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The relationship between adult attachment styles and epistemic trust measured by the Questionnaire Epistemic Trust: a cross-sectional study

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Abstract

Epistemic trust is suggested to have an effect on therapy outcomes. Theoretically, a safe attachment context is being associated with epistemic trust. Epistemic trust can be defined as an individual's willingness to consider new knowledge from another person as trustworthy. Therefore, it is desirable to empirically test the association between epistemic trust and (unsafe) attachment contexts. Because an unambiguous measuring instrument for epistemic trust was missing, a questionnaire epistemic trust (QET) was newly developed. The current study examines the initial psychometric properties of this questionnaire. Examined were the dimensions of epistemic trust and its relations with adult attachment styles in the general population. One hundred seventeen respondents (89 woman, 28 men, mean age 45.0 years, range 18-83) completed the 49-item QET, which was applied in the general population for the first time. The Experiences in Close Relationships Scale – Revised (ECR-R) was used to measure adult attachment style. The QET revealed four dimensions: Expertise practitioner, Suspicion, Accepting Help and Openness. Together the dimensions explained 45.2 percent of the variance, with Cronbach's *a* varying from .82 to .93. Results showed a link between epistemic trust and adult attachment styles, controlled for level of education ($R^2 = .27$; $F(3,112) = 13.56$; $p < .001$). Insecure attachment styles were associated with a lower score on the QET. Specifically, attachment-related avoidance was related to a lower score on the first two dimensions of the QET (Expertise practitioner and Suspicion). This study found four suitable dimensions of the QET with good internal consistency and it empirically shows a relationship between epistemic trust and adult attachment style, which are first steps in further development and validation of the QET.

Keywords: Epistemic Trust, Attachment, QET, General Population

Preface: word of thanks

In the process of writing this thesis I learned a lot and I owe this to a number of people; therefore, I want to thank them on a personal note. First of all, thank you Rinie for your guidance, sharing your expertise and for being passionate, positive and patient during this process. Most of all, thank you for all the meetings and your time, which has allowed me to learn a lot from you. Secondly, thankyou Wilma for your support, your positivity, encouragement and feedback. Saskia and Wendy thank you for the meetings and for allowing me to be part of this interesting research project, I look forward to the results of the full study. Also, thank you to all the participants who made this study possible. Finally, I would like to thank my family and friends for supporting me and giving me motivation, which was a necessary good in these peculiar times of corona-measures and lockdown.

Introduction

It is the ability to exchange social information that might be at the heart of the effectiveness of psychotherapies. Psychoanalytic thinking about epistemic trust provides a way of thinking about human consciousness and the phenomenological experience of psychotherapeutic intervention from which its effectiveness derives (Fonagy, Luyten, Allison & Cambell, 2019). Epistemic trust can be defined as an individual's willingness to consider new knowledge from another person as trustworthy, generalizable and relevant to the self. For example, whether a patient will take advice from his therapist or doctor and in how far one is willing to participate in the decision-making process, is influenced by epistemic trust. Epistemic trust (from here: ET) thus might play a role in psychological and medical treatment outcomes (Kienhues & Bromme, 2012; Schwab, 2008). McCraw (2015) argues that ET has been suggested to have four components: belief, communication, reliance, and confidence. The first two sets (belief and communication) are characteristically epistemic; in order to address knowledge, communication is necessary. In order to receive knowledge, belief is necessary. The second set of conditions (trust and confidence) are at the heart of any kind of trust. Since harmful childhood experiences are thought to make an individual epistemically mistrustful, ET might by associated with attachment style (Fonagy & Allison, 2014; Fonagy, Luyten & Allison, 2015). In order to test this association, a valid measurement instrument for ET is needed.

Earlier studies measured ET in experimental work, carried out in young children These studies aimed to measure ET by gathering data on how children reacted to new information and to which adult a child would turn to for information (Corriveau & Harris, 2009; Egyed et al., 2013; Fonagy & Allison, 2014). Next, to approximate ET in an adolescent population, researchers used the Inventory of Parent and Peer Attachment (IPPA) (trust in mother and father) self-report questionnaire, in the absence of a validated measure (Orme, Bowersox, Vanwoerden, Fonagy & Sharp, 2019). Furthermore, the Epistemic Beliefs About Medicine questionnaire (EBAM), can't be generalized to epistemic trust in general or in psychotherapy conditions (Kienhaus & Bromme, 2012). Finally, an ET assessment (ETA) was designed; by controlling and observing the content and amount of information passed to an individual and the degree to which the individual internalizes and generalizes that information (Schröder-Pfeifer, Talia, Volkert, & Taubner, 2018). Yet this procedure

necessarily demands considerable time both from patients and therapist, which limits its applicability (Schroder et al., 2018). It can be concluded that until now there is no efficient self-report questionnaire to measure epistemic trust.

The Epistemic Trust Questionnaire (QET) is currently in development. This self-assessment questionnaire on the degree of epistemic trust can be supportive in determining the need for appropriate (psychological) treatment (Knapen, Hutsebaut, van Diemen, & Beekman, 2020). The questions are drawn up on the basis of four modes in which a trait is manifested, namely: cognition, affect, behavior, and perception. These are divided into two subscales: general degree of ET and ET in treatment (for the questionnaire, see Appendix 1). The current study is one of the first steps towards exploratory research of the QET. The reliability, factor structure, and dimensions of the questionnaire will be tested in the general population. Given the theoretical considerations about the relationship between ET and attachment style, the present study will examine this relationship. If more is known about the usefulness of the QET and the relationship between ET and specific attachment styles, this information might be used trying to optimize the work alliance between client and practitioner, e.g., by fitting the communication to the attachment style of the client (Coyne, Constantino, Ravitz, & McBride, 2018).

Next, focusing on attachment, Bowlby's (1977) theory hypothesizes that an attachment system evolved to maintain closeness between infants and their caretakers under conditions of danger or threat. The quality of early attachment relationships is thus rooted in the degree to which the infant has come to rely on the attachment figure as a source of security (Ainsworth et al., 1978). Bartholomew and Horowitz (1991) conducted a four-category model for adult attachment. Consistent with Bowlby's original theorizing, research has converged on a definition of adult attachment based on two orthogonal primary dimensions; the anxiety dimension and the avoidance dimension (Bartholomew & Horowitz, 1991). According to Fraley and Shaver (2000) attachment-related anxiety reflects an individual's predisposition toward "anxiety and vigilance concerning rejection and abandonment," whereas the avoidance dimension "corresponds to discomfort with closeness and dependency or a reluctance to be intimate with others". These two adult attachment dimensions can be understood in terms of individuals' internal working model of self and others. Individuals with attachment anxiety tend to hold negative working models of self and positive working models of others. Conversely, individuals with attachment avoidance tend to

hold positive working models of self and negative working models of others (Pietromonaco & Barrett, 2000). Subjects scoring low on both dimensions are considered being safely attached, subjects scoring significantly high on both dimensions are called fearfully attached (Bartholomew & Horowitz, 1991).

Fonagy and Allison (2014) suggest that attachment might mediate the transmission of knowledge from one generation to the next. The primary caregiver has a key-position in the sensitivity and possible transmission of information to the child. Meaning, secure attachment helps to create a condition for the relaxation of epistemic attention. In addition, Fonagy, Luyten, Allison and Campbell (2017) argued that a lower degree of epistemic trust and insecure attachment are associated because they are both characterized by impairments in trusting and receiving information. Although attachment is a much older, evolutionary instinct than the development of epistemic trust, Fonagy and Allison (2014) find it plausible that previous attachment experiences and current attachment styles are closely interwoven with epistemic trust. Yet, there is still little empirical work to support this theory (Schroder et al., 2018). Adding to this, epistemic mistrust in health care workers may also be shaped by negative experiences later in life, what in itself can generalize to others. When examining epistemic trust relating to the information transfer from health care workers it is useful knowing to what extent epistemic trust is related to (adult) attachment styles.

Since there are theoretical considerations but limited empirical research on the relation between epistemic trust and attachment, it seems useful to shed light on constructs that are close to epistemic trust on which research has been conducted. A first construct that was explored is “willingness to ask for help”. Since the willingness to accept information is a part of ET’s definition, the willingness to accept or ask help – on a therapeutic or advise giving level – seems to be associated with ET. Second, McCraw (2015) referred to ET being associated with a state of “cognitive openness”, for example, ‘being open for new information’. Both constructs and their relationship to are discussed.

Regarding willingness to ask help, internal working models of the self and other are found to play a role in an individual’s willingness to ask for (professional) help. Anxious individuals perceive others positively, they wind up overemphasizing their distress to try eliciting help from others. Avoidant individuals see others negatively and tend to devalue the importance of others and keep distant from them in order to avoid relying on them for help

(Vogel & Wei, 2005). It seems that attachment avoidance may hinder a person from seeking counseling, whereas attachment anxiety may facilitate the use of counseling.

Secondly, focusing on cognitive openness, Mikulincer and Arad (1999) explored attachment working models on cognitive openness. Their findings showed that attachment working models appear to bias the way people cognitively process new information. First, secure adults are more open to new information than insecure adults. Their optimistic attitude and their sense of mastery may allow secure people to make adaptive and flexible changes in their knowledge. These persons might show no inherent preference for consistency and their judgments may be relatively free from prior expectations, commitments and choices. Second, anxious persons' may block the incorporation of new information due to their tendency to appraise environmental transaction as imminent threats and their failure to control accessibility of negative effect. These persons may be so preoccupied with the threatening aspects of new data as well as with the potential disorganization of knowledge that they do not have sufficient available resources to process information. Although they may be potentially open to new information because of a lack of effective defenses, they may lack resources to process it. Third, avoidant persons may also fail to process new information because of their way of regulating affect: defensive exclusion of any distress-related cues, repression of painful memories, and cognitive blocking of threat-related cues. Moreover, avoidant persons' overemphasis on self-reliance may lead them to reject any evidence that demands a revision of their beliefs. For these persons, this kind of information may be a threat to their self-confidence and thus should be removed from the cognitive system (Collins & Feeney, 2004; Shaver & Mikulincer, 2002).

Since ET appears to be a factor in both psychological and medical treatment outcomes, it is relevant to know what ET looks like in the general population and what ET is associated with. When ET appears to be lower than expected, interventions can be developed to increase ET in individuals with low ET. Given the indications in previous research for a relationship between ET and attachment (Fonagy, & Allison, 2014; Fonagy, Luyten, Allison, & Campbell, 2017), and the lack of empirical work to support this theory (Schroder et al., 2018), current research focuses on gaining empirical support. In the absence of a validated measurement tool, current study uses the newly developed QET which is currently in the process of being validated in a mental health care setting. The current study in the general population will contribute to the validation process of the QET.

The primary goal was to test the association between adult attachment styles and epistemic trust. To this end, a secure attachment style (scoring low on attachment related avoidance and anxiety) was expected to be associated with a relatively high score on ET. Attachment related avoidance was expected to be associated with a relatively low score on ET. It was expected that attachment related anxiety was associated with a relatively mean score on ET, given on the one hand dependency to the therapist and on the other hand fragile trust. Finally, it was expected that the fearfully attached group relatively had the lowest score on ET, given that this group has the combined adverse effects of both attachment-related avoidance and anxiety. (Collins & Feeney, 2004; Shaver & Mikulincer, 2002; Vogel & Wei, 2005).

The secondary goal of the study was to gain insight into the dimensions of the QET and the structure of epistemic trust in the general population. Based on development of the QET, the four dimensions are expected to be found: affect, cognition, behaviour and perception, based on the four modes in which a trait is manifested (Knapen, Hutsebaut, van Diemen, & Beekman, 2020).

Method

Participants

The sample consisted 117 participants from the general population (28 men, 89 women, mean age: 45 years old). The survey was conducted entirely voluntarily and anonymously. Respondents were recruited through a convenience sample and snowball sample in the research group's network, through the social media channels WhatsApp, Facebook, LinkedIn and Instagram. Exclusion criteria were not signing the informed consent and/or insufficient ability of the Dutch language to comprehend the consent process and/or the questionnaire. There were no inclusion criteria.

Procedure

Ethical permission

The study protocol was approved by the '*Commissie Wetenschappelijk Onderzoek*' (CWO) of the Altrecht Science institution (2020-09/oz1911). The study was also approved by ethics board of the faculty of Social and Behavioral Sciences at Utrecht University (FETC 20-0220, see appendix 2).

General procedure

Recruitment texts with a link to the online questionnaire on www.qualtrics.com were shared on the internet by posting messages on Facebook, Instagram and by sending e-mails and WhatsApp-messages (Qualtrics, 2019). Respondents were recruited from October 2020 until December 2020. Signing the informed consent was obligatory to be able to start the study. The information letter provided information about the purpose of the study and the confidentiality regarding the data (see appendix 3). Participants were given the right to end their participation at any time without stating a reason. Respondents provided demographics (age, gender, education level and country of birth). Respondents filled out the following questionnaires: Questionnaire Epistemic Trust-NL (QET), Severity Indices of Personality Problems - Short Form (SIPP-SF), Childhood Trauma Questionnaire-Short Form (CTQ-SF), Experiences in Close Relationships Scale – Revised (ECR-R), Brief Symptom Inventory (BSI), McLean Screening Instrument for borderline personality disorder (MSI-BPS), The Reflective functioning Questionnaire 8 (RFQ-8) and the Structured Clinical Interview DSM 5

Personality Questionnaire (SCID-5-PV). In analyses of the current study, the QET and the ECR-R were used. The other questionnaires were completed within the framework of the research project. All questionnaires were administered in Dutch. Responses were stored online anonymously.

Instruments

Epistemic Trust (QET)

The Epistemic Trust Questionnaire (QET) is a self-assessment questionnaire on the degree of epistemic trust (currently consisting of 49 items) which is currently in development (Knapen, Hutsebaut, van Diemen, & Beekman, 2020). The questionnaire was prepared by means of a Delphi study in which seven international experts in the field of treatment and research into personality disorders and epistemic confidence collaborated. The questions were drawn up on the basis of 4 facets of a “trait”, namely: cognition, affect, behavior, and perception and are divided into two subscales: general degree of ET and ET in treatment (for the questionnaire, see Appendix 1). The questions were presented in blocks of items belonging to a trait. Items are scored on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree) (Knapen, Hutsebaut, van Diemen, & Beekman, 2020).

Attachment (ECR-R)

The Experiences in Close Relationships - Revised (ECR-R; Fraley, Waller, & Brennan, 2000) is a self-report tool that measures individual differences on the two major dimensions of attachment style: intimacy avoidance and interdependence, and fear of rejection and abandonment. The two scales each contain 18 items, which are scored on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). Conradi, Gerlsma, Duijn and De Jonge (2006) examined the psychometric qualities of the Dutch questionnaire among students (Cronbach's alpha of Avoidance and Fear .93 and .88 respectively) and the general population (Cronbach's alpha of Avoidance and Fear, respectively .88 and .86). The Dutch study also found that the external validity was sufficient. The original list of Fraley, Waller, and Brennan (2000) was used, but the order of items was randomized. The Dutch research group had also modified the items to refer to "others" rather than "romantic partners." The suggestion to do so was made by Fraley et al. (Fraley, Waller & Brennan, 2000) This was done in order to make the list more applicable to people without a romantic relationship.

The publicized ECR-R norms by Fraley were based on people who had filled out the ECR-R on-line. The statistics were based on a sample of over 17,000 people (73% female) with an average age of 27 (*SD* = 10) years: attachment-related avoidance score *M*=2.92 (SD=1.19), attachment-related anxiety *M*=3.56 (SD=1.12). However, when looking at the group with an average age of 50 the scores were: attachment related avoidance *M*=3.12, attachment related anxiety *M*=3.47 (Fraley, Waller & Brennan, 2000). When looking at a Dutch outpatient mental health sample, the mean (*M*, *SD*) scores were 3.1 (1.3) for attachment related avoidance and 3.2 for attachment related anxiety, the majority of the sample (*N*=262) was female and middle-aged (Kooiman, Klaassens, van Heloma Lugt & Kamperman, 2013)

Data Analysis

To obtain dimensions of the QET, an exploratory factor analysis was performed. Dimensions were allowed to correlate. Therefore, a Principal Axis Factoring (PAF) (factor analysis) with oblimin rotation was chosen. The number of factors was determined using the content of the items, the eigenvalue criterion >1, the scree plot and the pattern of factor charges (Field, 2017). To be included within a factor, the items had to load on one factor > .40 and on the other factor < .30 (Peterson, 2000) A reliability analysis was performed to test the internal consistency of the factors. A Cronbach's alpha higher than .70 was considered adequate and higher than .80 was considered good (Gliem & Gliem, 2003).

To test whether the two attachment scales, anxiety and avoidance, were related to epistemic trust, a correlation analysis was first performed to test which variables could be included in the regression analysis. The correlation between epistemic trust and demographic data on the one hand and the two attachment scales on the other was tested. Subsequently, a regression analysis was performed with two attachment scales of the ECR-R as independent variables and epistemic trust as a dependent variable. Other correlating demographics were included as a covariate. To measure the magnitude of the difference, the Partial Eta Squared was used. From .01, partial eta squared reflects a small effect size, from .09 a medium effect size and > .25 a large effect size (Cohen, 1992).

A one-way analysis of covariance was performed for the scores on the QET and for the four attachment styles (Secure, Dismissing, Preoccupied, Fearful). A Post Hoc analyses was analyzed in order to compare the four attachment styles with each other.

An exploratory ancillary analysis was conducted to examine the relationship between the four dimensions of ET and the four attachment styles. These analyses were performed using regression.

All analyses had a significance criterion of $p < 0.05$. The analyzes were performed with the IBM SPSS Statistics 26 program (IBM Corp., 2019).

Results

Characteristics

The characteristics of the respondents are shown in Table 1. The sample concerns a homogeneous sample of mainly women and higher educated respondents.

Table 1
Descriptive variables of the respondent group (n = 117)

Variables	Data
Gender, *n* (%)	
Female	89 (76%)
Male	28 (24%)
Mean age in years (min-max, *SD*)	45 (18-83, 14.8)
Level of education, *n* (%)	
Low	12 (10%)
High	105 (90%)
Country of Birth, *n* (%)	
Netherlands	105 (90%)
Other	12 (10%)
Score on ECR-R* scale, *M (SD)*	
Attachment related avoidance score	3.70 (.60)
Attachment related anxiety score	2.43 (.84)
Attachment Style (ECR-R), *n* (%)	
Secure	36 (30.5%)
Dismissing	22 (18.8%)
Preoccupied	24 (20.3%)
Fearfull	36 (30.5%)

Note. Education level: low: primary school or lower vocational secondary education; high: intermediate general secondary education, intermediate vocational education or higher general secondary education, higher vocational education, or university education. *ECR-R = The Experiences in Close Relationships – Revised Scale.

QET dimensions

Table 2 shows the results of the principal axis factoring. The scree plot of eigenvalues suggested a three or five factor solution. However, the pattern of factor loadings after rotation, and the contents of the factors suggested four factors. Because the content was considered most important, a four-factor solution was chosen. Eleven of the 49 items were deleted, since they had factor loadings <.40 (Peterson, 2000). The remaining 38 items loaded clearly on one of four factors: The first factor was labeled "Expertise Practitioner." The 16 items of this factor reflect the patient's belief in the Practitioner (e.g., ‘‘My therapist provides me with valuable information and tips" and "I quickly doubt information from my therapist.’’). The second factor was named "Suspicion" (12 items, e.g., ‘‘I get suspicious about why someone wants to teach me something.’’). The other factors were named "Accepting Help" (7 items, e.g., ‘‘I go to other people for help or support.’’) and "Openness" (3 items, e.g., ‘‘I feel open to accept information from my therapist.’’), including items assessing the ability to openly taking opinions or positions.

The psychometric properties of the final 38-item questionnaire are shown at the bottom of Table 2. The total percentage of variance explained by the four factors was 45.2 %. Cronbach's *a* coefficients for the four dimensions were ≥.82, which is considered good (Gliem & Gliem, 2003). Pearson's correlation coefficients among the four dimensions varied from -.12 between Suspicion and Openness to .35 between Expertise Practitioner and Suspicion.

Table 3 shows the results of the principal axis factoring considering one factor. Fifteen of the 49 items were deleted: scoring <.45 on the factor (Field, 2017). Cronbach's *a* coefficient for the one dimension was .92, which is considered very good (Gliem & Gliem, 2003).

Table 2

Factor loadings of the original 49 items of Questionnaire Epistemic Trust, and Eigenvalues, percentages of explained variance, and internal consistency coefficients (Cronbach's a) of the final items (n = 114)

Items	Factor loadings			
	Factor 1	*Factor 2*	*Factor 3*	*Factor 4*
Expertise Practitioner				
25. I generally think that what my therapist is communicating to me is useless for me. (R)	**.74**	.00	-.05	.11
35. Tips or advice that my therapist gives me might help for others, but not for me. (R)	**.71**	-.16	-.21	-.02
42. I feel cautious when my therapist tries to teach me something.	**.63**	.25	.15	.02
23. I am easily suspicious about information from my therapist. (R)	**.61**	.23	.14	.02
33. My therapist is nice but doesn't know much. (R)	**.61**	-.09	-.02	.07
22. Advice or tips from my therapist usually do not work for me.	**.60**	-.10	-.16	-.03
48. I am highly selective in what information from my therapist I trust. (R)	**.59**	.16	.08	.01
34. My therapist does not know what is good for me. (R)	**.58**	.01	-.04	-.03
41. I am not interested in tips or advice from my therapist. (R)	**.58**	.01	.13	.10
36. My therapist provides me with valuable information and tips.	**-.56**	.14	.26	-.05
26. I quickly doubt information from my therapist. (R)	**.56**	.10	-.09	.07
39. I feel cautious about accepting information from my therapist. (R)	**.55**	.19	.01	-.02
47. I generally do not follow the advice or tips from my therapist. (R)	**.55**	-.10	-.21	.10
24. In treatment, I tend to be cautious to protect myself from misleading information. (R)	**.50**	.27	-.02	.06
40. I am afraid to accept what my therapist advises me to do. (R)	**.44**	.21	-.08	.02
37. My therapist wants to help me when giving me advice or tips	**-.44**	-.13	.14	-.21
46. I check with other sources before accepting information from my therapist. (R)	*.38*	*.28*	*.10*	*-.08*
38. I generally think my therapist has the best intentions when giving me advice or tips.	*-.37*	*-.26*	*.04*	*-.24*
17. I try to fix my problems on my own, without other people. (R)	*.30*	*.10*	*-.23*	*-.21*

18. I don't easily accept help from others. (R)	*.26*	*.20*	*-.12*	*0.16*
Suspicion				
2. I easily doubt other people's intentions when they give me advice. (R)	-.01	**.78**	.03	-.08
13. I get suspicious about why someone wants to teach me something. (R)	.12	**.74**	-.00	-.12
3. I tend to be cautious when people try to teach me something. (R)	.08	**.73**	.05	-.09
1. I am easily suspicious that information from most people cannot be trusted. (R)	0.4	**.67**	-.09	-.05
7. I have to be cautious to protect myself from misleading information. (R)	-.04	**.61**	.17	.14
8. I believe most people are generally sincere and honest in their intentions towards me.	-.10	**-.57**	-.03	-.14
5. I generally think that people have good intentions when giving me advice or tips.	.12	**.51**	.29	-.18
9. I can trust information from others when I don't know what to do	.06	**-.49**	.23	.01
12. I feel cautious in accepting information from others. (R)	.19	**.49**	-.01	-.06
10. People generally tell the truth.	-.14	**-.47**	.15	-.18
21. I generally check if information someone gives me is reliable. (R)	.12	**.44**	.07	-.04
14. I feel open to accepting information from others.	.05	**-.40**	.30	.12
16. I am highly selective in who to trust. (R)	*.29*	*.39*	*.07*	*-.13*
19. I ask questions when I don't understand something.	*-.02*	*-.37*	*.20*	*-.03*
6. Other people don't genuinely want to understand me. (R)	*.24*	*.36*	*.06*	*.11*
11. People can't help me unless they fully understand everything about me. (R)	*.15*	*.23*	*.11*	*.15*
Accepting Help				
49. I often use the things we have been discussing in a session in my daily life.	-.20	.09	**.70**	.01
31. My therapist has an interesting perspective on my problems.	-.17	.04	**.67**	-.08
32. My therapist helps me consider ideas that would never have occurred to me on my own.	-.17	.16	**.62**	.02
30. My therapist helps me see different points of view.	-.12	.06	**.61**	-.06
27. I believe that the things I am learning in this treatment will also be applicable in my daily life.	.01	-.25	**.49**	-.02

15. I am generally curious about things other people know about.	.03	-.22	**.44**	-.06
29. My therapist helps me understand myself and others.	-.25	-.01	**.42**	-.15
28. I expect that the advice from this therapist will help me.	*-.18*	*-.22*	*.39*	*-.06*
4. I generally think that information from most people is useful for me.	*.10*	*-.21*	*.39*	*-.26*
Openness				
45. I am interested in what my therapist can teach me.	-.05	-.02	.31	**-.78**
44. I am generally curious to tips or advice from my therapist.	-.18	.08	.24	**-.77**
43. I feel open to accept information from my therapist.	-.24	.11	.11	**-.76**
20. I go to other people for help or support.	*-.06*	*-.00*	*.29*	*.38*
Eigenvalue	12.8	4.2	2.8	2.4
% explained variance	26.1	8.5	5.6	5.0
Cronbach's alpha	.91	.87	.82	.93

Note. Items with bold factor loadings were included in the factor. Items in italics were deleted in the final version of the Questionnaire Epistemic Trust because of a too low factor loading or too high cross loadings.

* (R) stands for reversed items.

Table 3

Factor loadings of the original 49 items of Questionnaire Epistemic Trust and internal consistency coefficients (Cronbach's a) of the final items (n = 114)

Items	Factor loadings
25. I generally think that what my therapist is communicating to me is useless for me. (R)	**.70**
24. In treatment, I tend to be cautious to protect myself from misleading information. (R)	**.66**
42. I feel cautious when my therapist tries to teach me something. (R)	**.64**
26. I quickly doubt information from my therapist. (R)	**.63**
23. I am easily suspicious about information from my therapist. (R)	**.62**
37. My therapist wants to help me when giving me advice or tips.	**-.61**
35. Tips or advice that my therapist gives me might help for others, but not for me. (R)	**.61**
39. I feel cautious about accepting information from my therapist. (R)	**.60**
10. People generally tell the truth	**-.60**
13. I get suspicious about why someone wants to teach me something. (R)	**.59**
40. I am afraid to accept what my therapist advises me to do. (R)	**.58**
48. I am highly selective in what information from my therapist I trust. (R)	**.58**
38. I generally think my therapist has the best intentions when giving me advice or tips	**-.58**
47. I generally do not follow the advice or tips from my therapist. (R)	**.56**
28. I expect that the advice from this therapist will help me	**-.55**
36. My therapist provides me with valuable information and tips.	**-.54**
1. I am easily suspicious that information from most people cannot be trusted. (R)	**.54**
3. I tend to be cautious when people try to teach me something. (R)	**.54**
34. My therapist does not know what is good for me. (R)	**.52**
22. Advice or tips from my therapist usually do not work for me	**.52**
8. I believe most people are generally sincere and honest in their intentions towards me.	**-.51**
29. My therapist helps me understand myself and others.	**-.50**
33. My therapist is nice but doesn't know much. (R)	**.50**
31. My therapist has an interesting perspective on my problems.	**-.50**
12. I feel cautious in accepting information from others. (R)	**.49**
2. I easily doubt other people's intentions when they give me advice. (R)	**.49**
49. I often use the things we have been discussing in a session in my daily life	**-.47**
6. Other people don't genuinely want to understand me. (R)	**.47**
41. I am not interested in tips or advice from my therapist. (R)	**.47**
5. I generally think that people have good intentions when giving me advice or tips	**-.47**
16. I am highly selective in who to trust. (R)	**.46**
44. I am generally curious to tips or advice from my therapist	**-.45**
46. I check with other sources before accepting information from my therapist. (R)	**.45**
45. I am interested in what my therapist can teach me	**-.45**
27. I believe that the things I am learning in this treatment will also be applicable in my daily life	*-.44*
9. I can trust information from others when I don't know what to do	*-.42*
30. My therapist helps me see different points of view.	*-.41*
43. I feel open to accept information from my therapist	*-.41*
19. I ask questions when I don't understand something	*-.40*
15. I am generally curious about things other people know about.	*-.39*

17. I try to fix my problems on my own, without other people. (R)	*.39*
14. I feel open to accepting information from others	*-.37*
21. I generally check if information someone gives me is reliable. (R)	*.36*
32. My therapist helps me consider ideas that would never have occurred to me on my own.	*-.36*
4. I generally think that information from most people is useful for me.	*-.35*
7. I have to be cautious to protect myself from misleading information. (R)	*.33*
11. People can't help me unless they fully understand everything about me.	*.28*
18. I don't easily accept help from others. (R)	*.26*
20. I go to other people for help or support.	*-.10*
Cronbach's alpha	.92

Note. Items with bold factor loadings were included in the factor. The other items (in italics) were deleted in the final version of the Questionnaire Epistemic Trust because of a too low factor loading.

Attachment style and epistemic trust

The results of regression analyses examining the association of ET with attachment scores are shown in Table 4. The regression model predicting ET from education level, avoidance score and anxiety score, explained a significant portion of the variance in ET (R^2 = .27; F (3,112) = 13.56; p <.001).

Of the demographics that could be included as a covariate, only education level correlated with ET. A higher level of education was associated with higher levels of epistemic trust ($p < .001$). A higher level of avoidance was associated with a lower level of ET ($p < .001$). While taking account of this association, also a higher level of anxious attachment was associated with a lower level of ET ($p < .05$). The interaction avoidance score x anxiety-score was not significantly associated with ET ($p = .64$).

Table 4

Regression analyses predicting epistemic rust from education level, avoidance score (ECR-R), anxiety score and the avoidance x anxiety interaction

	Pearson correlation	Unstandardized Coefficients		Standardized Coefficients		
	r	*B*	Std. Error	*β*	*t*	Sig.
(Constant)		3.82	.10		37.49	<.001
Education Level	.31**	.25	.11	.20	2.31	.023
Avoidance score	-.42*	-.20	.06	-.32	-3.65	<.001
Anxiety score	-.36**	-.09	.04	-.21	-2.40	.018
Avoidance*Anxiety		.027	.06	.04	.48	.635

Note. ECR-R = The Experiences in Close Relationships – Revised Scale.
* $p < .05$
** $p < .01$

The results of the one-way analysis of covariance (corrected for level of education) for the scores on ET for the four attachment styles are shown in Table 5. The overall difference is significant F (3,111) = 6.51, p <.001, $\eta_p^2 = .150$. This effect is moderate (Kvålseth, 1985). Considering the Post Hoc analysis, the secure group was found to score higher on ET compared to the dismissing ($p < .05$) and fearful ($p < .001$) group, the comparison with the preoccupied was not significant ($p = .14$).

Table 5

Mean scores on the four attachment style groups for ET. Controlled for level of education

					95% Confidence interval	
Attachment style	*N*	Estimated Mean	Mean	Std. Error	Lower Bound	Upper Bound
Secure	35	4.24	4.26	.06	4.13	4.36
Preoccupied	24	4.03	4.04	.07	3.90	4.17
Dismissing	22	3.96	3.95	.07	3.82	4.11
Fearful	35	3.89	3.87	.06	3.78	4.01

Ancillary analysis

The results of exploratory regression analyses examining the association of the four dimensions of epistemic trust with attachment scores are shown in Table 6. Attachment-related avoidance was associated with a lower score on the first two dimensions of epistemic

trust; Expertise Practitioner and Suspicion. Both remain significant after Bonferroni correction of the *p*-value for multiple testing, which would imply p =.125 as cutoff value.

Table 6
Regression analyses predicting the four factors of epistemic trust from education level, avoidance score (ECR-R) and anxiety score (ECR-R)

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	*β*	*t*	Sig.
Factor 1: Expertise Practitioner					
(Constant)	4.10	.14		28.41	<.001
Education Level	.15	.15	.09	1.00	.320
Avoidance score	-.22	.07	-.29	-3.05	.003
Anxiety score	-.08	.05	-.16	-1.64	.104
Factor 2: Suspicion					
(Constant)	3.77	.13		29.85	.000
Education Level	.24	.13	.15	1.81	.074
Avoidance score	-.27	.07	-.33	-3.79	<.001
Anxiety score	-.11	.05	-.20	-2.22	.028
Factor 3: Accepting help					
(Constant)	3.60	.17		21.01	.000
Education Level	.34	.18	.18	1.91	.059
Avoidance score	-.13	.09	-.16	-1.56	.121
Anxiety score	.00	.06	.00	.01	.993
Factor 4: Openness					
(Constant)	4.07	.20		20.47	.000
Education Level	.28	.21	.12	1.32	.191
Avoidance score	-.01	.11	-.01	-.13	.901
Anxiety score	.08	.08	.10	.96	.341

Note. ECR-R = The Experiences in Close Relationships – Revised Scale.

Discussion

This study examined epistemic trust in the general population by using the QET for the first time and examined the association of ET with attachment-related avoidance and anxiety. The score distribution of attachment scores was good. Four ET dimensions were identified. As expected, a higher score on both attachment-related avoidance and fear predicted a lower score on ET. Attachment related avoidance had a stronger effect. The securely attached group had on average the highest ET score.

Both attachment-related avoidance and attachment-related anxiety were associated with a lower level of ET even when taking account of the other attachment dimension, controlled for level of education. This effect was stronger for attachment-related avoidance. In agreement with previous studies stating that attachment-related avoidance and anxiety are associated with less help seeking behaviour and impaired cognitive openness (Collins & Feeney, 2004; Shaver & Mikulincer, 2002; Vogel & Wei, 2005), this study indicated that attachment related avoidance and anxiety are associated with the amount of ET. However, 27% of the ET score was explained by adult attachment style corrected for level of education. The remainder is therefore due to other factors. A tentative idea is that this can be due to realistic previous experiences with healthcare practitioners that can be eighter positive or negative. It may also play a role how much contact someone had with a health care practitioner. For example, someone who only sees a practitioner once every three years can score differently on ET than someone who sees a practitioner every week. It also might make a difference whether the therapeutic or medical relationship is specialistic or universal. Other possible influences can be further investigated.

The secure group had the highest mean score on ET. Followed by, in order from highest to lowest, dismissing- and fearful group. The comparison with the preoccupied group was not found significant. The effect sizes of these findings were moderate. This information can help therapists to understand and empathize more with each client, and to design interventions that are tailor-made to the individual (Kamenov, Twomey, Cabello, Prina, & Ayuso-Mateos, 2016). Also, the working alliance between a practitioner (e.g., psychotherapeutic or medical) and a client can be improved when the attachment style - and its negative effects - of a client are known. Clients' insecure attachment dimensions (avoidant and/or anxious) are characteristics that have been shown to relate negatively to the alliance. Which in turn can lead to poorer therapy outcomes (Coyne, Constantino, Ravitz, & McBride,

2018). Avoidantly attached clients may be suspicious and withhold their therapist important information which leads to difficulties in making an emotional connection, whereas anxiously attached clients may ask for too much support and have too high expectations (Bernecker, Levy, & Ellison, 2013). These findings are corroborated by results of current study, showing that both avoidant and anxious attached individuals have lower ET. Future research can focus on the role of ET in the relation between clients' insecure attachment dimensions and the working alliance. For example, current research was retrospective. Future prospective research is desirable with observations of attachment in early childhood or later longitudinal surveys on attachment and ET, and observations of the therapeutic alliance.

The results of the ancillary analysis show that the dimensions Expertise Practitioner and Suspicion in particular are associated with avoidant attachment. This indicates that the other dimensions, Accepting Help and Openness could be considered more separate aspects that may play a role in the therapeutic alliance. It seems useful to take into account in treatment practice that avoidant attached people may be more suspicious and trust the expertise of their practioner less. By testing whether someone has an avoidant attachment style prior to therapy, it is possible to respond to the suspicion and lack of confidence in the therapist. A possible solution could be for the therapist to focus on creating a culture of trust through shared decision making (SDM). SDM is based on the idea that the client has expertise in the field of what gives their life value, meaning, purpose and quality and that both parties strive for agreement on what the problem is and what the outcomes of treatment should be (Deegan & Drake, 2006). Creating a culture of trust, through SDM, could be done by applying guidelines in a person-centered way and standing together as a team (Beyene, Severinsson, Hansen, & Rørtveit, 2018).

Considering the QET, the dimensions Expertise Practitioner, Suspicion, Accepting Help and Openness were identified in current study. This finding is in line with expectations that four factors are best suited to explain ET. Expected was that the dimensions would reflect the four traits on which the QET was based on, namely, cognition, affect, behavior, and perception. However, these former labels were reflected in the content and meaning of the factors that emerged. Since this is the first, and an exploratory study of the QET, there is still room for discussion about the titles of the dimensions. This study provides a first suggestion to indicate what ET looks like in the general population. When looking at ET as one dimension, the list consists of 38 items with a very good internal consistency, which suggests

that less items could be included when using a 1-factor assessment of ET. Considering the good internal consistency of both the four- and one-dimension solutions of the QET, the current study seems to be a step in the right direction regarding the reliability of the QET. However, important next steps have yet to be taken. It is suggested that the factors with few items may be expanded and the factors with many items may be shortened. In the future, it is desirable that in the questionnaire the items are offered randomly, rather than grouped by theme which may artificially have increased the internal consistency. Since the preliminary dimensions are now known, the test-retest stability and convergent and divergent validity can also be tested in follow-up research with a more final version of the questionnaire.

Methodologically, the ECR-R is considered to be of sufficient psychometric quality to test adult attachment style (Kooiman, Klaassens, van Heloma Lugt & Kamperman, 2013). The current population was also large enough for a reliable factor analysis (n = 117) based on the liberal recommendation of a subject-to-item ratio of >2 to a maximum of 5 (Anthoine, Moret, Regnault, Sébille, & Hardouin, 2014) However, there are also methodological limitations. First, the QET has not been validated yet; the current study addresses the validity of this questionnaire preliminarily. Second, the questions of the QET were asked in order in which the questionnaire was mainly based on; cognition, affect, behavior, and perception. This may have caused an overestimation of the internal consistency of the factors as suggested by some items numbers in factors being close together. Third, the sample did not match the general population, considering the mean level of education was very high and the majority of women. Last, the data was collected during the COVID-19 pandemic. This might have affected the degree of ET, for instance, because of polarizing discussion in the social media.

In conclusion, four internally consistent and interpretable dimensions of ET have been found. Attachment style was indicated to be related to ET where an insecure attachment indicates a lower score on the QET. This information can be useful in personalizing therapies to ensure effective therapy outcomes. It might be desirable that follow-up research focuses on the validation and applicability of the QET, and on the relationship between epistemic trust, the therapist-client relationship and therapy outcomes.

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Appendix

Appendix 1.

Questionnaire Epistemic Trust as recorded from the respondents.

Questionnaire Epistemic Trust - NL
(QET)
Vragenlijst Epistemisch vertrouwen/epistemisch wantrouwen

Deze vragenlijst bestaat uit een aantal stellingen. Geef per stelling aan in hoeverre u het eens bent met deze stelling. Dit kan op een schaal die loopt van 1 (helemaal niet mee eens) tot 5 (helemaal mee eens). De eerste 21 stellingen gaan over in hoeverre iets in het algemeen voor u geldt terwijl de daaropvolgende 28 stellingen specifiek ingaan op de behandelsetting. Denk bij een behandelsetting aan het contact met uw psycholoog, huisarts, medisch specialist, behandelarts, fysiotherapeut of vergelijkbare zorg.

ALGEMEEN

	Helemaal niet mee eens 1	Niet mee eens 2	neutraal 3	Mee eens 4	Helemaal mee eens 5
1. Ik word snel achterdochtig of de informatie die de meeste andere mensen mij geven betrouwbaar is	○	○	○	○	○
2. Ik twijfel meestal aan de bedoelingen van andere mensen wanneer ze mij adviezen geven	○	○	○	○	○
3. Ik heb de neiging om op mijn hoede te zijn wanneer iemand mij iets probeert te leren.	○	○	○	○	○
4. Ik denk meestal dat de informatie die andere mensen mij geven bruikbaar is voor mij.	○	○	○	○	○
5. Ik denk meestal dat andere mensen goede bedoelingen hebben wanneer ze mij adviezen of tips geven.	○	○	○	○	○
6. Andere mensen willen mij niet echt begrijpen.	○	○	○	○	○

	Helemaal niet mee eens 1	Niet mee eens 2	neutraal 3	Mee eens 4	Helemaal mee eens 5
7. Ik moet ervoor oppassen dat anderen mij geen misleidende informatie geven	○	○	○	○	○
8. Ik geloof dat de meeste mensen oprechte en eerlijke bedoelingen hebben wanneer ze met mij omgaan.	○	○	○	○	○
9. Ik kan vertrouwen op de informatie die andere mensen mij geven als ik niet weet wat ik moet doen.	○	○	○	○	○
10. Mensen spreken over het algemeen de waarheid.	○	○	○	○	○
11. Andere mensen kunnen mij niet helpen als ze mij niet volledig begrijpen.	○	○	○	○	○

ALGEMEEN

	Helemaal niet mee eens 1	Niet mee eens 2	3	Mee eens 4	Helemaal mee eens 5
12. Ik ben op mijn hoede wanneer andere mensen mij informatie geven.	○	○	○	○	○
13. Ik word achterdochtig wanneer iemand mij iets probeert te leren.	○	○	○	○	○
14. Ik sta open voor informatie die andere mensen mij geven.	○	○	○	○	○
15. Ik ben meestal nieuwsgierig naar dingen waar andere mensen verstand van hebben.	○	○	○	○	○

	Helemaal niet mee eens 1	Niet mee eens 2	3	Mee eens 4	Helemaal mee eens 5
16. Ik ben erg kieskeurig als het gaat om wie ik kan vertrouwen.	○	○	○	○	○
17. Ik probeer mijn problemen zelf op te lossen, zonder de hulp van anderen.	○	○	○	○	○
18. Ik neem niet gemakkelijk hulp van anderen aan.	○	○	○	○	○
19. Ik stel vragen wanneer ik iets niet begrijp.	○	○	○	○	○
20. Ik vraag andere mensen om mij te helpen en te ondersteunen.	○	○	○	○	○
21. Ik controleer meestal of de informatie die anderen mij geven betrouwbaar is.	○	○	○	○	○

IN DE BEHANDELSETTING

Denk bij een behandelsetting aan het contact met uw psycholoog, huisarts, behandelarts, fysiotherapeut of vergelijkbare zorg.

	Helemaal niet mee eens 1	Niet mee eens 2	3	Mee eens 4	Helemaal mee eens 5
22. Ik heb meestal niets aan de adviezen of tips van mijn behandelaar.	○	○	○	○	○
23. Ik word snel achterdochtig van de informatie die ik krijg van mijn behandelaar.	○	○	○	○	○
24. Tijdens behandelingen ben ik meestal op mijn hoede om mezelf te beschermen tegen misleidende informatie.	○	○	○	○	○
25. Ik denk meestal dat ik niets heb aan wat mijn behandelaar mij vertelt.	○	○	○	○	○
26. Ik twijfel snel aan de informatie die ik krijg van mijn behandelaar.	○	○	○	○	○
27. Ik ben ervan overtuigd dat ik de dingen die ik leer tijdens mijn behandeling ook kan toepassen in mijn dagelijkse leven.	○	○	○	○	○
28. Ik verwacht dat de adviezen van mijn behandelaar me zullen helpen.	○	○	○	○	○

	Helemaal niet mee eens 1.	Niet mee eens 2.	3	Mee eens 4.	Helemaal mee eens 5.
	○	○	○	○	○
29. Mijn behandelaar helpt me om mezelf en anderen te begrijpen.	○	○	○	○	○
30. Mijn behandelaar helpt me om verschillende perspectieven te bekijken	○	○	○	○	○
31. Mijn behandelaar heeft een interessante kijk op mijn problemen.	○	○	○	○	○
32. Mijn behandelaar helpt me om na te denken over ideeën die in mijn eentje nooit bij me waren opgekomen.	○	○	○	○	○
33. Mijn behandelaar is aardig, maar heeft weinig verstand van dingen.	○	○	○	○	○
34. Mijn behandelaar weet niet wat goed is voor mij.	○	○	○	○	○
35. De tips en adviezen die ik krijg van mijn behandelaar zijn misschien bruikbaar voor andere mensen, maar niet voor mij.	○	○	○	○	○
36. Mijn behandelaar geeft me waardevolle informatie en adviezen.	○	○	○	○	○
37. Mijn behandelaar wil me helpen wanneer hij me adviezen of tips geeft.	○	○	○	○	○
38. Ik denk meestal dat mijn behandelaar de beste bedoelingen heeft wanneer hij me adviezen of tip geeft.	○	○	○	○	○

IN DE BEHANDELSETTING

Denk bij een behandelsetting aan het contact met uw psycholoog, huisarts, behandelarts, fysiotherapeut of vergelijkbare zorg.

	Helemaal niet mee eens 1	Niet mee eens 2	3	Mee eens 4	Helemaal mee eens 5
39. Ik ben op mijn hoede om de informatie die ik krijg van mijn behandelaar te accepteren.	○	○	○	○	○
40. Ik schrik ervoor terug om adviezen van mijn behandelaar aan te nemen over wat ik moet doen.	○	○	○	○	○
41. Ik heb geen belangstelling voor tips of adviezen van mijn behandelaar.	○	○	○	○	○
42. Ik ben op mijn hoede wanneer mijn behandelaar mij iets probeert te leren.	○	○	○	○	○
43. Ik sta open voor de informatie die mijn behandelaar me wil geven.	○	○	○	○	○
44. Ik ben meestal nieuwsgierig naar de tips en adviezen van mijn behandelaar.	○	○	○	○	○
45. Ik ben geïnteresseerd in de dingen die mijn behandelaar mij kan leren.	○	○	○	○	○

IN DE BEHANDELSETTING

Denk bij een behandelsetting aan het contact met uw psycholoog, huisarts, behandelarts, fysiotherapeut of vergelijkbare zorg.

	Helemaal niet mee eens 1	Niet mee eens 2	3	Mee eens 4	Helemaal mee eens 5
46. Ik controleer eerst andere bronnen voordat ik informatie aanneem die mijn behandelaar me geeft.	○	○	○	○	○
47. Ik volg de adviezen en tips van mijn behandelaar meestal niet op.	○	○	○	○	○
48. Ik ben erg kieskeurig welke informatie van mijn behandelaar ik kan vertrouwen, en welke niet.	○	○	○	○	○
49. Ik pas de dingen die ik opsteek in de gesprekken met mijn behandelaar vaak toe in mijn dagelijkse leven.	○	○	○	○	○

Appendix 2:

Approval of the committee of Social Sciences

P.O. Box 80140, 3508 TC Utrecht The Board of the Faculty of Social and Behavioural Sciences Utrecht University P.O. Box 80.140 3508 TC Utrecht		**Faculty of Social and Behavioural Sciences** Faculty Support Office Ethics Committee **Visiting Address** Padualaan 14 3584 CH Utrecht
Our Description **Telephone** **E-mail** **Date** **Subject**	20-0220 030 253 46 33 FETC-fsw@uu.nl 01 September 2020 Ethical approval	

ETHICAL APPROVAL

Study: Valideringsstudie Questionnaire Epistemic Trust (QET)

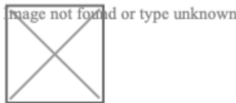
Principal investigator: A.L. van Dijk

Supervisor: Rinie Geenen

This student research project does not belong to the regimen of the Dutch Act on Medical Research Involving Human Subjects, and therefore there is no need for approval of a Medical Ethics Committee.

The study is approved by the Ethics Committee of the Faculty of Social and Behavioural Sciences of Utrecht University. The approval is based on the documents send by the researchers as requested in the form of the Ethics committee and filed under number 20-0220. The approval is valid through 28 February 2021. Given the review reference of the Ethics Committee, there are no objections to execution of the proposed research project, as described in the protocol and according to the GPDR It should be noticed that any changes in the research design oblige a renewed review by the Ethics Committee by submitting an amendement

Yours sincerely,



Peter van der Heijden, Ph.D.
Chair

Appendix 3:

Informed Consent

Informatiebrief

Informatiebrief voor deelnemers onderzoek epistemisch vertrouwen
Onderzoek naar een nieuw opgestelde vragenlijst naar epistemisch vertrouwen (Questionnaire Epistemic Trust; QET)

Geachte heer/mevrouw,
Wij vragen u vriendelijk om mee te doen aan een vragenlijstonderzoek naar Epistemisch Vertrouwen. Epistemisch vertrouwen is het durven vertrouwen op wat anderen zeggen, en zo van ze te kunnen leren en is daarom belangrijk bij het goed kunnen profiteren van een behandeling in de (geestelijke) gezondheidszorg.

U beslist zelf of u wilt meedoen. Voordat u de beslissing neemt, is het belangrijk om meer te weten over het onderzoek. Lees deze informatiebrief rustig door. Hebt u na het lezen van de informatie nog vragen? Dan kunt u terecht bij de hoofdonderzoeker (zie contactgegevens op de onderaan pagina). Voor vragen over de vertrouwelijkheid van de gegevens kunt u terecht bij mevrouw Wilma Swildens.

1. Wat is het doel van het onderzoek?
Onlangs is er een nieuwe vragenlijst ontwikkeld naar Epistemisch Vertrouwen. Het idee is dat hoeveel Epistemisch Vertrouwen je hebt, zou kunnen bepalen of een specifieke behandeling aansluit of juist niet voor patiënten van de reguliere of de geestelijke gezondheidszorg. Deze vragenlijst zou dus mogelijk een rol kunnen spelen in de keuze voor de juiste behandeling. Dit onderzoek is daar een voorbereiding op. Eerst meten we dit bij een algemeen deel van de bevolking. Daarna worden de vragenlijsten afgenomen bij cliënten in de geestelijke gezonheidszorg. We willen testen of de vragenlijst die we hebben opgesteld een goede kwaliteit heeft en meet wat we willen meten. Daarvoor dienen naast de vragen over Epistemisch Vertrouwen, ook diverse vragenlijsten over uw sociodemografische gegevens, psychische gezondheid en ervaringen afgenomen te worden.

2. Wat wordt er van mij verwacht?

https://survey.uu.nl/Q/EditSection/Blocks/Ajax/GetSurveyPrintPreview?ContextSurveyID=SV_exO5E7ysIgly16Z&ContextLibraryID=UR_0xlq6Yz2Her6kJL 1/67

12-1-2021 Qualtrics Survey Software

Voor het onderzoek wordt u gevraagd een aantal vragenlijsten in te vullen. Het invullen van de vragenlijsten zal in totaal ongeveer 60 minuten duren.

3. Wat zijn mogelijke voor- en nadelen van deelname aan dit onderzoek?
Deelname aan het onderzoek brengt geen gezondheids- of andere risico's met zich mee. Met dit onderzoek kunt u bijdragen aan onderzoek naar een betere behandeling voor cliënten van de GGZ.

5. Wat gebeurt er als ik niet wens deel te nemen aan dit onderzoek?
U beslist zelf of u meedoet aan het onderzoek. Deelname is vrijwillig. Als u besluit niet mee te doen, hoeft u verder niets te doen. U hoeft niets te tekenen. U hoeft ook niet te zeggen waarom u niet wilt meedoen. Als u wel meedoet, kunt u zich altijd bedenken en toch stoppen. Ook tijdens het onderzoek.

Alle gegevens worden vertrouwelijk behandeld en de vragenlijsten zijn volledig anoniem. Gegevens zullen niet aan derden worden verstrekt. Zie ook: https://www.altrecht.nl/privacystatement/ en https://www.autoriteitpersoonsgegevens.nl/

Bedankt dat u de tijd heeft genomen deze informatie door te nemen.

Wij stellen uw medewerking aan het onderzoek zeer op prijs!

Met vriendelijke groeten,

Amy van Dijk (a.l.vandijk2@students.uu.nl)

Sven Driehuis (s.r.driehuis@students.uu.nl)

Studenten master klinische psychologie

Hoofdonderzoekers:
Saskia Knapen, Psychiater/Promovendus
Dr. Wilma Swildens (w.swildens@altrecht.nl)