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A Concept Analysis of Trust

Trust is a dynamic concept frequently understood to be the foundation of the therapeutic nurse/client relationship; however, its definition is often implied and not clearly defined. Trust rests upon knowledge involving feelings, concerns, or worries, reveals the individual's attitudes and values, and suggests the likelihood of one to expose his concerns (Kerr, Stattin, & Trost, 1999). It has been conceptualized as a perception, state, process, or outcome, and denotes commitment, confidence, and responsibility (Elliott Ruditis, 1979; Hupcey, Penrod, Morse, & Mitcham, 2001; Johns, 1996). In pediatric nursing, trust is apparent during stressful periods with parents trusting the clinician's judgment with whom they make decisions for the child. This concept analysis will clarify the concept of trust, as utilized in pediatric nursing to create a conceptual road map for its use. This paper will utilize steps 1-5, 7, and 8 of Walker and Avant's chapter on concept analysis (1995).

USES OF THE CONCEPT

Trust has many definitions with both noun and verb forms. The American Heritage Dictionary of the English Language's definition is "firm reliance on the integrity, ability, or character

> of a person or thing; something committed into the care of another; reliance on something in the future, hope; a legal title to property held by one party for the benefit of another; a combination of firms or corporations for the purpose of reducing competition and controlling prices throughout a business or industry," and other very similar definitions (Morris, 1978, p. 1378).

Another dictionary further defines trust as "a risk-taking process whereby an individual's situation depends on the future behavior of another person" (Anderson, Anderson, & Glanze, 1998, online). Trust originated in Iceland from the word, "traust," meaning trust, and is likened to the Old World term, "treowe," meaning faithful. The Gothic word, "trausti," meaning agreement of pact, and the German word, "trosten," meaning "with a sense of comfort, cheer, encourage" are also possible

origins (Johns, 1996, p. 77). Similar concepts include faith, hope, acceptance, respect, confidence, and dependence.

Trust has many uses and is not all encompassing of every situation (Hagerty & Patusky, 2003). Nurses use trust to include the family trusting the expertise of the nurse as provider; the nurse trusting the family's decision-making; and nurses trusting each other as teammates to provide quality, non-judgmental care. In other disciplines, trust is used to conceptualize the need to trust physicians in medicine, interpersonal trust in psychology and philosophy, trust in society or institutions in sociology, organizational trust in business, trust fund accounts in economics, and trust in God discussed in the Bible and religious literature (Hupcey, Penrod, Morse, & Mitcham, 2001; Meize-Grochowski, 1984).

Thompson, Hupcey, & Clark (2003) state that the trusting relationship between the nurse and patient can also incorporate the family unit. Therefore, using the definitions above, the child's parents must rely on the nurse's integrity and ability to function in her role to care for their child. Utilizing discretion to discover the nurse's credentials as "Registered Nurse," any specialized training, and employed by the facility, the parents extend credit to the nurse that appropriate care will be delivered and commit the child into her care. The alternative definitions of legal titles and reducing competition in business are not appropriate in this concept analysis, as they are unrelated to the nurse/family relationship.

ANTECEDENTS

Antecedents must be present for trust to occur (Walker & Avant, 1995). There must be a need or form of decision-making to bring the individual into the healthcare system. The individual must expect that the other individual whom he is trusting will behave in a certain acceptable manner. Because trust involves vulnerability and risk, the environment must be perceived as safe (characterized by openness, honesty, caring, and empathy) in order for information or concerns to

be disclosed (Hupcey, Penrod, Morse, & MItcham, 2001). Maslow states in his Hierarchy of Needs that both basic physiological and safety needs must be met before an individual can trust. Erickson and Bowlby state that trust is one of the first developmental tasks and must be accomplished in infancy for trust to occur as an adult (Elliott Ruditis, 1979; Meize-Grochowski, 1984; Page, 1999). The trusting individual (parent) must also perceive competence in the other's (nurse) knowledge and skills, which can be accomplished through consistency, reliability, positive past experience with the individual or healthcare system, or willingness of the nurse to disclose information, credentials, and expertise. Nurses who know the limits of their skills, seek appropriate help, speak to the child at a developmentally appropriate level, and appear caring are more likely to be trusted than those who do not. Parental trust may also be facilitated by continuity of nursing care and the reinforcement of parental beliefs that parenting skills are still valuable (Thompson, Hupcey, & Clark, 2003).

DEFINING ATTRIBUTES

Defining attributes are the concept's characteristics that repeatedly occur in the literature (Walker & Avant, 1995). Trust's first attribute is that it is an active process characterized by a flow of energy between two human beings (Meize-Grochowski, 1984; Wright, 2004). Trust can only occur in humans with actual thought processes. Trust is bound to a specific time and place and is not all encompassing of every situation between the two individuals (Glasgow & Morris, 2005; Hupcey, Penrod, Morse, & Mitcham, 2001; Meize-Grochowski, 1984). Dependence on another to behave in a certain manner to meet the existing need is trust's third attribute, and the fourth attribute is the willingness of the individual to take a risk. As discussed above, trust involves a great deal of risk that an individual must be willing to accept in order to completely trust another. Trust's final attribute is that it is fragile and dynamic. Wright (2004) states that trust evolves with the life processes of discovering and creating change, and because of the element of risk involved, trust is fragile and can easily be broken. Based on these attributes, trust is defined in this concept analysis as

an active process in the nurse-family relationship characterized by a flow of energy between two humans with actual thought processes that is bound to time and place, involves dependence on another to meet an identified need, involves willingness to take a risk, and is fragile.

MODEL CASE

The following model case is a "real life" example which includes all of the concept's defining attributes (Walker & Avant, 1995). Natalia is an 11 year old female admitted to the pediatric unit with meningitis. During the last six days of her hospital stay, Natalia and her parents have developed a relationship with Julia. Julia initially introduced herself to the family with her credentials as a pediatric-specialized registered nurse for over 15 years and consistently fulfilled the family's requests with a positive attitude whenever they needed anything. Natalia's parents felt very comfortable with Julia to meet their needs and felt very relaxed in her presence.

All five of trust's defining attributes are present in this model case. It is understood that these individuals are humans. Natalia and her parents had an unmet need and felt comfortable to take the risk that Julia would meet their need. Natalia's parents actively trusted Julia to take care of Natalia while she was in the hospital (the specific time/place), as they could not meet this need. Fragility was subtly present in that if trust were breeched, Natalia's parents would have a difficult time regaining trust in Julia. This example of trust fits with Watson's description of nursing in that through the fundamental interaction between nurse and patient/family, the family is able to trust the nurse to obtain a higher degree of harmony within the family unit, thus empowering themselves (Glasgow & Morris, 2005).

EMPIRICAL REFERENTS

To fully conceptualize trust, all five of the defining attributes must be measured. This has not been done in the literature. Objective data is difficult to obtain; however, subjective reports may aid in its understanding. These can include narratives of times when parents trusted nurses;

however, Algase, Whall, & Colling (1996) state there may be times when attempting to have a parent discuss his/her feelings may dissipate and diminish the feeling of trust. Based on past experiences with the particular nurse, any nurse, or the healthcare system, parents may or may not readily trust. Parental trust can also be measured by a decrease in their vigilance of the nurse's actions or a decrease in the number of challenging questions about specific nursing care. Other factors, including the educational level, socioeconomic status, or personalities of the parents, or family structure can be influential. In some cultures, objective data such as the gender, age, or ethnicity of the nurse can cause an increase or decrease in the level of trust. In paternalistic cultures, trust may be measured by parental compliance with the nurse. The existing need must be met in a manner that is acceptable to both the parent and nurse with mutual agreement. Trust must also be measured by the willingness of the parent to take risks. Trust is fragile. The longer the positive relationship, the greater the trust; however, all trust can be lost in a split second with a breech of trust. There are currently no tools to measure trust, its defining attributes, or its cultural conceptualizations. Many questions have yet to be identified in the nursing literature, including various cultural definitions of trust, the ethical and cultural implications of trust, and how environment impacts trust and one's ability to trust. Because this concept has only been viewed from a Western cultural perspective, other cultural perspectives of the concept have not been identified. Algase, Whall, & Colling (1996) state that "by comparing responses to these questions as developed from multiple cultural orientations, nursing truths common across cultures can be explicated while those reflecting a particular cultural perspective can be more clearly identified and explored for their implications in developing theory" (p. 18).

CONSEQUENCES

Consequences occur as a result of the concept's occurrence (Walker & Avant, 1995). Small differences in relation to trust and gender have been found; however, manifestations of trust across

cultural contexts may differ. They may be either positive or negative, depending on whether the expectations were met. Johns (1996) states that trust is a prerequisite for patient empowerment and self-help, so if trust is present, patients are more likely to feel empowered. When trust occurs, the patient is accepted and recognized as a real person with the nurse perceived as a fellow human being. Parents who are more trusting are more relaxed, less vigilant, and feel respected and included in the child's care (Thomspon, Hupcey, & Clark, 2003). Parents may be more willing to work with the nurse to accomplish goals and divulge other personal information to the nurse, so she is able to assist in meeting these additional needs (Hagerty & Patusky, 2003). Multiple sources in the literature state that trust is an essential foundation for a therapeutic nurse-client/family relationship (and all human relationships) and that the absence of trust can lead to paternalism and a reduction in human dignity (Elliott Ruditis, 1979; Glasgow & Morris, 2005; Wright, 2004). Trust can also be the basis for spirituality and can be linked to power and life satisfaction, as "people do not feel a need to control others when they trust their own power" (Wright, 2004, p. 140). When individuals are more aware of whom they are, they are more powerful and more likely to make their own choices.

CONCLUSION

This paper has analyzed the concept of trust, which is essential in pediatric nurse/family relationships, as *an active process in the nurse-family relationship characterized by a flow of energy between two humans with actual thought processes that is bound to time and place, involves dependence on another to meet an identified need, involves a willingness to take a risk, and is fragile.* Because nurses experience high levels of trust in their relationships with families, they must "capitalize on this trust relationship and their enhanced power to participate in leading the way as advocates for public health policy and establishing the healthcare agenda" (Wright, 2004, p. 145). As trusted professionals, nurses have a mandate to use this granted power to advocate for the well-being of all children and to facilitate society's trust in the unparalleled discipline of nursing.

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