2012), as a fundamental part of the process and unavoidable (Zahavi, 2018b). An experience includes the meaning being made of it. Interpretation is like an art (Smith, 2007) used to reveal hidden meanings in addition to visible meanings (Smith, Flowers and Larkin, 2009) and "to uncover or disclose a phenomenon by pulling away layers of forgetfulness or hiddenness that are present in our everyday existence" (Frechette *et al.*, 2020, p. 2). Giorgi developed the hermeneutic lens, identifying "hermeneutics of faith" (or empathy) and "hermeneutics of suspicion": the first seeks the deeper meaning integral to the data, and the second seeks hidden or disguised meanings by employing theories and lenses from beyond the data (Josselson, 2004), and this affords the researcher scope to meld phenomenology with other disciplines to reach deeper understandings of data.

Addressing critics of IPA

Is IPA needed?

Why can researchers not use the original phenomenological method Husserl advocated (Giorgi quoted in Zahavi, 2018b)? Burch (2021) , in agreement with Dennett (quoted in *ibid*), suggests the limits of usefulness of the traditional methodology is reached when researchers wish to generate data of use beyond a transcendental application, or “intense introspection”. However, Zahavi, a contemporary AP practitioner, defends the dropping of this methodology while still claiming a valid entitlement to phenomenology if the field of study is other than philosophical, so long as the study adheres to: “central phenomenological concepts such as lifeworld, intentionality, empathy, pre-reflective experience, horizon, historicity and the lived body” (Zahavi 2019a: 905 quoted in Burch, 2021) ; and van Manen (2017b), a published challenger to IPA, espouses the benefit of Applied Phenomenology (presented in his construct) as valuable to non-philosophers in the way precisely IPA makes the claim.

Psychological phenomenological research is delineated from philosophical phenomenological research predominantly by its focus on data being from those other than the researcher (Laverty, 2003). To this end IPA does offer a valid addition to other methodologies for use within psychology (Brocki and Wearden, 2006).

The point for a PhD student choosing a methodology is that if a phenomenological lens is desirable, aligning with *any* AP will bring challenge from some quarter, and attempting to use a “phenomenological inspired” approach draws similar criticism. Burch (2021, p. 1) points to the confusion of terminology: “phenomenology” having been conflated with and obscured by what is in fact “phenomenality”, that is “the ‘what-it’s-like’ dimension of consciousness”.

Is IPA phenomenology?

This charge is levelled at many forms of AP, including IPA (Finlay, 2012; Brocki and Wearden, 2006; Chamberlain, 2011; Dahlberg and Dahlberg, 2020). van Manen (2017a) asks the question of IPA directly in a peer-reviewed paper, and claims the study of individual experience is not phenomenology and “not of phenomena, that is, the way something is given, or shows itself, in experience” (Dahlberg and Dahlberg, 2020, p. 459). He received a robust rebuttal from Smith (2018); parried with counter-rebuttals (van Manen, 2019), and alternate view-points weighed in (Zahavi, 2019).

IPA is only phenomenological if it is used in line with the explicit methodology outlined above (Smith, Flowers and Larkin, 2009; Smith, 2011). This study must demonstrate its interpretative phenomenological fidelity and show “density and richness” (Finlay, 2009, p. 476). It must not be a descriptive piece about experience with uninterpreted themes, or fall short on complexity, detail and nuance. To offer only themes, IPA would be undifferentiated from other qualitative methodologies (Watts, 2014; Burch, 2021; van Manen, 2017a), becoming TA by another name. Smith (2011) takes up the point by furnishing a proforma for a valid results section, with a meta-study of peer-reviewed papers, ranking them to demonstrate excellence in application of the methodology, and listing the facets required as a well-defined focus, experiential and detailed data and rigorous construction of themes. These themes need detailed exploration and justification, and move beyond description to fully operationalise the interpretative prerogative that phenomenology offers (Eatough and Smith, 2017). Given the ideographic nature, Smith also recognises the inevitability of divergence from commonality, and that both convergence and divergence must be explicit, and the write-up executed to present a “sustained narrative” (Smith, 2011, p. 24)

Is IPA interpretative enough? Is interpretation managed well?

This question arises both in challenges to IPA’s claims to be interpretative (van Manen, 2017a; Chamberlain, 2011; Todorova, 2011) but also from within IPA, where Smith and other commentators on the use of IPA (Eatough and Smith, 2017; Biggerstaff and Thompson, 2008) note scholars not fully adopting the hermeneutic aspect. This criticism links to the previous challenge of IPA not being phenomenological enough, but the subtle difference here is when the report uses the Husserlian descriptive rather than the Heideggerian hermeneutic phenomenology that IPA aligns; with when it limits itself to simply offering “granular descriptions of the personal experience of particular individuals" (Burch, 2021, p. 3). Too often published IPA research offers description of experience rather than the ontological meaning of experiences (Burch, 2021; Finlay, 2009).

Interpretation must be bold, rigorous and insightful to differentiate it from other forms of qualitative research (Larkin, Watts and Clifton, 2006), yet interpretations must not extend beyond meanings that the data can justify (Smith, 2011). Park and Zafran (2018) point to the importance of the researcher engaging deep and reflexive self-examination to ensure the ongoing use of bracketing, the "phenomenological attitude" and to catch moments of slipping back into the "natural attitude" (Finlay, 2005).

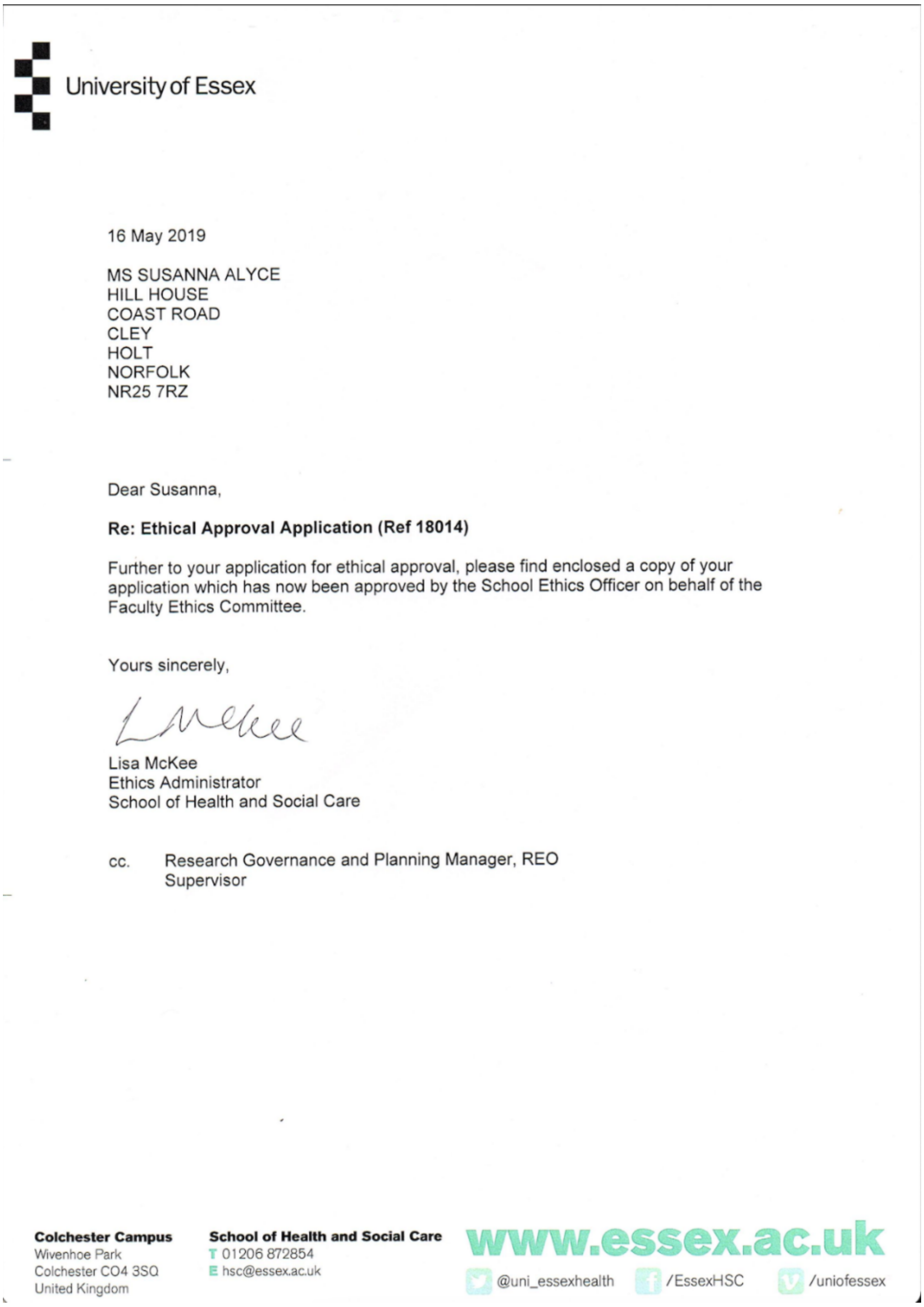
Criticism of the use of IPA has focused on incorrectly directed interpretation (Watts, 2014), where researchers have strayed into opinion-giving *of* the participant rather than the participants' experience. Accidentally the hermeneutics of suspicion can be misunderstood and stray into a suspicion of the participant (King *et al.*, 2008), rather than its intended use as the phenomenological attitude and bracketing tool to reach beyond the researcher's preconceptions (Zahavi, 2018b). In this context, questioning the validity of participants' experiences or assessing their assessments of the trustworthiness of the carer is not the point of this study.

Watts (2014, p. 2) warns against the reification of IPA (and all) methods, reminding researchers to remain alert to their role as "the most important instrument in qualitative research". This understanding of the role of the researcher as the "instrument of analysis" highlights the needs for alert and curious attention at every phase of the research to detect preconceptions, or the lure towards using the study to simply voice personal opinions (Nowell *et al.*, 2017). Reflexivity offers one solution, but Shaw (2010), quoting Woolgar, suggests its use must be overtly applied throughout data collection, analysis and discussion, with comprehension of the "radical constitutive" (ibid, p. 234) ability it offers as an interpretative tool. Reflexivity demands a turning of one's attention towards one's own part in the process, distinguishing it from the "benign introspection" (Shaw, 2010) of reflection, which adheres to an idea of the objective assessment of participants' data. However, confusion over usage of the term exists: Polkinghorne (1989, p. 46) proposes 'self-reflection' as a tool for the locating of "presuppositions and biases" during the research process.

As a reflexive agent, one becomes conscious of one's intentionality within the research project and overcomes "unelucidated prejudices" through transparency (Finlay and Gough, 2003, p. 108). Dahlberg and Dahlberg (2020, p. 460) suggest that "this shift from a natural attitude into a phenomenological attitude of openness is characterized by 'bridling' ", as another term for the reflexivity that utilises the hermeneutic circle of investigation and interpretation.

Consideration of these critiques enabled the researcher to design this study in a way that addresses issues and meets the study requirements and research questions.

Appendix Four: Ethics approval



University of Essex

16 May 2019

MS SUSANNA ALYCE
HILL HOUSE
COAST ROAD
CLEY
HOLT
NORFOLK
NR25 7RZ

Dear Susanna,

Re: Ethical Approval Application (Ref 18014)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Officer on behalf of the Faculty Ethics Committee.

Yours sincerely,

LMcKee

Lisa McKee
Ethics Administrator
School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
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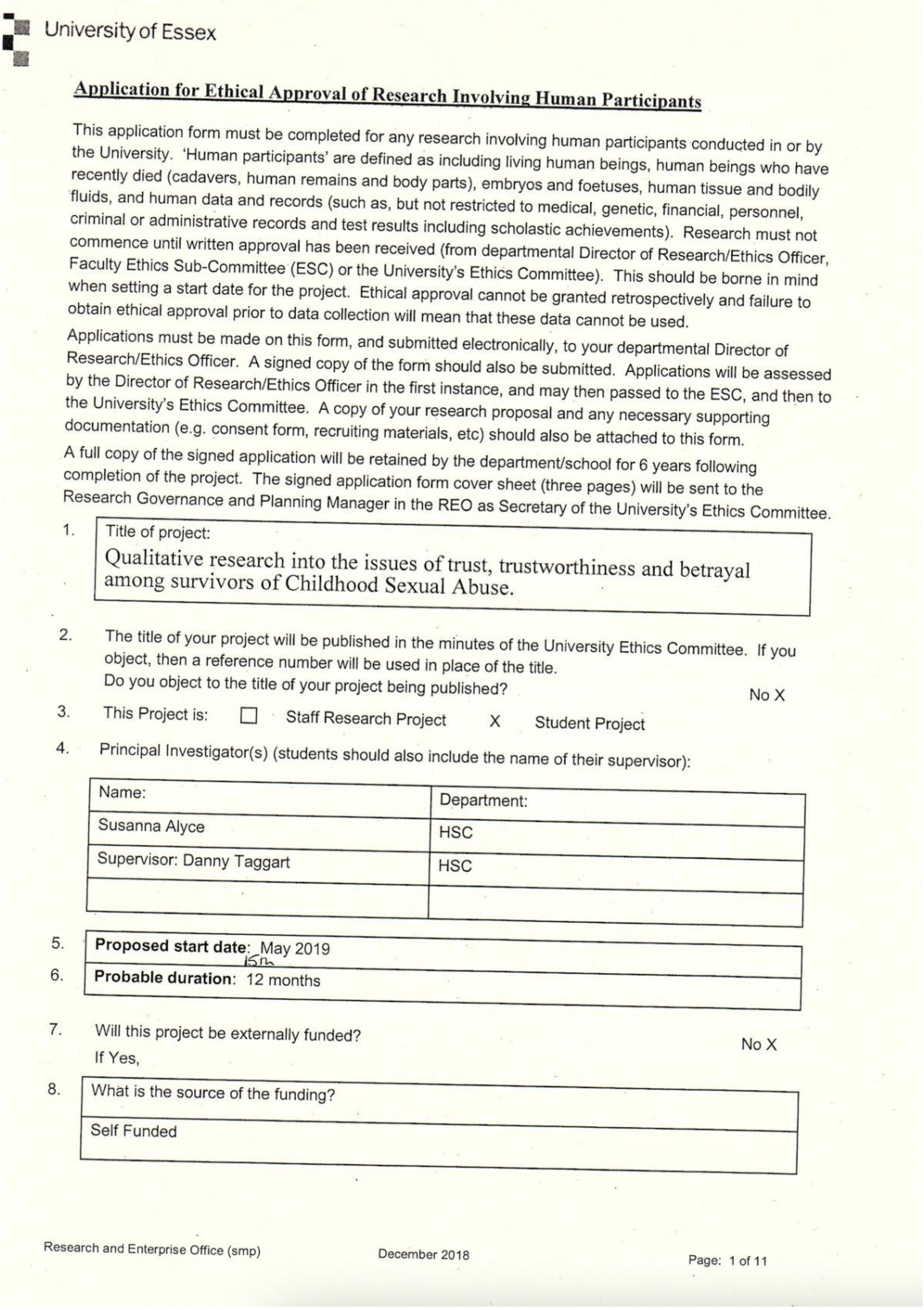


University of Essex

Application for Ethical Approval of Research Involving Human Participants

This application form must be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research must not commence until written approval has been received (from departmental Director of Research/Ethics Officer, Faculty Ethics Sub-Committee (ESC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project. Ethical approval cannot be granted retrospectively and failure to obtain ethical approval prior to data collection will mean that these data cannot be used.

Applications must be made on this form, and submitted electronically, to your departmental Director of Research/Ethics Officer. A signed copy of the form should also be submitted. Applications will be assessed by the Director of Research/Ethics Officer in the first instance, and may then passed to the ESC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (three pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:
Qualitative research into the issues of trust, trustworthiness and betrayal among survivors of Childhood Sexual Abuse.

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
Do you object to the title of your project being published? No X

3. This Project is: ☐ Staff Research Project X Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Susanna Alyce	HSC
Supervisor: Danny Taggart	HSC

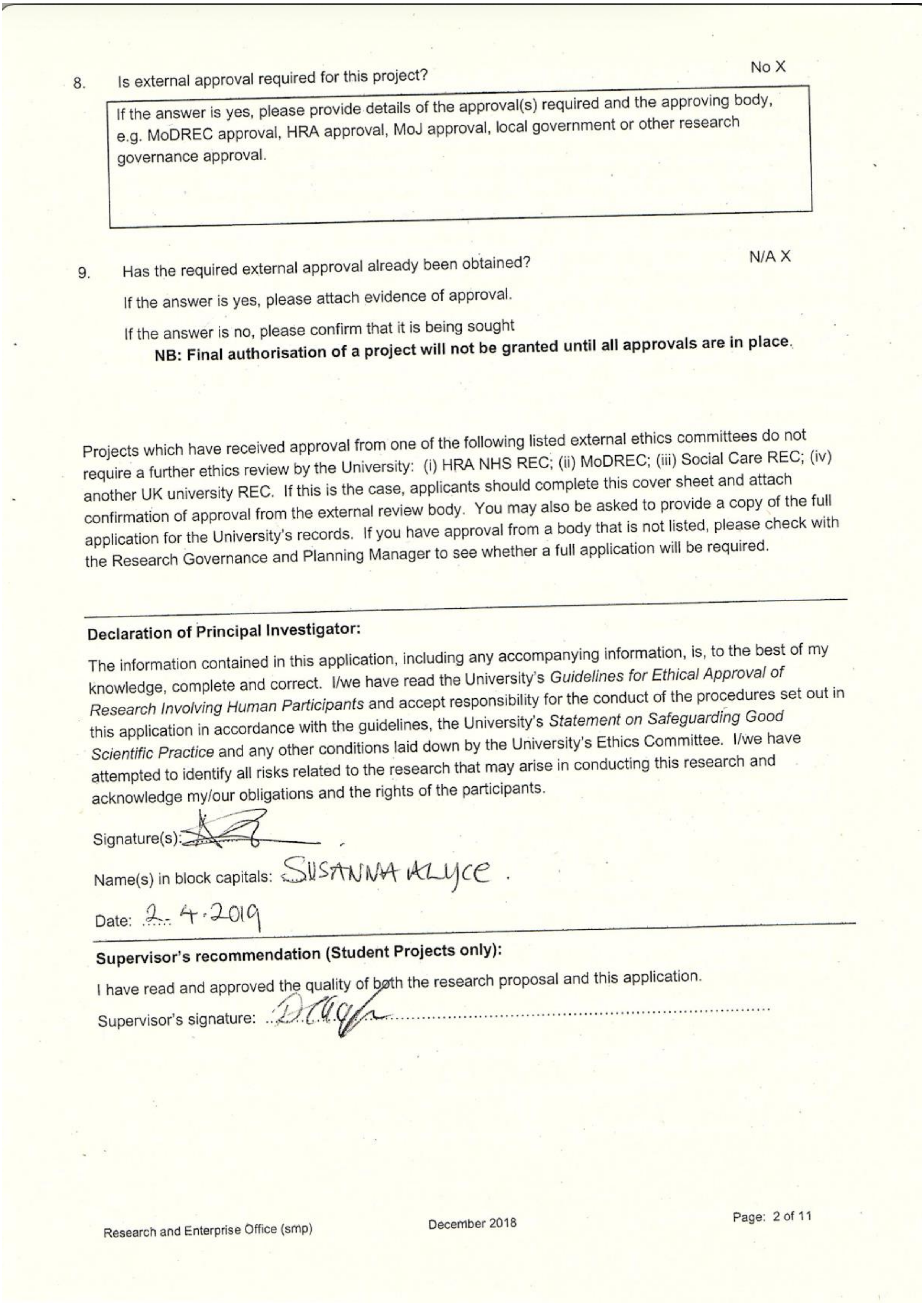
5. **Proposed start date**: 15th May 2019

6. **Probable duration**: 12 months

7. Will this project be externally funded? No X
If Yes,

8. What is the source of the funding?
Self Funded

Research and Enterprise Office (smp) December 2018 Page: 1 of 11



8. Is external approval required for this project? No X

If the answer is yes, please provide details of the approval(s) required and the approving body, e.g. MoDREC approval, HRA approval, MoJ approval, local government or other research governance approval.

9. Has the required external approval already been obtained? N/A X

If the answer is yes, please attach evidence of approval.

If the answer is no, please confirm that it is being sought

NB: Final authorisation of a project will not be granted until all approvals are in place.

Projects which have received approval from one of the following listed external ethics committees do not require a further ethics review by the University: (i) HRA NHS REC; (ii) MoDREC; (iii) Social Care REC; (iv) another UK university REC. If this is the case, applicants should complete this cover sheet and attach confirmation of approval from the external review body. You may also be asked to provide a copy of the full application for the University's records. If you have approval from a body that is not listed, please check with the Research Governance and Planning Manager to see whether a full application will be required.

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s):

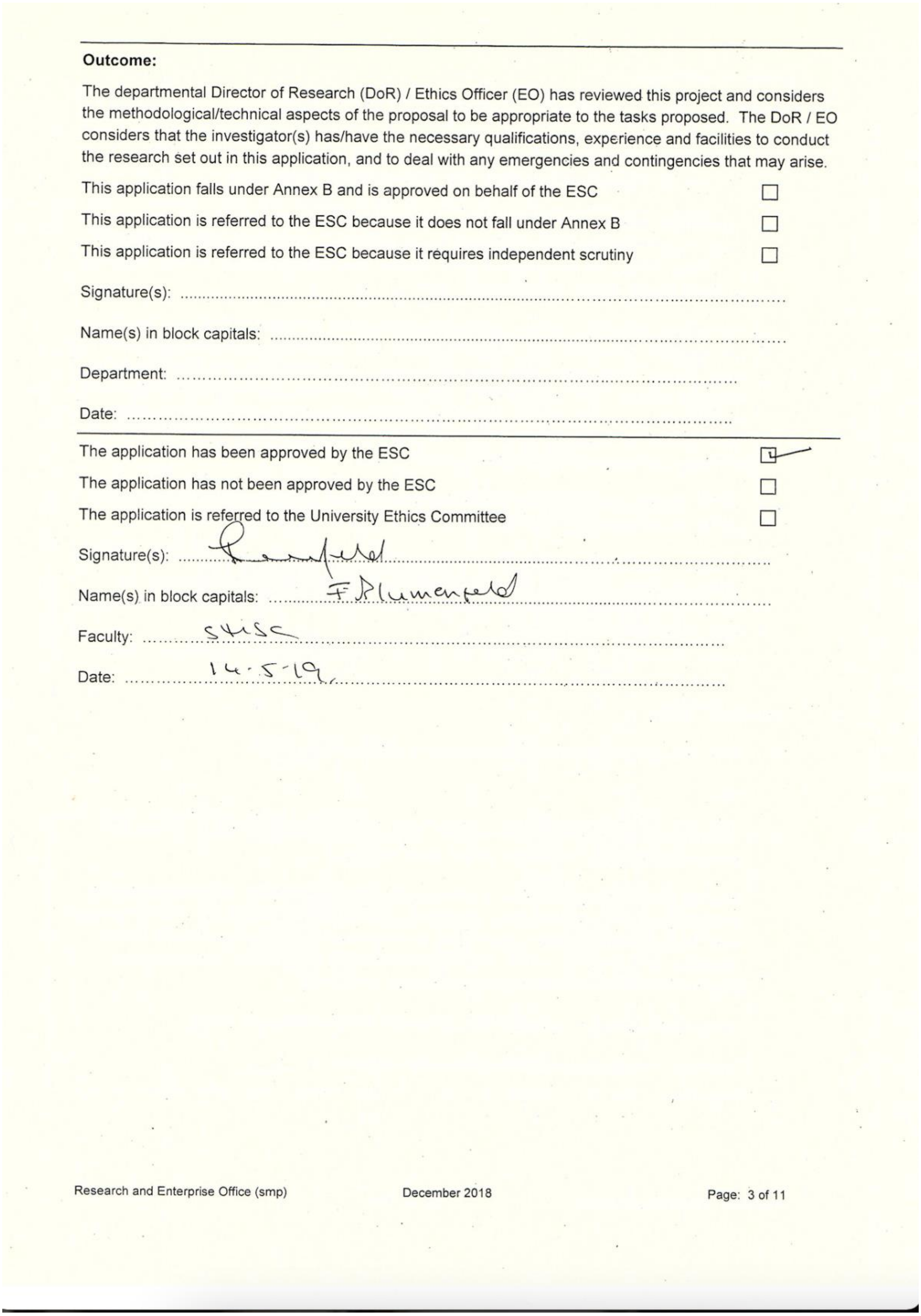
Name(s) in block capitals: SUSANNA ALYCE.

Date: 2. 4.2019

Supervisor's recommendation (Student Projects only):

I have read and approved the quality of both the research proposal and this application.

Supervisor's signature: ....



Outcome:

The departmental Director of Research (DoR) / Ethics Officer (EO) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR / EO considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the ESC ☐

This application is referred to the ESC because it does not fall under Annex B ☐

This application is referred to the ESC because it requires independent scrutiny ☐

Signature(s): ……………………

Name(s) in block capitals: ……………………

Department: ……………………

Date: ……………………

The application has been approved by the ESC ☑

The application has not been approved by the ESC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): ……………………

Name(s) in block capitals: F Blumenfeld

Faculty: SHSC

Date: 14-5-19

University of Essex

Informed Consent Form for Participants.

PLEASE KEEP A SIGNED COPY OF THIS CONSENT FORM AND THE INFORMATION SHEET.

Project Title: Qualitative research into the experience of trust, trustworthiness and betrayal among survivors of childhood abuse.

Researchers: Susanna Alyce, PhD Student in the School of Health and Social Care, Essex University.
Dr Danny Taggart, Lecturer in the School of Health and Social Care, Essex University, and Susanna's Supervisor.

Items for your consent	Please initial below if you consent to the following statements
The investigation and my part in the research project has been fully explained to me and I understand the explanation.	
I understand that I am free to withdraw my consent and terminate my participation at any time without any repercussions or penalty.	
I understand that I am free not to answer specific questions without explanation.	
I understand that all data will be stored, analysed, and published in a confidential and anonymous manner with regard to my identity.	
I agree for my data to contribute to this project's research results and any subsequent published work.	
Any questions about risk have been answered to my satisfaction, and I have considered how and where to seek support should I feel the need.	
I agree that my data may be used in any related future research provided that my data is handled securely, respectfully and confidentially. I understand that it will be archived at the Essex Research Data Repository and held anonymously.	
Please indicate if you would like a summary of the research results once the study has been completed.	YES NO

This is to certify that I ……………………………………………………….hereby agree to participate as a volunteer in a qualitative research interview conducted as part of an authorised study by the School of Health and Social Care, Essex University.
Signature………………………………………….. Date…………………………………………..

I the researcher, Susanna Alyce have fully explained the investigation to the above individual.

Signature……………………………………….. Date………………………………………….

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

School of Health and Social Care
T 01206 872854
E hsc@essex.ac.uk

www.essex.ac.uk
@uni_essexhealth /EssexHSC /uniofessex

Information Sheet for Participants.

PLEASE KEEP THIS INFORMATION SHEET AND A SIGNED COPY OF THE CONSENT FORMS FOR YOUR RECORDS.

Title of the project: Qualitative research into the experience of trust, trustworthiness and betrayal among survivors of childhood abuse.
Researchers: Susanna Alyce, PhD Student in the School of Health and Social Care, Essex University.
Dr Danny Taggart, Lecturer in the School of Health and Social Care, Essex University, and Susanna's Supervisor.

You have been invited to take part in a research study being conducted by the School of Health and Social Care, at Essex University. Before you decide whether to participate, it is important for you to understand why the research is being done and what is involved. Please take time to read the following information carefully and feel free to discuss this with friends, relatives or therapists etc. Please ask if there is anything that has not been explained clearly or in enough detail. If you feel willing to participate please sign the accompanying consent form.

Thank you for reading this.

Why is the research being done?

The purpose of the research is to contribute to the body of knowledge regarding health services both in the public and private sector, whose responsibility it is to care for and support victims and survivors who were sexually abused during childhood. This includes but also extends beyond mental health services to include all forms of treatment such as GPs, dentists, A and E and others. If the research is successful it will change the way that survivors are offered care and are cared for. The objective is to establish, from the point of view of survivors of sexual abuse, the meaning and value of trustworthy behaviours by service providers, how trust can be developed and how experiences of betrayal and/or a rupture of care have (or have not) been mended.

Who can take part?

The research is focused on people, men and women, who experienced sexual abuse during their childhood.

What will I have to do and when?

The interviews will be between you and the main researcher (Susanna), and will last about an hour. They will be at a time agreed between you. You will be able to signal if you feel you have said enough and wish to draw the session to a close soon than an hour, or if you have more to say than can be covered in about an hour a follow up session will be possible. The interview will not be following a set list of questions but will be a discussion exploring together your experiences of trust, trustworthiness and betrayal, so you will be able to say as much or as little as you like on these issues. If at any point you wish to withdraw from the research, you are at liberty to do so.

The interviews will take place in a venue close to where you live (probably the clinic where you heard about this research), and to be agreed between you and the researcher. The interviews are scheduled to run during 2019 and 2020. The report is due to be produced for assessment not later than 2024, papers may be published in a similar time period. The final report will be sent to you (if you request it) once it has been assessed by the University.

How will my information be used?

Once each of the interviews has been conducted it will be transcribed and analysed by the researcher, and then compared to the other interview transcripts. Up to 20 people may be interviewed. During this process common themes and meanings are discovered across all the participants. There is a paucity of research into these issues direct from service users, and trauma survivors in particular. Therefore, to gather this information from you, and others like you, means the service providers will have the information they need to better shape the services they offer.

Will I be paid or receive any form of compensation?

There will be no payment made, but out of pocket expenses such as fares will be reimbursed (please supply receipts) if you wish.

Will what I say be shared? Will I be identifiable?

The interview will be recorded on the researcher's iphone and macbook air (as a back-up) and both are password protected. Once completed the recording will be downloaded to the university M:drive, and the transcription will be made from this, and the iphone and macbook will be wiped clean. All participants' transcripts will be known by a code so that no name is associated with the voice. Your identity will remain anonymous throughout the process of transcription, analysis, and in the final report and any published papers or books arising from this research.

Your name will only appear on the consent form and this will be stored separately from the key to the codes.

The key to the codes will be held in a locked filing cabinet in the researcher's home. Only the researcher will have access to the key to the cabinet and the key to the codes.

It is possible that at some later date different researchers may wish to gain access to the anonymized transcripts. In compliance with the Data Protection Act, because the information is anonymized and held securely, it does not need to be destroyed after initial usage. This is just in case it may be needed in a linked research project at some point in the future. For example, if this research is deemed useful it may be that a larger scale study will be carried out or that the information may be analysed using a different methodology, or searched for different elements within what is said. In all of these instances the original transcripts will be needed. Therefore, the transcripts will be archived at the Essex Research Data Repository and held anonymously.

Can I have access to the data?

Once the report is completed you will be welcome to receive a copy of this; please indicate your wishes on the consent form. If you wish, at your request, you can have a copy of the transcript of the interview, or a copy of the recording of the interview.

What happens if I change my mind?

If at any point during the process of signing up, being interviewed or thereafter you change your mind about being involved you are at liberty to withdraw, and to request that your data be destroyed.

What happens if I get upset during the interview?

You are under no pressure, what so ever, to share anything that you do not want to share. The interviews will be conducted as more of a chat with a few opening prompt questions and NOT as an interrogation or cross examination. As the researcher is also a survivor of childhood sexual abuse, and has lived with the symptoms of post-traumatic stress, you will explore the issues of trust etc together.

The subjects being discussed are sensitive, and important and they may well hold emotional memories which come to the surface. These are all welcome; this is part of the information which can be so valuable to the findings of the research. There will be no pressure to dwell in painful places but equally there will be no expectation that you remain unmoved by what you share. A genuine and authentic exploration, together, into your experiences and feelings about the whole issue of trust is what is being requested, but at your own speed, in your own way, and for as long or short a time as you wish to continue. The interview is not seeking to probe the events of the abuse or your personal life in general. It is very much focused on your experiences with service providers and how they have helped you to feel you can trust them and when they have let you down or you feel you have not been able to trust them. At the end of the interview the option to seek further support will be explored and you will receive a sheet of useful support groups and on-line and/or telephone support services if you wish.

Who is the Researcher?

My name is Susanna. I was 50 when I discovered that I had memory loss of the extreme events of abuse which took place during my childhood. Until then I had been experiencing all the symptoms of complex-PTSD but had no idea why, or even that these were diagnosable as such. I just thought I was a sensitive, easily over-emotional, hyper-vigilant, stressed type who fainted a lot, had terrible headaches and nightmares, and was unsuccessful in relationships. To cope with myself (!) I did a lot of meditation and yoga; so much so that I became a teacher of both and have offered classes in both for nearly 20 years. I also have a diploma in counselling skills, and a Master's Degree in Mindfulness. As part of coping with my discovery that I had been sexually abused I read a huge amount about the subject, and this lead me to realise that I would like to add my voice and efforts to the growing world of Trauma Care. I feel as though those of us who know it from the inside out have much to say that is valuable, and that what we say needs to be added to the voices of professional researchers and therapists.

Essex is a forward thinking University which is actively involved in a movement called ‘Mad Studies’; and although I baulk at this title, I simultaneously value their commitment to letting those with mental health issues be part of the improvement to services to help and support us.

What happens after the interviews?

This may be the end of your contribution. During the interview your support network will be discussed (please see the consent form), and after the interview you may wish to meet with a therapist, doctor or friend to discuss anything that is lingering for you. If you do not currently have a therapist you may wish to consider how you will support yourself if you feel the need after the interview. The interview is not a therapy session and the researcher is not a qualified therapist, so while sensitive issues will be discussed, the aim is to glean the information rather than engage in any form of therapeutic process.

Is there a complaints procedure?

This study has been reviewed and approved by the University of Essex Ethics Committee , and has been designed as sensitively as possible to accommodate your needs while gaining your information. In the event of a complaint please contact:

Sarah Manning

Research Governance and Planning Manager

University of Essex

Wivenhoe Park

CO43SQ

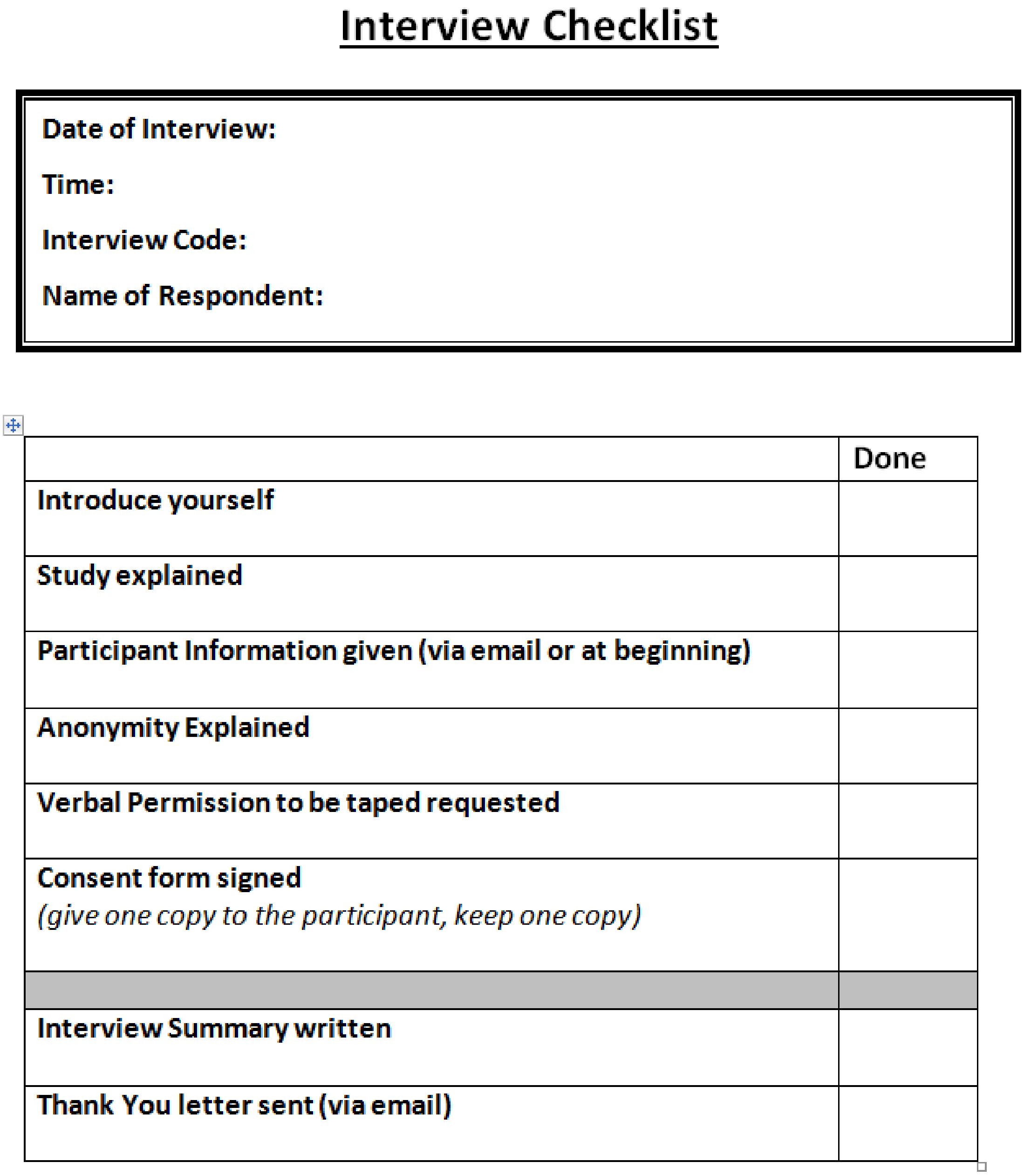
smanni@essex.ac.uk

If you have any further questions regarding the research project please contact me, Susanna, at susanna.alyce@essex.ac.uk or 07768422217

Appendix Five: Interview Schedule

Interview Checklist designed following in-house training by Danielle Tucker

University of Essex



Interview Checklist

Date of Interview:

Time:

Interview Code:

Name of Respondent:

	Done
Introduce yourself	
Study explained	
Participant Information given (via email or at beginning)	
Anonymity Explained	
Verbal Permission to be taped requested	
Consent form signed *(give one copy to the participant, keep one copy)*	
Interview Summary written	
Thank You letter sent (via email)	

Semi-structured Interview Schedule:

Prompts: Anonymity.

Sign Form.

Fine to stop at any time.

Or ask me questions : this is as much a discussion and an exploration together of trust.

Go over study?

Checklist for the end.

1. HOW HAVE YOU EXPERIENCED TRUST AND TRUSTWORTHINESS OR THE OPPOSITE:

   Ice breaker and rapport building.

2. COULD YOU SAY A LITTLE ABOUT YOUR EXPERIENCE OF ANY PEOPLE OR SERVICE YOU HAVE TURNED TO FOR SUPPORT ONLY TO FEEL THAT THEY HAVE LET YOU DOWN?

   Perhaps a doctor or a therapist, a body-therapist or a dentist for example.

   Have services been designed to help you do you think?

   What is it about a person that makes you feel you can trust them, that they are trustworthy?

   Are you thinking about anyone in particular?

   Can you give some examples:

3. HOW HAVE YOU EXPERIENCED TRUST AND TRUSTWORTHINESS IN A THERAPIST PARTICULARLY ?

   Can you tell me a little about your experience of therapist warmth? What does it means to you, this word "warmth"? What it does to or for you.

   Can you give some examples:

4. HOW DOES TRUST FEEL:

Have you ever experienced a sense of trust with anyone who has been helping you? Can you say a little about what it has felt like for you to trust someone please?

Can you give some examples:

5. WHEN YOU HAVEN'T FELT TRUST HAVE YOU BEEN ABLE TO ACCESS SERVICES AND HELP?

Can you give some examples:

6. HAVE YOU EXPERIENCED BETRAYAL:
   And what about how it has felt for you if that trust gets broken?

What consequences did it have for you in terms of your feelings towards this person and your choices or behaviours. Did it impact on your decisions regarding treatment?

Have you experienced a repair when trust has been broken?

In what ways have people/a person been able to re-gain your trust after you felt that they let you down?

I am using the words 'let you down', can you tell me about experiences which are stronger, perhaps feeling like you have been betrayed?

Can you say something about when you have noticed feelings of mistrust has impacted on your behaviour?

Can you suggest ways in which other survivors of childhood sexual abuse might cope with trying to rebuild a relationship with a helper or therapist they have felt let down by?

Can you give some examples:

7. HOW WOULD YOU SAY YOU FIND TRUST IN EVERYDAY LIFE WITH FRIENDS AND PARTNERS?
   How is your experience around trusting people with your story of abuse?

Has this changed over time ?

Or with different people?

As a child was there anyone you trusted, even if you didn't tell them about the abuse?

Can you give some examples:

8. WHAT DOES THE WORD SURVIVOR MEAN TO YOU? OR THE WORD VICTIM?

Do you prefer one or other to describe

How you feel about yourself as someone who suffered abuse?

Can you give some examples:

CLOSING:

Can you think of or recommend anyone else you know who might be willing to do an interview like this with me ?

When all the one to one interview was are finished it is possible that a group might be pulled together to discuss the findings.

How are you feeling now?
Do you feel you need support now or any further assistance after this interview?

Appendix Six: Supplementary Survivor Testimony

Footnotes to Chapter Four and Five.

1. *"I didn't tell anyone until I was 18/19 what it really all was, pause, it took me that long to figure out what it was" Anna*
2. *"I was abused up until I was 13 and I was not in contact with this until I was 40" Frank*
3. *"so I don't know, maybe I was maybe I wasn't, I don't know, there's so many weird old things, I can't find it, I just can't find it" Tessa*
4. *"education has always been a distraction it's been a coping mechanism a lot of people turn to alcohol or drugs, not me, I turn to research" Milla*
5. *"I found this defensive, in denial, way of being safe, bad things you know, relationships, men with money that could keep me safe" Tessa*
6. *"to share things in the survivors group, that often people come with stuff they want to say, they want to unburden themselves, they want to share um and but you know it's really hard to open your mouth, it's a lot of fears and things that hold us back" Milla*
7. *"he, well, basically told me if you tell you're going to lose everyone, you're going to, you know, lose your parents, lose your mum, um you'll lose all your things" Anna*
8. *"I come to think that maybe this is also kind of with the suspiciousness in me with not always interpreting things as being well meant, but to do me wrong, but maybe from the beginning it wasn't even meant to do me wrong but I interpret it like that" Yasmin*
9. *"I'm very, um I'm always reading body language, and I can, I find it very difficult to take people at face value because I'm always looking for what's actually underneath and that is because of my grandfather" Ruby*
10. *"I'm more understanding of mistrust, so I can handle that" Helen*
11. *"this sounds really weird they were still really kind to me, no they weren't kind to me, they still, this sounds really weird, they still fed me when my mum went out to work and I got looked after sometimes um but when she would go out to work that's when the nasty things would happen, um, I used to get locked in um, they used to have sort of like a coal shed, like inside the house, so they used to lock me inside that until my mum come home, sometimes they'd let me out and then my gran, bitch, I did love her" Patrick*
12. *"anybody else that's too kind, that says too nicer words, "what does she want" Rachel*
13. *"one is that how it affects you is that trust and and and when when you can't rely on your parents then you are thrown to someone who is able to do what he wants to you and he's supposed to be a priest he's supposed to be godly" Will*
14. *"I think my fear is, if, […]and it does happen occasionally, the papers get in, things get put in the paper and I don't want that, I don't want that for my children […] I don't want that for my husband, not that it would make me a different person but I don't want to be a victim. I don't want a label" Chloe*

15. *"the impact it's had on those two men [...], it's just so brave to, you know, open yourself up to openly, say what happened and to say it was wrong and yet they got such a vilification and abuse from all the fans, the Michael Jackson fans and that made me so angry [...] because [...] they don't want their idol to be tainted but it is something about, we should be able to stop a child abuser shouldn't we and no body spotted it"* Betty
16. *"if you look at what Rolf Harris did, he was in bed, his daughter's friend, was in bed with her, she was only a child, she was eight or nine and the daughter goes into court, as does his wife, holding this man up, as if the poor thing wouldn't do that, but he did and we spend our lives saying that children are liars, they're not, we spend our life saying that women have wiles, they're not, they're children, they're children"* Rachel
17. *"I just don't trust professionals [...], I think you always think if you go to your doctor you can trust your doctor they know everything, and they don't. It's only now that I've worked within sort of area I work I've worked in in mental health, [...] and it's only now I've realised they don't have training, they don't have what we think everyone does, but when you're younger you think your doctor knows everything. [...] Yeah they have all like this medical knowledge, and lots of it, but I don't think, even now I don't think, you know, there's not enough, they don't get enough training on this psychiatric stuff or anything and they certainly don't get any training in I think in abuse"* Chloe
18. *"I have a real thing about psychiatrists because I think they're all in, I have this theory that all psychiatrists are tied to drug companies, I used to be able to tell um, when I worked in housing mental health project I could tell someone's psychiatrist just by the medication they were prescribed and I never got it wrong [...] so I don't trust"* Stella
19. *"look I can't handle another trial I've been through it, how traumatising it is, I can't even if that means I'm selfish I'm not doing it"* Milla
20. *"you may never find that right person, you can probably go for years and years and years, go to different counsellors, different people and never find that right connection"* Chloe
21. *"I was quite good at English and and and the teachers love it if they've got a rapport, the teachers love it if you love the subject, so I had lovely teachers, I had dance teacher who seemed to really like me, and I loved to dance and so it's when things going, and they like what you're doing and you like that they like you"* Tessa
22. *"I think it is, a lot of it is being able to actually interact with that person, have a connection"* Chloe
23. *"it's about being comfortable with someone um, so maybe there is a sense of comfort, physical comfort around someone that you trust rather than a hyper vigilance"* Jake
24. *"everything just like all nice and smooth [...] there's no anxiety there"* Helen
25. *"it makes you feel like um, in my experience, it's a very safe place and extremely safe place to be open, to not be judged"* Patrick
26. *"I believe, I believe that they're not going to hurt me and that they can hear me"* Tessa
27. *"they might not believe me, you know, they will think I'm seeing attention it's an attention seeking thing and those were the things why I think I've minimized it"* Betty
28. *"one of the strategies is to kind of minimize the effect to see if people really are going to take you seriously before you disclose the enormity of it" Jake*
29. *"I don't really tell that many people I don't think, I try, well I don't like to go out my way to keep it a secret because this adds to this whole notion that it's something, it's*

shameful something to be embarrassed about, because it's not, I didn't do anything wrong" Julie

30. *"I suppose that comes from a long history of men with cold eyes, my dad […], my dad went, really he'd got cold eyes, really cold […] I'm like "get lost"" Helen*
31. *" how can you trust someone who don't look in your face […] really makes me like, I just think, a, you're not interested, you can't be bothered to look and b, what you hiding, are you hiding the fact you got no compassion in your eyes, because to me eyes is a massive" Helen*
32. *"you're just little and it was very, abuse with his big old fingers in your* mouth, and *so, that's saying the dentist, first, first, my earliest memories of the dentist were absolutely, I think abusive" Tessa*
33. *"professionals they say that a lot, I've found that, "I understand', no you don't […] don't tell me you understand, yeah, because you don't, you might have sympathy you have empathy, a lot of people have empathy over it and they think they know how it feels and cos once they find out they feel uncomfortable yes and you do, you know […] they have that sort of feeling of uncomfort [sic], but you don't actually understand and that word always gets to me, I can hear myself getting raised now […] I think that's the thing, then they try and take it on and they don't bless them and it's not their fault at all, but like I say, until you've been there you don't know […,] words are very powerful I think people use them because they think it's the right word they're supposed to use"* Chloe
34. *"there's a sense that people who don't, who've never experienced, don't understand they just can't* comprehend *it" Betty*
35. *"because I've got physical health issues and stuff as well […]and then the mental health diagnosis is PTSD which comes from the trauma, um it sort of, they treated me like I was crazy rather than like in terms of my physical health conditions, "a lot of people just hear the word sexual abuse and they think touching they don't hear child rape they don't hear the emotional implication" Milla […]* for example the dentist, *he you know, ignorant is the word that I feel like, yeah" Milla*
36. *"a lot of people just hear the word sexual abuse and they think touching they don't hear child rape they don't hear the emotional implication" Milla*
37. *"well one was "oh yes I think my daughter got, has been um, she had a nasty experience with a photographer", she hadn't even heard mine and she was wanting to tell me about her daughter" Betty*
38. *"the majority of the world thinks someone with a personality disorder is a psychopath or a sociopath they cannot distinguish between that and some someone being the victim" Stella*
39. *"I can't remember what his remark was now, […] it was like, something like are you doing that again or are you still doing that, […] or it was something like that, it was haven't you been there, done that, that was the sub text" Betty*
40. *"I know people don't understand and so, I can't, I find it difficult to like say anything because they just don't get it, like, because this whole sentiment of like "oh, it was years ago, move on", but when you're having to relive those things,[…] but she just didn't understand that all, she was just so nasty to me about it" Julie*
41. *"I am appalled at the lack of training that is given about child abuse in health professions. Um I think GPs get a days (sic) training in mental health" Jake*
42. *"it was almost no reaction from him, I thought he felt a little bit embarrassed, he wasn't really comfortable talking about it, really, so it's "ok" and then continue with something else" Frank*

43. *“it made me really angry, I was really disgruntled, it’s like, so what am I not worth helping because I’m not sitting there kicking off all the time”* Helen
44. *“I think the shit part of it is that, if someone’s a victim and they get given that diagnosis and the majority of the world thinks someone with a personality disorder is a psychopath or a sociopath they cannot distinguish between that and some someone being the victim” Stella*
45. *“the criminal courts have failed me, I’ve gone down that route already, they aren’t interested the civil courts are the only means I’ve got now to address it”* Will
46. *“the priest in the catholic church are elevated on pedestals and she came from a very catholic Irish family and the priest has this amazing power”* Betty
47. *“I think unfortunately the way the NHS operates is a hierarchical system so a lot of it is about a power dynamic that they may not even be aware of themselves [...] so you go to a doctor who is this gateway for all these other services so they have all this power and control over you, so you are immediately on the back foot”* Jake
48. *“I’m not big with clowns [...] I’m really sacred of like white faces and smiles [...] my um, dad used to, because I’m afraid of the dark still, am afraid of the dark, he used to dress himself in black, white his face out and put a smile on just to scare me [...] he would never let me have a nightlight or anything, [...] he liked power over women, he very much had power over women, he used to physically abuse my mum as well so for years and years and years”* Chloe
49. *“I suppose it was an issue of trust, there was this big thing between us and I felt very let down and she felt very guilty and we could never really talk about it because every time we tried to talk about it she’d get upset”* Betty
50. *“[following CSA disclosure] then he [GP] just move onto the next question it was almost as though it was completely irrelevant or not even worth…(tails off into silence)”* Julie
51. *“My mum just always called me the devil child, the devil’s child, like always punishing me, I was locked in a room, beaten up, hair shaved bullied at school [...], she put me in care because I was the devil basically”* Milla
52. *“he kind of had an answer to that went against what I said, he didn’t really agree with anything I said, he didn’t just listen and nod or whatever, he was like “oh well actually this or actually that”* Anna
53. *“ “what’s actually wrong with you”, and then I told her and she was like, “it’s not a reason to be off work” [...] the first thing she said “oh yet again external factors just mean you can’t be at work” ”* Julie
54. *“I went to a dentist who was supposed to be very patient-sensitive to working with people who are nervous so I said “look, I’ve got a dental phobia” and he said “yeah, Ok, yeah that’s fine, we deal with loads of patients who are quite, all the time, stuff keeps coming back” and that was it, that was the conversation”* Jake
55. *“I don’t like people over my face”* Chloe
56. *“How could two doctors who work in the same area, be so very different?”* Anna
57. *“she put me on more medication and discharged me but I was meant to see a, what is it, a STEPS group [...] and do intensive psychotherapy, never got onto the STEPS group because I was too complicated [...] so that made it more interesting, so [she] referred me to [charity] a special mental health team and I had a CPN come round and because I appeared to be, pause, “normal” I was meant to have a psychological assessment at [charity] but I got nothing [...] because basically she went back to the psychiatrist and the psychotherapist or whoever it was and the woman said “she doesn’t need to see me” because basically the history of what the psychiatrist said she*

didn't need to see me but the psychiatrist and psychotherapist were completely different" Helen

58. *"I ended up at A&E to see the crisis team. I knew I was 1000mph manic and to the edge of a cliff and wanted help to s(American Psychiatric Association, 2013)be going over it and crashing and I did not get it […] I knew the crash would be big. I told them what I needed. I was patronised, told to take meds I know don't help and refused the ones I did because of the cost of the tablets […] I've lived with this stuff for long enough to know what I need when I need it" Anna*
59. *"I didn't do it deliberately, what comes out of me is my 3 year old, my 5 years old, I'm just, I go very humble, I just fawn, I'm creeping, I'm begging, I don't choose to do that, it's the only way I can, because I think that was my dad you see, so I revert to that self" Tessa*
60. *"There are times where I don't even want my husband to see any of my skin, times when I don't want to see any of it myself, the scars, the memories" Anna*
61. *"I give people second chances, third chances, like I will try endlessly to go blank slate let's try again but it's not so much in terms of me showing who I am it's just about trying to make some kind of relationship work but it's not me going into, so it's not sincere in that I'm going to trust you in order to like NO, like I don't, trust is big for me" Ruby*
62. "*he was like focusing, […] he was looking at the right times and nodding at the right times" Chloe*
63. *"she realised that I was tearful, […] she asked if I would be ok waiting and if I needed anything and if I needed to speak to a duty person or anything and I felt like she was trying to keep me on the phone just for a little bit just until she was happy that I was ok to go" Anna*
64. *"she really understands, you know because of how she reacts and what she says and her insights, you know her way of working, she would never try and suggest things in a way that might lead you or but she would reflect back what she saw with the insight of someone who understands" Jo*
65. *"I didn't tell him (psychiatrist) anything at 12, he just could tell I was a traumatised child, I just sat on my hands" Caroline*
66. *"she never lectured me or, or, or tried to dig in a way that was, that I got defensive, she was very listening and listening and listening" Yasmin*
67. *" I don't do pity, I really don't do pity" Chloe*
68. *"it's reassuring knowing that it's there yeah it's nice that they're not going to judge you" Milla*
69. *"the things that we spoke about that were wider, the books that we discussed the fact that we came from two different ideologies and she was willing to listen to mine" Rachel*
70. "*they always ask at the end how do you feel, have I, have I been OK, and I go yes absolutely, I'm safe here" Tessa*
71. *"I think there is a personality gelling thing, I think you click with people, I don't think you always know why you click with people, um, so I clicked with all those people" Tessa*
72. *"I don't know I felt like I could just be more accepting of myself in a way and because they (group therapy) didn't judge me in fact when they did know about my story they were really sympathetic, in fact a couple of grown men sat there and cried like "ohhhherrr" […] and I don't think I'd be the person I am today if I didn't have that" Milla*
73. *no, it's just being a human being" […] it's about humanity" Jake*

74. *“she was very listening and listening and listening and finally I decided, and also I told her I think there’s something wrong with me, I think something is really really really wrong with me, either I’m bi-polar or I’m a borderline person or something is wrong with me, something is majorly wrong with this, and she was like what is this, what is this, where does it come from and she was always asking me and this, when I realised that maybe this is what everything is about” Yasmin*
75. *“I was in there like a blubbering wreck, I was literally crying like a nutter” Patrick*
76. *“I spent the first few weeks fighting her, nothing new there then (laughter) […] I’m very good at anger, […] so I’m imaging I was not confrontational but certainly robust in my approach and she was prepared to sit down and think about it” Rachel*
77. *“she was being honest and I need honesty even if it hurts I need honesty you know” Helen*
78. *“until a couple of years ago when I started with CBT and she (therapist) guessed”* Anna
79. *“I took an over dose and ended up in hospital at 12 and saw a child psychologist um Dr Hicks and he wrote “Caroline is remarkably intact” and he said it’s my mum’s an alcoholic and she needs to take responsibility and he recommended a child protection on me […] I requested to go and see him again at 17 and S: what was it about him you liked Caroline: that he saw that it wasn’t me, that it was her […] he saw me and he saw a child that had had trauma, that’s what he saw, he didn’t just see some mental case or a naughty kid or whatever other label people were giving me, he saw me” Caroline*
80. *“I think she was the only um adult that I had met who saw potential in me, […], she was one of the only teachers I had who saw me, I felt like she saw me and I felt like there was something that maybe she wondered if something was going on” Ruby*
81. *““well, thank you for tell me that, that can’t be easy for you”” Jake*
82. *“when they told me at the reception there was no appointment, I just burst into tears [but the psychiatrist] managed to squeeze me in, in between her other patients which was really really lovely, she didn’t have to’ Anna*
83. *“that she was there for my own good, that she wanted to help, that it wasn’t just a job to her […] it was her being dedicated” Rachel*
84. *“I told him about what I’d been through and what I did for a living and I think he understood that I actually knew what I was talking about” Jake*
85. *“With lots of practise though, I’ve learned to trust my body and know what type of pain is what. I know my nervous bottling things up stomach aches from my rupturing cyst ones... it’s why the whole thing with being ill at the moment is even more frustrating... I’ve had so much practise at knowing my own body and if I say something hurts it HURTS” Anna*
86. *“I wanted to, […] I was prepared to work really hard at it” Jo*
87. *“I had to have J__ [husband] with me initially to trust, to get the trust […] yeah and I think the second or the third time J__ didn’t come any more, I think I just needed support for the first two times and then I could sort of slightly trust this person” Chloe*
88. *“if I’m in the middle of something she doesn’t say ok, thanks, she likes me to get to the end of it” Rachel*
89. *“he’s […] not there to um to push me in either direction or to evaluate things that I say, he’s just there with love” Yasmin*
90. *“I disclosed it to the nurse and she said do you mind me disclosing it to your consultant, and I said no that’s absolutely fine and he was brilliant […] he come to*

me […] he wasn't patronising, he said to me you can tell me what you need to tell me […] you don't have to disclose anything to me that you don't want to" Chloe

91. *"I've had a massive fear of dentist for so long and fear of everything in my mouth um, […], and the first thing was just sitting in the chair, no, sitting talking and basically she built the rapport up and within the third session I was actually starting to have fillings […] and she said "shall we do this all of this or shall we do one at a time", and I thought just do it because it was a such a relief of um this whole trauma of my mouth which still goes on psychologically but it was like I was nurturing the part that was …(pause)" Helen*
92. *"it says on the doctors thing, "we only treat one thing", you know only bring one problem to the doctor and you can sit and talk to the doctor, and it says you've got a ten minute slot, and I'm not saying she goes right over, because she doesn't and she's very boundaried with her time, but what she does do is, she makes sure that all the parts of your body are working in conjunction with everything so I trust that" Stella*
93. *"I'd say to her, you know, I find this very difficult when I come here that I'm supposed to just start talking and she'd do the, like you know, one of those, I don't know one of those typical doctor-y kind of phrases "why does that make you feel uncomfortable" you know, like, because it feels weird […] there were times when she was somewhat engaging but it was only when I was talking about that, it wasn't when I was trying to deal with my suicidal thoughts waking, up in the middle of the night and going to the fridge and eating and then suddenly realising that I'd just completely gorged myself on food without even being aware of it" Ruby*
94. *"I mean he was a very good person at working with me in hypnosis, I think he was very skilled but he mixed his own, own traumatic experiences with mine and he gave advice to me that was based more on his own experience than what was good for me, for example he said, "you can never forgive your father for what he has done" and that was based more, I understand now, on his view, he has a similar relationship to his mother really, so I didn't understand that when I was in treatment with him but that was, I understood that that was not good for me, that was very bad, really" Frank*
95. *I pull your strings and use your limbs, To create your misery, […],You will become, so very twisted, I'll turn you into me, For I am the Puppet Master, Who will NEVER set you free" Helen*
96. *"I think we needed the gap so I think what made it possible we had a period when we didn't really contact each other um so some of the rawer feelings around what had happened could die down[…] we did a little bit of listening to each other like you do in mediation when you try and understand the other person's point of view […] we both sort of said actually I really miss being in touch with you and she said the same" Jo*
97. *"[what] happened to me in my childhood, (stutter) I'm not accountable for that, it's taken a while to realise that […]in the last ten years or so, maybe since we went through that civil court, and even writing it all out, you know, all the events […] I suppose, reconciles everything, all your thoughts, and where you are now in life" Will*

Appendix Seven: James Lind Alliance SVPSP

Table 2: Sexual Violence Priority Setting Partnership (SVPSP)

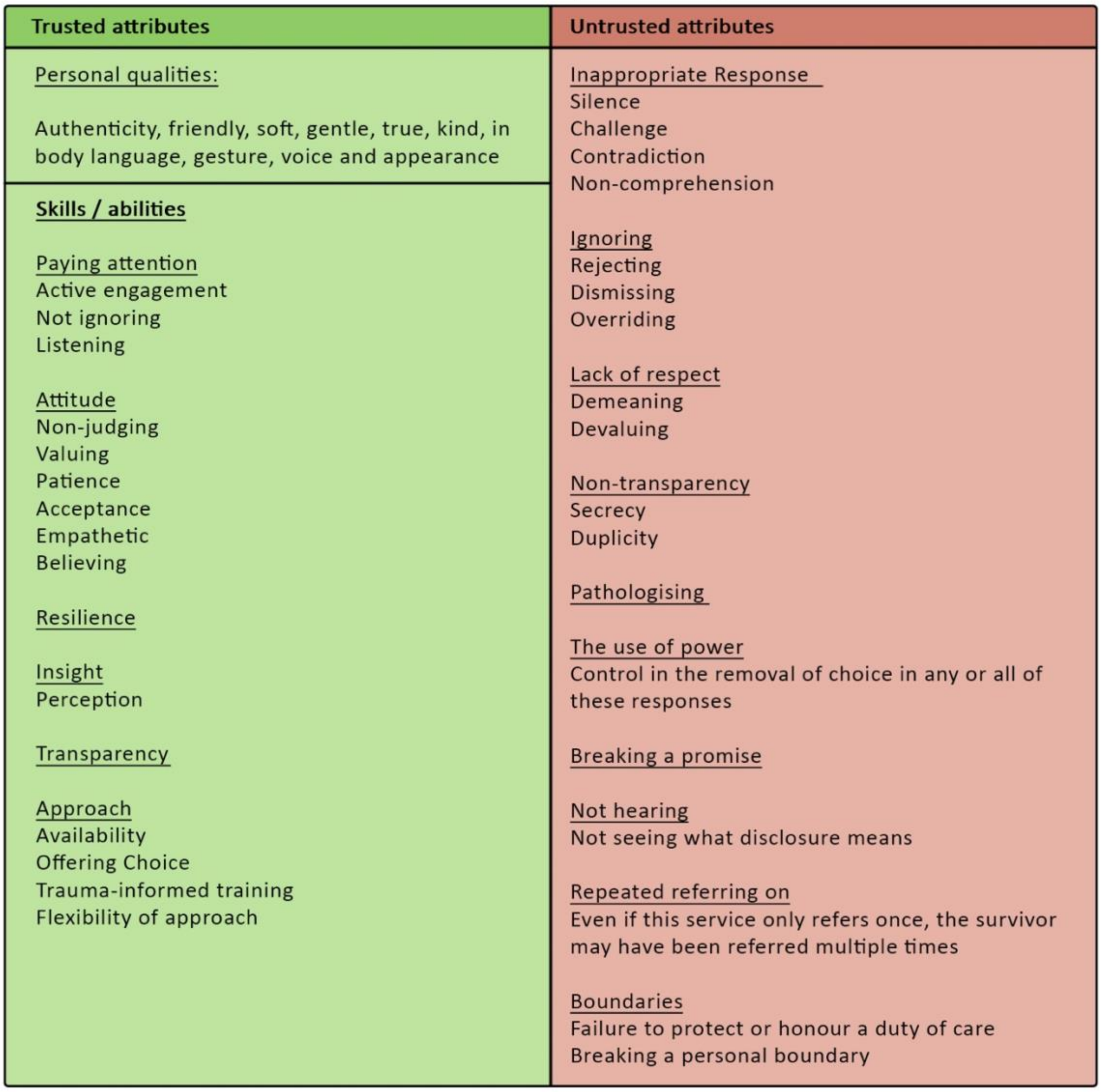
	Sexual Violence Priority For Research	**This Study's Contribution**
1.	From the perspective of survivors of sexual violence / abuse, what does recovery involve, what outcomes do they value and what factors can promote these outcomes?	Important Contribution: Relational trust operationalised with a trusted trustee is essential for recovery from traumatic distress following CSA
2	How can survivors of sexual violence / abuse who identify as People of Colour (POC) or as members of Black and Minority Ethnic (BAME) groups be best supported?	Initial indicators: Black participants in this study pointed to the importance of race in choosing trusted trustees.
3	How can access to high-quality psychological therapies for survivors of sexual violence / abuse be improved?	Important Contribution: By providing pathways that allow survivors sufficient time and choice to choose the people they feel able to trust.
4	What interventions with the general public could reduce misconceptions and stigmas about sexual violence / abuse and their consequences on survivors of sexual violence / abuse?	N/A

5	How can the process of police reporting and police investigation best support survivors of sexual violence / abuse and avoid retraumitisation, distress and victim-blaming attitudes?	Important Contribution: By providing police officers with trauma-informed training that enables/improves their ability to behave in a trustworthy manner when working with CSA survivors.
6	What support is most helpful to and valued by survivors of sexual violence / abuse themselves?	Important Contribution: The attributes and behaviours given in the trust enactment model flow chart and attributes chart. Both of which inform how to offer trustworthy care.
7	How can mental health services and physical healthcare services that are likely to come into contact with survivors of sexual violence / abuse (for example, dental care, general practice, accident and emergency, intimate healthcare and pregnancy termination settings) become more 'trauma-informed' to best support survivors and prevent re-traumatisation?	Important Contribution: Participants in this study call for more time and flexible working to create an environment where the service providers can ask the survivor what their specific needs are. In this way a trauma-informed service offers care in a patient/client centred way.
8	How does involvement in the criminal justice system impact survivors of	Initial Finding: When those at the interface with survivors are not

	sexual violence / abuse (for example, their emotional and psychological well-being), and what support do they need during and in the aftermath of criminal justice proceedings?	trustworthy they cause additional distress and the survivor's withdrawal from the process of seeking justice.
9	How can support be more accessible, inclusive and effective for survivors of sexual violence / abuse who identify as LGBTQ+?	N/A
10	How can survivors of sexual violence / abuse be supported to report sexual violence / abuse that happened many years ago, and what services should be offered to help them recover?	Initial Finding: Trustworthy services, in accordance with the findings of this study, and sufficient time to work at their own pace.

Appendix Eight Zone 4: Qualities and skills

Skills Appendix for Chapter 4: Findings 1.



Trusted attributes	Untrusted attributes
Personal qualities: Authenticity, friendly, soft, gentle, true, kind, in body language, gesture, voice and appearance	Inappropriate Response Silence Challenge Contradiction Non-comprehension Ignoring Rejecting Dismissing Overriding Lack of respect Demeaning Devaluing Non-transparency Secrecy Duplicity Pathologising The use of power Control in the removal of choice in any or all of these responses Breaking a promise Not hearing Not seeing what disclosure means Repeated referring on Even if this service only refers once, the survivor may have been referred multiple times Boundaries Failure to protect or honour a duty of care Breaking a personal boundary
Skills / abilities Paying attention Active engagement Not ignoring Listening Attitude Non-judging Valuing Patience Acceptance Empathetic Believing Resilience Insight Perception Transparency Approach Availability Offering Choice Trauma-informed training Flexibility of approach	

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