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EDITORIAL



## The 'Science of Trust': moving the field forward

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Trust in science is linked or should be linked to the 'source's expertise, integrity and benevolence' [1].

If there is anything that keeps me awake at night it is the ongoing global trust crisis about scientific and medical information. Not only are misinformation and disinformation increasingly rampant on social media and in our communities, schools, and workplaces, but they have been affecting people's behavior during the pandemic and vaccine acceptance rates, as well as fueling social discrimination against many groups and the pervasive stigma toward mental health issues, obesity, and other medical conditions. Trust in governments, local public health departments, science and clinical experts, and other official sources of health information has been declining even before the ongoing pandemic and, for example, contributed to the vaccine hesitancy epidemic [2]. We are in the midst of a trust crisis, which should be expected given the many health, racial, and social inequities in our society that have been eroding our collective sense of community and social justice.

Last year, our *Journal* launched the '*Science of Trust*' as a topic of concern for communication interventions and future investigation as part of an interview with representatives of the World Health Organization [3]. This is not a new topic for our *Journal* as over time we have been publishing research findings and insights on the role of trust (or mistrust) in health communication as well as strategies on the path forward [4–8]. We are also planning on upcoming events, special issues, and resources in our *Science of Trust* initiative. [https://think.taylorandfrancis.com/wp-content/uploads/2022/06/About-The-Science-of-Trust-Initiative.pdf?\\_ga=2.178250469.1162772.1656323851-643057123.1613346632&\\_gl=1\\*h21ibc\\*\\_ga\\*NjQzMDU3MTIzMjE2MTMzNDY2Mzl.\\*\\_ga\\_0HYE8YG0M6\\*MTY1NjMyMzg1MS4yLjEuMTY1NjMyNDA2NC4w](https://think.taylorandfrancis.com/wp-content/uploads/2022/06/About-The-Science-of-Trust-Initiative.pdf?_ga=2.178250469.1162772.1656323851-643057123.1613346632&_gl=1*h21ibc*_ga*NjQzMDU3MTIzMjE2MTMzNDY2Mzl.*_ga_0HYE8YG0M6*MTY1NjMyMzg1MS4yLjEuMTY1NjMyNDA2NC4w). We continue to believe that this is one of the most important issues of our time and want to do our share by providing resources to our professional and lay communities to help build or restore trust at population and community levels.

So, what are some of the factors to consider in moving the field forward and advancing our understanding and implementation of the '*Science of Trust*'? How can communication research, policy, and practice contribute to help remove systemic, community, and individual barriers to trust in healthcare and public health information?

As other authors have reported, 'trust [in science] rests not only on the assumption that one is *dependent* on the knowledge of others who are more knowledgeable; it also entails a *vigilance* toward the risk to be misinformed' [1]. A variety of determinants of health and social well-being may play a role in the effectiveness of community and individual vigilance toward misinformation risk, including past experiences, historical reasons for mistrust in official sources, information overload, the increasing politicization of health information, and health and civic literacy, to name a few. While traditionally trust has been associated (or should be associated) to the source's integrity and expertise (as for the quote at the beginning of this editorial), I want to focus primarily on the concept of 'benevolence' and its original meaning. '*Benevolence*' – from the Latin '*benevolentia*' (good will) – refers to the disposition to do good for others or the quality of being 'well-meaning and kind' [9], which are essential traits in eliciting trust among individuals and communities. Regarding sources as well-meaning is difficult for communities and populations who experience marginalization and bias or are under-resourced because of discriminatory policies or lack of investment. It's difficult to trust those whom we perceive as leaving us behind. These communities need to feel that despite potential differences in opinions and values, experts and policymakers with whom they interact prioritize their well-being, and in other words, are well-meaning.

Trust is built on relationships and presumably associated with the quality of our interactions. Yet research on the science of trust has been focusing primarily on the biology of trust (e.g. hormonal and brain-response), and less on the 'complex interplay' between

biology and the social, political and environmental factors that influence trust [10,11]. These factors include policies, past experiences, stress levels, cultural values, specific demands associated with a given behavior or task, socialization, and social discrimination, among others [10–12]. Moreover, for communities that have been marginalized, or experience other kinds of vulnerability or disadvantage (e.g. communities of color, immigrant communities, people living in poverty or with a disability) mistrust is often rooted in historical and personal experiences with health and social systems [11,12]. So, even if evidence shows that several biological factors 'moderately regulate' or are associated with trust [10], this is not very different from all other kinds of human behaviors that are somewhat linked to biology [10,11]. Conversely, we also know, for example, from evidence on chronic stress that biological responses (e.g. hormonal response) are influenced by social and political factors and other relevant contexts [13].

Focusing on biology alone is not likely to provide the full picture. Future research on the '*Science of Trust*' should strengthen our understanding of the interdependence between social factors and human trust, so that these insights can shape communication and other interventions across health and social issues. Moreover, while the implications of the '*Science of Trust*' on human behavior have been somewhat explored in interpersonal and family settings, more focused efforts are needed at the community and population levels, so that we can fully consider trust – as well as its many system-related contexts and implications – in the design of community – and patient-centered interventions.

In pursuing relevant endeavors, the role of community-based participatory research (CBPR) and community engagement should be strongly considered. After all, communities – and their leaders – know best what may help build or restore trust in scientific and clinical information – and official sources. Therefore, they should be engaged in establishing research priorities, designing suitable interventions and policies, and sharing information on what shapes their trust (or mistrust) in health and science information. Ultimately, 'trust starts with truth and ends with truth' [14].

## In this issue

In continuing with our commitment to provide our readers with diverse perspectives, this summer (July 2022) issue of our *Journal* includes articles from multiple countries and a diverse pool of authors. In addition to this editorial, which seeks to engage our authors and readers in exploring the '*Science of Trust*' and its implications for health communication, healthcare, and global health, our *Front Matter* section also features a new article in our *Patient Voices* series.

Focusing on '*Physical Therapy, Trust, and Conversations during the COVID-19 Pandemic*', this new piece is an example of the kind of insightful patient experiences we are looking to feature as *Patient Voices*. We would be grateful if you could publicize this section with your networks and encourage other patients to contribute their voices and perspectives to advancing the field of health communication and highlighting patients' needs and priorities.

The articles in this issue focus on a variety of topics, including partnerships in care, surgeon communication and its impact on patient satisfaction, narrative messages for adolescents with type 1 diabetes, and a health literate program to address health inequities with a specific focus on parents of children with sickle cell trait. It also includes two articles on COVID-19: one on the interrelation of message exposure, audience segmentation and protective behaviors in Vietnam, and the other on an innovative hospital role emerging from the COVID-19 pandemic as part of the experience of the Royal Free Hospital in London, United Kingdom.

In wishing you all a wonderful summer, we also want to remind you that despite great progress the COVID-19 pandemic is not over yet. Stay healthy and safe and advocate in your organizations and communities for getting tested regularly, using masks in indoor settings, getting the vaccine, and continuing to protect the groups that are most vulnerable to COVID-19.

Thank you for your readership and commitment to advancing the field of health communication. Happy summer!

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