The Relationship between Childhood Trauma and Epistemic Trust: a cross-sectional Study

Sven R. Driehuis (6253547)

Master Clinical Psychology, Faculty of Social Sciences, Utrecht University

Prof. Dr. R. Geenen – Utrecht University

Dr. W.E. Swildens – Altrecht Science Institute

S. Knapen – Altrecht AMBIT

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Abstract

Epistemic trust - the individual's willingness to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self - is considered predictive for treatment outcomes. Since epistemic trust is considered to have its roots in early development, traumatic experiences during childhood may be assumed to disrupt an individual's epistemic trust. Understanding the structure of epistemic trust and how childhood trauma is related to it therefore might have useful clinical implications. The current study included 117 participants with a majority of highly educated people and women with an average age of 45 years old. The vast majority of the participants indicated that they had experienced no or a low degree of childhood trauma. The Questionnaire Epistemic Trust (QET), a newly developed questionnaire, was used to assess the degree of epistemic trust. The Childhood Trauma Questionnaire - Short Form was used to determine the degree and form of childhood trauma. Four factors were derived from the factor analysis: epistemic mistrust in the practitioner, suspiciousness, willingness to accept help and openness for information. Together, the dimensions explained 45.2 percent of the variance. Internal consistencies were .91, .87, .82 and .93, respectively. Results showed that individuals who experienced childhood trauma did not differ significantly on the four aspects of epistemic trust, compared to individuals without a history of childhood trauma. Ancillary analysis revealed that epistemic mistrust in the practitioner was increased in people with a history of physical abuse, sexual abuse and physical neglect, whereas suspiciousness was increased in people with a history of physical abuse, sexual abuse but not physical neglect. Willingness to accept help and openness for information were not affected by any form of childhood trauma. The results are promising and show the feasibility of further development and validation of the QET; also in clinical populations. Understanding the relationship between childhood trauma and epistemic trust can be used to better tailor the treatment to the specific characteristics of the patient.

Keywords: childhood trauma – epistemic trust – factor analysis – general population

The Relationship between Childhood Trauma and Epistemic Trust: a cross-sectional Study

Epistemic trust (ET) – the individual's willingness to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self (Fonagy & Allison, 2014) – is considered predictive for treatment outcomes (Calnan & Rowe, 2006). Restoring ET within therapy potentially recreates openness and flexibility in social learning, making the world outside therapy a setting where new information about oneself and others can be acquired and internalized (Fonagy & Allison, 2014). Research suggests that ET might have its roots in early development (Fonagy & Allison, 2014). It has been suggested that experiencing a traumatic event during childhood might disrupt the development of ET (Allen, 2013). Measuring the patient's degree of ET prior to treatment could be used in tailoring the treatment to the specific characteristics of the patients more accurately, therefore improving treatment outcomes.

McCraw (2015) examined the structure of ET, suggesting that ET consists of four components (communication, belief, dependence and confidence). The first two sets (communication and belief) are considered characteristically epistemic, whereas the second two sets (dependence and confidence) are presented in any form of trust. To decide if information is trustworthy, generalizable, and relevant to the self, a form of communication is necessary to have ET in someone (McCraw, 2015). Additionally, to be able to acquire and internalize the provided information, a certain degree of believing someone is considered essential (McCraw, 2015). McCraw (2015) stated that having trust in someone is accompanied with a certain vulnerability, an openness to being deceived. Therefore, trust is suggested to have a dependence-component. The last component, confidence, is an attitude of optimism on the goodwill and competence of someone (Jones, 1996). Required is that someone is seen as authoritative, whose information has positive epistemic status (McCraw, 2015).

To date, limited empirical research is available on ET, particularly with adolescents and adults. Empirical research has been done to determine ET in a sample of young children

(Corriveau & Harris, 2009; Egyed et al., 2013). In both experiments, the processing of new information was measured to assess the degree of ET. The relevance of the new information was considered important; only information that was seen as relevant to themselves was internalized (Gilbert et al., 1993). Based on this underlying working mechanism of information processing, Schröder-Pfeifer et al. (2018) developed an app-based Epistemic trust questionnaire (ETQ) app to measure the degree of ET in adults. Individual differences in internalizing and generalization in processing information provided an indirect estimate of ET (Schröder-Pfeifer et al., 2018). In the absence of a valid measure of the estimate of ET itself for adolescents and adults, the Questionnaire Epistemic Trust (QET), a self-report questionnaire to assess ET has been newly developed (Knapen et al., 2020), but needs validation. As a first step, validation in the general population is needed as part of the validation process.

Adversities during childhood such as childhood trauma might disrupt the development of ET (Allen, 2013). Bernstein and Fink (1998) operationalized childhood trauma by measuring the five aspects of childhood abuse: physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect. Childhood abuse has been linked to attachment insecurity (Briere & Jordan, 2009), creating chronic mistrust (Courtois & Ford, 2012). In a therapy setting, this chronic mistrust in patients manifests itself in the inability to form a secure intra- and interpersonal relationship with the self and the therapist (Bowlby, 1969; Van der Kolk, 2005; Cloitre et al., 2011). The patient therefore could be seen as ‘hard to reach’ and interpersonally inaccessible (Fonagy & Allison, 2014).

The relationship between McCraw’s (2015) dimensions of ET and childhood trauma has been examined by several researchers. First, communication. Csibra and Gergely (2009) described communication as an evolutionary product that involves a teaching method in which individuals should acquire and generalize the presented information, because it belongs to human culture. This teaching is characterized by ostensive cues (e.g., eye contact, personal recognition and body gestures) as a means to identify the communicative intention (Russell, 1940). Childhood trauma has been related to factors that might affect the

ability to use ostensive cues. Kay and Green (2016) stated that abused children are more likely to perceive hostile intent and are less likely to use environmental cues to navigate decision making, which restricts the capacity to detect and use ostensive cues. This restriction leads to information not being acquired and internalized, causing epistemic mistrust (Fonagy & Allison, 2016). Second, belief. Ehlers and Clark (2000) stated that childhood trauma potentially leads to an overgeneralization of belief, with little discrimination and specificity involved. This implicates that not believing persons during a period of childhood trauma could be generalized to persons later on in life, including possibly a therapist. Third, dependence. McCraw (2015) concluded that openness to information, as a part of dependence, is impaired in people with low ET. Based on McCraw's theory, Sharp et al. (2013) stated that aversive early interpersonal events might result in a permanent state of hypervigilance, leading to closing off from information from outside. Fourth, confidence. As already mentioned, confidence is characterized by an attitude of optimism about the goodwill and competence of the other (McCraw, 2015), which is also potentially impaired.

Being able to assess the structure of ET and its relation to childhood trauma offers the possibility to test considerations in this clinical field. From a personalized medicine-oriented perspective, this information could be used for better tailoring the treatment to the specific characteristics of the patient. More accurately attuning to the characteristics of the patients, and therefore improving treatment outcomes, makes treatment more cost-effective.

The first aim of the study was to investigate the structure of ET measured by the QET in the general population. Hypothesized was that ET consisted of four dimensions: communication, belief, dependence and confidence, in line with the components derived from McCraw (2015). The second aim was to provide an answer on how these dimensions were related to childhood trauma. Hypothesized was that childhood trauma is negatively related to all four dimensions (communication, belief, dependence and confidence) of ET, based on the work of Kay and Green (2016), Ehlers and Clark (2000) Fonagy and Allison (2016), McCraw (2015) and Sharp et al. (2013). An exploratory ancillary analysis was performed to get more in-depth insight into the relationship between the four dimensions of

ET and the five aspects of childhood trauma. These insights potentially have clinical implications.

Method

Design

The current cross-sectional questionnaire study was commissioned by Altrecht Mental Health Care (MHC) under supervision of S. Knapen and dr. W.E. Swildens. As part of the validation process of the QET, developed by Altrecht MHC, people from the general population were recruited. Information about problems in psychological- and personality functioning, reflective functioning, attachment styles in relationships and childhood trauma was collected. These results were compared by Altrecht MHC with a psychiatric sample. The current study was focused on the construct childhood trauma and its relation to ET in the general population.

Participants

The sample of this study consisted of 117 participants from the general population, based on the recommendation of a subject-to-item ratio of >2 to a maximum of 5 (Anthoine et al., 2014) and consultation with the statistician of MHC inGeest, A. Hoogendoorn. Because of the pilot character and feasibility of the study, a power of 100 (subject-to-item ratio of 2) was chosen. Participants were recruited via convenience sampling and snowball sampling. The social media channels WhatsApp, LinkedIn, Facebook and Instagram were used for recruitment. Potential participants were excluded when they met any of the following criteria: unable to give informed consent or insufficient command of the Dutch language to comprehend the consent process and/or data collection questions. A minimum of 18 years old was used as an inclusion criterion. Attempted was to reach different groups by gender, age and education comparable with the psychiatric population at Altrecht. Therefore, a majority of women, an average age of 45 and an equal number of high and low educated people were aimed to include in the study.

All procedures followed were in accordance with both the ethical standards of the

‘Commissie Wetenschappelijk Onderzoek (CWO)’ of the Altrecht Science institution and the faculty of Social and Behavorial Sciences of Utrecht University. The local institutional review board had given permission for the study on September 1, 2020.

Procedure

Prior to participating, all participants were being provided with an information letter about the study, which provided information about the purpose of the study, the method and the confidentiality regarding the data. In addition, before participation, participants were asked to confirm the informed consent with which participants could indicate that they had been informed about the study, the confidentiality and the right to terminate their participation at any time without stating a reason. For both the information letter and informed consent, see appendix 4. The questionnaires were all anonymized and the data was treated confidentially. The data was not provided to third parties.

The participants filled out the demographic data (gender, age, educational level and country of birth). For the current study the Questionnaire Epistemic Trust - NL (QET) and Childhood Trauma Questionnaire - Short Form (CTQ-SF) had to be filled out. Additionally, questionnaires about psychological functioning (Brief Symptom Inventory), reflective functioning (Reflective Functioning Questionnaire), borderline personality (McLean Screening Instrument for borderline personality disorder), personality functioning (Severity Indices of Personality Problems Short Form) and attachment styles in relationships (Experiences in Close Relationships Scale – Revised) were administered.

Qualtrics was used for administering the questionnaires (Qualtrics, 2019).

Materials

For measuring ET, the QET was used. The QET was a newly developed self-assessment questionnaire measuring the degree of ET consisting of 49 items. 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 ET collaborated. The

questions were formulated 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. The items were scored on a 5-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). The instrument was developed in English because of the involvement of international experts and was subsequently translated into Dutch using a forward-backward procedure (Knapen et al., 2020).

For measuring childhood trauma, the CTQ-SF was used. The CTQ-SF was a self-report questionnaire assessing the five dimensions of childhood abuse: physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect (Bernstein & Fink, 1998; Bernstein et al., 2003). Each dimension consisted of five items that were scored on a 5-point scale from 1 (never true) to 5 (very often true). Three additional items were added as a control for socially desirable responses or false negative responses. The Dutch CTQ-SF had adequate internal consistency that was comparable to previous studies on the psychometric qualities of the English version of the CTQ-SF. The Cronbach's alpha values for the different scales ranged between .63 (Physical neglect) and .95 (Sexual abuse). The instrument could effectively distinguish between clinical and non-clinical groups (Thombs et al., 2009; Spinhoven et al., 2014).

Data-analysis

The data-analysis was performed using IBM SPSS Statistics 26 (SPSS). A *p*-value <.05 was considered significant for the test statistics in the current study.

Dimensions were derived using factor analysis. A Principal Component Analysis with oblique rotation was chosen because of the expected correlation between the factors. The number of dimensions was determined on the basis of the scree plot and the pattern and content of the factor loadings (Field, 2013). The eigenvalue had to be at least 1 (Kaiser criterion). Cronbach’s alpha was analyzed to determine the internal consistency within a dimension. In line with the guidelines of Spiliotopoulou (2019), a Cronbach’s alpha of 0.70 was chosen as a minimum. The criterion for excluding an item from the QET was a factor

loading <.40 on any single factor or a loading >.30 on two or more factors (Peterson, 2000). The choice for the number of factors was also guided by the scree plot (van Leeuwen et al., 2016). Additionally, a one-factor solution was conducted for the QET. A factor loading >.45 on a single factor was used as the criterion for inclusion (Field, 2013).

A multivariate analysis of variance (MANOVA) was conducted to examine the relationship between the dimensions of ET and childhood trauma. Therefore, scores on the different dimensions of ET were compared to the total score on childhood trauma. Prior to this, a univariate correlation was conducted to determine which demographic variables should be included in the first MANOVA. To this aim, Pearson correlations between the demographic variables (gender, age, education level and country of birth) and childhood trauma were calculated.

In addition to the main analysis, an exploratory ancillary analysis was conducted to examine the relationship between the five aspects of childhood trauma and the four dimensions of ET to get a more in-depth insight in the relationship between childhood trauma and ET. This was done with a second MANOVA.

For both the first and second MANOVA, several variables were dichotomized. The scores on childhood trauma (physical abuse, emotional abuse, sexual abuse, physical neglect and the childhood trauma total score) were dichotomized in the absence of a normal distribution of the scores. Two groups were created; the first subgroup where no childhood trauma was experienced and the second subgroup where low to severe childhood trauma was experienced. The demographic variables ‘educational level’ and ‘country of birth’ were dichotomized in respectively ‘high’ and ‘low’ and ‘The Netherlands’ and ‘other’. These dichotomies were also made in the absence of a normal distribution of the scores on both variables.

The Partial Eta Squared was used to determine the effect size. Richardson (2011) suggested that from .01 to .09, effect sizes were considered small. Effect sizes from .09 to .25 were considered medium, whereas effect sizes >.25 were considered large.

Results

Table 1 shows the demographic variables of the respondent group. The group included a majority of women and higher educated people. The mean age of the sample and gender were in line with the psychiatric sample examined at Altrecht, whereas the level of education was higher in the current study.

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* (%)	
The Netherlands	105 (90%)
Other	12 (10%)
Mean CTQ-SF	
Total childhood trauma (min-max, *SD*)	38.1 (25-125, 12.91)
Emotional abuse (min-max, *SD*)	8.1 (5-25, 3.94)
Physical abuse (min-max, *SD*)	5.6 (5-25, 2.10)
Sexual abuse (min-max, *SD*)	5.9 (5-25, 2.52)
Emotional neglect (min-max, *SD*)	11.4 (5-25, 4.84)
Physical neglect (min-max, *SD*)	7.0 (5-25, 2.54)

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.
CTQ-SF = Childhood Trauma Questionnaire – Short Form.

Table 2 shows the score distribution on respectively emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect and the total score on childhood trauma. The

majority of the respondent group scored none or low on the different forms of childhood abuse and on the overall score of childhood abuse.

Table 2

Score distribution of the respondent group on the CTQ-SF (N=117)

		Variables					
		Emotional abuse	Physical abuse	Sexual abuse	Emotional neglect	Physical neglect	Total childhood trauma
Score	None	80	108	94	48	80	72
	Low	24	4	9	41	21	29
	Moderate	7	2	10	16	14	12
	Severe	7	4	3	13	3	3
Total		118	118	116	118	118	116

Note. CTQ-SF = Childhood Trauma Questionnaire – Short Form.

Table 3 shows the results of the principal axis factoring for the QET. Guided by the scree plot of eigenvalues and the pattern of the factor loadings after rotation and based on the contents of the factors, four factors were suggested. These factors were labeled epistemic mistrust in the practitioner, suspiciousness, willingness to accept help and openness for information. 11 items of the original 49 items were deleted, due to factor loadings <.40. The remaining 38 items loaded on one of the four factors. The 16 items on the first factor ‘epistemic mistrust in the practitioner’ reflected to what extent knowledge from the practitioner was considered trustworthy, generalizable, and relevant to the self (e.g., ‘I am highly selective in what information from my therapist I trust’, e.g., ‘I generally think that what my therapist is communicating to me is useless for me’). The 12 items on the second factor were labelled ‘suspiciousness’. These items reflected feelings of doubt and a lack of trust in the provided information (e.g., I get suspicious about why someone wants to teach me something’, e.g., I

am easily suspicious that information from most people cannot be trusted'). The 7 items of the third factor were labeled 'willingness to accept help'. These items reflected the willingness to accept help from others (e.g., I believe that the things I am learning in this treatment will also be applicable in my daily life', e.g., My therapist helps me see different points of view'). The 3 items of the fourth factor, labelled 'Openness for information', reflected the attitude of openness for (new) information (e.g., 'I feel open to accept information from my therapist', e.g., 'I am interested in what my therapist can teach me).

Table 3

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

Items	*Factorloadings*			
	Factor 1	*Factor 2*	*Factor 3*	*Factor 4*
Epistemic mistrust in the 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*
Suspiciousness				
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)	.04	**.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*
Willingness to accept 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 for information				
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 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.

The psychometric properties of the final QET are shown at the bottom of table 3. Together, the four factors explained 45,2%. The minimum Cronbach's alpha was .82, which is considered good (Spiliotopoulou, 2019). Pearson's correlation coefficients between the four factors varied from .19 between suspiciousness and openness for information to .50 between epistemic mistrust in the practitioner and willingness to accept help.

Table 4 shows the one-factor solution conducted from the principal axis factoring. Fifteen items from the original QET were deleted based on the factorloading <.45. The Cronbach's alpha for the final 34-item questionnaire was .92, which is considered good (Spiliotopoulou, 2019).

Table 4

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

Items	Factorloadings
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. Items deleted in the final version of the Questionnaire Epistemic Trust because of a too low factor loading.

No significant correlations were found between the demographic variables (gender, age, level of education and country of birth) and childhood trauma. Therefore, no covariates were included in the MANOVA.

Table 5 shows means of the aspects of epistemic trust for the no trauma and trauma groups. The two groups on total childhood trauma did not significantly differ on the four factors of ET (epistemic mistrust in the practitioner, suspiciousness, willingness to accept help and openness for information) as derived from the QET.

Table 5

Means of the two trauma groups on the four aspects of epistemic trust

	Total childhood trauma				
Group	*No trauma*	*Trauma*			
	Mean (SD)	*Mean (SD)*	*F*	*P*	*Partial eta Squared*
Epistemic trust					
Epistemic mistrust in the practitioner	4.2 (.48)	4.3 (.44)	2.45	.12	.022
Suspiciousness	3.9 (.54)	4.0 (.43)	1.62	.21	.015
Willingness to accept help	3.9 (.56)	3.9 (.48)	.02	.88	.000
Openness for information	4.3 (.53)	4.3 (.75)	.04	.85	.000

Table 6 shows the relationship between the four factors of ET and the five aspects of childhood trauma. Firstly, physical abuse. The two groups on physical abuse significantly differed on epistemic mistrust in the practitioner and suspiciousness. Experiencing physical abuse was related to higher levels of both epistemic mistrust in the practitioner and suspiciousness. For both relationships, the effect size was small (Richardson, 2011). Secondly, emotional abuse. The two groups on emotional abuse did not significantly differ on the four factors of ET. Thirdly, sexual abuse. The two groups on sexual abuse differed significantly on epistemic mistrust in the practitioner and suspiciousness. Experiencing sexual abuse was related to higher levels of both epistemic mistrust in the practitioner and suspiciousness. The effect size of both relationships was small (Richardson, 2011). Fourthly, physical neglect. The two groups differed on epistemic mistrust in the practitioner. Experiencing physical neglect was related to a higher level of epistemic mistrust in the practitioner. The effect size of this difference was small (Richardson, 2011). Lastly, emotional neglect. The two groups on emotional neglect did not significantly differ on the four factors of ET.

Table 6

Means of the two trauma groups on the four aspects of epistemic trust

Trauma aspect	*No trauma*	*Trauma*			
Epistemic trust factor	*Mean (SD)*	*Mean (SD)*	*F*	*P*	*Partial eta Squared*
Physical abuse					
Epistemic mistrust in the practitioner	3.9 (.49)	4.3 (.44)	7.19	.01	.062
Suspiciousness	3.4 (.70)	4.0 (.42)	12.01	.00	.099
Willingness to accept help	3.7 (.62)	3.9 (.50)	1.71	.19	.015
Openness for information	4.1 (.58)	4.3 (.67)	1.47	.23	.013
Emotional abuse					
Epistemic mistrust in the practitioner	4.1 (.54)	4.3 (.40)	3.20	.08	.029
Suspiciousness	3.8 (.55)	4.0 (.44)	2.92	.09	.026
Willingness to accept help	4.0 (.53)	3.9 (.51)	.38	.54	.003
Openness for information	4.3 (.78)	4.3 (.60)	.25	.62	.002
Sexual abuse					
Epistemic mistrust in the practitioner	4.0 (.53)	4.3 (.42)	5.22	.02	.046
Suspiciousness	3.8 (.55)	4.0 (.45)	5.24	.02	.046
Willingness to accept help	3.9 (.53)	3.9 (.51)	.12	.73	.001
Openness for information	4.2 (.55)	4.3 (.69)	.50	.48	.005
Physical neglect					
Epistemic mistrust in the practitioner	4.0 (.46)	4.3 (.42)	7.39	.01	.072
Suspiciousness	3.9 (.53)	4.0 (.42)	1.81	.18	.019
Willingness to accept help	3.8 (.54)	3.9 (.49)	1.08	.30	.011
Openness for information	4.3 (.53)	4.4 (.64)	1.01	.30	.011
Emotional neglect					
Epistemic mistrust in the practitioner	4.2 (.44)	4.3 (.48)	.07	.79	.001
Suspiciousness	3.9 (.53)	4.0 (.39)	.52	.47	.005

Willingness to accept help	3.9 (.55)	3.9 (.44)	.20	.65	.002
Openness for information	4.3 (.52)	4.3 (.83)	.45	.50	.004

Discussion

The current study examined the structure of epistemic trust as measured with the QET in the general population and how the dimensions of the QET were related to childhood trauma. Four dimensions were distinguished: epistemic mistrust in the practitioner, suspiciousness, willingness to accept help and openness for information. Contrary to the hypothesis, the two groups on total childhood trauma did not significantly differ on the four factors of ET. The hypothesized association between the different forms of childhood trauma and the dimensions of ET were confirmed for physical abuse, sexual abuse and physical neglect, but not for emotional neglect and emotional abuse.

The QET was suggested to have four dimensions: epistemic mistrust in the practitioner, suspiciousness, willingness to accept help and openness for information, which partly overlapped with McCraw's (2015) theoretical distinction between four dimensions of ET (communication, belief, dependence and confidence). The first dimension epistemic trust in the therapist is related to communication; to decide if information is trustworthy, generalizable and relevant to the self, a form of communication is necessary to have epistemic mistrust (or trust) in the therapist. The second dimension suspiciousness is related to dependence, since dependence is accompanied with a sense of vulnerability, an openness to being deceived. Depending on the therapist therefore is difficult when having a sense of suspicion. The third dimension, willingness to accept help from the therapist (or in general), can only arise when the provided information is believed by someone, hence McCraw's construct belief and the willingness to accept help are closely interwoven. Lastly, the fourth dimension openness for information is overlapping with McCraw's dimension 'confidence'. Since confidence consists of an attitude of optimism on the goodwill and competence in the person in whom one trusted (Jones, 1996), having confidence in the practitioner might be seen as a condition for being receptive for provided information. The

current factor analysis is a first step in construction of the questionnaire. Since the internal consistency and structural validity of the QET are good, an important step in the validation process has been made.

The hypothesis about a negative association between ET and childhood trauma was rejected in an analysis using the total childhood trauma score. This unexpected finding can be tentatively explained from different perspectives. Based on earlier research of Weller and Fisher (2013) it can be stated that whether someone during childhood is exposed to trauma does not impact the ability to use ostensive cues. Since this ability is not impaired, information can still be believed and integrated into cognitive structures, therefore an attitude of ET can still be created (Fonagy & Allison, 2014). The preliminary finding in the current study may have implications for the use of ostensive cues to help patients with a history of trauma to develop trust in their environment, including the therapist. However, measuring ostensive cues was not part of the current study. More research is needed to examine whether using ostensive cues is or is not a moderator in the relationship between childhood trauma and ET. Using Gilbert's (2005) model of affect regulation as a framework for understanding whether childhood trauma leads to mistrusting the social world, several 'soothers' might buffer the impact of 'threats', such as childhood trauma. Since, according to the current study, childhood trauma does not always diminish ET, researchers should examine in greater depth which soothers buffer the negative sequelae of childhood trauma. For example, IQ has been shown to protect against the impact of experiencing a traumatic event during childhood (Breslau et al., 2006). Since the majority of the research group is highly educated and a significant positive relationship was found between epistemic trust and educational level, this may (partly) explain the absence of a relationship between childhood trauma and the four factors of ET. Before definitely refuting the hypothesis, a first next step is to examine in a larger population including more subjects with childhood trauma whether the current finding is rejected or whether childhood trauma is indeed associated with ET.

An exploratory ancillary analysis was conducted to get a more in-depth insight into not finding a relationship between ET and childhood trauma. The hypothesized association

between the different forms of childhood trauma and the dimensions of ET were confirmed for physical abuse, sexual abuse and physical neglect, but not for emotional neglect and emotional abuse. Since childhood trauma is measured within the family context, proximity and contact with an attachment figure outside this context could be found in people with a history of emotional abuse and emotional neglect (Atwool, 2006), compensating for the lack of responsiveness to the child's needs of the own family and thus restoring the degree of ET in social relationships (Venta, 2020). More direct forms of trauma inflicted by the primary attachment figures (physical abuse, sexual abuse and physical neglect) are considered more difficult to compensate for (Lahousen et al., 2019) and therefore have more negative consequences for the capacity to trust (Fonagy et al., 2000).

The two groups on sexual abuse and physical abuse significantly differed on both epistemic mistrust in the practitioner and suspiciousness, whereas only a significant difference was found in suspiciousness on the two groups on physical neglect. Willingness to accept help and openness for information were not affected by any form of childhood trauma. Contrary to findings of Sharp et al. (2013), aversive early interpersonal events did not lead to a permanent state of hypervigilance, since current results suggest that adults who have experienced trauma in their childhood have the same attitude of acceptance of help and openness for information as non-traumatized adults.

The study had some methodological limitations. First, the original English item 'I believe I was molested' was translated into the Dutch item 'Ik ben door iemand gemolesteerd' to measure the degree of sexual abuse during childhood. Whereas the English word molested refers to sexual abuse, the meaning of the translated Dutch word 'gemolesteerd' does not have sexual connotations. A major Dutch-English translation dictionary translates 'molesteren' into English as meaning 'beat up', 'annoy', 'wreck', or 'ruin' (Martin et al., 1991), which is more interpretable as related to physical abuse. Due this ambiguity, both physical and sexual abuse have not been measured accurately. For further research in Dutch samples it is suggested that this item should not be used in the Dutch CTQ-SF. Second, the current study was retrospective. Since Baldwin et al. (2019) found

poor agreement between prospective and retrospective measures of childhood maltreatment in their meta-analysis, it can be stated that the two measures cannot be used interchangeably to study its relation to ET. Due to the fact that measuring childhood maltreatment retrospectively has been linked to an underreporting of childhood maltreatment (Baldwin et al., 2019), future research in a prospective way can shed another light on the relationship between childhood trauma and ET. Third, the questions of the QET were based on four facets: cognition, affect, behavior and perception and they were divided into two subscales: general degree of ET and ET in treatment. Since the questions were presented in that specific order and not randomly, this could have impacted the results of the principal axis factoring for the QET (Rogan & Keselman, 1977) and have overestimated the internal consistency. For example, the dimension openness for information consisted of three consecutive items. Fourth, the data collection was during the Covid-19 pandemic with polarizing discussions about knowledge of physicians, which might have impacted the degree of ET both in general and in a treatment setting (Bunker, 2020). Fifth, an explanation for not finding a significant difference between the two groups on the four dimensions of ET was potentially caused by unequal sample sizes and variances on gender, level of education and childhood trauma (Rusticus & Lovato, 2014). Moreover, these skewed results might be not sufficiently representative (Manning et al., 2005).

Current results might have implications for both the QET and psychotherapy. For the development of the QET, the first version of the questionnaire was made with four distinctive dimensions. The quality of items was sufficient to differentiate between the respondents. Further steps in the development of the QET can be taken: as a first step, factors with a few items can be expanded and items in factors with too many items can be deleted. As a second step, items can be listed randomly, not grouped by facets of a trait (cognition, affect, behavior and perception). As a third step, a new exploratory and perhaps confirmatory factor analysis can be done from which a final version of the QET can follow. As a last step, since the preliminary dimensions are now known, other measures can be included in a validation study, for example questionnaires to determine the convergent and divergent validity.

From a clinical perspective, the results of the study may have implications for psychotherapy. Since physical abuse, sexual abuse and physical neglect, but not emotional abuse and emotional neglect were observed to be related to ET, it is suggested that it is relevant to know prior to treatment which form of childhood trauma has taken place. In people with a history of physical abuse, sexual abuse and physical neglect the main therapeutic goal should be aimed to reduce epistemic mistrust in the therapist and suspiciousness and facilitate the formation or use of soothers which buffer the negative sequelae of childhood trauma. Moreover, therapeutic strategies should be designed to emphasize the importance of the therapeutic relationship, since especially mistrust in the practitioner seems to be impaired in these patient groups. Within this therapeutic relationship, empathy and mentalizing - the capacity to understand others' and one's own behavior in terms of mental states - are considered generic ways to restore ET (Fonagy & Allison, 2014). Feeling understood in the therapeutic process is considered essential for opening patients up to learning that potentially changes their perception of the social world, especially for those whose trust has been disrupted during childhood (Fonagy & Allison, 2014).

In conclusion, the current study yielded four dimensions of ET and preliminary indicated that physical abuse, sexual abuse and physical neglect were related to ET. Results of the current study provide a basis for further development of the QET. Insight into the relationship between childhood trauma and ET can be used in better tailoring the treatment to the specific characteristics of the patient, which may improve treatment outcome.

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Appendices

Appendix 1: Syntax

```
USE ALL.

COMPUTE filter_$=(Q619_4 > 0).

VARIABLE LABELS filter_$ 'Q619_4 > 0 (FILTER)'.

VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.

FORMATS filter_$ (f1.0).

FILTER BY filter_$.

EXECUTE.


*Missende data na ECR-R verwijderen


DATASET ACTIVATE DataSet1.

FILTER OFF.

USE ALL.

SELECT IF (NMISS(Q376_6) < 1).

EXECUTE.


*DEMOGRAFISCHE GEGEVENS AANPASSEN


RENAME VARIABLES

Q646 = "Leeftijd".

VARIABLE LABELS

Leeftijd 'Leeftijd'.


RENAME VARIABLES

Q648 = "Geboorteland".
```

*Dichotoom maken opleiding voor correlaties. 0 is laag opgeleid, 1 is hoogopgeleid.

```
Compute Nieuwe_Opleiding=0.
Execute.
IF (Q652=5) Nieuwe_Opleiding=1.
IF (Q652=6) Nieuwe_Opleiding=1.
IF (Q652=3) Nieuwe_Opleiding=1.
IF (Q652=2) Nieuwe_Opleiding=1.
IF (Q652=9) Nieuwe_Opleiding=1.
Execute.
```

*QET 1,2,3,6 en 7 > 7 eruit

```
DATASET ACTIVATE DataSet1.
RECODE Q610_1 Q610_2 Q610_3 Q610_6 Q651_1 (1=1) (2=2) (3=3) (4=4) (7=5) INTO
QET_1 QET_2 QET_3
    QET_6 QET_7.
VARIABLE LABELS  QET_1 'QET_1' /QET_2 'QET_2' /QET_3 'QET_3' /QET_6 'QET_6'
/QET_7 'QET_7'.
EXECUTE.

RECODE Q610_4 Q610_5 Q651_2 Q651_3 Q651_4 Q651_5 (1=1) (2=2) (3=3) (4=4) (7=5)
INTO QET_4 QET_5
    QET_8 QET_9 QET_10 QET_11.
VARIABLE LABELS  QET_4 'QET_4' /QET_5 'QET_5' /QET_8 'QET_8' /QET_9 'QET_9'
/QET_10 'QET_10'
    /QET_11 'QET_11'.
EXECUTE.
```

*Overige items QET nieuwe naam geven

RECODE Q613_1 to Q181_7 (1=1) (2=2) (3=3) (4=4) (5=5) INTO QET_12 to QET_28.
Execute.

RECODE Q656_2 to Q619_4 (1=1) (2=2) (3=3) (4=4) (5=5) INTO QET_29 to QET_49.
Execute.

*Variable labels benoemen

VARIABLE LABELS
QET_1 ‘ Q610 - 1. Ik word snel achterdochtig of de informatie die de meeste andere mensen mij geven betrouwbaar is’
QET_2 ‘Q610 - 2. Ik twijfel meestal aan de bedoelingen van andere mensen wanneer ze mij adviezen geven’
QET_3 ’Q610 - 3. Ik heb de neiging om op mijn hoede te zijn wanneer iemand mij iets probeert te leren.’
QET_4 ’Q610 - 4. Ik denk meestal dat de informatie die andere mensen mij geven bruikbaar is voor mij.’
QET_5 ’Q610 - 5. Ik denk meestal dat andere mensen goede bedoelingen hebben wanneer ze mij adviezen of tips geven.’
QET_6 ’Q610 - 6. Andere mensen willen mij niet echt begrijpen.’
QET_7 ‘Q651 - 7. Ik moet ervoor oppassen dat anderen mij geen misleidende informatie geven’
QET_8 ‘Q651 - 8. Ik geloof dat de meeste mensen oprechte en eerlijke bedoelingen hebben wanneer ze met mij omgaan.’

QET_9 ‘Q651 - 9. Ik kan vertrouwen op de informatie die andere mensen mij geven als ik niet weet wat ik moet doen.’

QET_10 ‘Q651 - 10. Mensen spreken over het algemeen de waarheid.’

QET_11 ‘Q651 - 11. Andere mensen kunnen mij niet helpen als ze mij niet volledig begrijpen.’

QET_12 ‘Q613 - 12. Ik ben op mijn hoede wanneer andere mensen mij informatie geven.’

QET_13 ‘Q613 - 13. Ik word achterdochtig wanneer iemand mij iets probeert te leren.’

QET_14 ‘Q613 - 14. Ik sta open voor informatie die andere mensen mij geven.’

QET_15 ‘Q613 - 15. Ik ben meestal nieuwsgierig naar dingen waar andere mensen verstand van hebben.’

QET_16 ‘Q614 - 16. Ik ben erg kieskeurig als het gaat om wie ik kan vertrouwen.’

QET_17 ‘Q614 - 17. Ik probeer mijn problemen zelf op te lossen, zonder de hulp van anderen.’

QET_18 ‘Q614 - 18. Ik neem niet gemakkelijk hulp van anderen aan.’

QET_19 ‘Q614 - 19. Ik stel vragen wanneer ik iets niet begrijp.’

QET_20 ‘Q614 - 20. Ik vraag andere mensen om mij te helpen en te ondersteunen.’

QET_21 ‘Q614 - 21. Ik controleer meestal of de informatie die anderen mij geven betrouwbaar is.’

QET_22 ‘Q181 - 22. Ik heb meestal niets aan de adviezen of tips van mijn behandelaar.’

QET_23 ‘Q181 - 23. Ik word snel achterdochtig van de informatie die ik krijg van mijn behandelaar.’

QET_24 ‘Q181 - 24. Tijdens behandelingen ben ik meestal op mijn hoede om mezelf te beschermen tegen misleidende informatie.’

QET_25 ‘Q181 - 25. Ik denk meestal dat ik niets heb aan wat mijn behandelaar mij vertelt.’

QET_26 ‘Q181 - 26. Ik twijfel snel aan de informatie die ik krijg van mijn behandelaar.’

QET_27 ‘Q181 - 27. Ik ben ervan overtuigd dat ik de dingen die ik leer tijdens mijn behandeling ook kan toepassen in mijn dagelijkse leven.’

QET_28 ‘Q181 - 28. Ik verwacht dat de adviezen van mijn behandelaar me zullen helpen.’

QET_29 ‘Q656 - 29. Mijn behandelaar helpt me om mezelf en anderen te begrijpen.’

QET_30 ‘Q656 - 30. Mijn behandelaar helpt me om verschillende perspectieven te bekijken’

QET_31 ‘Q656 - 31. Mijn behandelaar heeft een interessante kijk op mijn problemen.’

QET_32 ‘Q656 - 32. Mijn behandelaar helpt me om na te denken over ideeën die in mijn eentje nooit bij me waren opgekomen.’

QET_33 ‘Q656 - 33. Mijn behandelaar is aardig, maar heeft weinig verstand van dingen.’

QET_34 ‘Q656 - 34. Mijn behandelaar weet niet wat goed is voor mij.’

QET_35 ‘Q656 - 35. De tips en adviezen die ik krijg van mijn behandelaar zijn misschien bruikbaar voor andere mensen, maar niet voor mij.’

QET_36 ‘Q656 - 36. Mijn behandelaar geeft me waardevolle informatie en adviezen.’

QET_37 ‘Q656 - 37. Mijn behandelaar wil me helpen wanneer hij me adviezen of tips geeft.’

QET_38 ‘Q656 - 38. Ik denk meestal dat mijn behandelaar de beste bedoelingen heeft wanneer hij me adviezen of tip geeft.’

QET_39 ‘Q143 - 39. Ik ben op mijn hoede om de informatie die ik krijg van mijn behandelaar te accepteren.’

QET_40 ‘Q143 - 40. Ik schrik ervoor terug om adviezen van mijn behandelaar aan te nemen over wat ik moet doen.’

QET_41 ‘Q143 - 41. Ik heb geen belangstelling voor tips of adviezen van mijn behandelaar.’

QET_42 ‘Q143 - 42. Ik ben op mijn hoede wanneer mijn behandelaar mij iets probeert te leren.’

QET_43 ‘Q143 - 43. Ik sta open voor de informatie die mijn behandelaar me wil geven.’

QET_44 ‘Q143 - 44. Ik ben meestal nieuwsgierig naar de tips en adviezen van mijn behandelaar.’

QET_45 ‘Q143 - 45. Ik ben geïnteresseerd in de dingen die mijn behandelaar mij kan leren.’

QET_46 ‘Q619 - 46. Ik controleer eerst andere bronnen voordat ik informatie aanneem die mijn behandelaar me geeft.’

QET_47 ‘Q619 - 47. Ik volg de adviezen en tips van mijn behandelaar meestal niet op.’

QET_48 ‘Q619 - 48. Ik ben erg kieskeurig welke informatie van mijn behandelaar ik kan vertrouwen, en welke niet.’

QET_49 ‘Q619 - 49. Ik pas de dingen die ik opsteek in de gesprekken met mijn behandelaar vaak toe in mijn dagelijkse leven.’.

EXECUTE.

*Factoranalyse 4 factoren

DATASET ACTIVATE DataSet1.

FACTOR

/VARIABLES QET_1 to QET_49

/MISSING PAIRWISE

/ANALYSIS QET_1 to QET_49

/PRINT INITIAL EXTRACTION ROTATION

/FORMAT SORT

/CRITERIA FACTORS(4) ITERATE(100)

/EXTRACTION PAF

/CRITERIA ITERATE(100) DELTA(0)

/ROTATION OBLIMIN

/METHOD=CORRELATION.

*Omscoren QET

RECODE

QET_1

QET_2

QET_3

QET_6

QET_7

QET_11

QET_12

QET_13

QET_16

QET_17

QET_18

QET_21

QET_22

QET_23

QET_24

QET_25

QET_26

QET_33

QET_34

QET_35

QET_39

QET_40

QET_41

QET_42

QET_46

QET_47

QET_48 (1=5) (2=4) (3=3) (4=2) (5=1) INTO

QET_1_R

QET_2_R

QET_3_R

QET_6_R

QET_7_R

QET_11_R

QET_12_R

QET_13_R

QET_16_R

QET_17_R

QET_18_R

QET_21_R

QET_22_R

QET_23_R

QET_24_R

QET_25_R

QET_26_R

QET_33_R

QET_34_R

QET_35_R

QET_39_R

QET_40_R

QET_41_R

QET_42_R

QET_46_R

QET_47_R

QET_48_R.

Execute.

*Factor 1 compute en betrouwbaarheid

```
COMPUTE
FACTOR_1=(MEAN.12(QET_25_R,QET_35_R,QET_42_R,QET_23_R,QET_33_R,QET_22
_R,QET_48_R,
QET_34_R,QET_41_R,QET_36,QET_26_R,QET_39_R,QET_47_R,QET_24_R,QET_40_R,
QET_37)).
Execute.


DATASET ACTIVATE DataSet1.
RELIABILITY
  /VARIABLES=QET_25_R QET_35_R QET_42_R QET_23_R QET_33_R QET_22_R
QET_48_R
QET_34_R QET_41_R QET_36 QET_26_R QET_39_R QET_47_R QET_24_R QET_40_R
QET_37
  /SCALE('ALL VARIABLES') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE CORR
  /SUMMARY=TOTAL.


*Factor 2 compute en betrouwbaarheid

COMPUTE
FACTOR_2=(MEAN.9(QET_2_R,QET_13_R,QET_3_R,QET_1_R,QET_7_R,QET_8,QET_5
,QET_9,QET_12_R,
QET_10,QET_21_R,QET_14)).
Execute.
```

```
DATASET ACTIVATE DataSet1.
RELIABILITY
  /VARIABLES=QET_2_R QET_13_R QET_3_R QET_1_R QET_7_R QET_8 QET_5 QET_9
QET_12_R
QET_10 QET_21_R QET_14
  /SCALE('ALL VARIABLES') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE CORR
  /SUMMARY=TOTAL.

*Factor 3 compute en betrouwbaarheid

COMPUTE
FACTOR_3=(MEAN.5(QET_49,QET_31,QET_32,QET_30,QET_27,QET_15,QET_29)).
Execute.

DATASET ACTIVATE DataSet1.
RELIABILITY
  /VARIABLES=QET_49 QET_31 QET_32 QET_30 QET_27 QET_15 QET_29
  /SCALE('ALL VARIABLES') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE CORR
  /SUMMARY=TOTAL.

*Factor 4 compute en betrouwbaarheid

COMPUTE FACTOR_4=(MEAN.3(QET_45,QET_44,QET_43)).
Execute.
```

```
DATASET ACTIVATE DataSet1.
RELIABILITY
  /VARIABLES=QET_45 QET_44 QET_43
  /SCALE('ALL VARIABLES') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE CORR
  /SUMMARY=TOTAL.
```

*Cronbach’s alpha voor de vier factoren

```
DATASET ACTIVATE DataSet1.
RELIABILITY
  /VARIABLES=FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4
  /SCALE('ALL VARIABLES') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE CORR
  /SUMMARY=TOTAL.

COMPUTE
FACTOR_ET_ALGEMEEN=(FACTOR_1+FACTOR_2+FACTOR_3+FACTOR_4)/4.
Execute.
```

*label aangepast van de CTQ-SF

```
RENAME VARIABLES
Q598_1 = 'CTQ1'
Q598_2 = 'CTQ2'
```

```
Q598_3 = 'CTQ3'

Q598_4 = 'CTQ4'

Q598_5 = 'CTQ5'

Q598_6 = 'CTQ6'

Q598_7 = 'CTQ7'

Q603_1 = 'CTQ8'

Q603_2 = 'CTQ9'

Q603_3 = 'CTQ10'

Q603_4 = 'CTQ11'

Q603_5 = 'CTQ12'

Q603_6 = 'CTQ13'

Q603_7 = 'CTQ14'

Q606_1 = 'CTQ15'

Q606_2 = 'CTQ16'

Q606_3 = 'CTQ17'

Q606_4 = 'CTQ18'

Q606_5 = 'CTQ19'

Q606_6 = 'CTQ20'

Q606_7 = 'CTQ21'

Q608_1 = 'CTQ22'

Q608_2 = 'CTQ23'

Q608_3 = 'CTQ24'

Q608_4 = 'CTQ25'

Q608_5 = 'CTQ26'

Q608_6 = 'CTQ27'

Q608_7 = 'CTQ28'.

EXECUTE.
```

*vragen verkort van CTQ

VARIABLE LABELS

CTQ1'Not enough to eat'

CTQ2'Someone take care and protect'

CTQ3'Called stupid, lazy or ugly'

CTQ4'Too drunk or high to take care'

CTQ5'Someone in family helped feel important'

CTQ6'Wear dirty clothes'

CTQ7'I felt loved'

CTQ8'Parents wished I never been born'

CTQ9'Hit so hard family had to see a doctor'

CTQ10'Nothing to change about family'

CTQ11'Hit so hard left me bruises'

CTQ12'Punished with belt'

CTQ13'Family looked out for each other'

CTQ14'Family said hurtful things'

CTQ15'I believe physically abused'

CTQ16'Had the perfect childhood'

CTQ17'Beaten so badly noticed by teacher'

CTQ18'Felt someone hated me'

CTQ19'Family felt close to each other'

CTQ20'Tried touch me sexual way'

CTQ21'Threatened to hurt unless sexual'

CTQ22'Best family in the world'

CTQ23'Make me do sexual things or watch'

CTQ24'Someone molested me'

CTQ25'I believe emotionally abused'

```
CTQ26'Someone take me to doctor'

CTQ27'I believe sexually abused'

CTQ28'Family source strength'.

EXECUTE.



*Syntax CTQ-SF


RECODE

CTQ2 CTQ5 CTQ7 CTQ13 CTQ19 CTQ26 CTQ28 (1=5) (2=4) (3=3) (4=2) (5=1) .


EXECUTE .


COMPUTE CTQEmotionalAbuse = CTQ3 + CTQ8 + CTQ14 + CTQ18 + CTQ25 .


VARIABLE LABELS CTQEmotionalAbuse 'CTQEmotionalAbuse' .


EXECUTE .


COMPUTE CTQPhysicalAbuse = CTQ9 + CTQ11 + CTQ12 + CTQ15 + CTQ17 .


VARIABLE LABELS CTQPhysicalAbuse 'CTQPhysicalAbuse' .


EXECUTE .


COMPUTE CTQEmotionalNeglect = CTQ5 + CTQ7 + CTQ13 + CTQ19 + CTQ28.


VARIABLE LABELS CTQEmotionalNeglect 'CTQEmotionalNeglect' .
```

```
EXECUTE .

COMPUTE CTQPhysicalNeglect = CTQ1 + CTQ4 + CTQ6 + CTQ2 + CTQ26 .

VARIABLE LABELS CTQPhysicalNeglect 'CTQPhysicalNeglect' .

EXECUTE .

COMPUTE CTQSexualAbuse = CTQ20 + CTQ21 + CTQ23 + CTQ24 + CTQ27 .

VARIABLE LABELS CTQSexualAbuse 'CTQSexualAbuse' .

EXECUTE .

COMPUTE CTQTotal = CTQEmotionalAbuse + CTQPhysicalAbuse + CTQEmotionalNeglect
+ CTQPhysicalNeglect + CTQSexualAbuse.

VARIABLE LABELS CTQTotal 'CTQTotal' .

EXECUTE .

*Verdeling antwoorden op de vragen CTQ

FREQUENCIES VARIABLES=CTQ1 CTQ2 CTQ3 CTQ4 CTQ5 CTQ6 CTQ7 CTQ8 CTQ9
CTQ10 CTQ11 CTQ12 CTQ13 CTQ14
    CTQ15 CTQ16 CTQ17 CTQ18 CTQ19 CTQ20 CTQ21 CTQ22 CTQ23 CTQ24 CTQ25
CTQ26 CTQ27 CTQ28
```

```
  /STATISTICS=MEAN
  /ORDER=ANALYSIS.

*categoriseren physical abuse

IF (CTQPhysicalAbuse<=7) CatunderscoreCTQPA = 1.
IF (CTQPhysicalAbuse>7 AND CTQPhysicalAbuse<=9) CatunderscoreCTQPA = 2.
IF (CTQPhysicalAbuse>9 AND CTQPhysicalAbuse<=12) CatunderscoreCTQPA = 3.
IF (CTQPhysicalAbuse>12) CatunderscoreCTQPA = 4.
EXECUTE.

*categoriseren emotional abuse

IF (CTQEmotionalAbuse<=8) CatunderscoreCTQEA = 1.
IF (CTQEmotionalAbuse>8 AND CTQEmotionalAbuse<=12) CatunderscoreCTQEA = 2.
IF (CTQEmotionalAbuse>12 AND CTQEmotionalAbuse<=15) CatunderscoreCTQEA = 3.
IF (CTQEmotionalAbuse>15) CatunderscoreCTQEA = 4.
EXECUTE.

*categoriseren sexual abuse

IF (CTQSexualAbuse<6) CatunderscoreCTQSA = 1.
IF (CTQSexualAbuse>=6 AND CTQSexualAbuse<=7) CatunderscoreCTQSA = 2.
IF (CTQSexualAbuse>7 AND CTQSexualAbuse<=12) CatunderscoreCTQSA = 3.
IF (CTQSexualAbuse>12) CatunderscoreCTQSA = 4.
EXECUTE.

*categoriseren phsyical neglect
```

```
IF (CTQPhysicalNeglect<=7) CatunderscoreCTQPN = 1.
IF (CTQPhysicalNeglect>7 AND CTQPhysicalNeglect<=9) CatunderscoreCTQPN = 2.
IF (CTQPhysicalNeglect>9 AND CTQPhysicalNeglect<=12) CatunderscoreCTQPN = 3.
IF (CTQPhysicalNeglect>12) CatunderscoreCTQPN = 4.
EXECUTE.

*categoriseren emotional neglect

IF (CTQEmotionalNeglect<=9) CatunderscoreCTQEN = 1.
IF (CTQEmotionalNeglect>9 AND CTQEmotionalNeglect<=14) CatunderscoreCTQEN = 2.
IF (CTQEmotionalNeglect>14 AND CTQEmotionalNeglect<=17) CatunderscoreCTQEN = 3.
IF (CTQEmotionalNeglect>17) CatunderscoreCTQEN = 4.
EXECUTE.

*categoriseren CTQ total

IF (CTQTotal<=36) CatunderscoreCTQTS = 1.
IF (CTQTotal>36 AND CTQTotal<=51) CatunderscoreCTQTS = 2.
IF (CTQTotal>51 AND CTQPhysicalAbuse<=68) CatunderscoreCTQTS = 3.
IF (CTQTotal>68) CatunderscoreCTQTS = 4.
EXECUTE.

*Labels aanpassen categorisatie CTQ

VARIABLE LABELS
CatunderscoreCTQPA'Physical Abuse Level'
CatunderscoreCTQEA'Emotional Abuse Level'
```

```
CatunderscoreCTQSA'Sexual Abuse Level'
CatunderscoreCTQPN'Physical Neglect Level'
CatunderscoreCTQEN'Emotional Neglect Level'
CatunderscoreCTQTS'Total Trauma Level'.
EXECUTE.

*Waarde labels aanpassen categorisatie CTQ

VALUE LABELS
CatunderscoreCTQPA 1 'None' 2 'Low' 3 'Moderate' 4 'Severe'.
EXECUTE.

VALUE LABELS
CatunderscoreCTQEA 1 'None' 2 'Low' 3 'Moderate' 4 'Severe'.
EXECUTE.

VALUE LABELS
CatunderscoreCTQSA 1 'None' 2 'Low' 3 'Moderate' 4 'Severe'.
EXECUTE.

VALUE LABELS
CatunderscoreCTQPN 1 'None' 2 'Low' 3 'Moderate' 4 'Severe'.
EXECUTE.

VALUE LABELS
CatunderscoreCTQEN 1 'None' 2 'Low' 3 'Moderate' 4 'Severe'.
EXECUTE.
```

```
VALUE LABELS
CatunderscoreCTQTS 1 'None' 2 'Low' 3 'Moderate' 4 'Severe'.

EXECUTE.

*Dichotomisering geboorteland

IF (Geboorteland=1) Autochtoon = 1.
IF (Geboorteland=4) Autochtoon = 0.
EXECUTE.

*Dichtomisering totaalscore CTQ (op 36)

IF (CTQTotal<=36)DichotoomTotaal=0.
IF (CTQTotal>36)DichotoomTotaal=1.
EXECUTE.

*Dichtomisering emotional abuse (op 8)

IF (CTQEmotionalAbuse<=8)DichotoomEA=0.
IF (CTQEmotionalAbuse>8)DichotoomEA=1.
EXECUTE.

*Dichtomisering physical abuse (op 7)

IF (CTQPhysicalAbuse<=7)DichotoomPA=0.
IF (CTQPhysicalAbuse>7)DichotoomPA=1.
EXECUTE.
```

```
*Dichtomisering sexual abuse (op 5)

IF (CTQSexualAbuse<=5)DichotoomSA=0.
IF (CTQSexualAbuse>5)DichotoomSA=1.
EXECUTE.

*Dichtomisering emotional neglect (op 9)

IF (CTQEmotionalNeglect<=9)DichotoomEN=0.
IF (CTQEmotionalNeglect>9)DichotoomEN=1.
EXECUTE.

*Dichtomisering physical neglect (op 7)

IF (CTQPhysicalNeglect<=7)DichotoomPN=0.
IF (CTQPhysicalNeglect>7)DichotoomPN=1.
EXECUTE.

*univariate correlatie demografische gegevens met totaalscore CTQ (zowel voor als na de
dichotomisering)

DATASET ACTIVATE DataSet1.
CORRELATIONS
  /VARIABLES=Leeftijd Q644 Autochtoon Nieuwe_Opleiding CTQTotal DichotoomTotaal
  /PRINT=TWOTAIL NOSIG
  /STATISTICS DESCRIPTIVES
  /MISSING=PAIRWISE.
```

```
*manova met 4 factoren epistemic trust en totaalscore CTQ (inclusief dichtomisering)
(HOOFDVRAAG)

GLM FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4 BY DichotoomTotaal
  /CONTRAST(DichotoomTotaal)=Difference
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /PLOT=PROFILE(DichotoomTotaal) TYPE=BAR ERRORBAR=SE(2)
MEANREFERENCE=NO
  /EMMEANS=TABLES(DichotoomTotaal)
  /PRINT=DESCRIPTIVE ETASQ
  /CRITERIA=ALPHA(.05)
  /DESIGN= DichotoomTotaal.

*manova met 4 factoren epistemic trust en afzonderlijke factoren CTQ (ANCILLARY
ANALYSIS)

*physical abuse

GLM FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4 BY DichotoomPA
  /CONTRAST(DichotoomPA)=Difference
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /PLOT=PROFILE(DichotoomPA) TYPE=BAR ERRORBAR=SE(2) MEANREFERENCE=NO
  /EMMEANS=TABLES(DichotoomPA)
  /PRINT=DESCRIPTIVE ETASQ
  /CRITERIA=ALPHA(.05)
```

```
  /DESIGN= DichotoomPA.
```

*emotional abuse

```
GLM FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4 BY DichotoomEA
  /CONTRAST(DichotoomEA)=Difference
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /PLOT=PROFILE(DichotoomEA) TYPE=BAR ERRORBAR=SE(2) MEANREFERENCE=NO
  /EMMEANS=TABLES(DichotoomEA)
  /PRINT=DESCRIPTIVE ETASQ
  /CRITERIA=ALPHA(.05)
  /DESIGN= DichotoomEA.
```

*sexual abuse

```
GLM FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4 BY DichotoomSA
  /CONTRAST(DichotoomSA)=Difference
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /PLOT=PROFILE(DichotoomSA) TYPE=BAR ERRORBAR=SE(2) MEANREFERENCE=NO
  /EMMEANS=TABLES(DichotoomSA)
  /PRINT=DESCRIPTIVE ETASQ
  /CRITERIA=ALPHA(.05)
  /DESIGN= DichotoomSA.
```

*physical neglect

```
GLM FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4 BY DichotoomPN
  /CONTRAST(DichotoomPN)=Difference
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /PLOT=PROFILE(DichotoomPN) TYPE=BAR ERRORBAR=SE(2) MEANREFERENCE=NO
  /EMMEANS=TABLES(DichotoomPN)
  /PRINT=DESCRIPTIVE ETASQ
  /CRITERIA=ALPHA(.05)
  /DESIGN= DichotoomPN.
```

*emotional neglect

```
GLM FACTOR_1 FACTOR_2 FACTOR_3 FACTOR_4 BY DichotoomEN
  /CONTRAST(DichotoomEN)=Difference
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /PLOT=PROFILE(DichotoomEN) TYPE=BAR ERRORBAR=SE(2) MEANREFERENCE=NO
  /EMMEANS=TABLES(DichotoomEN)
  /PRINT=DESCRIPTIVE ETASQ
  /CRITERIA=ALPHA(.05)
  /DESIGN= DichotoomEN.
```

Appendix 2: Datafile

Please see e-mail.

Appendix 3: Questionnaire Epistemic Trust

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 4: Provided information letter and informed consent

Utrecht University

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?

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)

Appendix 5: 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	20-0220	
Telephone	030 253 46 33	
E-mail	FETC-fsw@uu.nl	
Date	01 September 2020	
Subject	Ethical approval	

ETHICAL APPROVAL

Study: Valideringsstudie Questionnaire Epistemic Trust (QET)

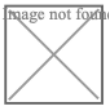
Principal investigator: A.L. van Dijk

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