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RESEARCH ARTICLE

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Trust, entrusting and the role of trustworthiness for adult survivors of child sexual abuse

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ABSTRACT

Background: Survivors of Child Sexual Abuse (CSA) are reported to have difficulties in trusting. Yet no previous study investigating CSA survivors' subjective experiences of trust exists and there is a paucity of clinical research into constructs and definitions of "trust."

Aims: To use a phenomenological lens to investigate CSA survivors' descriptions of trust relationships and trustworthy others by privileging their subjective experience. To better understand how trust can be built within therapeutic relationships.

Methods: A qualitative methodology using Interpretative Phenomenological Analysis was conducted within the survivor-research paradigm. The researcher was a person with lived experience of CSA who co-produced the study with CSA survivor advisors and co-constructed interviews with 17 adult CSA survivors.

Results: Findings present a "Survivor Trust Enactment Model" that delineates the process of building/repairing relational trust and advancing "transactional trust." Trust is portrayed as nuanced and formed across and according to context, including the demarcation of generalised and relational trust. The findings emphasise that trustees' trustworthiness is key to building trust which challenges assumptions that survivors are deficient in trust.

Conclusion: The foregrounding of subjective trust experiences challenges diagnostic and clinical views on trust deficiency in adult CSA survivors. The study develops clinical constructs of trust, considers implications for clinical practice, and indicates areas for further research into trust dynamics in therapeutic relationships.

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Child sexual abuse; trust; trustworthiness; trauma; lived experience; survivor; survivor-research

1. Introduction

Survivors of Child Sexual Abuse (CSA) are reported in the literature to have diminished trust resulting from abuse experiences (Finkelhor & Browne, 1985; Freyd, 1996; Herman, 1992; van der Kolk, 2014). CSA leaves mental, emotional and physical distress, frequently resulting in mental health diagnoses (Hailes et al., 2019; Ingrassia, 2018). Diagnoses assigned to CSA survivors often assume that survivors lack trust, and characterise this as a deficiency in the survivor. Borderline Personality Disorder (BPD) diagnostic criteria state: "problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships" (Bach & First, 2018; Table 6). Post-Traumatic Stress Disorder (PTSD) criteria in the Diagnostic and Statistical Manual (DSM-V) (American Psychiatric Association, 2013) list "persistent and exaggerated negative beliefs or expectations about oneself, others, or the world ('I am bad', 'No one can be trusted', 'The world is completely dangerous')." (National Library of Medicine, 2013). Trust is not specifically named in the diagnostic criteria for Complex Post-Traumatic Stress Disorder (CPTSD) (Rosenfield et al., 2018) in the ICD-11 (WHO, 2019), but relational issues alluding to trust are cited: "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."

Working effectively with survivors of CSA is significant because an estimated 7.5% of adults aged between 18 and 74 report having experienced sexual abuse as children (Office for National Statistics, 2019). Over 6000 adult CSA survivors from England and Wales spoke to The Truth Project (part of The Independent Inquiry into Child Sexual Abuse (IICSA Truth Project, 2022)), and 88% reported an impact on their mental health. A review of studies including reference to CSA survivors' trust confirmed that relationships, including therapeutic, other service provider, romantic and familial, were often problematic (Finkelhor, 1984; Gobin & Freyd, 2009; Kia-Keating et al., 2010; Laddis, 2019). Building trust took time and various trust factors influenced disclosure, which is seen as an indicator of trust (Blanchard-Dallaire & Hébert, 2014; Hirakata, 2009; Kia-Keating et al., 2010; Parry & Simpson, 2016).

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The empirical study of trust is hampered by the failure to delineate parameters of meaning (Simpson, 2007) and ambiguity in the use of the word "trust" (O'Neill, 2002). Unclear definitions of trust are especially true in clinical settings (Banyard & Williams, 2007), including an unspecified boundary between trust and trustworthiness (Hartman & & others, 1998). Implicit assumed meanings have changed over time, making comparison of studies difficult (Robinson, 2003; C. Wright & Gabriel, 2018), but one unifying principle is that trust is always relational (Hardin, 2002). A cross-discipline literature review identified trust as "a force that works for and through individuals, but at the same time for and through human association" (Möllering, 2001, p. 405). Trust is a dynamic process since it is a reaction or decision (Mayer et al., 1995) taken by one person in response to another, where the "other" is not necessarily an individual but includes groups, institutions, society or the Divine (Simpson, 2007). "Three-place" trust (Ratcliffe et al., 2014) conceptualises the trustor as trusting a specific person to accomplish a stipulated or "orienting" task, which requires the trustor to make a robust appraisal of *this* situation, and the assessment of the trustworthiness of the trustee in achieving *this* orienting task before "entrusting" emerges (Hardin, 2002). Some disciplines view this as "transactional trust" (Colquitt et al., 2007; Reina & Reina, 2009), a concept which acknowledges that sufficient, or enough, trust can emerge for the trustor and trustee to work together but that this may not signify a complete trust. Transactional trust draws into question the validity of any binary notion of "I trust/I do not trust." Trust in other usage ignores the role of the trustee and places the "propensity to trust" or "predisposition" (Gill et al., 2005, p. 287) within the trustor. This generalised (dis)trusting (in)ability could be considered as an epistemic ability which is shaped by early attachment relationships and can be harmed or destroyed by inadequate early years care (Crittenden, 2016; Fonagy et al., 2015; Ratcliffe et al., 2014).

No previous study has focused solely on CSA survivors' subjective experience of trust, or the meaning they make of its significance when seeking help from caregivers. There is no previous interrogation of the mechanisms that facilitate survivor trust or the necessary factors for entrusting. These are the gaps in knowledge that this study sought to address.

2. Methodology

2.1. Phenomenology

Interpretative Phenomenological Analysis (IPA) was used to privilege CSA survivors' ideographic lived experience of trust. Phenomenology foregrounds the relationality of a person within the context of their life (Zahavi, 2018, p. 24), which resonates with the damaged relationality of CSA, where supposed trustworthy adults abuse children. IPA validates participant experiences (Frechette et al., 2020) and facilitates the double hermeneutic of the researcher to interpret and represent participant data (Smith, 2007). It also necessitates a robust explicit researcher-reflexivity to justify and demonstrate claims. Reflexivity also gives transparency for the evaluation of the trustworthiness of the study (Nizza et al., 2021).

2.2. Lived experience epistemology

The first author is a CSA survivor, and issues raised within post-positivist methodologies, such as bias, diminished objectivity or relativism, are viewed differently in first-person epistemology paradigms (Russo & Sweeney, 2016). Shared ontological perspectives and language between researcher and survivor participants grant testimonial and epistemic justice (Alyce et al., 2023; Fricker, 2007), which enables a rich and detailed view into the world of CSA survivors (Ratcliffe, 2012). The researcher's explicitly-stated lived experience helped flatten the usual power hierarchy between researcher and participant, and proved advantageous as participants stated the shared history motivated their recruitment and openness during data collection. Many said they trusted the researcher (Alyce et al., 2023).

2.3. Method

2.3.1. Study design

A CSA survivor with significant professional experience was consulted on study design and recruitment strategy, to embody trustworthiness and prioritise participant safety. Researcher transparency and participant agency in recruitment and interview processes minimised the power differentials between researcher and participants (Survivors Voices, 2022). Frequent supervision and personal counselling safeguarded the researcher's wellbeing. Reflexivity throughout the research process facilitated awareness of additional support needs (Davies & & Others, 2008; Mann, 2016). The University of Essex (ref 18014) granted ethical approval.

2.3.2. Recruitment

Recruitment by "snowballing" (Gilbert & Stoneman, 2016) informed the author and consultant in distributing participant information forms to known survivors, who were in turn invited to share with their CSA peer groups. The inclusion criterion was self-identifying adult survivors of CSA. Table 1 shows socio-demographics for the 17 participants. All gave consent for their data to be used in research and were anonymised by pseudonyms.

2.3.3. Data collection

Interviews were co-constructed by the participant and researcher considering together a prompt sheet of areas for discussion. Each participant spoke about what felt pertinent to their experience of trust. Interviews lasted approximately one hour.

Data analysis followed IPA's iterative steps of deepening stages within and between transcripts, as developed in IPA methodology (Larkin et al., 2021; Smith et al., 2009). The researcher used a structured reflexive diary to analyse her interpretations, which is central to IPA's hermeneutic prerogative (Nizza et al., 2021). Capturing and interpreting

Table 1. Socio-demographic profile of participants.

	Pseudonym	Gender			Ethnicity		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			

meaning beyond language (Forrester, 2010) and prosody (Eatough & Smith, 2017) redressed survivor silence by including non-verbal cues, silences and body language (Poland & Pederson, 1998). NVivo software facilitated data coding. Transcripts and printed materials were held in locked digital files or cabinets.

3. Findings

This study offers a relational Survivor Trust Enactment Model that posits entrusting as process, emphasising the role of therapist trustworthiness and challenging the extant view of the origin of trust difficulties arising solely from abuse experiences. It delineates the types of trust, and evidences both survivor generalised distrust and conditions that make relational and transactional trust possible.

3.1. *Survivors' enactment of trust*

In contrast to portrayals of survivors having an impaired ability to trust, the participants in this study described eloquently how they gauged trustworthiness and built trust. In so doing they revealed seminal differences between generalised and relational trust, understanding the latter as a process which ebbed and flowed with the revelations of vulnerable information to a specific trustee. This is in contrast to binary constructs of survivors' trust as "on-off": "I trust/I do not trust." The Survivor Trust Enactment Model (Figure 1) proposes zones that survivors move through in building, repairing or exiting entrusting relationships. The feedback arrows show the iterative and circuitous (re)evaluations of moving towards and away from sharing the vulnerability necessary, and motivated by the need, to attain something with the potential trustee.

3.2. *Generalised and relational trust as distinct (zone 1)*

Survivors described coping alone (zone 1) before entering a dyadic trusting relationship with potential caregivers. In this zone survivors acknowledged levels of generalised distrust towards unknown others. Will remarked: "It's very hard to trust anyone, isn't it? Especially anyone who has any authority about them." This was because of the way his teachers and parents ignored the signs of distress and requests not to have to spend time with the family Priest. Generalised distrust was not solely shaped by abuse and grooming, but also the actions of past trusted trustees who had let them down, or parents who had not prevented the abuse. Generalised distrust was extrapolated from one relational bad experience to other people holding the same role or to the institution the original person had worked within. Conversely, a good experience with an individual did not change the overall view of an institution considered untrustworthy:

> "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

While generalised distrust was in evidence, it did not disqualify relational trust. Tessa expressed a generalised distrust

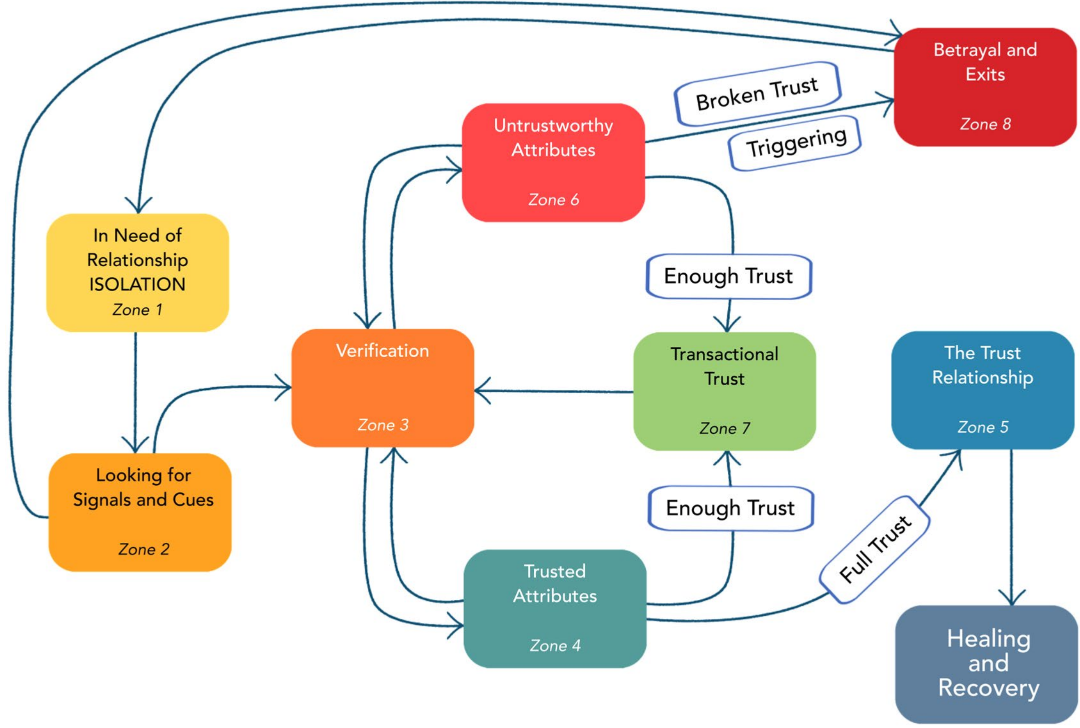

Figure 1. Survivor trust enactment model.

saying: "I don't trust anything, society, […] society is my biggest thing […] society doesn't give a toss," yet she trusted three therapists at a third-sector provider: "I believe that they're not going to hurt me and that they can hear me, […] I've trusted [them], […], I'm safe here."

3.3. Looking for signals of trustworthiness (zone 2)

Survivors spoke of a time when they found themselves in need of help with trauma distress or other issues, and this need had propelled them to locate and evaluate potential trustees. Often these people were interfaces to other caregivers, such as receptionists or initial assessors, but could also be their nominated caregiver. In initial interactions, survivors were cautiously looking for signals and cues of trustworthiness (zone 2) of institutions or individuals. Many participants felt they knew what trustworthiness looks like and what trust feels like:

> "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

For some, the skill of assessing people's trustworthiness was learnt directly from CSA, and was seen as advantageous in managing relationships in adulthood:

> "I'm pretty good to get a feeling of what people I can talk to and people that I cannot talk to, I think it has to do with the ability that I developed when I was a kid, […] I was like a radar system, I sensed what, how are they feeling today, would they come tonight are they angry, not angry […] and I think that ability I have used going forward as well to see ok, can I trust this person?" Frank

All but one participant had trusting relationships in childhood, often with a close relative or teacher. Milla, who was brought up in care, said "a key worker always fought for me[…], it's these sort of relationships that I really am grateful for" and indicated that being sexually abused did not destroy her trust in other people at the time of the abuse.

Survivors had not always found trustworthy professionals to reveal details needed for effective service provision. Anna said:

> "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"

All participants spoke of attempts to disclose which had resulted in further isolation and (re)traumatisation due to the actions of their interlocutor (see below). This reinforced the need for caution before entrusting:

> "A psychiatrist who 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 […] and I felt quite stamped on really […] and I just wanted to get out of there" Helen

Trust issues arising from intersectional trauma (Crenshaw, 2017) suggested multiplying and conflating of experiences related to poverty, race, gender, and sexuality. Patrick, a Black, gay CSA survivor, 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…"

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."

These excerpts indicate that multi-layered traumatic experiences of being misunderstood, diminished, or disregarded had amplified experiences of discrimination and marginalisation. This suggests that these survivors did not have the same access to safe (trustworthy) relationships, and this had shaped heightened caution in the process of assessing trustworthiness of service providers.

3.4. Exits caused by trustee behaviours (zone 8)

Indications that potential trustees might not satisfactorily receive CSA disclosure could all result in survivor exits. Survivors described indicators such as hints that the potential trustee was not sufficiently resilient and might be traumatised by their narrative, might reject or silence a disclosure, or had shown a lack of respect.

Some survivors recognised that it is more difficult to assess someone's trustworthiness when they are triggered into trauma responses by the interaction, and this had sometimes generated incorrect assessments of non-trustworthiness:

> "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

An exit resulted in the survivor returning to the isolation and need to cope alone of zone 1. However, if the initial interaction was tolerable, this allowed the survivor to stay within the relationship and move to zone 3, verification.

3.5. Testing the water: verification (zone 3)

Having satisfied an initial reading of trustworthiness, survivors then spoke of "testing the water":

> "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 all right" Milla

Caution was a keynote of this phase and survivors described using a mask or façade, such as happiness or self-confidence. Will said:

> "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."

Partial revelations were indicative of trust developing but did not signify total transparency or full entrusting at this stage. These revelations nonetheless necessitated the survivor revealing their vulnerability to the trustee:

> "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

While assessing the trustee, participants assessed trustworthiness according to both the "personhood" and the actions of the trustee (zone 5). Personhood speaks to attributes or character, such as the general demeanour, prosody of voice, a look in the eyes. These signals were read from the silent communication of body language and appearance, and their "vibe" (Tessa). Being "friendly and accessible" (Betty), "gentle" (Jo), "true" (Tessa) points to a key component of trustworthiness as something the trustee *is* rather than something they *do*. Some survivors looked for shared attributes, such as similar interests, political opinions or skin colour, which gave "a cultural understanding" (Rachel). Conversely, aspects of the trustee that reminded the survivor of their abuser made entrusting problematic: "it's like her hands […] it reminds me of my grandfather's hands" (Yasmin).

Untrusted actions (zone 4) included disclosure being rejected, challenged, ignored, not understood, silenced, minimised, shamed, or blamed on the survivor:

> "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" Jake

Many survivors knew such actions were due to a lack of training and/or the willingness and/or empathic aptitude of professionals to receive narratives. Survivors recognised this as the repeated refusal and incapacity (personal or societal) to engage with narratives of CSA. Survivors also recognised untrustworthiness arising from insufficient resources in institutions, especially insufficient time. Tessa said:

> "there's never enough time, you're hurried out the door, […] it's going to take me longer than that to even be able to let go enough to even find words."

Paucity of resources meant that several survivors were repeatedly referred on and then refused services because their CSA and mental health diagnoses were considered "too complex" (Caroline, Milla), which left these two survivors feeling abandoned and beyond help and placed the possibility of trusting future caregivers yet further from reach.

In contrast, trustworthy actions rested on trauma-informed skills and sufficient knowledge to be able to read "what I was saying underneath what I was presenting" (Jake). Frank said: "I was dissociated, so, I mean, she started talking to 'us' rather than talking to me, […] she started to build the trust with all these small persons within me." Some survivors needed help to speak, or "pull this out of me like 'cos I can't just walk in and go blah" (Ruby). Others needed to be listened to without therapists' advice or opinion. Chloe's trusted therapist "didn't try to put their two pence in all the time." Authenticity, transparency, reliability and honouring promises was important, and Milla felt "things being predictable and routine" created a known environment. Working together by giving choice and agency to the survivor was crucial.

During this iterative process of trustworthiness verification, survivors remained in relationships with sufficient trust to be able to work towards the orienting task: "we manage

my mental health together" (Jake). This is shown in the model by the arrows moving between zones 3, 4 and 5. For many survivors, verification of enough trustworthiness facilitated a transactional trust for the dyad to attain the orienting task; Frank's transactional trust of the consultant to perform 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"

During this verification process, relationships were ended by survivors for different reasons than in zone 2 above. For example, when actions or attributes of the untrusted trustee were triggering or were felt as betrayals: "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" (Betty). Other times a survivor could stay by lessening trust and revealing less vulnerability. Exits were also enacted by the emotional or psychological withdrawing of "freezing" (another form of triggering) or dissociation.

> "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

Ending a relationship at this point prohibited task attainment and impacted negatively on participants' recovery and relationship to themselves, meaning a return to the isolation of zone 1. Anna spoke of the impact on her self-esteem of an interaction with an untrusted psychiatrist: "I left my appointment with him 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."

3.6. Building a "trust relationship" (zone 8)

Zone 8 conceptualises the dyad entering a "trust relationship" with a fuller, more resilient "opening" (Chloe) to greater revelations and vulnerability. The flourishing of a trust-relationship allowed the two individuals to "gel" (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

Mutuality and equality emerged, where each held the other in esteem with a sense of shared humanity:

> "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

In this stage ruptures were more easily repaired, and facilitated learning around the humanity of others aside from this trustee. Equality operationalised flat(ter) power hierarchies where choice and control were shared or negotiated, which was validating and seeded esteem:

> "I feel less like I'm a just nothing, I don't know, been a bit more valued or something […]. She (psychiatrist) knows that while she was at university learning about mental health, I was out there living it" Anna

4. Discussion

This study addresses a key gap in the evidence about how CSA survivors experience trust and entrusting, and how they verify the trustworthiness of service providers using a step-wise approach. While feelings of generalised distrust were expressed, all participants spoke of having trusted adults both as children and in adult life.

4.1. Relational entrusting

This study indicates that CSA survivors demonstrated the ability, as children and as adults (Hirakata, 2009; Kia-Keating et al., 2010), to engage in relational trust while cautiously gauging the trustworthiness of trustees. The findings offer information evidencing survivors' embodied knowledge and felt sense (Gendlin, 1991) of trust. This reveals a nuanced picture beyond conceptualising trust residing solely as the propensity within the survivor. It recognises that trust is constructed within relationships and contexts, and across time. Labelling survivors as deficient in trust has stigmatising and discriminatory overtones (Mulder & Tyrer, 2023). When survivors' narratives are rejected this can be understood as an epistemic injustice, which Fricker (2007) recognises arising when a listener's lack of virtuous ability means they fail to understand and receive a testimony because it is beyond their comprehension. Epistemic violence then enacts, as the survivor's words are discredited or ignored, thereby disenfranchising them and undermining their credibility as a witness (Alyce et al., 2023).

The study supports previous non-clinical research (Hardin, 2002; Ratcliffe et al., 2014; Schoorman et al., 2007) indicating that relational trust involves a set of conditions which trustor and trustee construct together to attain an orienting task. Previous studies noted that building trust took time (Matheson & Weightman, 2020; Parry & Simpson, 2016; C. Wright & Gabriel, 2018). A process flow chart adds nuance to time-frames of survivors operationalising an accurate verification process of potential trustee trustworthiness (Banyard & Williams, 2007; Harvey et al., 2000; Hirakata, 2009; Kia-Keating et al., 2010; Mullen et al., 1994; Senn et al., 2011). It shows gradations of entrusting. Caution may extend to hypervigilance, as seen in previous studies (Gobin, 2012; Hailes et al., 2019), but this study considers it useful self-protection rather than always indicative of misplaced avoidance.

Successful relationship rests with survivor and trustee working together in building trust. Locating transactional trust (Colquitt et al., 2007; Reina & Reina, 2009) (not

previously flagged in empirical research with CSA survivors) in clinical relationships may bring nuanced understanding to the meaning being made of the "task" the dyad is working towards. It reinforces the paramount importance of trust as prerequisite to disclosure (Brennan & McElvaney, 2020) and suggests disclosure is not a "reveal all" (Alaggia et al., 2019; Brennan & McElvaney, 2020), but a series of revelations regarding events of the abuse, layers of trauma distress and difficult feelings constituent to it. Recognising transactional trust also operationalises the testimony of survivors who state they are able to "trust enough" to remain within the relationship in order to attain the task or outcome the relationship has been built around.

The study accentuates the link between trust building and healing (Banyard et al., 2001; Harvey et al., 2000; Hirakata, 2009; Kia-Keating et al., 2010) and highlights how triggered states impact entrusting (van der Kolk, 2014). It indicates that trust-relationships facilitate self-understanding, self-respect and self-trust (Parry & Simpson, 2016). Survivors spoke of the helpful capacity to self-protect (Blanchard-Dallaire & Hébert, 2014; Easton et al., 2019; Parry & Simpson, 2016) by withholding vulnerability until trustworthiness had been established. This ability was also used to protect trustees deemed insufficiently psychologically strong, who may be harmed by receiving disclosure. In some clinical literature this desire to protect others is portrayed as relational over-protection and self-blame, or a transference of an internalised abuser (Laddis, 2019). However, scholarship on the damaging nature of vicarious trauma (McNeillie & Rose, 2021) suggests that survivors' caution on the effect of abuse narratives is well placed.

4.2. Trustee trustworthiness

Survivors in this study delineated trustworthy attributes from actions, and this separation is new information. Attributes, or personal qualities, may be difficult for trustees to learn or change but are crucial constituents to relational trust (Hirakata, 2009; Kia-Keating et al., 2010). Potential trustees may wish to reflect on their suitability in trust-dependent CSA relationships and seek insights from managers or supervisors.

Trustworthy actions by service providers included engaged or benevolent listening (Weger et al., 2014) and "radical empathy" (Ratcliffe, 2012), relinquishing or sharing choice and control, transparency, equality, believing, and not ignoring, shutting down or rejecting the survivor or their testimony (Alaggia et al., 2019; Banyard & Williams, 2007; Chouliara et al., 2011; Harvey et al., 2000; Parry & Simpson, 2016). Participants in this study described flexibility on the length and number of sessions in response to specific or momentary needs as important to building trust. These behaviours created "the opportunity to tell" which resonates with previous research (Brennan & McElvaney, 2020, p. 97), reinforcing the trustee's role in facilitating needed safety (Banyard et al., 2001; Blanchard-Dallaire & Hébert, 2014; Bowers, 1992; Hirakata, 2009; Parry & Simpson, 2016; J. K. Wright & Thiara, 2019). Mutuality was demonstrated to reduce inevitable power hierarchies between survivor and trustee and engenders fuller trust, a factor also previously identified (Banyard et al., 2001; Hartman & & others, 1998; Hirakata, 2009; Parry & Simpson, 2016).

When trustees demonstrate resilience (Lakioti et al., 2020) and a willingness not to "give up" (Banyard et al., 2001), it bolsters entrusting, and this study supported this finding. Demonstrations of appropriate mutual vulnerability were also helpful for participants and did not preclude recognition by survivors of the need for safe boundaries indicated previously (Parry & Simpson, 2016) or the essential nature of CSA being a breach of essential boundaries (Finkelhor & Browne, 1985; Freyd, 1996; Gobin & Freyd, 2009).

4.3. Generalised trust

The ability to build relational trust does not disavow the extant view that survivors hold a generalised distrust of unspecified others (Finkelhor & Browne, 1985; Freyd, 1996; Parry & Simpson, 2016). However, generalised distrust was seen as a rational response to past untrustworthy others. Poor experiences with professionals in specific roles who had failed to receive disclosure contributed to generalised distrust of potential trustees holding similar roles (Klest et al., 2019). Likewise, broken trust and betrayal in the context of an institution transferred to other individuals within that institution (Easton et al., 2019; Klest et al., 2019).

The failure of non-abusing parents to prevent the abuse also contributed. Distrust was not solely due to the abuse or abuser (Freyd, 1996; Gobin & Freyd, 2009) and could be overridden by tangible evidence when in relationship.

The study's strengths included the co-production element of its design, including drawing on experience of a CSA survivor as consultant, and the lived experience of the researcher building rapport and shared understandings with the participants. One weakness of the study was the limited range of people with protected characteristics offering their voice. This study foregrounded survivor experience and therefore does not include the trustee's experiences of the interactions these survivors spoke of, thus further research exploring these two perspectives of the same interaction may be fruitful.

5. Conclusion

This study foregrounded CSA survivor trust from a survivor perspective and indicates the significance of trustee trustworthiness and the mutual endeavour between survivor and trustee when creating relationships necessitating trust. The Survivor Trust Enactment Model is an empirically tested addition to clinical understandings of trust building as relational when working with CSA survivors. The study repudiates inability to trust as residing in the survivor's psyche regardless of behaviours of the trustee, be that an individual, institution or society. Ignoring textured and intersectional histories to portray survivors in a flattened manner risks robbing them of their personhood and (re)traumatisation

(van der Kolk, 2014), by replicating the powerlessness inherent in the original abuse (Morrigan, 2017). This can also preclude the individual's development as an esteemed person beyond the status of mental health patient, trauma sufferer or survivor (Austin, 2021; Reese, 2021).

The study proposes recognition of the distinction between generalised and relational trust and the need for clear and shared definitions. Further research to build on, develop and extend these finding is indicated, with the verification and elucidation of parameters of trustworthiness of service providers for CSA survivors. The comparison of subjective survivor and clinician perspectives to explore the shaping of trustworthiness, safety and propensity to trust as responses specific to individuals within relationship would add to the knowledge in this area. Lastly, a study utilising a series of interviews with each participant, or alternative data collection methods and engaging survivors at varying stages of recovery, is suggested.

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