

Reworking the sociology of trust: making a semantic distinction between trust and dependence

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Abstract

Trust, as a sociological construct, has become increasingly important in recent times but an agreed definition is yet to be found. A potentially useful way of 'defining' trust is by distinguishing it from other semantically similar concepts. Niklas Luhmann has provided semantic distinctions between trust and familiarity, and trust and confidence. The purpose of this paper is to provide empirical evidence of a further semantic distinction between trust and dependence. This distinction allows us to further define trust and also to investigate the difference between 'trust' and 'dependence'.

Keywords: Trust, Dependence, Niklas Luhmann, Power, Risk

Introduction

Trust is a complex phenomenon, around which there are many definitions and theories. There is no commonly shared understanding of what trust means (Hall et al. 2001) and the concept of trust has yet to be universally defined within and across disciplines (Baier 1986; Brownlie and Howson 2005; Crease 2004; Gilson 2003; Mollering 2001; Schoorman et al. 2007). Although post-structural sociologists may argue that trust will never be universally defined, we address the concept of trust in line with the underpinning framework of Giddens and Luhmann's social theories of trust. Both theorists approach trust in terms of its function in society as part of structure and agency rendering an understanding the operationalisation of trust fundamental. While we recognise the difficulty in generalising trust as a concept, it is

important that we know what trust is/is not in order to investigate how it is operationalised – it needs to be distinguished from other concepts. While empirical trust literature has suggested that there is a distinction between trust and dependence (Lupton 1997a; Ward et al. 2000), they acknowledge that dependency exists in relationships but they do not provide a semantic distinction between trust and dependence. This paper adds to the knowledge of sociology by making a semantic distinction between trust and dependence which may aid in finding a common definition of trust for sociological research into the operationalisation of trust. The distinction also allows a critique of current quantitative research (e.g. social capital) which purports to research ‘trust’ but which may in fact be measuring similar something else, such as dependence.

Within sociological literature on trust, three names consistently arise: Niklas Luhmann, Anthony Giddens and Georg Simmel (Brownlie and Howson 2005; Gilson 2003; Lupton 1997a; Mechanic and Meyer 2000; Meyer et al. 2008; Mollering 2001; Ward 2006; Ward and Coates 2006). For the purpose of this paper, we turn to Niklas Luhmann whose contributions have been useful for defining and investigating how trust is operationalised because his theory offers semantic distinctions between trust and confidence and trust and familiarity (Luhmann 1979; Luhmann 1988; Luhmann 1995). Luhmann has made significant contributions to trust literature however, nowhere does he make the distinction between trust and dependence. The following paper outlines the semantic distinctions that Luhmann makes between trust and familiarity and trust and confidence. Secondly the background, methods and findings of research on coronary heart disease patients’ trust in healthcare professionals’ recommendations will be presented. Finally, a discussion of these findings will be used to highlight the semantic distinction between trust and dependence.

Conceptualisations of Trust

Despite the lack of agreement regarding its definition, across health sociology literature there is some consistency which we will use to define trust for the purpose of this paper. Trust is the optimistic acceptance of a vulnerable situation which is based on positive expectations of the intentions of the trusted individual or institution (Dugan et al. 2005; Gilson 2003; Hall et al. 2001).

Luhmann addressed the concept of trust in terms of its function in society (Luhmann 1988). He argued that trust functions as a way to reduce complexity in society. Systems need to reduce complexity in order to function properly. Luhmann viewed trust as the medium of interaction between social systems and the representatives of those systems.

Trust can be understood as 'social' in that trust occurs as a result of communication within and between system(s). While Luhmann focused on the function of trust between systems, his theory is applicable at an individual level as well. By reducing the complexity of how we think about the world around us, trust assists us by simplifying our decisions to act (Pearson et al. 2005). An individual's decision to place (dis)trust reduces complexity in society because both decisions function as a means for rational decision-making (Luhmann 1979).

Luhmann argues that individuals base decisions to place (dis)trust in an individual or system¹ on both experience (history of past (un)successful trust) as well as the risks associated with decisions made for the future. Trust helps us to make future decisions based on experience but also uses the knowledge of the past to minimize risk by tapering the number of possible actions (Luhmann 1979). It is for this reason that he

argues that trust can only exist in situations of risk. If there is no risk considered, there is confidence or expectation rather than trust (Luhmann 2005).

In addition to providing a conceptualisation of trust, Luhmann also makes semantic distinctions between trust and familiarity, and trust and confidence.

Trust vs. Familiarity

Luhmann argued that both familiarity and trust are linked to one another with trust presupposing familiarity (Luhmann 1979). Familiarity is based on experience that is represented in history and similar to trust, familiarity reduces complexity because it excludes unanticipated action (Luhmann 1979). Both serve as complementary ways of absorbing complexity (Luhmann 1988).

Familiarity differs to trust in that although it too reduces the complexity of our decisions based on past experience, trust is based on past information but *also* the risks associated with decisions made for the future. Nevertheless, although they differ, trust and familiarity belong to the same family of self-assurances (Luhmann 1988).

While trust is a solution for problems of risk, it has to be achieved within a familiar world. Familiarity is a factor involved in our decision(s) to place trust in an individual or an institution (Luhmann 1988). For example, how long we have known someone impacts our level of familiarity with them which subsequently affects whether we (dis)trust them. Whether or not a person places trust in future events is subjective as each individual has a different level of risk-seeking/risk-avoiding, trusting or distrusting. People use familiarity as a mechanism for calculating risk (Luhmann 1988).

Trust vs. Confidence

Luhmann also distinguishes trust from confidence. Both refer to expectations which may lapse into disappointment, however, they differ in attribution (Luhmann 1988). Trust requires some element of risk and is only possible in a situation where the likelihood of negative outcomes *may* be greater than the positives that successful trust awards (Luhmann 1988). If we choose one action in preference to another, despite the possibility of being disappointed, we are trusting. As a result of this *decision* to trust, any disappointment is attributed internally (Luhmann 1988). Confidence occurs when we do not consider alternatives and rely on our expectations. We have confidence that our expectations will not be disappointed. In the case of disappointment, blame is attributed externally because we did not choose, but expected, and therefore the disappointment was not a result of our erroneous trust (Luhmann 1988). In this sense, trust means that we are retaining our agency; we ‘choose’ to trust. Confidence on the other hand, involves giving over agency to the system or individual involved; the decision is no longer our ‘choice’.

Luhmann on dependence

While Luhmann makes the distinction between trust and confidence and trust and familiarity, he does not make a semantic distinction between trust and dependence. Dependence is mentioned briefly by Luhmann in reference to his influential social system theory. While his discussion of dependency is important for understanding social systems theory, he does not address dependency with regards to social theories of trust and therefore, it is not beneficial for defining or operationalising trust.

This paper moves on to a study which highlights a distinction between trust and dependence. Some people involved in the study argue that they ‘trust’ the medical system because they have no choice but to trust. Using Luhmann’s conceptualisation

of trust, the findings suggest dependency rather than trust because trust indicates 'choice' (agency) where as dependency indicates 'no choice' (no agency).

Methodology

The data presented in this paper are based on a study investigating social theories of trust. Based on a critique of current social theories of trust, the study aimed to investigate several factors which have been identified as affecting an individual's decision to place (dis)trust in an individual or institution. These factors include: the negotiation of trust between individuals, the level of trust one has in the system or institution, and the level of risk involved in trusting (Giddens 1990; Giddens 1994; Luhmann 1979; Luhmann 1988; Luhmann 2005), and personal experience and social factors (socioeconomic status (SES), age, sex) (Meyer et al. 2008). As a vehicle for this research, patients with coronary heart disease (CHD) were interviewed regarding trust in dietary recommendations provided by health care professionals.

People with CHD were chosen as participants because CHD is a chronic condition that is the most common cause of death in Australia and the risks involved may be reduced by making lifestyle change (National Heart Foundation of Australia 2008) including complying with the dietary recommendations of healthcare professionals. Participants were considered to be high risk CHD patients and were chosen based on the premise that the health risks they have may potentially affect their decision to trust in dietary recommendations. In addition, because CHD affects one in two Australian men and one in three Australian women over the age of 40, a large sample size provided ease of obtaining participant diversity with regards to age, SES and sex.

A qualitative inductive approach has been adopted for this research. Qualitative research is useful for understanding the complexity of opinions from the perspective

of the research participants. In investigating trust, qualitative research is necessary to understand how individuals conceptualize trust, especially given that trust as a concept is often taken for granted.

Semi-structured interviews were conducted with 13 Australian participants interviewed between October 2008 and June 2009. Based on the aforementioned theoretical frame, the sampling strategy was developed to investigate risk² and socioeconomic status³ (as well as sex and age) as well as factors affecting interpersonal and institutional trust. Participants were sampled from 13 different suburbs in Adelaide, SA in order to provide diversity with regards to socioeconomic status.

Participants were recruited through South Australian cardiac rehabilitation programs which ensured that they had high risk CHD as all participants of cardiac rehabilitation program in South Australia have had some form of cardiac event and/or heart surgery. Participant demographics consisted of 8 males and 5 females from areas of both high and low SES, with ages ranging from 32-80 years.

Participants were recruited and interviewed by the researcher. Initial questions were designed to develop rapport and focused on the participants' current diet opposed to what they were eating prior to their diagnosis of CHD. Subsequent questions investigated participants' relationships with their general practitioner (GP), healthcare providers in general (cardiologists, cardiac nurses, dieticians), their experiences with the medical system, their thoughts on the medical system, the risks involved in non-compliance with dietary changes, their trust in institutions (mainly the medical system and the government) and their trust in medical advice.

All interviews were conducted in English, audio recorded, and verbatim responses to each question were transcribed by the primary researcher. Transcripts were reviewed

for transcription accuracy and revised if necessary. In addition, transcripts were reviewed by the research team for triangulation in analysis after the initial thematic analysis was carried out using Nvivo version 8. All transcripts were analysed using open-coding, axial coding and selective coding (Flick 2006).

Findings

The findings indicate that participants have a high level of trust in their GPs. When asked if they have ever doubted or distrusted any of the information provided by their healthcare professionals (GPs, cardiologists, nurses and dieticians), all respondents indicated that “no”, they had never doubted the information they had been provided with. When asked whether or not they trust their GP, every participant indicated that “yes”, “definitely”, “absolutely” they did trust them or they made statements such as, “I’ve got faith in him to do the right thing” (Trish), “I’d put my life in her hands” (Cindy), and “I trust them completely” (Paul). The respondents of this study have all been seeing their GPs between 3 and 50 years and suggested that they are familiar with their GPs. Luhmann would argue that the level of familiarity they have with their GPs impacts the development of *trust* in the doctor patient relationship (Luhmann 1988) which was evident in the participants responses.

When speaking about seeking medical attention for minor health problems, most of the participants stated that they trust their GP specifically and that they did not have a general trust in all GPs. For example, when asked if they would see a different GP if theirs was not available, some participants said that they would see someone from their GP’s team, but that they would not visit another clinic. Others noted that they would wait to see their specific GP. Reasons for this included that they were familiar with their GP (and for some, the other GPs at their usual clinic), their GP knew their

history, they trusted their GP, they had been going to that clinic for up to 50 years etc.

Ruth explains,

We've had the locum come here but they're often not very interested and they're not very good cause I had them come one night when I was fibrillating and he said 'Ah, don't think there's anything I can do. See your doctor in the morning'.

Ruth's went on to discuss how she would not be likely to see another locum doctor.

While she would see anyone else at the clinic where she sees her regular GP, she would no longer see a locum. This suggests that the level of familiarity she has with the medical clinic she attends affects her trust in the doctors that practice there.

The theme of dependency emerged when participants spoke of their experiences in emergency situations. Participant's responded that they would 'trust' any doctor when they were in emergency situations. We question whether this is 'trust' (i.e. choice) or 'dependency' (i.e. no choice). Many participants discussed how this was the case when they had their heart attack. For example, Mary stated "Yeah I think when you're in an emergency you *have to have* [emphasis added] trust in the medical system. For emergency things you do have to trust them."

The extent to which these participants were actually 'trusting' rather than 'depending' on the healthcare professionals in emergency situations remains unresolved. Participants suggested that their GPs need to have certain qualities to be trusted: being "thorough", "caring", "speaking my language", "he took the time to explain" or that their GP is "sincere" or "genuine". Conversely, when it came to emergency situations, participants found that they did not have a choice but to trust. For example, Cindy, a 65 year old woman who has had two heart attacks and bypass surgery stated "If I don't trust them, who else am I going to trust?" Similar statements were given by several other participants. When discussing with Bob about his trust in the medical

system he noted, “*You don’t have a choice* [emphasis added] that’s what I’m saying. You still have to trust.” Similarly, Bob’s wife Lynda discussed patients’ lack of options when it comes to seeking advice, “You just have to trust that they’ll do the right thing. And if they’re not doing the right thing, what can you do?”

Several of the participants have had negative experiences within the medical system and yet their trust has not been affected. The medical system did not function in the interest of both Cindy and George⁴ as medical errors resulted in both of them having heart surgery. Despite this, both of them still have ‘trust’ in both the medical system and healthcare professionals. Cindy says she still trusts the doctor who overlooked her heart attack even though his reputation has led her to be sceptical, “I’d have trust in him but there’s been a few stories.” Her argument is that she trusts him however, the following statement indicates dependency. She discussed how he is the only doctor who works Sundays and if she has to go in on Sunday, she’ll see him and trust his information, “if you’re not going to listen to them, who the hell are you going to listen to?” Uncertainty remains as to whether or not Cindy and many of the other respondents actually ‘trust’, or if their health risks make them dependent on the most reliable source of information; healthcare professionals or ‘experts’.

Concluding remarks

Findings suggest that the degree of urgency in a medical decision (the risk involved in a medical decisions) is useful for determining the level of dependency an individual has on the medical system. Participants’ responses indicate that they have a great deal of *dependence* on medical professionals because of their health condition (CHD). This suggests that participants do not have ‘trust’ in medical advice in emergency

situations but rather, they have no choice but to follow expert medical advice. They are 'dependent' on it.

Trust can be differentiated from dependency just as trust differs from familiarity and confidence. As noted above, Luhmann suggests an individual's decision to trust is based on both experience and the risks associated with their decision. Dependency differs to trust in that a person who is dependent does not make decisions based on past experiences. They base their decision on the immediate risk and urgent need for medical advice and treatment from an 'expert'. In this case of this study, it may be argued that the participants are dependent on medical advice because of the urgency of their medical condition.

The findings may also be explained using Luhmann theorisations of power (Luhmann 1979). The relationship between doctor and patient may be understood as asymmetrical, especially in situations of emergency. As noted in the findings, many of the patients suggested that they did not trust *all* doctors. Their GPs needed to have specific characteristics such as being 'sincere', 'caring' etc. Luhmann would suggest that patients making a conscious reflexive decision to trust GPs with certain characteristics do so because these participants are familiar with their GPs. They base their decision to trust them on past information but they also have the time to assess the risks in their decisions because they are not likely in a state of emergency when visiting a GP surgery. If they are not satisfied with the care they receive from one GP, they can see another GP of their choice just as Ruth did after having a negative experience with a locum GP. Conversely, in situations of emergency, participants said that they would trust any doctor, regardless of if they had the qualities which were required for trust in a GP. In situations of risk, the power imbalance between doctors and patients becomes more defined. Luhmann (1979:109) suggests that "power

involves causing outcomes despite possible resistance” which is evident in participants responding that they ‘don’t have a choice’. Cindy’s testimony is evidence of this as she suggests that she does not trust the doctor who allegedly misdiagnosed her, but she would still see him because he is the only one that works Sundays. Although she might be reluctant to see him, she has no choice if she has an urgent need to see a doctor on Sunday.

The findings might also be explained using Foucault’s discussion of the ‘clinical gaze’ and notion of medicalisation (Foucault 1973). Foucault’s suggests that since the birth of the medical clinic, discourse and dialogue between doctors and patients has changed. This shift altered the patient-physician relationship as the divide between ‘lay’ and ‘expert’ was cultivated. The lay-professional relationship remains asymmetrical and therefore, the patient falls dependent on the medical professional and the medical system in times when ‘expert’ information is needed. Indeed, Foucault’s suggestion of the asymmetrical relationship is evident in participant’s discussion regarding their ‘trust’ in times of risk. In situations of risk, the asymmetry is heightened and there is no choice but to trust. Similarly, Luhmann (1979:114) argues that power “secures possible chains of effect independent of the will of the participant which is subjected to power – whether he so wishes or not – the causality of power lies in neutralizing the will, not necessarily in breaking the will of the interferer – this affects him also, and most precisely when he intended to do the same thing and then learns that he has to do it anyway”. Regardless of if they would have trusted the medical professional in times of emergency, patients do not have a choice but to trust.

The findings are in fitting with Foucault and Luhmann but it must be acknowledged that Foucault’s notion of ‘medicalisation’ has been challenged (Lupton 1997b).

Recent sociological literature suggests that patients are taking control back over their medical decisions (Crawford 2004; Kraetschmer et al. 2004) and are increasingly critical of those making decisions on their behalf (Birungi 1998; Davies and Rundall 2000; Gilson 2003; Mechanic and Meyer 2000; Russell 2005) as late modern individuals become more autonomous through access to information and technology. This critique is evident in the findings as participants made reflexive 'choices' to trust certain GPs. Nevertheless, power and medicalisation do appear to be important when addressing with concept of patient dependency.

The findings suggest a distinction between trust and dependency. While there are many factors that influence an individual's decision to 'trust' in situations of risk or emergency including the asymmetrical power relationship between doctors and patients, the concept of dependence is useful for investigating how trust is operationalised. We argue that in situations of risk, patient compliance or submission is not a matter of trust but rather, dependence. A person who is dependent does not base their decision to put their life in the hands of a doctor on past experience as they would in situations of trust. They base their decision on the immediate risk and urgent need for medical attention that only a medical professional can provide.

Similar to Luhmann's distinctions between trust and confidence and trust and familiarity, making the distinction between trust and dependence adds to the knowledge of sociology because it delineates the semantically different concepts. In addition, this distinction has sociological ramifications regarding human agency. As suggested earlier in this paper, trust is a matter of choice. When we trust we retain our agency because if the trust is broken, we attribute the blame internally. Conversely, when we place confidence, we give over our agency and blame is attributed externally. When we are dependent, we do not act. Rather, we have no agency

because we do not consciously decide to place trust or confidence. We passively accept decisions to be made for us (docile bodies). The notion of dependence is in need of further investigation, although findings suggest that power appears to be an influential facet in patient autonomy, agency, reflexivity and dependence.

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Notes:

- 1 Luhmann identifies two types or levels of trust; system based and interpersonal trust. System-based trust is that which is placed in the system or institution (e.g. the economic or legal system, a University or hospital) whereas interpersonal trust is negotiated between individuals (a decision to trust someone or not) but also being a learned personal trait. He argues that trust is invested in and originates as an institutional level; the institutional trust that society places in one social system is highly dependent on their trust in other social systems Luhmann, Niklas. 1979. *Trust and Power: Two works by Niklas Luhmann*. Brisbane: John Wiley and Sons.
- 2 For the purpose of this study, participants who have high risk CHD have been defined as patients who have had some form of cardiac event/heart surgery.
- 3 Socioeconomic status was determined by area of residence (using the SIEFA scale), level of education and profession.
- 4 Cindy went to her local medical centre when having chest pains. She was seen by a doctor that she does not usually see. When she suggested she needed an echocardiogram because she had not had one since her last heart attack (24 years earlier), her doctor decided against it. He diagnosed her with gallstones and sent her home. As it turns out, she had suffered a heart attack which was later diagnosed by her regular GP through an enzyme test that picks up if you have had a heart attack in the last 48 hours. George was diagnosed with a heart murmur 6 years ago. His cardiologist said that they needed to keep an eye on it and said George would be mailed a letter asking him to come in for regular check-ups. George was never contacted and 7 years later (2008) he suffered from a heart infection as a result of the murmur and had to have bypass surgery.

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