A PORTFOLIO OF RESEARCH, PRACTICE AND STUDY

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SECTION A : PREFACE

PREFACE

Several milestones were important to my professional development, which culminated in my carrying out the research included in this doctoral project. First, from 1986 I started training as a personal construct psychotherapist whilst working as a clinical psychologist. One of the clients whom I saw under the aegis of the training course disclosed to me that she did not trust anyone. This intrigued me. George Kelly (1955), the founder of personal construct psychology (PCP), devised a technique, the dependency grid, to understand how much and in whom people place their dependency. Following in his footsteps, I guided her into making two lists, the first consisting of some important people in her life, and the second of a number of situations which involved trusting others. Then, she rated the people according to how much she would trust or not trust them with respect to each of these situations prior to elaborating her reasons for trusting or not trusting them. Her remark also led to a small research project involving ten participants, all of whom were under 40 years of age, as part requirement for a research project within the PCP psychotherapy training. It was aimed at investigating some of the intra- and interpersonal factors leading people to trust or not to trust.

Secondly, five years ago, the head of the clinical psychology service for older people within the Trust in which I work who was due to retire spoke to me about her job. I was struck by the similarities between working with younger and older people as well as by her description of the richness and diversity of the work with older people. By the time I had finished preparing for my job interview I was fully 'converted' and felt enthusiastic at the possible prospect of working with this age group. Thankfully, I secured the job, but still retained one day a week with clients within the Adult Mental Heath specialism.

Thirdly, within eight months of starting the new job, I attended an international PCP conference where I presented a paper based on the small research project mentioned above. I always find conferences stimulating but my resolve in pursuing research gets drowned under the pressures of clinical work. This occasion was different because of the encouraging feedback on the paper I presented. I returned to England with a desire to engage in further research. Undertaking a doctoral degree would provide the structure and focus to complete the work.

This portfolio is divided into three sections according to the following outline. Section B, the research project, reflects my interest in younger and older populations as it focuses on the granting of trust and dependency in both age groups within the context of mental health. Section C presents a case study and concentrates exclusively on an individual therapeutic encounter with a younger client. The focus of Section D is again on older people, specifically, a literature review on the attitudes of professionals towards them. A unifying theme within the three sections is my commitment to personal construct psychology (PCP), as it informs the research and also provides the theoretical and practical framework for the case study. Recommendations for training based upon a personal construct understanding of professionals' construing of older people are included in Section D. Each of these sections are presented in further detail below.

Section B, the research project, focuses on trust and dependency. Visiting older people who had been bereaved of their loved ones, in situations of physical or existential loneliness, be it in their own homes or in residential settings, provided a new focus for my interest in trust. In addition to the loss of life-long trusted friends or relatives, some had very few people whom they could turn to, even for sharing simple human activities, like a cup of tea. Through meeting them, my previous desire to understand more about trust broadened to include the issue of dependency. I formed the impression that both trust and dependency, although different human experiences, were needed for mental health, preferably with some overlap, so that people who were depended upon could also be trusted and vice versa, at least in some respects. As a personal construct psychotherapist, I have been influenced by the theoretical understanding and the means of understanding the allocation of dependency which PCP offers. Within PCP, neither dependence nor independence is regarded as having more intrinsic worth than the other. Instead, the emphasis is placed upon the importance of being able to choose to be dependent upon people for the things they are happy to provide, and to be able to discriminate amongst people in order to be dependent upon some people for some things and other people for others.

George Kelly (1955), the founder of personal construct psychology, developed techniques to understand and measure clients' construing of themselves and of other people, including the way they depend on others, in a more idiographic way than provided by standard questionnaires. One technique he elaborated is the role construct repertory test (Kelly, 1991, p. 189), an extension of which is the repertory grid (p. 191); the other is the

situational resources repertory test (Kelly, 1991, p. 233), currently known as the dependency grid. The present research includes several objectives: (i) in the tradition of PCP, to devise a trust grid to measure trust and the granting of trust, (ii) to attempt to provide some empirical evidence that trust and dependency are separate psychological processes, although some overlap between the two is acknowledged in Chapter 4, (iii) to test whether there is a difference between the number of people who are trusted and depended upon for younger and older people, (iv) to examine whether people for whom there is a lesser correspondence between people who are trusted and depended upon experience less psychological distress and (v) to inquire whether older people and younger people experience the same amount of distress.

Forty people were interviewed; they were divided equally by gender and age. The younger subsamples were aged between 30 and 45 and the older subsamples were 65 and over. There was no difference in the level of distress experienced by the two age groups. Overall, the greatest number of significant relationships between distress and other variables was found amongst younger women and the least number of significant relationships between distress and other variables was found amongst older women. A significant relationship existed for younger women and older men in terms of the number of people whom they trusted and depended upon and their level of psychological symptoms and interpersonal dissatisfaction, such that the lesser the number of people they trusted and depended upon, the more distress they experienced. With respect of these variables, no significant relationship was found for older women and younger men. In keeping with previous research (Rossotti, 1995), it was also found that several interpersonal factors influence the granting of trust: participants granted more trust to people whom they construed as more similar to themselves, and/or people whom they liked, and/or people whose construing system they thought they understood, and/or people who, they thought, understood their construing system. Replication of previous investigations by Larson and Chastain (1990) led to similar results to theirs for the younger age group as self-concealment was significantly correlated with several types of psychological symptoms for younger people. However, no such relationships were found in the older age group.

Section C focuses on the psychotherapeutic work with a client seen as part of my work in the Adult Mental Health Specialism of a clinical psychology department. This case study aims to illustrate the value of personal construct psychology with a client who was referred

for treatment as a result of a phobia of doctors. A modification of a specific technique, fixed-role therapy, elaborated by Kelly (1955) was used and its effectiveness with this client was demonstrated. This section provides a background to personal construct theory prior to elaborating the therapy. As the client participated in an outcome research study which was conducted in the clinical psychology department, pre- and post-treatment measures, as well as data from two follow-ups were available and are reported. At the end of the therapy, the client said that he had benefited in a number of ways from the therapy, as he had developed the ability to construe and behave differently in situations in which he had previously felt anxious. His own progress report was supported by his scores on successive psychometric assessments which indicated that he became less depressed, less anxious, less hopeless and developed higher self-esteem during the course of therapy. Overall, he maintained these improvements at follow-up.

Working with older people provided the inspiration for the literature review which constitutes section D. Two specific issues focused my attention: first, the renowned difficulties in recruiting within the specialism and secondly, the surprise repeatedly expressed by clinical psychologists-in-training within our department at how much they were enjoying their placement with older people. This led me to an interest in carrying out a research project with such trainees. This study would be three-fold: (i) to measure and compare the trainees' construing before starting the placement and after finishing it, (ii) to understand the elements of their construing which may have changed as a result of their experiences with older people and (iii) to assess the influence of their construing of their grandparents on their views of future older clients prior to their placement. Before embarking upon this new research, I wished to survey the literature on the topic with respect to a number of professional groups. This review therefore focuses upon the attitudes of professionals towards older people. Five professional groups are included: medical staff, nurses, social workers, physiotherapists and clinical psychologists. The review takes into account the views of professionals and trainees, working in physical as well as mental health settings. It was found that there are a number of factors which make it difficult to reach clear-cut comparisons of studies. These are: (i) the variety of the instruments used to measure attitudes, (ii) the diversity of training in the countries where research has been carried out, (iii) the fact that research is done with people at different stages of training or with different levels of qualifications. So whether attitudes of professionals towards older people are favourable or unfavourable remains an open debate, but the lack of enthusiasm reported in the studies with regard to working with older people

appears universal. Surprisingly, the level of desire to work with this age group does not seem to be influenced by the training that people went through though, overall, it would seem that attitudes are affected by their training. Contact with well older people prior to and/or during training is also seen as valuable in the development of more positive attitudes.

The process involved in completing the work included in this thesis has been enriching and has consolidated my interest in conducting research. The place that trust and dependency hold in people's lives remains of interest to me. As the current research has not elucidated all the problems that intrigued me at the outset, I hope very much to return to them in the future. At times, during the reviewing of the literature for Section D, I was profoundly saddened by many of the attitudes towards older people prevailing in society at large and by those of some professionals within the caring disciplines. Yet, the extensive literature surveying attitudes towards older people unfailingly conveys an immense concern amongst many professionals about the inadequacy of the status quo as well as an acknowledgement of the need for change. This is vitally necessary for people, young and old alike, if they are to be accorded their due dignity and a fair opportunity to fulfil their potential. Meanwhile, I would like to dedicate this thesis to the older people who try to keep faith in themselves in adverse circumstances.

SECTION B : RESEARCH

A Personal Construct Investigation of Trust and Dependency in Younger and Older People

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ABSTRACT

Trust and dependency are construed as important and separate human processes. The research presents the development of a new instrument, the trust grid, the design of which was based upon personal construct theory and methodology. The study compares trust and dependency in younger and older people. It also investigates the relationship of the number of people trusted and depended upon, with mental health on the one hand and interpersonal satisfaction on the other. Trust and dependency were assessed for 20 younger people (10 men and 10 women aged 30 to 45) and 20 older people (10 men and 10 women aged 65 and over) who were clients either in therapy or awaiting therapy from a National Health Service Clinical Psychology Department. The repertory and dependency grids (Kelly, 1955; 1991) were used, as were four questionnaires to measure mental health, interpersonal satisfaction, self-concealment and interpersonal trust. Statistical measures included Pearson's correlations, *t*-tests, and where required by the properties of the data, Mann-Whitney *U* tests and Wilcoxon Signed-Ranked tests.

Results provided empirical evidence confirming that trust and dependency constitute two psychological processes. They also showed that there were significant differences between the two age groups, with gender also an important variable. A greater correspondence existed between the people who were trusted and those who were depended upon in the younger age group than in the older age group. There was evidence that the higher the number of people that younger women depended on and also trusted, the lower the level of psychological and interpersonal distress they experienced. No significant relationship existed for younger men. Older men experienced a positive relationship between psychological distress and the number of people they trusted and depended upon, as well as between interpersonal distress and the number of people they trusted and depended on. No positive relationships were found for older women.

The study provides a new contribution to the interpersonal literature as trust and dependency have not, to the researcher's knowledge, previously been investigated together. It provides findings which concord with earlier studies regarding the importance of relationships for younger women and their lesser importance for younger men. The results for older people are difficult to interpret as they appear to contradict clinical experience. Further research is suggested with larger samples of older men and women.

CHAPTER 1

INTRODUCTION

1.1 Background to the study

Of central importance to our relationships with others are our decisions about whom to trust and whom to distrust, when to do so and with what confidences. An interest in understanding the process of granting or withdrawing trust arose some years ago whilst the writer saw a client who affirmed that she did not trust anyone. An analogy was offered by George Kelly's (1955; 1991) conceptualisation of dependency, for whom it was not a question of being dependent or independent, but of whom one depends upon and for what. It seemed possible to help the aforementioned client to view trust with similar discrimination, as "it is equally faulty to trust everyone and to trust no one" (Seneca, 1917 Edn). The therapist, therefore, enquired of the client when and with what she did and did not trust particular individuals in the course of her life. Work with this client led to the development of a technique (Rossotti, 1995) aimed at understanding how trust and mistrust are granted.

The present project aims to compare the experience of a sample of young mature adults which was the basis of the 1995 work with that of a sample of older people. Home visits to older persons whose relatives and close friends were all deceased, and consultations in residential and nursing homes, prompted further thoughts about trust and also dependency. It appeared that, towards the twilight of our lives, some of us, following bereavements and physical and/or mental ill-health, live in situations of high dependency without the people to care for us whom we have trusted for much of our lives. Even though this writer thought of trust and dependency as separate processes, a degree of correspondence between the two was judged to be necessary for mental and physical health.

1.2 Outline of the research

Three primary aims motivated this research. The first was to redesign an instrument to assess the degree of interpersonal trust placed in other people, based on an instrument previously used for a pilot study (Rossotti, 1995). This instrument, the trust grid, was created for use in this current research, and for use in therapy with the aim of exploring the reasons behind clients' trusting and not trusting others. The second was to attempt to establish empirically that trust and dependency are separate psychological processes. The third was to compare, using quantitative research methods, a group of younger people (aged between 30 and 45) and a group of older people (aged 65 and over), investigating the similarities and differences in the people they trust and depend on, as well as the relationship this has to their mental health. The theoretical orientation that the researcher follows, Kelly's (1955; 1991) personal construct psychology (PCP), has informed the aims, methodology and design of the study.

For practical reasons, participants came from a narrow cross-section as all of them were out-patients. All were seen individually for the purpose of research. Three different instruments (the repertory grid, the dependency grid and the trust grid) derived from personal construct psychology, and four questionnaires were used in the study. The repertory grid (Kelly, 1991) consists of a matrix of people and characteristics: in addition to their "ideal self", 11 people known to each participant were rated on personal or interpersonal qualities, some which were provided by the participant and others by the researcher. For the dependency grid (Kelly, 1991), the same 11 people were rated according to the extent to which the participant would turn to them in specific situations, and for the trust grid, these people were rated according to the degree to which the participant would or would not trust them with particular feelings or in particular situations. As the trust grid is a new instrument, a previously validated trust scale (The Specific Interpersonal Trust Scale, Johnson-George & Swap, 1982) was used to test the validity of the trust grid. Psychological distress was measured with the Brief Symptom Inventory (Derogatis, 1993), and interpersonal dissatisfaction was measured by the Inventory of Interpersonal Problems - Short Form (Soldz, Budman, Demby & Merry, 1995). Replication of previous findings (Larson & Chastain, 1990) concerning the relationship between psychological health and self-concealment was carried out using the Brief Symptom Inventory and the Self-Concealment Scale (Larson & Chastain, 1990).

The three chapters which follow this brief introduction focus on a review of the literature: Chapter 2 covers trust, Chapter 3 dependency, and Chapter 4 the relationship between trust and dependency. Chapter 5 sets out the hypotheses and introduces literature relevant to the study but unconnected either to trust or dependency. Chapter 6 describes the Methods and Procedures and Chapter 7 provides the results. Chapter 8 includes a discussion of the results as well as of the methodology.

As the study has been informed by PCP, terms pertaining to this theory have been used within the text. PCP words or expressions, that are removed from every day language, have been replaced by plain English. Otherwise, PCP terms, denoted by an asterisk the first time they are used, are defined in the glossary in appendix 1.

CHAPTER 2

TRUST

2.1 Introduction

This chapter focuses on the first important construct under investigation: trust, and is divided into seven sections. The first is a review of the different definitions which have been proposed; the second follows an examination of the reasons which make trust an important construct for study. The next section provides a list of the antecedents of trust. The fourth delineates the components of trust from psychological and sociological perspectives. The relationship between trust and three other constructs (gullibility, self-disclosure and loneliness) is then considered. This is followed by demographic data concerning trust, especially with regard to gender. The last section provides a review of the most frequently used trust inventories and scales.

2.2 Definitions

Trust has received much attention in psychological, social, philosophical and, more recently, management writings, yet it still lacks a unified definition. Prior to considering the definitions from the areas of study which bear some similarity to this research, dictionary definitions are considered as a starting point. The Compact Oxford English Dictionary (1993, p. 2122) provides early meanings as "confidence" in the thirteenth century, and "reliability" and "fidelity" in the fifteenth century. Chambers' (1983, p. 1388) definition reads: "worthiness of being relied on: fidelity: confidence in the truth of anything: confident expectation: a resting on the integrity, friendship, etc., of another: faith, hope: ....". Stack (1978, p. 564) reported that "Webster defines trust as a sense of belief: an assured reliance on some person or thing; a confidence dependent on the character, ability, strength, or truth of someone or something. The distinguishing feature ... is that it may rest on blended *evidence of experience* and on more *subjective grounds*, such as knowledge, affection, admiration, respect or reverence." According to Stack (p. 564), "These dual sources of trust (objective and subjective) seem to differentiate it from related concepts", such as confidence, reliance, and faith.

There exists a substantial amount of research on trust, with many writers having attempted to provide a definition. Hosmer (1995) provided a comprehensive review of the status of trust and noted like many others before him that, owing to the wide variety of contexts and approaches to the concept, a lack of agreement regarding its definition has persisted.

Definitions of trust developed in academic papers have tended to focus, either singly or in combination, on notions of contract, predictability, vulnerability and probability, as well as differences between person-specific and generalised trust. Definitions considering these different aspects are considered in turn. Lastly, one definition from the field of psychotherapy is provided.

From the perspective of social-learning theory, Rotter (1967, p. 651) defined trust as "an expectancy held by an individual or a group that the word, promise, verbal, or written statement of another individual or group can be relied upon." Rotter's definition is very different from that of other authors, as it is based on a contract which excludes the non-verbal, subjective assessment of the character of another upon which trust can also be based.

An emphasis on the positive characteristics of others without the notion of contract can be found in the work of writers such as Gurtman (1992), Sorrentino, Holmes, Hanna & Sharp (1995) and Pistole (1993). Gurtman (p. 989) saw trust as "an individual's characteristic belief that the sincerity, benevolence, or truthfulness of others can be relied on". Sorrentino et al.'s definition read: "[T]rust is the antithesis of doubt: It is conceptualized as a state of felt security that marks at least a temporary resolution of feelings of uncertainty" (p. 314). For Pistole (1993, p. 96), whose definition is based on Erikson's (1987) conceptualisation, "Trust is a pervasive attitude that implies an experience of goodness as well as confidence in the sameness and continuity of the other".

These definitions imply that trust is based on predictions. Yet for Lewis & Weigert (1985, p. 976), "trust begins where prediction ends." The definitions provided by Gurtman (1992), Sorrentino et al. (1995), and Pistole (1993) are also in sharp contrast to those who have considered that risk and vulnerability are an essential feature of trust, such as Boon & Holmes (1991) and Zand (1972). Boon & Holmes (p. 194) emphasised both factors and they viewed trust "as a state involving confident positive expectations about another's motives with respect to oneself in situations entailing

risk" whereas Zand (1972) emphasised vulnerability. He viewed trust as the willingness to "increase one's vulnerability to others whose behavior one cannot control" (p. 231). Baier (1986, p. 235), a philosopher, also stressed this same idea: "Trust ... is accepted vulnerability to another's possible but not expected ill will (or lack of good will) toward one." Yet, vulnerability cannot be complete as this would shift the ground from trust to gambling (Simmel, 1978).

Deutsch's (1958) definition comprised three components: the probability of an event occurring as well as the consequence of an event, and the vulnerability associated with trusting. For Deutsch, "*An individual may be said to have trust in the occurrence of an event if he expects its occurrence and his expectation leads to behavior which he perceives to have greater negative motivational consequences if the expectation is not confirmed than positive motivational consequences if it is confirmed*" (italics in text) (p. 266).

Larzelere & Huston (1980) distinguished between generalised trust and trust attached to one particular other person. Their starting point is a general definition of trust, leading to a very significant differentiation within the particular rather than the general context.

> Trust exists to the extent that a person believes another person (or persons) to be benevolent and honest. Dyadic tyrust [sic] can be distinguished from generalized trust in that the former refers specifically to the benevolence and honesty of a significant other toward the individual making the judgment. Generalized trust, in contrast, refers to a person's belief about the character of people in the aggregate. (p. 596)

Surprisingly, only one definition was found from a psychotherapist, Clarkson (1989, p. 75), who wrote that "Trust is that state of being during which people believe that their needs can be met without injury by others or their environment. Distrust is the conviction that the environment will be neither nourishing nor benign."

Whereas agreement on a definition of the construct of trust is not to be found, its importance within interpersonal relationships from the private to the public domain is not in doubt, as is shown in the following section.

2.3 The importance of trust

Rotenberg (1990, p. 141) said that " Researchers have found that trust plays a key role in children's and adolescents' peer relationships and moral reasoning." Research does indeed indicate that trust plays a critical role in young adults' formation of intimate relationships and in their social communication. The correlates of trust amongst children and young people have been researched in terms of the implications for them as individuals and for society as a whole. Trusting adolescents experience higher self-esteem (Earl, 1987) and, conversely, "A lack of trust has been consistently implicated in the development of maladjustment including socially irresponsible criminal and delinquent behavior" (Bernath & Feshbach, 1995, p. 15).

Johnson-George & Swap (1982, p. 1306) also spelled out the gains derived from interpersonal trust: "Interpersonal trust is a basic feature of all social situations that demand cooperation and interdependence." For Altman & Taylor (1973), the progression and reciprocity of exchange found in on-going relationships was predicated upon building mutual trust. Stinnett & Walters (1977) suggested "that trust increases security in a relationship, reduces inhibitions and defensiveness, and frees people to share feelings and dreams" (quoted in Larzelere & Huston, 1980, p. 595).

Trust often manifests itself in self-disclosure and mistrust in self-concealment. Derlega, Metts, Petronio & Margulis, (1993, p. 1) acknowledged loosely defining self-disclosure "as what individuals verbally reveal about themselves to others". Jourard (1971, p. 6), following the tradition of the existential philosopher, Buber (1937), considered that self-disclosure is "the index of man functioning at his highest and truly *human* level" (italics in text), and that one of the pre-conditions for self-disclosure is an attitude of trust. Larson & Chastain's research (1990) indicated that people who scored highest on their Self-Concealment Scale experienced significantly more physical symptoms, anxiety and depression than others who scored lowest on the Self-Concealment Scale.

Butt, Burr & Bell (1997) investigated the experience of being-within-relationships. They found that, for their respondents, trust was an important factor in "differentiating between relationships" (p. 25). The importance given to trust was as an ontological process. For their respondents, what mattered most was not sharing a secret or revealing the inner depth of one's soul, but the quality of the experience of being with the other:

> [T]rusting the other to accept and validate whatever version of our self should emerge in that relationship. ... There was a consensus that being oneself referred to the absence of self-consciousness and the relaxing of self-monitoring. Being oneself meant allowing oneself to be carried along in the social flow unreflectively and without exercising effort. Allowing a social situation to unproblematically conjure up a particular self seems to be what people most enjoy. Having to manage and reflect on an interaction produces unease. (p. 25)

The importance of trust in the functioning of society has also been stressed (Stein, Soskin & Korchin, 1974; Lewis & Weigert, 1985; Bok, 1978). Bok (p. 19) wrote that "A society ... whose members were unable to distinguish truthful messages from deceptive ones, would collapse. But even before such a general collapse, individual choice and survival would be imperiled." Bok (1978, p. 31) appeared to view trust as a wholly positive construct as witnessed by this quotation: "*Whatever* matters to human beings, trust is the atmosphere in which it thrives" (italics in text). Yet, Baier (1986, pp. 231-232) cautioned against an indiscriminate view of trust as she considered that "Exploitation and conspiracy, as much as justice and fellowship, thrive better in an atmosphere of trust."

Nevertheless, the need for trust and its importance to human beings in their relation with others is well established, and the effect of distrust poignantly expressed by George Eliot (1871-1872; 1965 Edn, p. 480): "what loneliness is more lonely than distrust?" Trust remains a valuable subject of study because "We are doomed if we trust all and equally doomed if we trust none" (Stack, 1978, p. 561), so the quest for deciding how to place one's trust judiciously is very valid.

2.4 Antecedents of interpersonal trust

Conceptualisations of the antecedents of interpersonal trust differ with regard to the number of influences considered. Some writers have focused exclusively on attachment history, thus emphasising the determinant effect of the influence of the primary caregiver upon the infant (Erikson, 1994; Bowlby, 1973). Others (e.g., Boon & Holmes, 1991) have theorised about various influences upon trust, considering attachment history one variable amongst others such as *"relationship history"* (p. 198, italics in text), and the *"effects of perceptual distortions on trust"* (p. 199, italics in text) also playing a significant influence on whether trust or mistrust is displayed.

Erikson (1987; 1994) "regard[ed] basic trust as the cornerstone of a vital personality" (1994, p. 97). For Erikson (1987), trust was a basic sense of faith in the self and the world, whereby the infant developed the ability to regulate bodily functions and, with sensitive maternal caregiving, resolved the inner conflict surrounding dependency. Erikson (1994, p. 82) emphasised the crucial role of the mother in meeting the infant's needs in the development of a "sense of basic trust". This occurs through satisfying his or her feeding needs and through communicating "to the baby, through the unmistakable language of somatic interchange, that the baby may trust her, the world, and - himself" (p. 82). Similarly, Bowlby (1973; 1991) emphasised the primordial importance of the quality of the mother-infant relationship in helping the infant to develop "working models" (1973, p. 203). These working models are based on the mother's or carer's responsiveness to the infant's needs and within them are embedded the views that others would also be responsive to his/her needs. Stern (1985) also stressed the importance of the carer being sensitive to the affect expressed by the infant.

Ainsworth et al. (1978) investigated the quality of the mother-infant relationship by way of the nature of attachment. Ainsworth studied behaviours displayed by one-year-old infants towards their mother following reunion after separation, which prompted the classification of patterns of attachment into three main groups: securely attached, avoidant, and anxious/ambivalent. Ainsworth (1978) reviewed longitudinal studies which have compared attachment patterns in infants and then repeated behavioural measures as these infants grew into older children, up to six years of age. Ainsworth (1979, p. 936) wrote that "In comparison with anxiously attached infants, those who are securely attached as 1-year-olds are later more cooperative with and affectively more positive ... toward their mother and other less familiar adults." She added that "in problem-solving situations, they are more enthusiastic, more persistent, and better able to elicit and accept their mother's help. They are more curious, more self-directed, more ego-resilient" (p. 936). In other words, they appear to have acquired the three kinds of trust described by Bernath & Feshbach (1995), that is, trust in others, self-efficacy, and self-trust.

The link between attachment styles and the type of intimate relationships people formed as young adults was researched by Hazan & Shaver (1987). They conducted two studies investigating the relationship between the nature of people's romantic relationship and their attachment style (secure, avoidant, and anxious/ambivalent). They found that secure individuals differed significantly from the non-securely

attached participants and described "their love experiences as happy, friendly, and trusting" (p. 518). Hazan & Shaver (1987) reported that Hindy & Schwarz (1984) found that, when more than one close relationship was being investigated, the extent of security or anxiety which were experienced in those relationships depended not only upon the attachment style but also upon particular factors involving the partner and circumstances.

Unlike Erikson (1987) and Bowlby (1973), Boon & Holmes (1991) argued against "a relatively enduring and stable disposition to trust" (pp. 195-196) and considered that this disposition is one factor amongst a number of variables which account for the display or denial of trusting behaviour. For them, other factors, such as the history of the relationships and the effects of perceptual distortion, also greatly influence the display of trusting behaviour. Within the relationship history, they placed an emphasis upon the patterns of met and unmet needs. "Patterns of responsiveness and validation that have characterized the relationship in the past lay the foundation for ... the subjective forecast of what the future holds" (Boon & Holmes, 1991, p. 198). Yet, the decision to trust will be based on an interplay between the history of the relationship and the chronic disposition to trust or to mistrust.

Boon & Holmes (1991) also considered the effects of perceptual distortion on trust. They suggested that this might happen through unwittingly eliciting in the other behaviour confirming one's expectation of the other (that is, a self-fulfilling prophecy), or exclusively construing the evidence corresponding to one's expectations and ignoring contrary information.

Another aspect of the origin of trust was investigated by Into (1969) in a study focusing on the parental roles in the development of trust amongst college students, using recollections of child-raising behaviours in their parents. It was found that the strongest influences were modelling from both parents - although this emerged as a little stronger from fathers than mothers - and direct teaching. Further evidence of the role of modelling, and especially by the father, has been gathered by a study by Katz & Rotter (1969) who investigated the level of general trust in college students and their parents. Reporting on Into's study, Rotter (1971) added that

> the parents of high trusting subjects were more trusting to their children, were more trustworthy, trusted outsiders more, and directly taught trust and trustworthiness. ... Low trusters were likely to report that their parents made no threats or made them and did not keep them, and high trusters were likely to report

that their parents both made and kept threats. (p. 449)

Finally, Bernath & Feshbach (1995) considered some of the factors which have been shown to impair the development of trust. These are sexual abuse, physical abuse or maltreatment, maternal alcoholism combined with a number of stressors within the home, and conflict between parents.

Thus, whilst there is consensus about the importance of the influence of the primary caregiver upon the infant as an antecedent of interpersonal trust, a variety of other potential variables has also been investigated. There is also considerable diversity of theoretical positions with respect to the components of trust, which are reviewed in the following section.

2.5 Trust components

An understanding of the components of trust has been sought from psychological and sociological perspectives. Writing from a psychological perspective, Rempel, Holmes & Zanna (1985) considered trust in terms of three developmental stages: predictability, dependability and faith. The first stage is the most basic level which, according to Rempel et al., originates from social learning experiences. They placed an emphasis upon the previous behavioural pattern exhibited by others in terms of consistency and stability. The second stage, dependability, concerns people rather than action. At this level, one asks oneself about the reliability, honesty and ability to count on others. It refers also to the dispositional qualities of the partner which are relevant for trust. To attain this level in relationship, risk, including the potential for rejection and ridicule, needs to be taken into account. Attainment of these two levels in any relationship is based on past experience. According to Rempel et al., the third stage involved in trust requires faith, as "there are no guarantees that the hopes and desires invested in a close relationship will ever be realized (p. 97). ... Thus with faith, the focus is not on specific behaviors and goes beyond even an emphasis on dispositional attributions" (p. 97). Rempel et al. argued that both predictability and dependability would influence the development of faith, but they conceded that so too do factors not covered by this model. These include intrapersonal factors within the person who trusts or does not trust, including personal security and self-esteem. They suggested that these characteristics "contribute to the extent to which a person is willing to take emotional risks in uncertain circumstances" (p. 98).

A later psychological understanding of trust was developed by Rotenberg (1994) who identified a three-dimensional model of trust composed of three bases of trust. These are further differentiated into two domains, with both bases and domains further differentiated into the qualities of the trusted or distrusted people. At the first level, the three bases of trust are:

> a) reliability, which refers to the fulfilment of word or promise ... b) emotional trust, which refers to the reliance on others to refrain from causing emotional harm, such as being receptive to disclosures, maintaining confidentiality of them, refraining from criticism and avoiding acts that elicit embarrassment ... and c) honesty, which refers to telling the truth and engaging in behaviors that are guided by benign rather than malicious intent, and by genuine rather than manipulative strategies. (p. 153)

The two domains are cognitive/affective and behavioural. The former domain refers to beliefs/attributions pertaining to the three bases of trust and "the emotional experiences accompanying those beliefs or attributions" ... while "The behavioral domain pertains to individuals' behavioral tendencies to rely on others to act reliably, in an emotional trustworthy fashion and honestly" (Rotenberg, 1994, p. 154). The third dimension, which further subsumes the bases and domains just described, refers to the qualities of the trusted or distrusted target. These can be unspecific (people in general) or specific (friends), as well as unfamiliar (politicians) or familiar (partner).

Sociologists have been very critical of psychological explanations of trust and their emphasis on the individual. Lewis & Weigert (1985, p. 968) stated that "From a sociological perspective, trust must be conceived as a property of *collective* units (ongoing dyads, groups, and collectivities), not of isolated individuals. Being a collective attribute, trust is applicable to the relations among people rather than to their psychological states taken individually." In their view, "the primary function of trust is sociological rather than psychological, since individuals would have no occasion or need to trust apart from social relationships" (p. 969). They added, in a more provocative fashion, that "the *bases* on which trust rests are primarily social as well" (p. 969) which, they argued, "raises the question of how trust in other persons and institutions is established, maintained, and, when necessary, restored" (p. 969). Their conceptual analysis of trust included the three bases of trust described by Rotenberg (1994). Within their model, trust comprised three distinct components, cognitive, emotional, and behavioural, "which are merged into a unitary social experience" (Lewis & Weigert, 1985, p. 969). "First, trust is based on a cognitive process which discriminates among persons and institutions that are trustworthy,

distrusted, and unknown" (p. 970). Discrimination at this level referred to the respects and the circumstances in which trust is granted or withheld. A precondition for trust according to Lewis & Weigert (1985), Simmel (1978), and Luhman (1979) is "a degree of cognitive familiarity" (Lewis & Weigert, p. 970); this involves neither total knowledge nor total ignorance, as both of these conditions exclude the possibility of trust. The former precludes trust as no element of risk or vulnerability is involved and in the latter condition gambling, rather than trust, would result. The second condition or basis of trust is emotional in nature, and complementary to the first. Lewis & Weigert (1985) stated that "the emotional component is present in all types of trust, but it is normally most intense in close interpersonal trust" (p. 971). The third component of trust is behavioural, that is "the undertaking of a risky course of action on the confident expectation that all persons involved will act competently and dutifully" (p. 971). The first and the last components are dependent on each other as, when one person behaves in a trusting way, the other is more likely to reciprocate, with its opposite also being true. Finally, within everyday life, they considered that the decision to trust would be based on two elements, feelings and rational thought.

2.6 Trust and its relationship to other constructs

In this section, a summary of the relationship between trust and four other constructs is presented. A more detailed comparison between trust and dependency, the two constructs central to this study, appears in Chapter 4. Those considered here are trustworthiness, gullibility, self-disclosure and loneliness.

Rotter (1980) reviewed experimental studies exploring the relationship between trust and gullibility (Geller, 1966; Hamsher, 1968; Wright, 1972). Trust was defined as "believing communications in the absence of clear or strong reasons for not believing (i.e. in ambiguous situations)" (Rotter, p. 4) and gullibility was considered as foolishness and naiveté, which for the purposes of these studies was operationalised as "believing another person when there was some clear-cut evidence that the person should not be believed" (p. 4). It was found that high trusters were not more gullible than low trusters. This was later confirmed in a study by Gurtman (1992). Yet, Rotter suggested that there was an important difference between high and low trusters in their attitude towards strangers of whom they had no previous knowledge. High trusters would choose to trust people until they obtained clear-cut evidence that others could

not be trusted, whereas low trusters would adopt the reverse position of not trusting others until they gathered the evidence that they could be trusted.

The relationship between self-disclosure and trust has been considered by various writers (Jourard, 1971, Altman & Taylor, 1973; Steel, 1991). Self-disclosure has been seen by Jourard (1971) as making oneself fully known to at least one other significant human being. Altman & Taylor (1973) suggested that, when self-disclosure is followed by reciprocity of disclosure and fulfilment of positive expectations expected from self-disclosure, relationships grow in trust and in turn further self-disclosure might take place. Steel (1991) studied the relationship between trust and self-disclosure in a sample of 100 American undergraduates. Trust was measured with Rotter's (1967) Interpersonal Trust Scale and self-disclosure with a 60-item version of Jourard's (1971) Self-Disclosure Questionnaire. She found a low but significant correlation between the two constructs ($r = .236$, $p < .01$). Rawlings (1983) considered that one's construing of the other person's ability to be discreet was an important factor in self-disclosure, whereby the likelihood of self-disclosure is predicated upon, first, trust in the other person's discretion and, secondly, the need to be open.

Rotenberg (1994) investigated the relationship between loneliness and interpersonal trust in undergraduate students over three studies. Having reviewed several conceptualisations of loneliness (McWhirter, 1990; Solano, Batten & Parish, 1982; Stuewe-Portnoff, 1988), he concluded that it "corresponds to an individual's lack of satisfaction with his/her social relationships" (p. 152). Loneliness was measured with the revised UCLA Loneliness Scale (Russell, 1982), and trust was measured in different ways according to the hypotheses and investigations of each study. These included the measurement of trusting behaviour towards unknown individuals (confederates) and the rating of two aspects of trust (emotional trust and reliability) and the quality of individuals' relationships with chosen close peers. Also, in one study, students predicted the degree of trust that these close peers felt towards them, whilst in another study, students and close peers participated in the research and rated the quality of their relationship and the degree of trust. Rotenberg found that "loneliness was negatively associated with individuals' trust in their close peers, as well as in perceptions of closes [sic] peers[']' trust in them (the individuals)" (p. 166). However, the findings also suggested that the students' loneliness was not related to the degree of trust placed in them by their close peers as "lonely students were not less trusted, emotionally or [in terms of] reliability, than were nonlonely students by close peers" (p. 170). He hypothesised instead that lonely people did not provide as much intimate

disclosure as nonlonely people because they believed that others would be critical or would not keep their disclosures confidential.

2.7 Trust and demographic data

The work on trust that has been reviewed to this point takes no account of the potential influence of such demographic factors as position in the family, race, religion, socioeconomic status and gender.

Rotter (1967) presented data indicating differences in trust between children's rank position within the family (with youngest children being the least trusting) and religious affiliations. Although students affiliated to any religion were more trusting than those who were atheists, agnostic, or those who wrote that they had no religion, Rotter (1971) nevertheless emphasised that these differences, although statistically significant owing to a large number of subjects, represented very small differences in means, with much overlap existing between groups. Wrightsman (1974) reported that black people were found to be less trusting than white people and similarly Asians obtained lower trust scores than Caucasians (Steel, 1991). Several explanations have served to account for these findings. This result concords with Rotter's (1967) finding of a relationship between trust and economic level, whereby people enjoying the highest economic level show more trust than those at the lowest economic level. Also, the scales used in these studies measured trust towards aspects of society (such as politicians) or people in general, rather than people known to the respondents. A sociological explanation for the racial difference was provided by Stack (1978), in terms of the societal support necessary for the development of trust and unavailable to these non-Caucasian groups. Steel (1991) found that people who scored low on trust of people in general disclosed more often to family members than to nonfamily members. Even though Jourard's (1971) self-disclosure scale does not measure trust, he contends that an attitude of trust is needed for self-disclosure. This supports the implication that Wrightsman's (1974) and Steel's (1991) studies measured individuals' trust only in a specific context.

Stack (1978) reviewed the research investigating patterns of trust with respect to gender. In the 1967 study, Rotter found no differences in total scores in interpersonal trust between men and women. According to Roberts (1972), similarity in total scores concealed differences in the distribution of trust, whereby men were significantly

higher in Political Trust and women in Trust of Peers. Using the same scale and taking into account gender differences, a significant drop in trust was found over six successive intakes of university students (Rotter, 1971). Item analyses revealed that items with the greatest decrease in trust related to politics, peace keeping and communication, in contrast to items relating to interpersonal relations, be they with family or salesmen, which showed little or no change.

Further evidence of gender differences was found by Johnson-George and Swap (1982) when they devised the Specific Interpersonal Trust scale. The same items given to male and female undergraduates yielded such different factors as to necessitate the formation of two separate scales, one for males and one for females. Four factors appeared for men (General Trust, Emotional Trust, Reliableness, and Dependability) and three emerged for women (Reliableness, Emotional Trust which, unlike for men included items related to an aspect of another's credibility or honesty, and Physical Trust). Women also used "more differentiated dimensions" (p. 1315). Although the scale was constructed for measuring trust in meaningful interpersonal relationships, two experiments were carried out to test some properties of the scales. Under conditions of experimental manipulation they found that women were consistently more trusting in their rating of their experimental partners.

Contradictory evidence is provided by Lagace & Gassenheimer (1989) using the eight-item Self-report Trust Scale (MacDonald, Kessel, & Fuller 1972), which Lagace & Rhoads (1988) showed to represent two factors, trust and suspicion. Lagace & Gassenheimer (1989) found no gender difference regarding trust, but within their samples men were more suspicious than women. This study included 242 adults (with 52.5% of men and 47.5% of women). The present writer speculates that the discrepancy in the results yielded by the use of two different scales might be accounted for by the difference in the number and the breadth of items covered by the scales.

2.8 Trust inventories and scales

Trust inventories and scales are reviewed in detail with the aim of selecting the most appropriate one to compare with the present researcher's trust measure, the trust grid, which has not been validated.

Overall, three main types of trust measurement have been developed. Two of these are standard form questionnaires, of which two different types exist; the first one tends to measure a generalised expectancy of whether other people can or cannot be trusted. The second focuses on the respondents' construing of specific people's trustworthiness. Both of these represent measurement at the cognitive level as they investigate the respondents' subjective perception of their trust towards others. A different type of measure was developed as a behavioural correlate of trust; this is a variant of the Prisoner Dilemma Game developed by Luce & Raiffa (1957). Deutsch (1960) modified the roles of the participants and renamed the game the two-person non-zero-sum game. Even though Deutsch's version of the game has been used in subsequent research, the original name has been employed in most reviews and, therefore, will be used in this writing.

Scales and inventories measuring trust towards people in general or specific groups of people are reviewed first. This is followed by scales and inventories measuring trust in specific people, and finally by the Prisoner Dilemma game. In each case, the focus and, when they are available, theoretical basis, validity and reliability are indicated.

2.8.1 Scales measuring generalised expectancy of others' trustworthiness

The most frequently used and studied scale focusing on a generalised expectancy of people's trustworthiness is Rotter's Interpersonal Trust Scale (Rotter, 1967). Others include the Philosophy of Human Nature (Wrightsman, 1964), the Self-report Trust Scale (MacDonald, Kessel & Fuller, 1972), and the Trust Scale of the Erikson Psychosocial Stage Inventory (Rosenthal, Gurney & Moore, 1981).

2.8.1.1 Rotter's Interpersonal Trust Scale (ITS) (Rotter, 1967)

Rotter's (1967, p. 653) understanding of people was based upon the principles of social learning theory. When applied to trust this meant that "individuals would differ in a generalized expectancy that the oral or written statements of other people can be relied upon." Rotter (1967, p. 653) cited the works of Mahrer (1956) and Mischel (1961a; 1961b) to corroborate his assertion, as their findings "strongly suggest that children who have experienced a higher proportion of promises kept by parents and authority figures in the past have a higher generalized expectancy for interpersonal trust from

other authority figures." Examining the assumptions of Rotter's scale, MacDonald, Kessel & Fuller (1972) suggested that trust as defined by Rotter and measured by this scale is contractual in nature.

Research demonstrated good reliability for the Interpersonal Trust Scale and support was provided for its validity. Rotenberg (1990) reported other researchers' findings regarding factors found within the scale. Three reliable factors were found:

> 1) political cynicism which is skepticism about politicians and political bodies; 2) interpersonal exploitation which is a cautious orientation that corresponds to the perception of others as exploitative; and 3) belief in that dependability of people which is the belief in the consistency between what others say and do. (p. 143)

Chun & Campbell (1974) found a fourth factor concerning "hypocrisy [in society] and the failure to fulfill role requirements" (p. 1064). Rotenberg (1990) modified the scale for use with older people, by simplifying the language and reducing the number of items. His analysis also yielded four factors, but although the third concerning dependability and the fourth concerning hypocrisy coincided with factors found by Chun & Campbell, the first pertained to "the dependability of social-legal organizations" and the second involved a "fear of being cheated" (p. 147). Rotenberg hypothesised that these two aspects of trust were more important to older people than to younger cohorts.

2.8.1.2 The Philosophy of Human Nature (Wrightsman, 1964)

The Philosophy of Human Nature (PHN) is made up of six components, one of which is trustworthiness, defined by its author as "the extent to which people are seen as moral, honest, and reliable" (Wrightsman, 1964, p. 744). Out of the total 84-item scale, 14 are devoted to trust. Altruism, independence, strength of will and rationality, complexity of human nature, and variability in human nature form the other components. Results based on studies of 530 undergraduates did not bear out the unrelatedness of all the components, and Wrightsman (1991, p. 387) stated that it was found that "people who are considered unreliable and dishonest are also perceived as selfish and uncooperative." The Revised Philosophies of Human Nature Scale, with only 20 items, is recommended by Wrightsman (1991) for the exclusive study of trust and cynicism.

When comparing the Interpersonal Trust Scale (IT) and the Philosophy of Human Nature (PHN), Stack (1978, p. 569) found that they were "remarkably similar" although she also stated that "trust [as measured by the IT] has been tied somewhat more successfully to actual behaviors and other validating evidence than has trust" as measured by the PHN.

2.8.1.3 The Self-report Trust Scale (STS) (MacDonald, Kessel & Fuller, 1972)

The STS was devised specifically for a research project to test out previous findings by Rotter (1967) regarding the positive relationship between the Interpersonal Trust Scale and self-ratings of trust. Having also set out to investigate the relationship between trust and self-disclosure, Kessel devised the STS, consisting of 10 items, with one half worded positively for trust (e.g. "I expect other people to be honest and open") and the other half expressed in terms of distrust (e.g. "I feel that other people are out to get as much as they can for themselves"). The STS, used in Macdonald et al.'s study (1972) was correlated with the Interpersonal Trust Scale (total sample: $r = .56$, $p < .01$). Nevertheless, a significant difference exists in the types of items making up the two scales. In the IT, participants rate their belief in the trustworthiness of others (e.g. "Most people can be counted on to do what they say they will do") whereas in the STS they rate their construing of other people on a broader range of characteristics (e.g. "I expect other people to be honest and open"). Based on their small sample of 63 undergraduate students, MacDonald, Kessel & Fuller (1972) found an internal consistency of .84. Lagace & Rhoads (1988) tested the properties of the STS on a much larger sample of 287 adults. Their results did not confirm the unidimensionality of the scale reported by MacDonald, Kessel & Fuller, but they found two "unique but intercorrelated" factors making up the STS. These were trust and suspicion, each being represented by four items. These findings were replicated by Lagace & Gassenheimer (1989) with eight items from the scale rather than the original 10.

2.8.1.4 The Erikson Psychosocial Stage Inventory (EPSI) (Rosenthal et al., 1981)

Rosenthal et al. (1981) developed an inventory, the Erikson Psychosocial Stage Inventory (EPSI), based on Erikson's (1987) first six stages of development: trust, autonomy, initiative, industry, identity and intimacy. As their target population for administration of the EPSI was early and late adolescents, the last two stages of development (generativity versus self-absorption, and integrity versus despair) were omitted. Development at each stage is assessed by twelve statements which were closely modelled after Erikson's own descriptions of the stages. Items on the EPSI include trust towards oneself, other people and the larger world.

2.8.2 Scales measuring trust in specific others

The scales which focus on trust in specific others include the Trust Scale (Rempel, Holmes & Zanna, 1985; Rempel & Holmes, 1986), the Dyadic Trust Scale (Larzelere & Huston, 1980), the Specific Interpersonal Trust Scale, or SITS (Johnson-George & Swap, 1982) and the Conditions of Trust Inventory (Butler, 1991) .

2.8.2.1 The Trust Scale (Rempel et al., 1985)

The Trust Scale was developed by Rempel, Holmes & Zanna (1985) to test their hypotheses regarding the relationship between the factors which make up trust and the degree of success of an emotional partnership. Trust was defined by Rempel & Holmes (1986, p. 28) as "the degree of confidence you feel when you think about a relationship." The Trust Scale originally comprised 26 items, but was later reduced to 17 items after two analyses of the items which were "designed to detect and eliminate any items that clearly failed to measure trust adequately" were carried out (Rempel et al., 1985, p. 103). Rempel et al. conceptualised trust as being made up of three hierarchical elements (predictability, dependability and faith). They stated that "individual items were composed to sample representative content areas within each domain" (p. 101).

2.8.2.2 The Dyadic Trust Scale (Larzelere & Huston, 1980)

The Dyadic Trust Scale, designed for use between intimate partners, comprises eight items chosen from a pool of 57 items which were borrowed and adapted from previous scales, and considered to be suitable for administration to both partners of a couple. According to the authors, analyses based on two samples (dating versus married couples) totalling 322 persons "demonstrated good face validity, high reliability, and excellent construct validity with regard to [trust's] association with love, self-disclosure and relationship status" (p. 602). Dyadic trust also has very low correlations with generalised trust scales (Rotter's IT: $r = .02$, $p > .05$; Wrightsman's PHN: $r = .17$, $p < .05$), thus providing evidence of discriminant validity. As Larzelere & Huston (1980) found no correlation between the Dyadic Trust Scale and Rotter's Interpersonal Trust Scale ($r = .02$, $p > .05$) they deduced that generalised trust does not help to predict trusting behaviour in relation to people in close relationship. This prompted Johnson-George & Swap (1982) to infer that trust as a construct needs to be utilised in relation to specific people rather than as a general predisposition.

2.8.2.3 The Specific Interpersonal Trust Scale (SITS) (Johnson-George & Swap, 1982)

In contrast to the Dyadic Trust Scale, the SITS was developed for measuring several aspects of trust within any meaningful relationship. In his review, Wrightsman (1991, p. 396) stated that "The SITS is oriented toward the measurement of the varieties of interpersonal trust held by one individual for a specific other person." Following a review of the literature and discussion with others, Johnson-George & Swap (1982) devised a list of 50 items which, after being rated by judges for validity, was narrowed down to 43. The items were combined with 13 items from the Liking/Loving Scales (Rubin, 1970) to assess for discriminant validity. Questionnaires were completed by 180 men and 255 women undergraduates. The items on the SITS generally fell into the following four categories: "trusting another with one's material possessions, a belief in the other's dependability or reliability, trusting another with personal confidences, and trusting another with one's physical safety" (p. 1308). Results prompted the authors to refine the scale by sub-dividing it into a scale for men (SITS-M) and a scale for women (SITS-F) as different factors of trust were found for each gender. The subscale for men contains four factors. These are: General Trust, Emotional Trust, Reliableness, and Dependability. The subscale for women comprises three factors: the first is an

amalgam of the last two factors from the Male Scale and was termed Reliableness, the second was similar to the male factor of Emotional Trust, and the third was called Physical Trust. Johnson-George & Swap (1982, p. 1308, p. 1310) hypothesised that the fact "That this factor did not emerge for males may reflect societal norms dictating that women, more than men, may acknowledge their physical dependence upon others."

2.8.2.4 The Conditions of Trust Inventory (CTI) (Butler, 1991)

The Conditions of Trust Inventory focuses upon trust within organisations and consists of 11 scales of four items each. Items were chosen following very extensive semi-structured interviews with 84 managers, and a review of literature. Ten conditions of trust were identified: *"availability, competence, consistency, discreetness, fairness, integrity, loyalty, openness, promise fulfillment, and receptivity"* (p. 648) (italics in text). The eleventh scale measured overall trust. Convergent validity for some of the scales of the CTI was assessed by comparing scores on the CTI with those on the Dyadic Trust Scale and the Specific Interpersonal Trust Scale (SITS). A high correlation was found between overall trust on the SITS and the CTI (.88), between reliableness (SITS) and promise fulfilment (CTI) (.73), and finally between emotional trust (SITS) and discreetness (CTI) (.71) as well as between emotional trust (SITS) and loyalty (CTI) (.75).

2.8.3 Trust measured in experimental games

The final measure of trust to be discussed stands on its own, as trust is not measured by means of questionnaires but through a game played with another person under laboratory conditions.

2.8.3.1 The Prisoner Dilemma Game (Deutsch, 1958; 1960)

Deutsch devised an experimental situation to test his definition of trust, the implication of which is that "trusting behavior may have either positive or negative motivational consequences, depending upon whether or not the trust is fulfilled. When the fulfilment of trust is not certain, the individual will be exposed to conflicting

tendencies to engage in and to avoid engaging in trusting behavior" (Deutsch, 1958, p. 268). Deutsch's game involves two people playing independently of each other, with a choice of behaving cooperatively or competitively. As a consequence, both can win or both can lose, or either one can win with the other losing. His research, published in 1958, was carried out under three different types of motivational orientation (cooperation, individualism, and competitiveness) and four different experimental conditions (communication, no communication, non-simultaneity of choice, and the possibility of revision of choice after communication). Further investigation (Deutsch, 1960), which did not provide any motivational orientation, showed that subjects who were trusting when they played first tended to be trustworthy when they played second, and in parallel people who were suspicious when they played first tended to be untrustworthy when they played in second position. Deutsch's game has received criticisms in several respects. First, the operationalisation of trust in the Game is narrow, as trust is viewed as cooperation with others (Lewis & Weigert, 1985; Stack, 1978). Stack's view was that "cooperation depends on a variety of factors (e.g., risk-taking behavior, perceptions of the partner, partner's strategy, etc.)" (p. 581). According to her, "Players evidently do not perceive the PD game as a situation relevant to trust or mistrust, because" as Wrightsman (1974) reported "no consistent relationships have been found between game cooperation and trust questionnaire scores" (Stack, 1978, p. 581). Secondly, Johnson-George & Swap (1982) also criticised the format of the PD game, as it is usually played with a stranger, or with an experimental stooge, with the result that it brings into focus participants' construing of game playing and laboratory situations; according to Rotter (1967), the latter are "highly competitive in nature" (p. 652). Such a criticism is upheld by Oskamp & Perlman's (1966) research findings which were that greater cooperation is elicited in the game when players are friends.

Several researchers have modified the PD game in an effort to test trusting behaviour (e.g. Wrightsman, 1966; Schlenker, Helm & Tedeschi, 1973). The game was modified by the former author by including an expectation for cooperation from one's partner and by the latter authors by inserting a promise of cooperation from the other player. In these new experimental conditions, it was found that cooperative behaviour in the game was positively related to scores on the Interpersonal Trust Scale (Schlenker et al., 1973), and on the Philosophies of Human Nature Scale (Wrightsman, 1964).

2.8.4 Trust scale for use in this research

As the focus of this research is on the degree of interpersonal trust shown towards a number of other people, the only applicable validated scale was the Specific Interpersonal Trust Scale, and therefore it was applied alongside the trust grid, the development of which is described in Section 6.3.2. The modifications that were required to the SITS are discussed in the chapter on Methods and Procedures.

From the evidence provided by the theoretical writings and research findings mentioned in this section, it emerges that it is neither possible nor desirable to measure trust as a unified or single construct. Measurement of trust thus needs to be as complex as the construct itself and the choice of instrument needs to depend upon its purpose and its context.

2.9 Summary

This chapter has focused on several aspects of trust starting with varied definitions and ending with measurement. As scholars and researchers have disagreed in terms of their conceptualisation of trust, they have also generated different ways of measuring it. Other areas of exploration have included its antecedents, its different components, the relationship between trust and four other dimensions (trustworthiness, gullibility, self-disclosure and loneliness), and demographic factors. The importance of trust in human relationships, be it at an interpersonal or societal level, has not been doubted. Since trust is a state of mind but trusting is an activity which requires the willingness to turn to other people, the next chapter addresses dependency.

CHAPTER 3

DEPENDENCY

3.1 Introduction

Theorists have taken very different positions towards dependency as a concept. For some people, dependency is a wholly negative concept (Ainsworth, 1969; Siegel, 1988). Others (Birtchnell, 1988; Bowlby, 1991) have considered that dependency could be seen as normal or as pathological depending upon whether it is appropriate to a specific context, or maladaptive and inflexible (Bornstein, 1993). Others still (e.g., Kelly, 1955; 1969a) proposed that the emphasis upon dependence versus independence is misplaced and emphasised instead the importance of "dispersion of dependency". The concept of dependency is explored in the next sections through a brief consideration of the main theoretical approaches, with the exception of personal construct theory, which is elaborated at greater length. This is followed by a review of dependency and its putative consequences for dependent individuals and, finally, by a review of measures of dependency.

Despite the fact that "[d]ependency is a highly multifaceted construct" (Baltes, 1996, p. 8), this review focuses exclusively on dependency and attachment as part of the universal human condition rather than on dependency enforced on particular individuals by a circumstance such as disability, imprisonment or hospitalisation.

3.2 Theories of dependency

As dependency is the second construct under investigation in this research, there follows an examination of the concept from several theoretical stances. The acknowledgement of the importance of dependency in understanding human behaviour was clearly stated by Bornstein (1992; 1993, p. 2): "Every theory of personality implicitly or explicitly includes a conceptual model of dependency." Historically, psychoanalytic and social learning theories have given dependency a central place in their own understanding of human behaviour. Other theorists have also considered the construct an important one and have provided their own conceptualisations; these are

humanistic, existential, and personal construct. The contribution of each of these theories is considered in the following review. Distinctions are also drawn between dependency and attachment.

Prior to exploring the concept further, a brief elaboration of the terms dependency and dependence is needed. Ainsworth (1969, p. 970) wrote that, "Although 'dependency' and 'dependence' may be used interchangeably, 'dependency' has been preferred as a technical term in scientific and professional writing." However, exceptions to this generalisation do occur: Birtchnell (1988) writes about "dependence", and George Kelly (1955; 1969a) and other personal construct theorists (Chiari et al., 1994) use both terms. The present writer uses the term dependency unless the word "dependence" is the one used in the literature under review. A considerable difficulty with the construct is that, as with trust, the meanings attached to it are diversified but, unlike with trust, the negative connotations of the construct have prompted some theorists (such as Bowlby, 1991) to differentiate between dependency and another construct freed from negative implications such as attachment (Bowlby, 1958; 1991) or affiliation (Murray, 1938). Yet, other theorists such as Ainsworth (1969, p. 970) consider that "dependency in the psychoanalytic context ... has nonspecific implications", but that the connotations of dependence are decisively negative implying helplessness and immaturity.

3.2.1 Psychoanalytic theories

Bornstein (1992) has reviewed the theoretical formulation of dependency from the standpoint of psychoanalytic and social learning theories. Three psychoanalytic theories have considered the origin of dependency, starting with Freud's classical psychoanalytic model, from which evolved the object relations model (e.g., Guntrip, 1968) and ethological theories (e.g., Ainsworth, 1969; 1979; Bowlby, 1973; 1988; 1991). The object relations model is concerned with dependency and the ethological theory with attachment. The difference between these two concepts is considered in the next section.

Freud (1953) emphasised the experience of feeding as the prototype for adult relationships; frustation or overgratification were postulated to lead to "oral dependency", manifested in dependence on others for nurturance and support. Later models (Ainsworth, 1969) did not incorporate feeding in their understanding of

attachment, but placed much emphasis on the "overall quality of the infant-caretaker relationship during infancy and early childhood [as] the primary determinant of dependent traits in adulthood" (Bornstein, 1992, p. 4). Within the object relations model of dependency, the critical developmental tasks consist of separation-individuation and the development of the self-concept, with internalised representations of self and important others as mediating factors (Guntrip, 1992). In contrast, the ethological approach (Bowlby, 1973; 1991) placed much emphasis on "the innate, biological underpinnings of infant-mother bonding as a determinant of the self-concept and subsequent interpersonal behavior" (Bornstein, 1992, p. 4).

3.2.2 Dependency and attachment

Psychoanalytically-influenced writers view dependency and attachment as different constructs, not only developmentally but also semantically. For Bowlby (1991, p. 228), dependency and attachment occur at different times, whereby "dependence is maximum at birth and diminishes more or less steadily until maturity is reached, attachment is altogether absent at birth and is not strongly in evidence until after an infant is past six months."

"Dependency refers to a class of behaviors stimulating general help, approval, and attention" (Hirschfeld, Klerman, Gouch, Barrett, Korchin & Chodoff, 1977, p. 616), and "Dependency relations vary according to the exigencies of the situation" (Ainsworth, 1969, p. 971). In contrast, "the attachment bond is enduring and specific to a single individual ... [and] is associated with strong emotions" (Hirschfeld et al., 1977, p. 616) and tends to be "independent of specific situations" (Ainsworth, Blehar, Waters & Wall, 1978, p. 302). Ainsworth's (1969, p. 1015) view of the two constructs is that "Attachment is a synonym of love; dependency is not." She added that "attachments can and often do survive periods of absence, undiminished in strength" (p. 1017). This is in agreement with Bowlby's (1991) view that the differentiation between attachment and dependency is evident in any two or three year old child who, whilst being looked after by someone other than his mother, remains very attached to her without being dependent on her.

Bowlby (1991) also reviewed the connotations applied to the two terms, which were mostly negative for dependency and positive for attachment. "[T]o call someone dependent in his personal relations is usually rather disparaging" (p. 229) In contrast,

"for members of a family to be attached to one another is regarded by many as admirable" (p. 229). Yet, in his 1988 publication, Bowlby appeared to consider that the negative connotations of dependency had contaminated the usage of "attachment behaviour", such that "whenever [it] is manifested during later years, it has not only been regarded as regrettable but has even been dubbed regressive" (1988, p. 12).

On the basis of his review of the work of Ainsworth (1972) and Livesley, Schroeder & Jackson (1990), Bornstein (1992) affirmed that attachment behaviour and dependent behaviour represent two important and differing aspects of the concept. As mentioned earlier, dependent behaviour is characterised by help-seeking whereas attachment behaviour is manifested by proximity-seeking. Also, "attachment behaviors are object specific and are consistently directed toward the same person. In contrast, dependent behaviors may be directed toward any number of people who represent, in the eyes of the dependent person, potential nurturers, protectors, or caretakers" (p. 4). Some degree of confusion appears to prevail, with Bowlby (1988) defining attachment behaviour as aspects of attachment and also of dependency as, on one hand, it is proximity seeking and, on the other hand, it is directed "to some other clearly identified individual who is conceived as better able to cope with the world" (p. 27). Establishing relationships with individuals who are more capable than oneself has been considered by some other theorists as a manifestation of dependency.

Empirical support for a conceptual distinction between attachment and dependency is provided in a study by Livesley et al. (1990), in which they devised a scale to test the relationship between the two constructs. Principal component analyses of responses provided by patients with personality disorder and by members of the general population yielded two components and revealed that the two constructs (attachment and dependency) were orthogonal. The authors posit that "Only [one dimension] Need for Care and Support [had] substantial loading on both factors, probably because it assesses general care-seeking behaviors" (p. 136). The five main dimensions within the first factor which Livesley et al. called "insecure attachment" were "Separation Protest, Secure Base, Proximity Seeking, Feared Loss, and Need for Affection" (p. 136). The main dimensions within the second factor (dependency) were "Low Self-esteem, Submissiveness, Need for Advice and Reassurance, and Need for Approval" (p. 136).

Birtchnell (1996) adopted a different theoretical position from those which focus on dependency or attachment, both of which he criticised as "hybrid concepts" on the

basis of their comprising two dimensions, one involving closeness-seeking and the other upward directedness. In response, he elaborated a new interpersonal theory based upon two bipolar dimensions (closeness-distance and upperness-lowerness). In his view and that of Horney (1937), human beings make use of four ways to "try to protect [themselves] against basic anxiety: securing affection (closeness), withdrawing (distance), gaining power (upperness), and adopting a submissive attitude (lowerness)" (p. 51).

3.2.3 Social learning theories

Early social learning theorists conceptualised dependency as a secondary or learned drive, acquired through "the reduction of primary drives (e.g., hunger)" (p. 5) within the context of the infant-mother relationship (Bornstein, 1992). Later social learning theorists considered "the importance of social reinforcement provided by caretakers for the development of childhood and adult dependency" (Bornstein, 1992, p. 5). Social learning theorists hypothesised that people learn to be dependent. As social learning theories developed, the role of cognitive processes received greater emphasis than conditioned responses in accounting for the maintenance of dependent behaviour.

3.2.4 Humanistic and existential theories

Bornstein (1993) provided a brief overview of the conceptualisation of dependency from the humanistic and existential positions. From the humanistic personality theorists' point of view, dependency was regarded "primarily as a 'defensive' behavior, the purpose of which is to minimize the anxiety and discomfort associated with an individual's failure to become fully self-actualized" (p. 2). From the existential position, dependency was also seen as a defensive behaviour, "an attempt to abrogate (i.e. externalize) responsibility for one's actions as a means of denying one's mortality and one's isolation in an unpredictable, uncontrollable world" (Bornstein, 1993, p. 2).

On the whole, these four theories (psychoanalytic, social learning, humanistic, and existential) appear to view dependency as a failure, be it failure of reaching independence, or self-actualisation, or self-responsibility.

3.2.5 Personal construct theory

As quoted previously, Bornstein (1993) stated that 'Every theory of personality implicitly or explicitly includes a conceptual model of dependency' (p. 2). Yet, in his review of dependency (1992) and in his book, *The Dependent Personality* (1993), he omits the original contribution of George Kelly (1955; 1969a) and of later personal construct theorists. Kelly's assessment of the superordinacy of dependency accords with that of the aforementioned theorists as evidenced in the following quotation: "The construct of dependence versus independence is, in one form or another, a major reference axis in the lives of most people" (1969a, p. 199). Yet, when he propounded his views on dependency, he was unusual in contradicting the common belief that children are dependent and adults are independent; adults in his view were also very dependent, more so than children, although Kelly conceded that children's dependency requirements expand as the world becomes more complex. Kelly considered the construct from a different angle, rejecting dependence and independence as the only choice available in relating to other people. He proposed instead that "we ought to throw the emphasis upon variation in the dispersion of *dependencies*" (italics in text) rather than view "*dependency* [italics in text] as an axis along which people vary from time to time and from person to person" (1955, p. 914). Kelly construed human beings as being interdependent.

For Kelly, "A child's dependency constructs are relatively impermeable" and preemptive (1955, p. 669). By impermeable, Kelly meant that only certain people, such as mother, were seen as able to meet the child's dependencies, and by preemptive, that these people were seen only as those who met his or her dependencies. Therefore, the developmental tasks consisted of construing the primary recipients of one's early dependencies in a more permeable and a less preemptive way. Construing more permeably "permits [the child] to depend upon persons other than his parents" and construing less preemptively "permits him to relate himself to people in other ways" (Kelly, 1955, p. 670). This developmental process results in the mother or the primary caregiver being seen as more than the person upon whom the child depends, and consequently in being seen as someone who also fulfils other roles and other functions. The corollary of this process of construing the primary caregivers in more complex ways is that the child "begins to develop role constructs. That permits him to depend upon the persons who want him to depend upon them, and for the things which they are willing to supply" (Kelly, 1955, p. 670). Assigning one's dependencies

discriminately to a greater number of available people was considered, by Kelly, to be another aspect of the maturing process.

Chiari et al. (1994) developed a conceptualisation of dependency based on personal construct psychology. Their usage of the term dependency, unlike Kelly's, might seem similar to the concept of attachment; within personal construct theory, a differentiation between attachment and dependency predicated upon positive or negative connotations is unnecessary as dependency is not seen as pathological. The authors assumed that the pattern of early social interactions, especially the interactions with the most significant others, would be a very influential factor in determining the degree of dispersion of dependencies in adults. They postulated three separate developmental paths initiated by three separate types of childhood experiences. In their view, each of these developmental paths would lead to different levels of dispersion of dependency and differing degrees of dependence on oneself and on others, and on the mother and the father. For them, the only developmental path that would lead to high dispersion of dependency was one in which parents' attitudes toward their children would be "characterized by acceptance, that is, by their readiness to understand and to take into account (not necessarily approve) their children's points of view" (p. 19). They tested their theory and found results that they interpreted as corresponding to their prediction. Their view of high dispersion of dependency appears to be akin to Bowlby's (1973) view of secure attachment.

3.2.6 Differences between psychoanalytic, social learning and personal construct theories with regard to dependency

Bornstein (1992) provided a comparison of the psychoanalytic and social learning theories, especially of the role of cognitions and the inevitability of conflict within the two models. The role of cognitive processes was noted in both theories. Fundamental differences, nevertheless, characterised their conceptualisation. In psychoanalytic theories, cognitions are internal representations of important, including parental, figures who are "hypothesised to play a key role in determining the degree to which a person experiences (and expresses) strong dependency needs. In social learning theory, beliefs and expectations regarding rewards and punishments associated with expresssing (or not expressing) dependency needs are regarded as a central determinant of a person's dependency-related behaviors" (p. 5). Personal construct theory, by virtue of considering the whole of the person as a construing and indivisible being, does not

require the highlighting of the role of cognitions as a determining factor in the experience and expression of dependency needs.

Another similarity between psychoanalytic and social learning theories concerns conflict, which is seen to be inevitable in both models. "Dependency conflict within the psychoanalytic model is conceptualized in terms of a struggle between unconscious dependency needs and conscious prohibitions against expressing these needs. In social learning theory, dependency conflict arises from inconsistent socialization practices" (Bornstein, 1992, p. 5), whereby autonomous behaviour is required of children in some situations whilst deferring to adults' authority is expected in others. Conflict is created both by resolving the inconsistency of the messages and by determining when one or the other behaviour is expected. In contrast, personal construct theory does not postulate the inevitability of conflict. Conflict may or may not occur for an individual, as a result of the presence or absence of fragmentation* within his or her construing system.

3.3 Dependency and related constructs

Owing to his interest in dependence and the evidence he obtained for a link between depression and dependence (Birtchnell, 1984), Birtchnell (1988) sought a greater understanding of the concept of dependence. He examined the developmental tasks necessary to achieve increasing independence and the "deficiencies" manifested in adults who had not fully negotiated these developmental tasks. Birtchnell conceded that "It is appropriate at times to be dependent and at others to be independent. At various times and in various situations people change in the extent to which they are dependent on others or others are dependent on them. The normal well-adjusted adult adopts such behaviour as befits the situation" (1988, p. 111). His paper focused on people who are "excessively and unvaryingly dependent to a degree that is detrimental to [their] well-being and to [their] relationships with others" (p. 111). The developmental tasks to be achieved are separation from the mother, individuation - that is the rise of a separate identity, the acquisition of competence, and of self-worth, and finally, feeling accepted in the adult world. When proper separation has not occurred, the adult is clingy and fails "to establish a secure personal identity, ... a general feeling of competence and a realistic assessment of self-worth" (p. 111). Also, he or she does not "feel deserving of the status of adult and to feel on equal terms with other adults" (p. 111). Some other behavioural correlates are found in the excessively

dependent adult, namely, a need to look up to others, and while he or she "projects a parental image upon all other adults" ... [he or she] "is unduly fearful and respectful of them" (Birtchnell, 1988, p. 118).

In his 1992 article, *The dependent personality: developmental, social and clinical perspectives*, Bornstein reviewed a vast array of studies in order to look at dependency in a gender context. In terms of gender, he found that the data available from studies were contradictory when measured with different instruments. With self-report questionnaires, women acknowledged a much higher level of dependence than men (Birtchnell & Kennard, 1983; Singh & Ojha, 1987), whereas with projective techniques, men and women achieved comparable dependency scores (Greenberg & Bornstein, 1989; Mills & Cunningham, 1988). Studies of children indicated that dependency levels were not significantly different between young children (Kagan & Moss, 1960), but that on self-report measures, as children grew older, the difference in level of reported dependency between the boys and girls increased. This led Bornstein (1992) to propose that "The causes of the increasing gender differences in dependency levels with increasing age may well lie in traditional sex role socialization practices" (p. 8). The overall results of these studies supported the hypothesis that the level of dependency needs might not be different for men and women, but that "overt expression of dependency needs in both men and women is a function of the degree to which they ascribed to traditional sex roles" (p. 9).

In 1994, Bornstein published *Adaptive and maladaptive aspects of dependency.* Where maladaptive aspects of dependency are concerned, he found that high levels of dependency were associated with an increased risk of psychological disorders and physical illness. They were also shown to be a precursor to "susceptibility to peer and group pressure" (1994a, p. 624) and, therefore, to greater influence by individuals considered as having high status. Two of the psychological ailments which have been well researched have been depression in both men and women, and eating disorders in women. Bornstein (1994a) wrote that high levels of dependency in women faced with interpersonal loss or stress "predict the onset of eating disorder symptomatology" (p. 624). Studies have shown that levels of dependency and depression covary in clinical and normal samples, with a "slightly stronger dependency-depression relationship" in men than in women (Bornstein, 1994a, p. 624). However, the association between dependency and depression is small to moderate, with only 10 to 20 per cent of the variance in depression accounted for by dependency (Bornstein, 1992). Bornstein (1992) also emphasised that most studies are correlational, allowing no assumption of

causality as people with a high level of dependency could be predisposed to depression, or dependency could be a product of depression or both could be "products of an underlying variable" (p. 14). However, he pointed out that a number of studies (e.g., Hammen, Ellicott & Gitlin, 1989) suggested that "dependent individuals who experience significant interpersonal stressors ... are at increased risk for depression" (Bornstein, 1994a, p. 624), whereas this was not the case for nondependent people.

Bornstein (1994a) also reviewed the link between dependency and physical disorder. He argued that most studies which show a relationship between the two do not allow any causal relationship to be proposed, especially as Baltes (1988) has indicated that the onset of physical illness could be an antecedent of dependent, help-seeking behaviour. Yet, he mentioned two longitudinal studies (Greenberg & Dattore, 1981; Vaillant, 1978) which "have indicated that high levels of dependency actually predispose individuals to a variety of illnesses and diseases" (Bornstein, 1994a, p. 625), but did not predict the type of illness or physical condition that would be developed. The increased risk of physical illness in highly dependent individuals might arise from their being particularly sensitive to interpersonal stress and loss (Greenberg & Bornstein, 1988), which may, in turn, adversely affect their immune system (Bornstein, 1993).

The third maladaptive factor associated with dependency is that, as people with a higher level of dependency are "highly motivated to please other people" (Bornstein, 1994a, p. 625), they tend "to be influenced by the opinions of others, to yield to others in interpersonal transactions, and to comply with others' expectations and demands" (Bornstein, 1992, p. 10). People who are dependent are more strongly influenced by high-status rather than low-status figures (Tribich & Messer, 1974; Bornstein, Masling & Poynton, 1987).

Bornstein (1994a) reviewed the adaptive aspects of dependency. A number of studies have shown that people with a high level of dependency seek medical help quicker after the onset of symptoms than nondependent individuals (e.g., Brown & Rawlinson, 1975). Furthermore, dependent individuals are more likely to be co-operative and to comply rigorously with medical treatment and psychotherapeutic regimes (e.g., Davis & Eichorn, 1963). Also they are likely to rate their physicians more positively than do nondependent individuals. In terms of interpersonal relationships, dependent individuals have been found to be more sensitive to interpersonal cues than nondependent individuals. This relationship was investigated in terms of gender, with

studies providing different results and the gender relationship therefore remaining inconclusive.

Birtchnell (1991) considered the confusion over the concept of dependence including normal and pathological dependence. He wrote that pathological dependence has been viewed as an extreme form of normal dependence but he disagreed with this assessment and asserted that extreme forms of dependence can be normal, for instance, in a person with severe physical disability. He introduced a different conceptualisation based upon the difference between "dependent lifestyle" and "dependent emotional response to others".

> A person with a dependent life-style has been brought up to be excessively reliant upon and deferential towards others. Providing he/she pairs off with the right kinds of people, this person may survive without difficulty. A person who exhibits a dependent emotional response is either fearful that someone, or others, upon whom he/she has come to rely is/are going to harm him/her or let him/her down, or is depressed because he/she believes he/she/they have done so. A person with a dependent life-style will only exhibit such a response if he/she is untrusting or insecure in his/her dependent relationship. Pathology therefore is associated with insecurity and lack of trust, and not with the extent of the dependence. ... Measures should clearly differentiate between life-style and emotional response (dependent pathology). (p. 291)

Unlike a number of psychoanalytic writers who have postulated the existence of psychopathological traits within excessively dependent individuals, personal construct psychologists, in keeping with the spirit of the theory, have not focused their attention on psychopathology nor on traits. Yet, problems resulting from specific types of construing are acknowledged. Walker (1993) considered that "problems with failure to disperse one's dependencies do not necessarily result in unhappiness nor in an inability to cope" (p. 76). If and when the needs of the individual are well provided for by those few undispersed others, he or she will not experience difficulties caused by this aspect of construing and behaviour. However, problems are predicted to arise when the dependency constructs with which people have anticipated such relationships can no longer be applied, or can be applied decreasingly. Two instances of constructs which would become decreasingly fruitful in meeting one's dependency needs across a whole life span are 'depending only upon "the family" or "those I have grown up with"' (Walker, 1995, p. 6); as geographical distance or bereavement curtail these relationships, those constructs do not allow the inclusion of new people to replace displaced or deceased friends or relatives.

Some of the research findings based on personal construct theory will now be reviewed, with an emphasis on interpersonal relationships. As many have not been published, Walker (1997) has been the source of the material. In keeping with Kelly's assessment that greater dispersion of dependency would be associated with increased maturity, Herbert-Lowe (1990) found that dispersion of dependency "discriminate[d] according to psychosocial development" for adolescent males (in Walker, 1997, p. 76). She explained the positive result she obtained for young men and not for young women as a consequence of the measure of psychosocial development she used, namely, the Erikson Psychosocial Scale (EPSI) (Rosenthal, Gurney & Moore, 1981), which appeared to have been constructed to measure psychosocial development in adolescent males rather than females (Doherty, 1973). In her study, Herbert-Lowe also found no relationship between levels of dispersion of dependency and self-esteem. Clark (1991) found a relationship "between loneliness as measured by the UCLA scale (Russell, Peplau & Cutrona, 1980) and dispersion of dependency, with higher loneliness associated with undispersed dependency" (Walker, 1997, p. 79). No statistical gender difference was found in terms of dispersion of dependency although, in the six studies that Walker (1997) surveyed, women consistenly obtained a higher dispersion mean score than men. Finally, dispersion of dependency and ability to adapt to a new social environment was investigated by Whetman (1996). His study researched the dependency pattern of the clergy, the second most mobile profession in Australia, and found that "those who cope best with this itinerant occupation (and hence remain clergy) are those who have a more dispersed dependency pattern" (Walker, 1997, p. 78). However, the research allowed for neither causality nor for the direction of the relationship to be established.

3.4 Measurement of Dependency

As the present study does not make use of a dependency test other than the Situational Resources Repertory Test (Kelly, 1955), other measures of dependency, such as objective tests and projective techniques, will be mentioned only briefly. Objective tests are divided into those which measure interpersonal and oral dependency, with the latter comprising items based on psychoanalytic theory. Projective tests also seek to gauge the dependent content and/or the oral dependent content of the person's responses. Objective tests include the Interpersonal Dependency Inventory (Hirschfeld et al., 1977), and Sinha's (1968) Dependence Proneness (DP) Scale, whilst projective techniques include Masling, Rabie & Blondheim's (1967) Rorschach Oral Dependency

Scale (ROD). Bornstein (1994b) claims that "one of the most widely used" tests is the Interpersonal Dependency Inventory (IDI), which comprised three factors. These are "Emotional reliance on another person", "Lack of social self-confidence", and "Assertion of autonomy" (Bornstein, 1994b, p. 66). Yet Birtchnell (1991) wrote that, as the scale is unable to distinguish between people who are independent and people who deny being dependent, he does not regard it as a measure of dependence.

None of these measures of dependency are reviewed at length nor used in the research as the measure chosen is the dependency grid, which has been used extensively as demonstrated in its review provided in the following section. In contrast, the purpose of a detailed analysis of trust scales and inventories was to find a comparable scale to the trust grid, a new instrument, in order to test its validity.

3.4.1 The dependency grid

In keeping with his assertion that maturity in an adult was not akin to independence but consisted in placing one's dependencies judiciously, Kelly (1991) devised a grid, which he termed the Situational Resources Repertory Test. This was designed to understand whether and how a person dispersed his needs amongst the people (resources) available to him. The resource grid was later renamed by Fransella and Bannister (1977) the dependency grid, and later by Walker, Ramsey & Bell, (1988) the being helped Grid. As it is currently most usually referred to as the dependency grid (Winter, 1992), this term will be used throughout this research. The grid consists of a matrix comprising a number of known people (such as members of one's family, friends, colleagues, oneself) and a range of situations and feelings which might prompt people to turn to others for help. Two examples of situations taken from Kelly's (1991, p. 234) original list were: "The time when things seemed to be going against you - when your luck was particularly bad" and "The time when you lost your temper or got very angry." Kelly's instructions for this grid consisted of asking clients for the time in their lives when they had felt most acutely a particular feeling/situation listed (for instance, "The time when you felt most discouraged about the future"), and then to choose all the people in their grid to whom they would have turned for help if these people had been around at the time. Fransella and Bannister (1977) suggested an alternative in asking clients whom they would turn to for help now. Indications of whom one would turn to have been most frequently provided by ticks or crosses. More recently, Whittingham (1990) devised dependency grids in which a *T* was assigned to people one would seek tangible

support from and *E* for those one would look to for emotional support. Qualitative information has been sought by Beail and Beail (1985), who asked respondents for their reasons for turning to some people and not to others and by Walker, Ramsey and Bell (1988), who asked people their reasons for turning to people for particular problems but not for others. In accordance with Kelly's view that the important factor was dispersion of dependencies across resources as opposed to independence, Walker et al. (1988) sought to measure this dispersion. They adapted a measure (diversity index) used by biologists (Smith & Grassle, 1977) to estimate the diversity of species in given geographical areas. They developed statistical analyses to measure dispersion of dependency using the pattern of responses participants gave to Kelly's dependency grid. They named their new measure the Dispersion of Dependency Index.

3.5 Summary

This chapter outlined and compared different theoretical perspectives on dependency. Dependency has been differentiated from attachment and has been considered in relation to other constructs, including the adaptive and maladaptive qualities that correlate with high dependency. Another, less judgmental, way of viewing dependency, provided by the theoretical and research contributions of personal construct theory, has been elaborated. Some measurements of dependency have been specified. Having treated the concepts of trust and dependency in Chapters 2 and 3, Chapter 4 reviews the similarities and differences between them.

CHAPTER 4

TRUST AND DEPENDENCY

4.1 Introduction

This chapter aims to consider trust and dependency in terms of their conceptual similarities and differences. A certain confusion appears to exist as one can find either term covering the same types of behaviours. This chapter aims to seek an understanding of those aspects of trust and dependency which might be similar and those which might be different. Research findings will be mentioned where relevant, as well as theoretical writings.

4.2 Similarities between trust and dependency

In his analysis of dependency, Kelly (1969a) stated that "civilized man has an intricate social system of dependencies" (p. 191). Even though he did not spell it out, one might assume that this social system not only includes social and personal relationships but also impersonal ones such as, for instance, dependence upon one's employer to pay one's salary, or dependence upon trains or tubes to run. This type of dependency appears to be conceptualised by Birtchnell (1996) as trust. He provides many examples of social and impersonal aspects of trust, like trusting "that water and gas will flow from our taps" (p. 184). In these instances of impersonal interactions, trust and dependency are synonymous with reliance upon some event, within the control of an impersonal other, actually taking place. This might indicate that an element of trust and dependency could be similar, although one would not want to assume that the construing which lies behind each of these concepts is identical.

4.3 Differences between trust and dependency

Within the phases of human development, it would seem that dependency, attachment and trust (and their opposites) succeed one another. The relationship between attachment and trust has been discussed in Chapter 2, Section 2.4. Jacobs (1986) considered that when the infant's mother is able to provide security, is reliable and dependable, and "is able to *contain* the painful feelings in her baby" (p. 33) (italics in text), a basic sense of trust develops. In turn, following the views espoused by Erikson in the 1950's and 1960's (e.g., 1994 edition), Jacobs maintained that this basic sense of trust in the mother becomes the foundation for trust in the world and later for trust in oneself.

The closeness of the relationship between these distinct constructs was also noted in three juxtaposed sentences by Rotter (1971, p. 443), in which he said: "The entire fabric of our day-to-day living, of our social order, rests on trust - buying gasoline, paying taxes, going to the dentist, flying to a convention - almost all of our decisions involve trusting someone else. The more complex the society, the greater the dependence on others. If trust weakens, the social order collapses." As a high level of dependency is inevitable in a complex society, trust must also be present for a society to survive. Recent events, such as irregularity of salary payments and growth of organised crime in Russia, are a painful reminder that these two factors are indeed intertwined.

In everyday life, dependency and trust can be linked and also separate. On the one hand one depends on one's garage to carry out a proper service on one's car but, on the other hand, after servicing, one takes it on trust that they have carried out everything they have charged one for. It may be that dependency here refers to another person carrying out with competence some operation which one is either unwilling or unskilled to perform whereas trust involves relying on their honesty or integrity. The difference between dependence and trust might also be illustrated by the experience of selling a house, in which one might depend on one's estate agent (whose fees, in England, are paid by the seller) to sell one's house, but one may or may not necessarily trust him or her to act in one's best interest. In this second case one has entered into a precisely delineated dependency relationship, with or without trust being present. One might choose whether or not to pursue this particular dependency relationship in the light of any evidence of the extent to which the agent has promoted or undermined one's interest.

In Section 2.5 on the components of trust elaborated in Chapter 2, Rotenberg (1994) postulated that one of the bases of trust was reliability. Yet, being able to rely on people is not sufficient. Baier (1986) establishes the difference with regard to reliability between trust and dependency; for her, trust represents "reliance on [other people's] good will", whereas dependency involves reliance on their "dependable habits".

Other aspects of trust exist as one can trust people on whom one can no longer physically depend, and on whom one can no longer rely, for example because they are dead. It is argued that the maintenance of most dependency relationships involves some tangible connection from person to person, but that trust, like attachment or love, survives without that connection.

4.4 Trust, dependency and personal construct psychology

Within personal construct psychology, dependency has elicited much theoretical and practical interest, whereas trust remains for the most part an unploughed field. When he wrote his seminal work, *The Psychology of Personal Constructs*, Kelly (1955; 1991) displayed a keen interest in dependency, elaborating his personal views on the topic, and later devoted a chapter to it (Kelly, 1969a). In contrast, trust does not get one entry in the index of his magnum opus. Even though it seemed that trust might have found its way into a talk given in 1962 (published 1969a) which appeared to bring together in its title trust and dependency: "In whom confide: on whom depend for what?", trust was not elaborated upon, and was mentioned only once (Kelly, 1969a). Yet, in the following quotation, Kelly might be referring to a construct which is akin to trust:

> "Even if one person did not get what he wanted from the other, the fact that his outlook was understood by the other and that the other could see what it was like to have such wants, and that the other can agree that, from the same point of view, he, too would experience a similar yearning - all this is likely to provide greater security in the dependency relationship than getting literally what was asked for." (p. 204)

Dependency and feeling understood or "greater security in the dependency relationship" may be similar to the experience of trust. Again, Kelly seemed to bring together trust and dependency in one sentence towards the end of his paper (1969a), in which he made a scathing attack upon the psychological theories of the time but also hoped "that the

psychological theories of the future will have significance for all human beings, their longings, and the way they trust and depend upon each other" (p. 204). Even though this differentiation of trust and dependency was not pursued in the rest of the paragraph or the remainder of the paper, it would indicate that Kelly might not have considered the two constructs as synonymous.

Walker, Ramsey & Bell's (1988) study seems to provide some indication that dependency and trust are different and that trust might be considered to be superordinate to dependency. In one of their studies they asked respondents their reasons for depending upon particular individuals. One of the responses they obtained was that these were the people who were trusted. It is hypothesised that for the individuals who provided this answer trust was superordinate to dependency. In this style of questioning, a unipolar version of Hinkle's (1965) laddering technique, the first construct (which, in this case, was dependency) is assumed to be subordinate to the next construct elicited from it (in this case, trust).

Some evidence for the need to differentiate between trust and dependency is provided by Butt et al. (1997) as a result of a research project aimed at investigating people's construal of themselves within different relationships. They found that trust was an important factor in "differentiating between relationships" (p. 25) but what mattered most was not trusting someone with a secret or "allowing the other into some inner sanctum of the true self ... [r]ather it was about trusting the other to accept and validate whatever version of our self should emerge in that relationship" (p. 25). Trust was construed as an ontological process. Butt et al. (1997) wrote: "Allowing a social situation to unproblematically conjure up a particular self seems to be what people most enjoy. Having to manage and reflect on an interaction produces unease" (p. 25). In many circumstances, dependence upon someone might involve an action, whereas trust, according to Butt et al., refers to the qualitative aspects of being-with-someone.

4.5 Summary

Some areas of similarity and difference between trust and dependency have been suggested. Trust might or might not involve some aspects of dependency. Special consideration has been given to the personal construct understanding of dependency,

including to Kelly's (1969a) writings, and to reflecting upon whether some aspects of dependency relationships that Kelly wrote about might be akin to an experience of trust. It has also been hypothesised that, at least for some individuals, trust might be superordinate to dependency.

CHAPTER 5

FOCUS OF THE STUDY AND HYPOTHESES

Thus far, this project has provided a review of theoretical writings concerning trust and dependency, the two constructs to be investigated in the study. The importance of trust and the need to be able to depend on people discriminatingly has been shown in the preceding chapters. To date, researchers have focused either on trust or dependency. The main contributions of this study are to investigate the psychological consequences arising from trusting and depending upon the same or different people and to compare two different age groups, whose experiences of trust and dependency might be different owing to the putatively greater number of bereavements in the older sample.

This chapter considers other aspects relevant to the research and to the hypotheses tested in this study. For instance, as age and bereavements are important in relation to the number of people that can be trusted and depended on, some of the literature on ageing and bereavements is presented. This chapter is divided into four sections: (i) an introduction to the study, based on literature review, clinical experience and previous research, (ii) the main aims of the study, (iii) an introduction to the trust and dependency grids and (iv) the delineation and operationalisation of the hypotheses.

5.1 Introduction to the hypotheses

Several areas of inquiry are introduced: the difference between trust and dependency based on the conclusion of the last chapter, a review of some of the literature on ageing and bereavement, a consideration of the way people may place their trust or mistrust and its implications for interpersonal satisfaction, as well as the replication of four hypotheses.

5.1.1 Trust and dependency

The comparison between trust and dependency in the previous chapter led to the understanding that, from a theoretical stance, trust and dependency can be considered as separate processes. One of the hypotheses of this study is to test this proposition.

5.1.2 Ageing and bereavements

Apart from the relationship between trust and dependency per se, another area of interest concerns ageing in relation to trust and dependency. Factors to be reviewed here are selected according to their degree of relevance to the current study and include: impact of conjugal bereavement with regard to age and to gender, and the effects of loneliness and of social support in ageing.

The review of the literature on bereavement centres on symptom differences between older widows and widowers and control groups, as well as between younger and older widowed people. Other factors within the lives of the bereaved which affect future adjustment or maladjustment are also considered.

Breckenridge, Gallagher, Thompson & Peterson (1986) compared the Beck Depression Inventory scores of bereaved older people two months after bereavement and of a well-matched control group. A number of depressive symptoms characterised the bereaved men and women: sadness, tearfulness, dissatisfaction with self, insomnia, appetite loss, and weight loss. Comparison of the effects of bereavement amongst two age groups was provided by Sanders (1980-81). With a mean of 73.3 years, Sanders' older sample was older than Breckenridge et al.'s sample whose mean was 67.7 years; Sanders' younger group's mean age was 53.5 years. She found that younger widows and widowers showed greater intensity of grief than their older counterparts shortly following bereavement but that the trend was reversed at eighteen months' follow-up. Furthermore, with time, older people experienced increased death anxiety, social isolation and loss of vigour. Nevertheless, Lund, Caserta & Dimond (1986, p. 319), who studied the course of bereavement in elderly men and women over a two year period, concluded that "bereaved elders were found to improve gradually over time ... [but] bereavement is a long-term experience that does not end at 2 years".

Offering a multi-dimensional perspective on the subject, Wortman & Silver (1990) provided a theoretical and research review on the "successful mastery of bereavement". They suggest that mastery, or the reverse, non-adjustment following bereavement will depend upon a number of factors which need to be understood within a life course perspective. Reactions to bereavement will be affected by the nature of the marital relationship, the nature of what is lost, the tasks to be mastered, the circumstances of the loss, the coping resources present in the individual, and the presence or absence of other social roles. People involved in ambivalent marital relationships face longer-term problems in bereavement than those in non-ambivalent relationship (Parkes & Weiss, 1983). Even within non-ambivalent relationships, the deprivation suffered as a result of a partner's death can vary enormously in scope and include some or many of the following: "the loss of companionship, emotional support, sexual intimacy, financial support, social status, and assistance with household tasks and [for younger widows with] childcare" (Wortman & Silver, 1990, p. 246). For some elderly bereaved people the tasks to be mastered led to "increased sense of competency" and self-esteem, whilst "for others the strain of managing alone produced anxiety and frustration" (Sanders, 1980-81, p. 230).

Resources available to the remaining spouse such as health, financial status, social support, and cognitive abilities are also considered as affecting the outcome of the bereavement process. In terms of social contact, lacking social support with close relatives, and having no-one to telephone increased the risk of mortality following bereavement (Bowling, 1988-89).

Several writers have looked at the influence of religious beliefs on the way one copes with bereavement and found little evidence of a measurable effect (e.g., Stroebe & Stroebe, 1987). Others have found a gender difference with regard to church or temple membership, this being associated with a lower risk of depression in men but not in women. Broadening from religious beliefs, one might consider the type of life belief and its effect on coping with bereavement. For instance, people who believe that bad things can happen at any time and to everyone might find the negative experiences of bereavement easier to cope with than people who believe that if one works hard and is a 'good person', one will be protected from misfortune.

Thus far the writing has focused upon the consequences of the death of a spouse, but it has also been acknowledged that older people have experienced a greater number of bereavements than younger people (McKiernan, 1996).

The discussion will now be widened in order to include trust and dependency. In addition to the stressful effect of the death of a spouse, the increased number of bereavements of other family members and friends can have a great impact on the well-being of some older people. The effects of cumulative bereavements can be increased loneliness and loss of people who were trusted. The number of people who can be depended upon might also be diminished. However, clinical evidence indicates that, for many bereaved people, some types of dependency relationship (such as sharing a cup of tea with a neighbour) are established anew more easily than trust relationships, although for many others both might be difficult to develop. Two clinical examples will illustrate the impact of multiple bereavements. One relates to the loneliness experienced by an eighty-year old widowed woman, whose siblings, all older than herself, had died, whose family only consisted of two nephews whom she saw once or twice a year, and whose neighbours, with whom she had little in common, she saw only occasionally. In contrast, another client was a seventy-eight year woman whose relationships with new friends and neighbours were good and provided much valued support, even though they could not replace the companionship and intimacy provided by two deceased partners and other life-long friends.

A distinction has been drawn between two types of people: 'isolates' and 'desolates'. In the latter, loneliness arises out of one's personal construing and out of the lack of quality rather than the lack of quantity of one's personal relationships (Stokes, 1992 p. 102). Lowenthal & Haven (1968) have identified the benefits for an elderly person of at least one confidant, adding that intimacy is a significant factor which influences adjustment to the exigency of ageing. Stokes (1992) confirms that older people who are lonely are at greater risk of experiencing depression and anxiety. This is not surprising as being less socially connected is related to depression for people of all ages.

An extreme of the discrepancy between dependency and trust might be found in people who through ill-health live in hospital, or in residential or nursing homes. Inevitably, if one can no longer look after oneself for one's physical needs, one depends upon others for meeting these needs. In addition to the relevant aspects of one's interpersonal construing system, whether trusting relationships develop within nursing or residential settings might be predicated upon the quality and length of the dependency relationships.

Although the effects of bereavements on younger and older people have been studied, the resulting psychological effects with regard to trusting relationships seem to have been understudied. The psychological consequence of loss of trust and dependency amongst

older people is one of the foci of this study. Even though older people were not chosen on the basis of the number of bereavements they had experienced, it is expected that by virtue of their age the older sample would have known more bereavements than the younger sample. The difference in the number of bereavements between the two samples is assumed to carry implications in terms of dependency and trust. It is postulated that people who can trust other people but can no longer depend on them will experience greater psychological distress than people who can trust and depend on people. Therefore, it is thought that older people would experience more psychological distress.

5.1.3 Trust and interpersonal satisfaction and dissatisfaction

The next set of propositions concerns the relationship between trust and interpersonal satisfaction. People who trust people greatly or mistrust others deeply, as opposed to people whose pattern of trust is much less polarised, are perceived to obtain either complete validation* of their views (validation here being synonymous with confirmation or for Button (1996, p. 142) a "strengthening" of one's hypothesis) or complete invalidation (or its disconfirmation or for Button a "weakening"). Following validation, these individuals are very likely to keep anticipating others with the same constructs. In contrast, when they are faced with invalidation, it is hypothesised that they might experience, for instance, anxiety*, and/or threat* and/or guilt*, and would need to reconstrue. This might involve their views of the people whom they had trusted or had not trusted, and/or the basis on which they had granted trust and mistrust. Assuming they were habitual extreme construers, invalidation would be expected to provoke slot-rattling* in their construing, that is, a movement from one pole of their construct to the other which, in this case, would involve their swinging from 'trusting someone very much' to 'not trusting them at all'. It is proposed that undifferentiation of trust, with people being seen as either very trustworthy or very untrustworthy, would lead to interpersonal dissatisfaction.

Another area of inquiry concerns the type of people who may have difficulty in deciding whom to trust, and the consequence this might have in terms of their level of personal satisfaction. It is assumed that people who have difficulty in deciding whom to trust would experience more interpersonal dissatisfaction than people who find it easier to decide in whom to place their trust. People who construe loosely or very tightly might both have difficulty in deciding whom to trust. People who operate with constructs which

are "mostly loose", will make inferences which "vary from occasion to occasion" (Kelly, 1955, p. 853). On the other hand, for people who construe in very tight ways "Every prediction, every anticipation, must be precise and exact" (Kelly, 1955, p. 849). The former type of person, the one who operates mostly with loose construing would have difficulty in knowing whom to trust. Conversely, the person who is very tight may know whom to trust but may not dare to grant their trust so as not to be invalidated (that is, to have his or her prediction disconfirmed) in order to avoid such experiences as anxiety, threat, or guilt. It is further anticipated that a corrolary of their difficulty in knowing whom to trust would be interpersonal dissatisfaction.

In a similar vein, it is considered that people who consistently do not feel confident in their judgment of whom to trust or to distrust would experience anxiety and interpersonal dissatisfaction.

5.1.4 Replication of previous findings

An attempt will be made to replicate three main findings. (i) In keeping with Rossotti (1995), it is proposed that people whose view of the world is rigid trust other people less than people who hold a more complex and diversified view of people. (ii) Following Larson & Chastain (1990), it is expected that there will be a positive relationship between self-concealment as measured by their scale and psychological distress (including anxiety and depression) as well as physical symptoms. (iii) Finally, the researcher will attempt to replicate previous within-subjects findings (Rossotti, 1995), which indicated that most people grant more trust to people whom they see as more similar to themselves, and/or whom they like, and/or whom they feel they understand, and/or who they feel understood by.

5.2 Aims of the study

This study is constructed with three main aims:

(i) To re-design a measuring instrument for trust, based on an instrument previously used in a pilot study (Rossotti, 1995). This instrument will be created for use in this

research, and for use in therapy with the aim of exploring the reasons behind clients' granting and not granting trust.

(ii) To attempt to establish empirically that trust and dependency are separate psychological processes.

(iii) To compare, using quantitative research methods, a group of younger people (aged between 30 and 45) with a group of older people (over 65). The difference between the people they trust and the people they depend on, as well as the relationship this has with their mental health will be investigated.

5.3 Introduction to the trust and dependency grids

A detailed review of the techniques and tests used in the research is provided in the next chapter. Overall, three techniques called grids, arising from personal construct theory, were employed: a repertory grid (Kelly, 1955), a trust grid (as devised by Rossotti), and a dependency grid (Kelly, 1955), as well as four questionnaires: the Brief Symptom Inventory (Derogatis, 1993), the Inventory of Interpersonal Problems - Short Form (Soldz, et al., 1995), the Self-Concealment Scale (Larson & Chastain, 1990), and the Specific Trust Interpersonal Scale (Johnson-George & Swap, 1982). Without a brief introduction to the trust grid and the dependency grid, the operationalisation of the hypotheses within the following section would be obtuse. Both of these grids consist of a matrix of 12 situations and 11 known people whom one could trust or mistrust with regard to these situations (for the trust grid), or whom one might turn to or not (in the dependency grid). Of the twelve situations, the first six were specific to each grid, that is, the trust grid contained six trust situations and the dependency grid six dependency situations measuring physical dependency, but the last six are common to the two grids. The last six dependency situations are referred to in the text as psychological dependency. The people chosen by participants to be included in their grids will be referred to as "elements" (as well as, on occasion, "people") not only because it is Kelly's (1955) nomenclature but also in order to avoid confusion with the participants.

5.4 Hypotheses

Six main hypotheses are posited for this research. Four of these are divided into subhypotheses. The research includes a between-subjects and a within-subjects design; the within-subjects subhypotheses are presented last.

In order to avoid unnecessary repetition, the hypotheses and their operationalisation are written sequentially. For ease of reading, the hypotheses are written in normal text and the operationalisations in italics.

5.4.1 Between-subjects design

5.4.1.1 Trust and dependency

It is hypothesised that dependency and trust are two separate psychological processes rather than representing only one psychological process with different names.

This hypothesis will be tested by considering only the situations common to trust and dependency, and by grouping participants according to age and gender. For each situation, the scores for trust and dependency for the group of ten participants within each subsample will be correlated. Each correlation will be obtained from the raw scores for trust and dependency obtained by each participant. The raw score will be the sum across situations of the scores given to ten elements, excluding the self element.

5.4.1.2 Trust, dependency and psychological distress

It is hypothesised that the degree of correspondence between trust and dependency is significantly different between the two age groups, with implications for psychological distress.

Some specific predictions are drawn as follows:

5.4.1.2.1 Correspondence between people who are trusted and depended upon

As an important difference between the two age groups is the greater number of bereavements experienced by older people, it is, therefore, predicted that there is a greater correspondence between the people who are depended upon and the people who are trusted for the younger age group than for the older group.

This hypothesis will be tested in two ways: (i) for each participant, by correlating the total dependency score and the total trust score obtained for all elements, (ii) for each participant, by correlating the score on the last six dependency situations with the score on the last six trust situations obtained for all elements. The next step will consist of converting each correlation into Fisher's Z scores, and to look at the difference in the Z scores between the two samples using a t test.

5.4.1.2.2 Psychological distress and age

As a corollary of the higher correspondence between trust and dependency for the younger group than for the older one, it is further predicted that the younger group experiences less psychological distress.

This hypothesis will be tested by comparing the Global Severity Index (GSI) scores of the Brief Symptom Inventory (BSI) of the two age groups using either the Mann-Whitney Test if the data requires a non-parametric test or a t test if the data permits the use of parametric statistics.

5.4.1.3 Trust and interpersonal dissatisfaction

It is predicted that there are significant differences in trust between people regardless of their age with regard to four main factors: (i) the number of trusted people whom they can also depend on, (ii) the pattern of participants' granting of trust, (iii) the subjective ease or difficulty that people experience in trusting others, (iv) participants' perceived accuracy in placing their trust.

5.4.1.3.1 Number of people trusted and depended upon, and psychological distress

It is predicted that people who have very few people whom they trust and whom they can also depend on suffer more psychological distress.

For each participant, the number of elements who are depended upon and also trusted will be correlated with their score on the GSI, and also on the Inventory of Interpersonal Problems (IIP). Two further analyses will take place: (i) the number of elements who are trusted and depended upon on all situations will be considered, (ii) the number of elements who are trusted and depended upon only on the situations "common" to trust and dependency will be considered. It is expected that the smaller the number of elements who are depended upon and trusted, the larger the score on the GSI, and the larger the score on the IIP.

5.4.1.3.2 Pattern of granting trust and interpersonal dissatisfaction

It is hypothesised that people whose views of trust and, by extension, whose granting of trust, are very undifferentiated experience more dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way.

This will be tested by correlating the total number of extreme ratings (+3 and -3) in each participant's trust grid with his or her score on the Inventory of Interpersonal Problems (IIP). A positive correlation is expected between the two sets of scores.

5.4.1.3.3 Ease of / difficulty in trusting and interpersonal satisfaction

It is hypothesised that people who have great difficulty in deciding whom to trust experience more dissatisfaction in the interpersonal sphere than people who find it easy to decide whom to trust.

This hypothesis will be tested by correlating each participant's numeric answer to the question "How easy or difficult is it for you to decide whether to trust or not to trust somebody?" with his or her score on the Inventory of Interpersonal Problems (IIP). The

answer to the question about the ease or difficulty in deciding whether to trust or not is given on a 1 to 7 scale, whereby 1 is "very easy" and 7 "very difficult". A positive correlation is predicted.

5.4.1.3.4 Perceived accuracy in trusting and interpersonal satisfaction

It is further hypothesised that people who do not feel confident in their judgment of whom they can or cannot trust experience more dissatisfaction in the interpersonal sphere than people who feel confident in their judgement of whom they can or cannot trust.

This hypothesis will be tested by correlating each participant's numeric answer to the question "How often do you find that you have reached an incorrect judgment about someone (i.e. that you trusted somebody when he/she turned out not so trustworthy or when you did not trust somebody who later was found to be trustworthy?" with his or her score on the IIP. Again, the answer to the question regarding participants' subjective appraisal of the correctness of their judgment is on a 1 to 7 scale, with 1 being "very often" incorrect and 7 "never" incorrect. A negative relationship is predicted.

5.4.1.4 The trust grid and the Specific Interpersonal Trust Scale - Short Form

It is hypothesised that there will be a positive relationship between ratings given on the trust grid and scores from another measure of trust, the already validated Specific Interpersonal Trust Scale - Short Form (SITS-SF).

This hypothesis will be tested by correlating the participants' total trust score on the trust grid and their total score on the SITS-SF.

5.4.1.5 Replication of previous findings

The researcher will seek to replicate findings from two other research projects that are related to the current study. The first (Rossotti, 1995) concerns the relationship between trust and the structure of participants' construing systems, and the second (Larson & Chastain, 1990) the relationship between self-concealment and psychological health.

5.4.1.5.1 Trust and tightness / looseness of interpersonal construing

Even though in general a non-linear relationship is predicted to exist between the tightness/looseness dimension of interpersonal construing and trust, it is hypothesised in this study that, because of the small number of people in each age group, people whose view of the world is rigid trust other people less than people who hold a more complex and diversified view of people.

This sub-hypothesis will be tested by correlating the variance accounted for by participants' first principal components on the repertory grid with their total trust raw scores. (The first principal component accounts for the largest single proportion of the variance in the analysis.)

5.4.1.5.2 Self-concealment and psychological distress

Finally, replicating the findings of another study (Larson & Chastain, 1990) it is predicted that there is a positive relationship between self-concealment and psychological distress.

It is anticipated that there will be a positive correlation between participants' scores on the Self-Concealment Scale and their scores on the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI), as well as with the somatisation scale, the depression scale and the anxiety scale of the BSI.

5.4.2 Within-subjects design

In keeping with previous findings (Rossotti, 1995), it is hypothesised that most people place more trust in people whom they see as more similar to themselves, and/or whom they like more, and/or whom they feel they understand better, and/or whom they feel better understood by.

These four subhypotheses are tested using a within-subjects design. Their operationalisations are listed separately below.

5.4.2.1 Trust and similarity of construing self and other people

In order to test the subhypothesis that most people place more trust in people whom they see as more similar to themselves, for each participant, the total trust score for each element will be correlated with the distance between the self element and each of the other elements obtained from the repertory grid analysis. Each correlation will be transformed into a Fisher's Z score. This hypothesis will be tested with a one sample t test.

5.4.2.2 Trust and liking of other people

The subhypothesis that most people grant more trust to people whom they like will be tested by correlating the total trust score for each element with the distance between the participants' ideal self and each element. This distance is provided by the analysis of the repertory grid. Then, each correlation will be transformed into a Fisher's Z score. Finally, the hypothesis will be tested with a one sample t test.

5.4.2.3 Trust and understanding of people

In order to test the subhypothesis that most people place more trust in people whom they understand, the total trust score for each element will be correlated with the distance between the total trust score and the rating given each element on the first supplied construct of the repertory grid. This reads: 'I understand how this person sees himself/herself and other people versus I don't.' Again each correlation will be transformed into a Fisher's Z score. Then, the hypothesis will be tested with a one sample t test.

5.4.2.4 Trust and other people's understanding of oneself

The subhypothesis that most people grant more trust to people whom they feel undertood by will be tested by correlating the total trust score for each element with the rating given to each element on the second supplied construct of the repertory grid which reads: 'This person understands how I see myself and other people versus he/she does not understand.'

Each correlation will be transformed into a Fisher's Z score thus allowing this hypothesis to be tested with a one sample t test.

CHAPTER 6

METHODS AND PROCEDURES

This chapter focuses upon the practical aspects of the research. It includes sections on obtainment of ethical approval, research participants, design and procedure. Evidence for the validity of the measurements is advanced.

The selection and the design of the research instruments, especially the repertory, dependency and trust grids are explained in section 6.3, where evidence for the validity of the trust grid, the only new and untried grid used in this research, is also presented. The section on procedure demonstrates the administration of the techniques to the participants, aiming to enhance clarity and replicability.

6.1 Ethical approval

The Barnet Research Ethics Committee approved the research on 28th June 1996. The researcher had been asked to complete a form about the research, to submit a Research Proposal, as well as copies of letters to referrers and prospective participants, of the consent form and of the four questionnaires to be used with participants. The Committee required 12 copies of each submission.

6.2 Participants

6.2.1 Sampling procedure

Two samples, each consisting of twenty people, participated in the research. An older sample consisted of people aged 65 and over, whilst a younger sample was aged between 30 and 45. This range was chosen so that the two samples would be likely to be faced with different life issues, but not be so different as to make comparisons between them difficult to interpret. In other words, both samples were deemed to be made up of mature adults. Each sample contained an equal number of men and

women. Exclusion criteria for participants included the following: people who presented with cognitive impairment of organic origin, people who were psychotic and those who were paranoid, as it was surmised that people belonging to the former category would be unable to complete the research procedure competently, and that the latter two categories of people might belong to different populations with regards to trust. The inclusion of such people within the samples might bias the data.

The client population of the NHS Trust within which the researcher works is highly heterogeneous. All clients on the Clinical Psychology Department's waiting lists who fulfilled the age requirement, and did not fall into any of the psychological categories which were excluded under the criteria described in the preceding section, were written to, regardless of race, religion and place of birth.

Both samples were drawn from people who were on two psychotherapy waiting lists within a North London Trust Clinical Psychology Department. In the case of the older sample people who were already receiving therapy were included, as the waiting list for older people awaiting therapy was short. At the time the research started 55 younger people fulfilled the criteria for the research as opposed to only two older people. All consultant psychiatrists from the Trust were contacted in order to seek permission to write to their patients; two replied that they wanted to know the name of every patient they had referred who fulfilled the criteria of the research, so that they could give their approval regarding every person. When a suitable patient was referred by a general practitioner, the researcher sought written permission to invite him or her to participate in the research, along with any other patient who might subsequently be referred. Four general practitioners said that they wanted to be informed of the name of every potential participant whom they had referred and three general practices, which accounted altogether for ten general practitioners, did not want their patients to be included in any research. A copy of the letter to the consultant psychiatrists and general practitioners is included in appendix 2a.

Once permission was obtained from referring agents to write to their patients, the researcher sent these patients a letter explaining the purpose of her research (appendix 2b), along with a consent form (appendix 2c) and a stamped addressed envelope for its return.

The experience of other researchers in the clinical psychology department where this writer works indicates that, on average, one in four clients who is asked to participate in research agrees to do so. The ratio of agreement for this research was smaller, averaging about one in six for younger people. The waiting time for psychotherapy in the Adult Mental Health section (under 65 years of age) was 18 months. Anecdotal evidence revealed that people were less willing to participate in a task in which they saw no direct and immediate benefits when they were waiting a very long time for their own needs for therapy to be fulfilled. In spite of the unflinching efforts of the current researcher, it took 13 months to collect data for 40 participants.

6.2.2 Demographic characteristics of the samples and participants

The mean age and standard deviation for the two samples were separated by gender. For the younger men, the mean was 38.20 years and the standard deviation was 4.94 years. For the younger women the mean was 36.10 years and the standard deviation 4.31 years. For the older men, the mean was 69.9 years and the standard deviation 4.79 years. Finally, the mean for the older women subsample was 71.7 years and the standard deviation was 4.30 years.

As some of the hypotheses are based upon the greater number of bereavements that older people as a group have experienced compared to younger adults, the marital status of the participants is seen as relevant. Amongst the younger men, five were single, four were married, and one had a live-in partner. Amongst the younger women, three were single, three were married, three lived with a partner and one had a non-live-in partner. Of the older men, one was single and nine were married. Of the older women, one was single, two were married (but one of these was about to be separated), four were widowed and three divorced.

6.3 Design

The introduction of the grids in the section below does not correspond to the order in which they were administered to the respondents who completed the repertory grid first, followed by the dependency grid and lastly the trust grid. Following a discussion of the repertory grid, the order in the text is dictated by the need to introduce the trust

grid first, including the design of the trust situation list, in order to demonstrate its validity. This is followed by the dependency grid, as half of the dependency situations were identical to six of the situations in the trust grid.

First, an elucidation of the need to use three grids in the research is provided. The repertory grid is used in the study to seek to replicate previous findings (Rossotti, 1995) that participants whose view of the world was more rigid trusted other people less than people who held a more complex and diversified view of other people. Results from the repertory grid are also used to replicate previous within-subjects findings (Rossotti, 1995), namely that people placed more trust in people whom they saw as more similar to themselves, and/or whom they liked, and/or whom they felt they understood, and/or whom they felt understood by.

The trust and dependency grids are used to test three hypotheses. The first of these concerned the prediction that the correspondence between people who are trusted and people who are depended upon would be greater for younger than older respondents, and that older participants would experience more psychological distress. Another hypothesis related to the degree to which respondents' patterns of granting trust would be correlated with the level of satisfaction they experience in the interpersonal sphere. The last hypothesis which involves these two grids pertained to the number of people whom respondents trust and depend upon and its relationship to psychological distress.

6.3.1 The Repertory Grid

In the current research, the repertory grid comprises twelve elements and twelve bipolar descriptions or constructs; the Role Specification List comprises the descriptions of twelve people. Some of the descriptions are so tight as to involve no (or little) choice as in 'mother' and 'father', whereas others leave the membership of some elements very wide, such as 'someone I like'.

As constructs are formed and modified through interactions with other people, role titles for the elements were chosen with the aim of eliciting a representative sample of important people in the participants' lives, including 'mother', 'father', 'partner or close friend corresponding to sexual orientation'. Six descriptions were drawn in order to elicit significant elements related to the research hypotheses. These were 'someone I

trust very much', 'someone I have depended on over the last year', 'someone I don't really trust', 'someone I would not want to depend on'. Potential opposites on the dimension of trust and dependency were 'partner' and 'ex-partner or former friend'. Two general descriptions were also included: 'someone I like' and 'someone I am not close to', as well as two self elements, namely, 'me now' and 'how I would like to be'. Participants were asked to assign suitable people whom they knew personally, alive or deceased, to the descriptions.

As described in the Procedure Section 6.4.3, constructs were elicited from each participant using three elements at a time (the combination of three elements being known as triads), which were decided upon beforehand and were the same for all participants. Triadic sets, or sorts, were arranged in such a way as to facilitate the elicitation of meaningful constructs. Sorts can be composed of similar or different elements. Both types were included so as to permit the emergence of constructs at different hierarchical levels. Similar elements in the sorts tend to elicit constructs tapping finer discriminations whereas different elements tend to generate broader discriminations. Combinations of elements were not repeated and each element was used a similar number of times, with the exception of 'how I would like to be' which was excluded from the triads.

Six constructs were supplied and were chosen for their relevance to the research. The first one read: 'I understand how this person sees himself/herself, other people, the world versus I don't understand'. Inclusion of this construct was based on the theoretical assumption that people would find it easier to trust people whose construing system they understood. The second supplied construct was 'this person understands how I see myself, other people, the world versus he/she does not understand'. Again it was thought that people would find it easier to trust others who, they feel, understand how they construe themselves and other people. Both of these hypotheses received support in a previous study (Rossotti, 1995). The third supplied construct, 'discreet versus indiscreet', also related to the theoretical assumptions relevant to trusting others as, if other variables were equal, people would be less likely to be trusted if they were deemed to be indiscreet.

The next three supplied constructs respectively sought to measure how elements were perceived on aspects of the psychological constructs fundamental to the research, that is trust and dependence. The fourth supplied construct concerned whether elements

were seen as 'trustworthy versus not trustworthy'. The fifth supplied construct included aspects of trust and psychological dependency, and asked participants to rate whether each element was 'somebody I confide in now versus somebody I don't confide in now'. The last one sought to understand how much participants considered that they depended on people at the present time. It read: 'I depend on this person now versus I don't depend on him/her now'. Inclusion of the fourth and sixth supplied constructs would allow correlations respectively between these ratings and the ratings obtained by all elements on the trust and the dependency grids.

All grids were rated on a 7-point scale. The most extreme rating on the emergent pole (the description provided first by the respondent) of the repertory grid was 7 and the most extreme rating on the contrast pole (the opposite for the respondent of his or her emergent pole) was 1. Ratings on the dependency grid and trust grid ranged from +3 to -3 whereby people whom the participant 'would definitely turn to' and/or 'would trust a lot' would be given +3 whereas people whom they 'definitely would not turn to' and/or they 'would not trust at all' would be rated with -3.

The repertory grids were analysed using a Principal Component Analysis and other procedures with Flexigrid 5.2 (Tschudi, 1992). A number of measures were obtained for the dependency and trust grids, and these are detailed in section 6.4.2 and section 6.4.3 respectively.

6.3.2 The Trust Grid

The trust grid is an instrument which was used in a previous study (Rossotti, 1995). Because the design of the earlier instrument had attracted criticism as its unintended focus appeared to have been self-disclosure rather than trust, a new instrument was devised for this research. There follows a description of the different steps required to arrive at the list of situations which made up the trust grid. The description of the procedure used also serves as an indication of the validity of the items on the list in measuring trust.

6.3.2.1 Validity

The design of the trust situations list was achieved in three steps and required three consecutive versions:

(a) First, a list of 22 feelings/events/situations was compiled, all of which were surmised to require trust before confiding in another person. It was rated by four clinical psychologists, one research psychologist and one psychiatrist according to how much trust they judged these items to require. They also provided comments on the instructions and the items, and supplied items of their own with a view to increasing the range of the types of trust represented. In an attempt to ensure that, as much as possible, situations would be comparable across participants, emphatic phraseology was employed. An example is the phrase 'being very frightened' rather than 'being frightened'.

(b) Following this, a new list of 33 items (appendix 3) was then devised, which included the 22 items of the former list. These are numbered one to 22 in this 33-item list. This was rated by 22 people under 65 and seven over that age. Some of these were clients, others were friends or colleagues, including some of the same people who had rated the first list. The rating scale comprised six scale points denoting the degree of trust each person imagined they would need to feel in another person before disclosing the feelings or events. The extreme points tapped whether the respondent felt that no trust would be required (scale point 1) or whether he/she felt they 'would never reveal this under any circumstances' (scale point 6). The verbal labels for the four intermediary points were as follows: little trust is needed (scale point 2), some trust (scale point 3), a lot of trust (scale point 4) or complete trust (scale point 5). The means were calculated for each item. It was decided that an item would be included in the last piloted list if its mean rating across the two samples was 3.5 or as near as possible to this rating (between some trust and a lot of trust). Of the fifteen items chosen to be included in the final list for testing, only ten items received a mean rating over 3.5. These ten items are indicated with asterisks in the appendix. A further five items were included for the following reasons: average mean over 4 for younger people and over 3.4 for older people (item No 17), average mean over 4 for the younger sample with an average mean of 3 but a mode of 5 for the older sample (item No 21), average mean of 4.5 for the younger sample, with the older being polarised in their responses with either one or five and six (item No 10), average mean near 3.5 for the

younger sample and again polarised for the older sample (item No 19), and finally very near 3.5 for the younger sample and over 3.5 for the older sample (item No 16).

(c) The third list (appendix 4) included the 15 items just described as well as 15 items from Kelly's (1955) list for the Situational Resources Repertory Test. Kelly's original list comprised twenty-two items, which were all considered for inclusion, most of which were represented in this pilot trust list but with some modification in wording to make them more widely applicable. (For instance, Kelly's phrasing which read "The time when you had trouble with your wife (husband) or girl (boy) friend - or the time when you came nearest having trouble with one of them" was omitted and replaced by "Experiencing an important problem within a close relationship".) Only two items were completely excluded because they were ambiguous and could have been read as relating to dependency rather than trust. Those of Kelly's situations which were used are numbered 14 to 28. Appendix 5 provides a list of his original 22 situations and explains modifications or exclusions.

This third list was completed by 44 people under 55 and seven people over 65. The rating scale provided was the same as in the previous scale from 1 (no trust is required) to 6 (I would never reveal this). This list was analysed and items included in the trust grid were those which obtained a mean score of at least 3.5. Appendix 6 ranks the twelve situations which obtained a mean score of at least 3.5 in the younger sample. Twelve items met the criteria for inclusion from the younger sample. Of these, three items were excluded:

(i) 'feeling guilty', as it was correlated very significantly with 'feeling ashamed'. The former obtained a higher mean in the older age group and the latter in the younger age group. As the younger age group involved a much larger sample the researcher chose to include 'feeling ashamed' for inclusion in the trust situation list of the trust grid (Section 6.4.5);

(ii) 'being open about a time in your life when you might have lost your will to live' as it obtained the 8th rank in the younger age group but was ranked 26 in the older age group;

(iii) 'discussing your feelings regarding an important problem within your relationship with the person you're talking to' as it was ranked 10th in the younger age group but last in the older group.

Three items replaced these, two of which had means over 3.43 for both groups. These two items were:

(i) 'opening up in depth the positive and negative influences which have made you the person you are', and

(ii) 'feeling very jealous'.

Finally, one last item was included as construct validity was provided by definitions of trust from the literature review rather than through formal testing. This last item read: 'I would trust this person not to behave knowingly through actions or words in ways which would be hurtful to me.'

As validity depends not only on the chosen situations but also on the question asked of the respondents with regards to each situation, the instructions stressed that the ratings were to be based on trust rather than on self-disclosure. The researcher emphasised that participants were not asked whether they had confided this information or these feelings to these people, or whether they ever would, but they were asked instead whether, in principle, they would trust, and how much they would trust or not trust these people with each item on the list.

The analysis of the trust grids used in this research was based exclusively upon the raw scores provided by the participants. Several measures were sought. These were:

(i) Each participant's total trust score. This was obtained by subtracting their negative trust score (the sum of all the negative ratings within their grid) from their positive trust score (the sum of all the positive ratings within their grid). This score was used to test hypothesis 5.4.1.4, which concerned the relationship between the trust grid and the Specific Interpersonal Trust Scale - Short Form.

(ii) For each participant, the total score for each of the last six situations. This was calculated in order to allow comparisons with the psychological dependency scores.

Again, the total scores were calculated by deducting the sum of the negative scores from the sum of the positive scores. This calculation was used for hypothesis 5.4.1.1, which predicts that trust and dependency are two separate psychological processes.

(iii) The total trust score for each element, and the trust score for each element on the last six trust situations. This was calculated in the same way as described above. The total trust score was used in the four within-subjects hypotheses 5.4.2.1 to 5.4.2.4. These hypotheses predict that most people experience more trust towards people whom they see as more similar to themselves, and/or whom they like more, and/or whom they feel they understand better, and/or whom they feel better understood by. The total trust score for each element and the trust score for each element on the last six trust situations were used for hypothesis 5.4.1.2.1. This hypothesis envisages that there is a greater correspondence between the elements who are trusted and the elements who are depended upon for the younger age group than for the older group.

(iv) The total number of +3 and -3 ratings within the trust grid was also calculated for use in hypothesis 5.4.1.3.2. This hypothesis tests the prediction that people whose views of trust, and by extension whose granting of trust, are/is very undifferentiated experience more dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way.

6.3.3 The Dependency Grid

The aim in devising the situation list for the dependency grid was to include two dissimilar types of situations. The first type requires physical dependency on another person and the second psychological dependency without requiring the other person's physical presence. This difference in types of dependency gave rise to two separate ways of rating the elements. The first type of situations required respondents to consider whether people could be turned to in the event of a situation occurring in the present whereas, for the second type of situations, the physical presence of another person was no longer a necessary condition for a positive rating.

Devising the first type of situations necessitated thinking of areas of dependence which would exclude trust to as great a degree as possible. For instance, instead of asking someone to post a letter, which might have involved much trust, this request was

watered down to posting a gas or electricity bill payment, as the universality of such a bill was thought to reduce the need for trust. The first type of situations are numbered 1 to 6 in the dependency situation list in Section 6.4.4.

It had been intended that the dependency situations which were more psychological in nature would be the same as the six trust situations included in the trust grid which had obtained the highest mean ratings. (The six trust situations with the highest rankings can be found in appendix 6.) However, some modification of this principle was necessary as two of the trust situations were not suitable for the dependency grid. 'Allowing someone to look after your child or grandchild' was excluded as it did not involve solely psychological dependency but also dependency based on someone being present. The need for physical dependency had to be excluded from the psychological dependency situations. 'Lending a belonging which is very precious to you' was excluded as it does not involve either type of dependency. The items chosen to replace these regarded 'having been involved with something illegal' and benefiting from 'a large lottery win'.

Situations which involved psychological dependency on another person were chosen to be the same as six of the trust situations in order to be able to make possible a direct comparison between trust and dependency between groups of participants and within the responses of each participant. It was predicted that older people trust people whom they can no longer depend on, and that anyone may trust other people without being willing to or without choosing to confide in them. It was predicted that a scarcity of people whom one can trust and on whom one can depend would affect one's mental health most adversely.

Participants were asked to rate the elements according to how much they would turn to the elements if the situations/ feelings, listed below, happened to them at the present time.

The analysis of the dependency grids used in this research was based exclusively upon the raw scores provided by the participants. Several measures were calculated. These were:

(i) For each participant, the total score for all the dependency situations. This was calculated in order to allow comparisons with the trust scores. The total scores were calculated by deducting the sum of the negative scores from the sum of the positive scores. This calculation was used to test hypothesis 5.4.1.1. As mentioned in the previous section on the trust grid, hypothesis 5.4.1.1 predicts that trust and dependency are two separate psychological processes.

(ii) The total dependency score for each element, and the dependency score for each element on the psychological dependency situations. This was calculated in the same way as described above. These scores were used for hypothesis 5.4.1.2.1. This hypothesis predicts that there is a greater correspondence between the elements who are depended upon and the elements who are trusted for the younger age group than for the older group.

(iiia) For each participant, the number of elements whom he/she trusted and depended upon when all situations were considered. (iiib) For each participant, the number of elements whom he/she trusted and depended upon when only the last six situations were considered. A simple count sufficed and both types of calculations (iiia) and (iiib) were used to test hypothesis 5.4.1.3.1. This hypothesis predicts that people who have very few people whom they trust whom they can also depend on suffer more psychological distress.

Even though one of the elements of the trust grid and the dependency grid was "self now", the self element was excluded from all the analyses as in this research the focus was exclusively upon interpersonal trust and dependency, therefore it was considered that the analysis should only include other people. The self element was nevertheless included in the grids so that further analyses could be performed at a later date and compared with the present results.

6.4 Procedure

6.4.1 Overview of Procedure

Participants were invited to come for one or two research sessions. At the beginning of the first meeting the overall structure of the research was introduced. It was explained that, over the course of one or two meetings and with the help of the researcher, they would complete three grids designed to explore their views of themselves and of some important people in their lives. Specific explanations would be provided prior to starting each grid. It was indicated that, at the end of the meeting, they would be given three (or four) questionnaires to complete at home.

6.4.2 Summary of procedure

During the research session(s), participants completed three grids in this order: a repertory grid, a dependency grid and a trust grid. In addition, they were asked to complete either three or four questionnaires at home. The older people were asked to complete only three, the Brief Symptom Inventory (Derogatis, 1993), the Inventory of Interpersonal Problems - Short Form (Soldz et al., 1995), and the Self-Concealment Scale (Larson & Chastain, 1990). The younger people were invited to complete yet another questionnaire, the Specific Interpersonal Trust Scale (SITS) (Johnson-George & Swap, 1982). This required them to answer eight questions in respect of each of ten relatives, friends or acquaintances. Of the sixteen participants who were asked to rate the SITS, 15 returned their questionnaires.

6.4.3 The Repertory Grid

The researcher proceeded by specifying the four separate steps involved in the first grid: first, a list of twelve people whom they knew personally would be drawn up, based on the repertory grid list; then, on six successive occasions, the interviewer would ask them to compare and contrast three people at a time; following this, they would be asked to rate all the people on the six characteristics they had provided. Finally, they would be asked to rate these twelve people on six predetermined characteristics.

Within the theory of Personal Construct Psychology, people from whom constructs or characteristics are elicited are known as elements. Descriptions of the elements are provided below, in the same format as on the hand-out given to the participants. Participants also received 11 small index cards.

Participants' sheet

Role Specification Sheet

Below are some titles which should suggest people to you. Do the best you can to find someone who fits the description. Fill in each name and its corresponding number on the cards provided, one person per card. As you move on through the list, please give me the number and name of each person one at a time. Do not use the same person for more than one role. It is not necessary to reveal the name of the person you choose. You may use initials/nicknames or first names if you prefer. **You may use people whom you know now or used to know in the past; people may be alive or deceased.**

1. Mother (or the person who acted as a mother)
2. Father (or the person who acted as a father)
3. Self now
4. Partner or close friend corresponding to sexual orientation
5. Someone I trust very much
6. Someone I have depended on over the last year
7. Someone I would not want to depend on
8. Someone I don't really trust
9. Someone I like
10. How I would like to be
11. Someone I am not close to
12. Ex-partner or former friend

Words in bold in the text above were written in the same way in the intructions to participants.

Participants wrote the names of the elements on cards, one person per card, whilst the interviewer wrote their names on a grid response sheet. For one older person with severe arthritis in her hands, the interviewer wrote the names on the cards as well. Next, came the elicitation of six constructs from six different sets of three elements (or triads). Each time the respondent was given three cards with the names of the three elements. The interviewer wrote on a repertory grid response sheet the emergent poles and the contrast poles of these elicited constructs. After being given a sheet with the rating scale of 7 to 1 with 5, 6 and 7 describing the emergent poles and 1, 2 and 3 the contrast poles, participants were asked to rate the elements one at a time alongside their first construct, before moving on to the next construct and so on. The interviewer wrote the ratings on the grid response sheet.

Next, each participant was given a sheet with the rating scale on top, and supplied constructs underneath. He/she was shown only one construct at a time; again he/she told his/her rating for each of the elements to the interviewer who wrote them on the response sheet.

The following instructions were the interviewer's in the administration of the repertory grid. Words in bold and italics in the instructions used by the interviewer are reproduced in the same way in this text. The writing in italics were not read to the participants.

Interviewer's sheet

Elicitation of constructs

Interviewer chooses cards according to the sort codes listed below.

Interviewer: In what important way is one of these people different from the other two?
Interviewer writes down in the first left hand rectangle the participant's response.

Interviewer: What is for you in general the opposite of (*the participant's last response)*?

Interviewer writes down the answer in the right hand side rectangle.

Repeat procedures five more times.

Sort codes:

Construct No 1: *people 1, 2, 3 (self and parents)*
Construct No 2: *people 4, 5, 6 (all positive)*
Construct No 3: *people 7, 8, 11 (all negative)*
Construct No 4: *people 3, 9, 12 (mixed)*
Construct No 5: *people 4, 8, 12 (mixed)*
Construct No 6: *same gendered parent, 5, 9*

Interviewer has prepared a blank sheet of paper with a rating scale from 7 to 1 with a dividing line under 4.

The interviewer says to the participant:

Now I would like you to rate each person on each characteristic on a scale of 7 to 1 whereby 7 and 1 are the highest ratings on either side of the scale. *On a scaled sheet of paper, the interviewer writes the first construct and hands it to the participant*: The first characteristic is X (both poles of the first construct *), people who are very *(or very much, or a lot)* (the emergent pole *) are rated 7, if they are moderately (like this description *), they are rated 6, and if they are a little (like this description *) they are rated 5. ***Repeat with the other side of the scale.***

Make sure that the participant understands the incremental nature of the scale. If needed, the interviewer might explain using such construct as tall versus short.

Then say: the first person you are going to rate is your mother; is your mother (EP or CP*)? *Respondent answers and then interviewer asks*: is she a little (EP/CP*), moderately like this, or very much/very (EP/CP*)? *Interviewer writes down the number in the grid form.*

The next person is your father, is your father (EP or CP*); *Respondent answers*. And would you say he is a little (EP/CP*), moderately (EP/CP*), or very much (EP/CP*)?

Interviewer writes down the number in the Grid form. Proceed in the same way for every element. When you know that the participant understands the nature of the task, do not repeat all the instructions. Only confine yourself to saying: What about Aunt Julie?

After the first construct has been rated, request the sheet from the participant. Write down the second construct, and while doing so, give the poles of the second construct, and mention that People who are (EP*) are rated 5, 6, or 7, and people who are (CP*) are 1, 2, 3. People who are very (EP*) are 7 and people who are very (CP*) are 1. *Then proceed in the same way as with construct one.*

Then proceed in the same fashion with every construct and every element. Stop giving the long instructions when it is no longer necessary to do so.

*** in these parentheses, insert the participant's constructs poles in their own words.**

Supplied Constructs for Repertory Grid

You have chosen 6 characteristics. I will now give you six more. *(Interviewer reads one supplied construct at a time from the list; each construct is rated before proceeding with the next one.)*

The first one is :

1. I understand how this person sees himself/herself, other people versus I don't understand. **

Then the second one is:

2. This person understands how I see myself, other people versus they don't understand. **

and proceed in the same way, rating one supplied construct at a time.

3. Discreet versus indiscreet.
4. Trustworthy versus not trustworthy.
5. Somebody I confide in **now** versus somebody I don't confide in **now**
6. I depend on this person **now** versus I don't depend on him/her **now**.

** *After reading these constructs once or twice in their long form, the next readings can omit 'other people'.*

6.4.4 The Dependency Grid

Two sets of instructions for the dependency grid were drawn up, one for the interviewer and another for the participants. Participants' instructions were identical to the interviewer's provided below, with the exception of the writing in italics which was excluded from their instruction sheets. The writings in italics were not read to participants. Words in bold in the instructions are reproduced in the same way in this text.

In addition to the instruction sheet, participants were provided with oral instructions for the dependency grid, explaining that they would be asked to rate the same elements as previously, with the exception of 'how I would like to be', on twelve dependency situations, rating elements on one situation at a time. It was also pointed out that two different types of situation existed, requiring them to consider in the case of one type the geographical distance between themselves and the elements. In order for the elements to be rated positively, the first six situations required people to live sufficiently near them so that they could turn to them with regard to each of these situations, whereas the last six situations did not require people to be present as they could turn to them in other ways, for instance, by telephone. It was suggested that they think about specific situations or events from their lives for situations numbered 7 to 11, and that they write the situations down, as they needed to remember their choices for use in the next technique. Participants were told that the researcher would not ask them about the specificity of the situations. If they could not fit personal situations to the descriptions, they were to make up suitable situations.

Interviewer's sheet

The second technique or grid consists of twelve situations and the people you have chosen previously, excluding "how you would like to be". This time you are to consider the people in your list with regards to **whether or not you would turn to them** if you were faced with particular situations or problems now.

Dependency situation list

1. Being ill at home and needing someone to post a stamped gas or electricity bill payment
2. Not wanting to go alone to the cinema, or bingo, or a show or a football match OR wanting to engage in your hobby with somebody else (such as sport, card playing, walking) (choose an activity relevant to you)
3. Wishing to have a meal or a cup of coffee/tea with someone
4. Wanting someone to accompany you or to take you to and from hospital for a minor operation
5. Having a broken leg and needing someone to help you up the stairs
6. Needing someone to take your photograph to send to a friend
7. @ Feeling very ashamed about something you have done
8. @ Discussing feelings of sexual inadequacy or sexual habits
9. @ Having been involved with something illegal (excluding minor traffic offences, and breaking copyright)
10. @ Having made one of the most serious mistakes of your life
11. @ Sharing your darkest secret
12. Disclosing a large lottery win

(Whilst the participant reads and thinks of (or imagines) situations within their lives for those annotated with @, the interviewer writes the names of the elements on the dependency grid sheet.)

(Encourage the participant to write down a shorthand of what he/she has chosen for each item annotated with @ so that he/she can remember their choice for use in the trust grid and let each participant know that his/her situations and/or feelings will remain confidential from the interviewer.)

I would like you to rate each person on a scale of +3 to -3. A rating of **+3** means that you **would definitely turn to** this person and a rating of **-3** that you **definitely would not turn to** this person. A rating of **+2** means that you **would probably turn to** this person whilst a rating of **-2** that you **probably would not**. A rating of **+1** means that you **would possibly turn** to someone whilst a rating of **-1** that you **possibly would not. In the dependency grid people are only given a positive or negative rating according to whether you would or would not turn to them now;** therefore, **if people are deceased they will receive a rating of 0.**

If the situation you chose happened in the past, I would like you to consider what you would do now if you were faced with the same situation; if this situation never happened, I would like you to imagine it happening now.

Starting with your mother, consider whether you would turn to your mother if you experienced an important problem within a close relationship now. *Suggest to the participant that he/she look at the second sheet which gives a summary of the ratings.* What number from +3 to -3 would you give your mother? *Interviewer writes down the rating; interviewer needs to keep in mind which elements are alive or deceased. Then*: What about your father, would you turn to your father or would you not turn to him? What number would you give him? Then yourself, and so on. *When you have rated each person on the first situation, please move on to the next situation, and so forth.*

** *If the participant says something like: What do you mean by turn to him/her, suggest that you mean "turn to them for help".*

Summary of ratings

+3 = **I would definitely turn to** this person if faced with this situation now
+2 = **I would probably turn to** this person if faced with this situation now
+1 = **I would possibly turn to** this person if faced with this situation now

0 = people are deceased

-1 = **I possibly would not turn to** this person if faced with this situation now

-2 = **I probably would not turn to** this person if faced with this situation now

-3 = **I definitely would not turn to** this person if faced with this situation now

Gently query positive ratings for deceased persons and try to ascertain whether they can tell you a little of the process of how they do it; e.g., Would you now turn to X if (this situation) happened now? Could you tell me a little bit what you would do or how you would do this.

6.4.5 The Trust Grid

The same procedure was repeated with the trust grid. Instructions for the trust grid are provided below. As previously, these instructions are those used by the interviewer; participants' instructions were identical except for the omission of all the writing in italics.

Interviewer's sheet

The last grid consists of the same people as previously and twelve situations, six of them were included in the dependency grid. You may remember that I shall not ask you what your situations are. I shall ask you to let me know **the extent to which you would trust these eleven different people with the depth of your feelings and understanding regarding the following situations/events. I am not asking whether you have confided this information or these feelings to these people, or whether you ever will; I wish to find out whether in principle you would trust, and how much you would trust or not trust these people with each item** on the list.

Trust situation list

1. Experiencing an important problem within a close relationship
2. Allowing someone to look after your child or grandchild **
3. Feeling very jealous
4. Opening up in depth the positive and negative influences which have made you the person you are
5. Lending a belonging which is very precious to you
6. I would trust this person not to behave knowingly through actions or words in ways which would be hurtful to me
7. Feeling very ashamed about something you have done
8. Feelings of sexual inadequacy or sexual habits
9. Having been involved with something illegal (excluding minor traffic offences and breaking copyright)
10. Having made one of the most serious mistakes of your life
11. Sharing your darkest secret
12. Obtaining a large lottery win

** If you do not have a child or a grandchild, you may wish to imagine having one. Alternatively, you can choose a pet or imagine having a pet.

(Whilst the participant thinks of specific situations which fit the items in the list above, the interviewer writes the name of the elements on the trust grid sheet.)

Now that we have chosen the events, we shall proceed with the next step. I would like you to rate each person on each situation on a scale of +3 to -3. A rating of **+3** means that **you would trust this person a lot** (as much as you could trust anyone), and a rating of **-3** that **you would not trust this person at all.** A rating of **+2** means that **you would trust this person moderately** and a rating of **-2** that **you would moderately not trust this person.** A rating of **+1** means that **you would trust this person a little**, with a rating of **-1** that **you distrust this person a little**.

I would like you to rate deceased people according to how much you trusted them when they were alive.

Turning to the first situation: if you experienced an important problem within a close relationship, how much would you trust or not trust each person?; starting with your mother, how much would you **trust** your mother **with the depth of your feelings and understanding in this regard?** *Do not hesitate to remind the participant that he/she is asked to rate whether he/she would trust someone with the depth of his/her feelings and understanding and not whether he/she has disclosed his/her feelings.* Then what about your father, how much would you trust or not trust your father in this situation? and so on. *The interviewer writes down the ratings.*

Summary of ratings

+3 = I would **trust** this person **a lot** with my feelings / this situation
+2 = I would **trust** this person **moderately** with my feelings / this situation
+1 = I would **trust** this person **a little** with my feelings / this situation

-1 = I **distrust** this person **a little** with my feelings / this situation
-2 = I would **moderately not trust** this person with my feelings / this situation
-3 = I would **not trust at all** this person with my feelings / this situation

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When the three grids were completed the participants were asked for their rating from 1 to 7 on two questions. As they were given the questions in writing and orally, their answers could be written either by themselves or by the interviewer. In due course, the responses were entered on a spreadsheet. The questions read as follows:

(i) How easy or how difficult is it for you to decide whether to trust or not to trust somebody? Very easy was rated as 1 and very difficult as 7.

(ii) How often do you find that you have reached an incorrect judgement about someone (i.e. that you trusted somebody when he/she turned out not so trustworthy or when you did not trust somebody whom later you found trustworthy)? Very often was rated as 1 to never as 7.

These two questions related to an aspect of the fourth hypothesis, which postulated that people who had great difficulty in deciding whom to trust would experience more dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way, and who feel confident in their judgement of whom they can or cannot trust.

Younger participants were seen for one or two sessions, as the length of a session was left up to the participant. Most of those who came after work chose to complete the grids over two sessions, and most of those who were seen in the day-time completed them in one session. For older people, no such pattern emerged, as some were seen once, and others twice, and two people three times. On all occasions but one, breaks within the research occurred at the end of one grid, usually after the repertory grid. At the end of their first (and for many their only) session, participants were provided with three or four questionnaires, to be returned to the interviewer at the next meeting, or to be returned by post in a stamped addressed envelope which was given to them. One client, who could not read the questionnaires because of the size of the writing, was read the instructions and the questions, and the interviewer circled her answers as appropriate.

6.5 Standardised questionnaires

6.5.1 The Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1983; Derogatis, 1993).

The BSI is a "self-report symptom inventory designed to assess the psychological symptom status of psychiatric and medical patients, as well as individuals who are not patients" (Derogatis & Melisaratos, 1983, p. 596). It was used in this study to measure levels of psychological distress and to test the hypotheses that people who trusted very few people who are alive, and who could also depend on few people would experience more psychological distress; and that older people, owing to a putatively greater number of bereavements suffered in this age group, would suffer greater distress than the younger age group.

The BSI is a short version of a well-established scale, the Symptom Checklist-90R (SCL-90-R) (Derogatis, 1977), which, with 53 items, includes nine primary symptom

dimensions (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism) and four additional items (which load on several symptom dimensions). Within the *Administration, Scoring, and Procedures Manual* of the Brief Symptom Inventory, Derogatis (1993) provided evidence concerning several types of validity. Convergent validity was assessed by correlating the BSI with comparable dimensions of the MMPI. Reliability of the instrument was assessed by means of internal consistency, using Cronbach's coefficient alpha from data which involved a large number of psychiatric outpatients. Derogatis reports that the alpha coefficients for the nine dimensions were very good, with a range from .71 to .85. Test-retest reliability was also established with nonpatients; reliability coefficients varied from .68 to .91 on separate symptom dimensions, and .90 on the Global Severity Index, which combines all nine dimensions as well as the additional items.

A copy of the items of the BSI has been reproduced in appendix 7.

6.5.2 The Inventory of Interpersonal Problems-Short Form (Soldz et al., 1995)

The Inventory of Interpersonal Problems (IIP) was designed in order to "identify interpersonal sources of distress" (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988) and was used in this study as a measure of interpersonal dissatisfaction. It was originally developed by Horowitz et al., 1988 and included 127 items which could be differentiated into six separate scales. A version of the IIP with only 64 items was developed by Alden, Wiggings & Pincus (1990) to form the IIP-Circumplex scales (IIP-C), in a "theoretically principled manner" (Soldz et al., 1995) which allowed a differentiation of symptoms into separate and circumplex scales. Owing to the length of both of these instruments, Soldz et al. (1995) halved the IIP-C, and although psychometric properties were found to be similar regarding the position of individuals on the circumplex scales, the authors suggested that "the IIP-SC should prove adequate in situations where researchers are primarily interested in individual subjects' mean level of interpersonal disturbance, or overall location in circumplex problem domains." This view was also corroborated by Horowitz (1996) in correspondence to the current researcher. He wrote "I should think that the 32-item version would provide a stable

measure that is highly correlated with the corresponding score on any of the longer versions."

The IIP-SC will be used to test the fourth hypothesis which states that people whose views of trust, and by extension whose granting of trust, are/is very undifferentiated, or conversely who have great difficulty in deciding whom to trust, experience more dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way, and who feel confident in their judgement of whom they can or cannot trust.

A copy of the IIP-SC is provided in appendix 8.

6.5.3 The Self-Concealment Scale (SCS) (Larson & Chastain, 1990).

This scale was developed to measure "[active concealment] from others of personal information that one perceives as distressing or negative" (Larson & Chastain, 1990, p. 440). It was used in this research to try to replicate previous findings (Larson & Chastain, 1990) that a high degree of self-concealment is related to greater levels of physical and psychological symptoms.

Psychometric properties of the Scale were provided by the authors. With "an exploratory maximum-likelihood factor analysis, ... two factors were extracted" (p. 447). Yet, according to Larson & Chastain (p. 447), the evidence indicates that the SCS "appears to be a reliable and essentially unidimensional instrument", as "the first factor accounted for over 65% of the common variance ... with item loadings on the first component rang[ing] from .46 to .71." Further weight in favour of this claim was provided by an internal consistency coefficient of .83. It is used in this research in order to replicate previous findings by Larson & Chastain, that self-concealment is related to physical and psychological symptoms.

A copy of the SCS can be found in appendix 9.

6.5.4 The Specific Interpersonal Trust Scale (SITS) (Johnson-George & Swap, 1982).

The Specific Interpersonal Trust Scale was developed for measuring different aspects of trust within any meaningful relationship, and of all the Trust Scales (reviewed in Section 2.8) it matched the focus of the trust grid most closely. The purpose of using the SITS in this research is aimed at providing convergent validity for the trust grid. In his review, Wrightsman (1991) stated that the SITS "is designed to measure trust of another person under particular circumstances." The authors devised the scale and tested its validity in terms of specific interpersonal trust and they also assessed discriminant validity. A disadvantage of using this scale was that, owing to the discovery that different factors of trust were found for each gender, the authors refined the scale by sub-dividing it into a Scale for men (SITS-M) and a Scale for women (SITS-F). The subscale for men contains four factors which tap General Trust, Emotional Trust, Reliableness, and Dependability. The subscale for women comprises three factors. The first is an amalgam of the last two factors from the Male Scale, and was termed Reliableness, the second was similar to the male factor of Emotional Trust, and the third was called Physical Trust. As it was not possible to use two different scales in this research, after a telephone conversation with the second author, and with his agreement, the items common to the male and female scales were combined to create a short form, even though some reliability was to be lost as a result of shortening the scales.

A copy of the SITS-SF is in appendix 10.

The testing of all hypotheses was carried out by using the Statistical Package for the Social Sciences 7.5 (SPSS) for Windows 95.

6.6 Choice of personal construct methodology

This research is based upon methodology arising out of Personal Construct Psychology. Embedded within the theory is Kelly's view of human beings as scientists and as construing agents, rather than as objects to be studied. Amongst the assumptions about individuals that Neimeyer & Neimeyer (1993, p. 3) identified, they cited two which are particularly relevant to constructivist research. First, people "are

oriented actively toward a meaningful understanding of the world in which they live," and, secondly, they "are continuously in the process of development and change." Therefore, for personal construct psychologists, participants in research projects are fellow-construers and "fellow psychologist[s]" (Kelly, 1969b, p. 145).

As mentioned before in section 5.3, in addition to his theory, Kelly offered a method of inquiry and understanding he called the Role Construct Repertory Test, which led to the repertory grid. Even though Bannister (1981) expressed reservation about the pre-eminence of investigations using grids, and the dearth of studies employing self-characterisations (Kelly, 1955) in PCP research, grids remain a tool used in a variety of contexts as they present undeniable advantages over nomothetic psychometric tools. They are highly flexible and adaptable to the research questions, they allow researchers not to impose their view of the world upon participants, they yield applications which have generalisability unlike other research methods, such as self-characterisations, which are more strictly constructivist (Viney, 1988; 1992). Finally, the questions posed by this research could not have been carried out without the use of grids, as the repertory grid is designed so that both between-subjects and within-subjects data can be obtained. The within-subjects data could not have been gathered and tested quantitatively in any other way.

Grids provide a snap-shot of a portion of people's construing system which, in the case of this research, concerns participants' interpersonal construing. Even though much consistency over time occurs when testing is repeated, grids are also very sensitive to change. Studies demonstrating the ability of grids to measure consistency of construing, and others establishing grids' sensitivity to measure change have been reviewed by Winter (1992).

Devising and using the trust grid for this research provided an extension of methology whose value has been well documented, both within research and clinical settings (e.g., Sheehan, 1985; Winter, 1985; 1992; Button, 1987; Winter & Gournay, 1987). Personal construct researchers have made extensive use of repertory and dependency grids, and this research follows in this tradition.

CHAPTER 7

RESULTS

The results of the research are reported in the same order in which the hypotheses were listed in Chapter 5, with the between-subjects results reported first followed by those derived from the within-subjects analyses. As the aim of this research is to investigate interpersonal trust and dependency, the self element has been excluded from the analyses, as indicated in the last paragraph of Section 6.3.3 in the Methods Chapter.

7.1 Between-subjects results

7.1.1 Trust and dependency

The first hypothesis concerned the relationship between trust and dependency, which were predicted to be separate psychological processes rather than one single process. As indicated in the Methods Chapter, Section 6.3, there were six corresponding trust and dependency situations on which participants gave trust and dependency ratings. Only the ratings assigned to the elements who are alive were used to calculate the correlations, as in the dependency grid deceased elements were given a rating of 0, which did not exist in the trust grid. These ratings were correlated for each subsample (younger men, younger women, older men, older women) using the Pearson product-moment correlation. Correlations are provided in Table 7.1.

In order to make this reading more meaningful, the situations common to trust and dependency are listed here again and numbered from seven to 12 as they were in the research protocol. Raw scores for all the participants are provided in appendix 11.

Situation 7: Feeling very ashamed about something you have done
Situation 8: Feelings of sexual inadequacy or sexual habits
Situation 9: Having been involved with something illegal (excluding minor traffic offences and breaking copyright)
Situation 10: Having made one of the most serious mistakes of your life
Situation 11: Sharing/knowing your darkest secret

Situation 12: Obtaining a large lottery win

Table 7.1 - Pearson correlations between participants' trust and dependency scores for situations numbered seven to 12

	Younger Men	Younger Women	Older Men	Older Women
Situation 7	0.63	0.25	0.81**	0.44
Situation 8	0.74*	0.74*	0.67*	0.73*
Situation 9	0.69*	0.62	0.60	0.43
Situation 10	0.83**	0.07	0.65*	0.47
Situation11	0.44	0.85**	0.75*	0.40
Situation 12	0.55	0.88**	0.59	0.15

Note. Each correlation coefficient is obtained by correlating, for each subsample, participants' total scores for each of the situations above in the trust grid and in the dependency grid. Each participant's total score is obtained by adding all the ratings he or she assigned to his or her elements with respect to each situation.
* $p < .05$ (two-tailed test). ** $p < .01$ (two-tailed test).

The scores for trust and dependency on some situations are well correlated and others are not. The overall pattern is not homogeneous across situations nor across groups. The results would tend to indicate that trust and dependency constitute two separate psychological processes.

As the original hypothesis aimed to explore the relationship between trust and dependency, the raw data were examined in order to provide further understanding of the meaning of the significant correlations, and to compare and contrast the way the trust and dependency situations were construed. As each person's score on each situation was obtained by adding the score (from +3 to -3) they gave to each element, the total score for each participant on each situation could be positive or negative. Within each subsample, the number of participants with positive scores on situations seven to 12 for trust and dependency was obtained and is provided in Table 7.2.

Table 7.2 - The number of participants who obtained positive scores on trust and dependency situations, by subsample

		Younger Men	Younger Women	Older Men	Older Women
Situation 7	Trust	7	4	7	7
	Dependency	1	1	2	2
Situation 8	Trust	**3**	**2**	**4**	**3**
	Dependency	**1**	**0**	**2**	**1**
Situation 9	Trust	**6**	7	7	5
	Dependency	**3**	2	1	1
Situation 10	Trust	**6**	5	**8**	4
	Dependency	**3**	2	**5**	2
Situation 11	Trust	5	**4**	**5**	4
	Dependency	2	**1**	**2**	1
Situation 12	Trust	7	**9**	6	5
	Dependency	7	**9**	6	3

Note. For each participant the score on a situation was obtained by summing up the scores given to the elements.

When considering only those correlations which were significant, denoted in bold in Table 7.2, the raw data concerning situation 12 show that most younger women had positive ratings for trust and dependency. The other results tend to show two patterns: (i) a higher number of positive ratings for trust than for dependency, which means that individuals placed more trust in people than dependency, and (ii) a low number of positive scores for trust and dependency.

These results would indicate that, except for situation 12, the significant correlations do not indicate a similarity between trust and dependency. This is because they were construed very differently by the participants, and because the correlations often arose from people not trusting and not depending upon others in their grids, suggesting a relationship between lack of trust and lack of dependency rather than between trust and dependency.

Further evidence that trust and dependency are different constructs was gained from the results of Wilcoxon Signed-Ranked test for related samples. A significant difference between trust and dependency was obtained in 16 of the 24 pairs. The Wilcoxon Signed-Ranked test values are shown in Table 7.3. As Bryman & Cramer (1997) advised the use of non-parametric statistics for sample sizes under 15, Wilcoxon Signed-Ranked tests were chosen in preference to *t* tests for related samples.

Table 7.3 - Wilcoxon Signed-Ranked Tests performed between trust and dependency scores for situations numbered seven to 12

	Younger Men	Younger Women	Older Men	Older women
Situation 7	1.94	2.50*	2.67**	2.24*
Situation 8	2.66**	2.55*	2.24*	2.67**
Situation 9	2.20*	2.71**	2.70**	1.78
Situation 10	2.08	1.63	2.31*	0.61
Situation 11	2.67*	2.81**	2.10*	1.72
Situation 12	0.18	2.81**	0.84	2.14*

Note. The sum of the ratings for each trust and dependency situation for each participant were used to calculate the related Wilcoxon Signed-Ranked Test.
* $p < .05$ (two-tailed test). ** $p < .01$ (two-tailed test).

The combined results from the correlational data and from comparisons of ranks of the trust and dependency scores indicate that the two constructs, trust and dependency, constitute separate psychological processes.

7.1.2 Trust, dependency and psychological distress

Two hypotheses were formulated with a view to comparing the younger and older samples: first, in respect of the similarity between their trust in and dependency upon others and, secondly, in respect of their degree of psychological distress.

7.1.2.1 Correspondence between people who are trusted and depended upon

This hypothesis predicted a greater correspondence between the people who are depended upon and those who are trusted for the younger age group than for the older group. It was tested in two ways: (i) for each participant, the total trust score and the total dependency score of all the elements were correlated (that is, all twelve situations were used to calculate the scores); (ii) for each participant, the trust score and dependency score of all the elements were correlated for the six situations which were the same in the trust and dependency grids.

The table of correlations for the 12 and the six situations is presented in appendix 12. The correlations were transformed into Fisher's Z scores with the use of a table from

McNemar (1955). *T* tests were performed comparing the *Z* scores of the younger and older samples. Levene's Test for Equality of Variances was performed alongside the *t* tests. Bryman & Cramer (1997, p. 144) stated that "If the Levene's test is significant ... then the variances are unequal and so the *separate* variance estimate is used to calculate the *t* value" (italics in the text). Under both conditions mentioned above, the Levene's test was not significant. The *t* test based on 12 situations provided a $t(38)$ value of 1.34 ($p < .10$) with a one-tailed test (Table 7.4). When based on six situations the $t(38)$ test value was 1.74 ($p < .05$) with a one-tailed test (Table 7.5).

Table 7.4 - *T* test based on Z scores for the relationship between trust and dependency across all 12 situations

			Levene's Test for Equal variances			
Age group	Mean	Std Deviation	F	Sig	$t(38)$	p (1-tailed)
Younger	1.07	.55	2.39	0.13	1.34	< 0.10
Older	.87	.36				

Table 7.5 - *T* test based on Z scores for the relationship between trust and dependency across the six common situations

			Levene's Test for Equal variances			
Age group	Mean	Std Deviation	F	Sig	$t(38)$	p (1-tailed)
Younger	1.33	.74	3.69	0.62	1.78	< 0.05
Older	.98	.48				

The results indicate that, when all situations are considered, the difference between the two age groups in terms of people whom they trusted and whom they depended upon was not significant but the level of probability indicated a trend. When only the situations common to trust and dependency were taken into account, a significant

difference was found to exist between the two age groups. As predicted, there was a greater correspondence between the people who are depended upon and the people who are trusted in the younger age group than in the older group, as the former obtained the higher mean *Z* score.

As this hypothesis arose because it was predicted that the two age samples would experience different bereavement levels, analyses concerning the number of bereavements in the two samples and statistical differences are now reported. Out of 10 elements rated by each participant, the mean number of bereavements experienced by younger people was .60, and for older people 2.40, and the variances for the two age groups were respectively .46 and .98. In addition to the difference in the size of the variances, the number of bereavements for each age group was not normally distributed; the Mann-Whitney *U* Test was used to test whether the two age groups had experienced a similar number of bereavements. The value of *U* was 27 ($p < .001$, with a one-tailed test). This indicates that, as anticipated, there was a significant difference in the number of bereavements experienced by younger and by older people.

Both younger groups had a mean number of bereavements of .60, whilst the older men had experienced 1.9 bereavements, and the older women 2.9. Differences in the number of bereavements between older men and older women were also explored with the Mann-Whitney *U* Test, as Bryman & Cramer (1997) advised the use of non-parametric statistics for sample sizes under 15. The value of *U* was 50 ($p < .02$, with a two-tailed test). Although it was not expected, the difference in the number of bereavements experienced by older men and women was also significant.

7.1.2.2 Psychological distress and age

It was predicted that the younger age group would experience less psychological distress than the older age group. This was tested by comparing the scores of younger people and older people on the Global Severity Index (GSI) of the BSI using the Mann-Whitney *U* Test. The GSI means for the younger and older age groups were 1.37 and 1.29 respectively, and the variances were respectively .75 and .36. The difference in the variances dictated the use of non-parametric statistics. The value of *U* was 197.50 ($p > .05$, with a one-tailed test). This indicates that no difference existed between the two samples with regard to psychological distress.

To summarise, within this section two hypotheses were tested. It was found that (i) only when the constructs which are common to trust and dependency are taken into account, a greater correspondence existed between trust and dependency for the younger group than the older one. This was not the case when all the constructs in both grids were correlated. (ii) Contrary to prediction, older and younger people did not differ with regard to the level of psychological distress they experienced.

7.1.3 Trust and interpersonal dissatisfaction

Four subhypotheses were drawn up to predict that there might be significant differences between people irrespective of their age with regard to four main factors: (i) the number of trusted people whom participants can also depend on, (ii) the pattern of their granting of trust, (iii) the subjective ease or difficulty that people experience in trusting others, and (iv) participants' own perceived accuracy in placing their trust.

7.1.3.1 Number of people trusted and depended upon, and psychological distress

This hypothesis predicted that people who have very few people whom they trust and whom they also depend on suffer more psychological distress. People who were trusted and depended upon were operationalised in two ways: (i) by considering the number of elements whom each participant trusted and depended upon on all situations, and (ii) by considering the number of elements whom each participant trusted and depended upon with regard to the six common trust and dependency situations. Two of the inventories used in this research were considered to test some aspects of psychological distress, namely the Brief Symptom Inventory (BSI) and the Inventory for Interpersonal Problems (IIP). The BSI measures "self-report[ed] ... psychopathology or psychological distress" (Cohran & Hale, 1985, p. 777), and the IIP "interpersonal sources of distress" (Horowitz, et al., 1988, p. 885).

First, the number of elements trusted and depended upon (within both conditions described above) was correlated with the score each participant obtained on the Global Severity Index (GSI) of the BSI using the Pearson product-moment correlation. These correlations were not significant. Table 7.6 presents these results.

Secondly, the number of elements in each of the two measures described above was correlated with the score each participant obtained on the IIP using the Pearson product-moment correlation. Only one correlation reached significance: the elements trusted and depended upon for the six common trust and dependency situations with the IIP yielded a r value of -.28 ($p < .05$, with a one-tailed test). The results are presented in Table 7.6.

Correlations were also calculated for each age group separately. Only one relationship was significant: for younger people, when the number of elements depended upon and trusted on the six situations common to trust and dependency was correlated with the IIP, the correlation coefficient was -.43 ($p < .05$, with a one-tailed test). Table 7.6 presents these results.

Table 7.6 - Pearson correlations between the number of people trusted and depended upon (on all 12 situations and on the six common situations) and psychological distress as measured by the GSI (BSI) and the IIP

		GSI	IIP
All participants			
	12 situations	-0.14	-0.15
	6 situations	-0.05	-0.28*
Younger people			
	12 situations	-0.31	-0.33
	6 situations	-0.16	-0.43*
Older people			
	12 situations	-0.002	-0.07
	6 situations	-0.01	-0.28

* $p < .05$ (one-tailed test).

Further exploration of the data revealed that, for younger people, the depression dimension of the BSI was negatively correlated with the number of elements trusted and depended upon when this number was based on all situations ($r = -.60$, $p < .01$, with a one-tailed test), and when only the six common situations were taken into account ($r = -.41$, $p < .05$, with a one-tailed test). Therefore this indicates that in the younger age group the greater the number of people trusted and depended upon the lesser the degree of depression this age group experienced. No such relationship existed for older people. The number of people depended upon and trusted was also correlated with all the other dimensions of the BSI for all participants, for younger

people, and for older people. None of the other correlations was significant. Correlations between the dimensions of the BSI and the number of people trusted and depended upon based on all situations and on the six common situations for all participants, for younger people and older people are presented in appendix 13.

Even though the hypotheses were drawn with regard to age alone, the data were explored further and new analyses, based on small subsamples of only 10 people, were carried out separating gender and age. Table 7.7 sets out the correlations between the number of people trusted and depended upon, and the IIP, the GSI, and the Depression dimension of the BSI for the four subsamples.

Table 7.7 - Pearson correlations between number of people depended upon and trusted based on all situations, on situations common to trust and dependency, and IIP, GSI , and the Depression (Dep) dimension of the BSI for each subsample

IIP/GSI/DEP	No. of situations	Younger men	Younger women	Older men	Older women
IIP	12	-0.17	-0.52	-0.14	0.07
IIP	6	-0.35	-0.64*	-0.67*	0.18
GSI	12	0.00	-0.69*	-0.57*	0.44
GSI	6	0.08	-0.68*	-0.54	0.44
Dep	12	-0.38	-0.81**	-0.40	0.54
Dep	6	-0.29	-0.73*	-0.48	0.60(*)

(*) $p < .10$ (two-tailed). * $p < .05$ (one-tailed). ** $p < .01$ (one-tailed).

For the sample of younger men, there was no significant relationship between the number of people trusted and depended upon and any of the measures of distress. For the sample of younger women, all correlations but one were significant, indicating that the higher the number of people trusted and depended upon, the lower the distress (interpersonal, psychological, and depression) the younger women experienced. For the older men, the higher the number of people they trusted and depended upon on the common situations, the lower their interpersonal distress, and the higher the number of people they trusted and depended upon on all situations the lower their psychological distress. None of the results for the older women were significant. Yet, results show a tendency towards more depression as the number of people they trusted and depended upon on the six common situations increased. This unexpected result is discussed at length in section 8.1.1.3.2 as the trend towards significance in the opposite direction to that predicted arose because the scores of two older women exerted much leverage on the data.

7.1.3.2 Pattern of granting trust and interpersonal dissatisfaction

It was predicted that people whose views of trust, and by extension, whose granting of trust, are/is very undifferentiated, experience more dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way. This was tested by correlating each participant's IIP score with the number of extreme ratings (+3 and -3) which he/she gave on his/her trust grid. The Pearson product-moment correlation coefficient was .10 ($p > .05$, with a one-tailed test). This indicates that people who trust and/or mistrust people very much do not experience greater dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way.

7.1.3.3 Ease of / difficulty in trusting and interpersonal satisfaction

This hypothesis concerned the relationship between the subjective ease or difficulty that people feel in deciding whom to trust and the degree of satisfaction or dissatisfaction they experience in the interpersonal sphere. It was predicted that people who experience greater difficulty in deciding whom to trust also experience more dissatisfaction in the interpersonal sphere than people who find it easy to decide whom to trust. This hypothesis was tested by correlating the numeric response participants gave to the question: "How easy or how difficult is it for you to decide whether to trust or not to trust somebody?" with their score on the IIP. Calculation of the Pearson product-moment correlation yielded an r value of .22 ($p > .05$, with a one-tailed test). The value of the correlation indicates that no significant relationship exists between the two variables.

7.1.3.4 Perceived accuracy in trusting and interpersonal satisfaction

This hypothesis concerned the relationship between participants' own perceived accuracy in trusting others and the degree of satisfaction or dissatisfaction they experience in the interpersonal sphere. It was predicted that people who feel less confident in their judgement of granting trust to others also experience more dissatisfaction in the interpersonal sphere than people who are more confident in their ability to predict whom they can or cannot trust. This hypothesis was tested by correlating the numeric response participants gave to the question: "How often do you find that you have reached an incorrect judgement about someone (i.e., that you trusted

somebody when he/she turned out not so trustworthy or when you did not trust somebody who later was found to be trustworthy)?" with their score on the IIP. As the numeric answer was given on a scale of 1 to 7, with 1 being 'very often' and 7 being 'never', a negative relationship was predicted. Calculation of the Pearson product-moment correlation yielded an r value of -.27 ($p < .05$, with a one-tailed test). The value of the correlation coefficient indicates that there exists a weak but significant relationship between the two variables, such that people who feel less confident in their judgement of whom they can trust might be more likely to experience interpersonal dissatisfaction than people who feel more confident in their own judgement.

The data were explored further in terms of age and gender and the results are presented in Table 7.8. Calculations were performed with the Pearson product-moment correlation.

Table 7.8 - Pearson correlations between frequency of perceived inaccuracy of assigning trust, and interpersonal satisfaction/dissatisfaction (IIP)

IIP	Younger people	Older people	Younger Men	Younger Women	Older Men	Older Women
	Question 2	Question 2	Question 2	Question 2	Question 2	Question 2
IIP	-0.45*	-0.08	-0.21	-0.67*	0.25	-0.37

* $p < .05$ (one-tailed).

Table 7.8 shows that the significant relationship for younger people comes from the data for younger women alone. The more often younger women construed reaching incorrect judgements in placing their trust, the more interpersonal distress they experienced.

7.1.4 Trust grid and Specific Interpersonal Trust Scale - Short Form

This hypothesis predicted a positive relationship between the scores from the trust grid and the Specific Interpersonal Trust Scale - Short Form (SITS-SF). Sixteen younger people were asked to complete the SITS-SF, and fifteen, six men and nine women, completed and returned it. The scores from the trust grid and the SITS-SF were correlated with the Pearson product-moment correlation, which yielded a correlation coefficient of .71 ($p < .01$, with a one-tailed test). Thus, there is evidence of a relationship between the two measures, whereby the trust grid scores were positively

correlated with scores on the SITS-SF. However, there were only 15 people in the sample, and with two points exerting a lot of leverage, this relationship would need to be confirmed with more data.

7.1.5 Replication of previous findings

The testing of two hypotheses was replicated in the between-subjects research. The first concerned the relationship between trust and the structure of interpersonal construing. The second concerned the relationship between self-concealment and interpersonal distress.

7.1.5.1 Trust and tightness / looseness of interpersonal construing

In an attempt to replicate previous findings (Rossotti, 1995) this hypothesis predicted a negative relationship between rigidity of interpersonal construing and amount of trust placed in other people. The sizes of the first principal component of the repertory grids and the total trust scores were correlated with the Pearson product-moment correlation. This yielded an r value of -.29 ($p < .05$, with a one-tailed test). This indicates that, as people construe more tightly, they tend to trust others less, but this is a weak effect. The sizes of the first principal components and the total trust scores are listed in appendix 14.

7.1.5.2 Self-concealment and psychological distress

In keeping with prediction, the scores obtained by all participants on the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI) and on the Self-Concealment Scale (SCS) were significantly correlated as shown by the Pearson product-moment correlation coefficient. The correlation coefficient was .44 ($p < .01$, with a one-tailed test).

In order to provide a closer replication of the results obtained by Larson & Chastain (1990), self-concealment scores were correlated using the Pearson's product-moment correlation with three separate dimensions of the BSI: Somatization, Depression and Anxiety. In keeping with their findings, it was predicted that there would be a positive

relationship between each of these dimensions and self-concealment. These results are reported in Table 7.9.

Table 7.9 - Pearson correlations between SCS, and GSI, Depression, Anxiety, and Somatization dimensions of the BSI

SCS	BSI	All participants	Younger people	Older people
SCS	GSI	0.44**	0.68**	0.10
SCS	Depression	0.37**	0.74***	-0.02
SCS	Anxiety	0.29*	0.55**	0.04
SCS	Somatization	0.36*	0.57**	0.29

* $p < .05$ (one-tailed). ** $p < .01$ (one-tailed). *** $p < .001$ (one-tailed).

Further exploration of the data took place in order to ascertain whether significant relationships existed between self-concealment and other dimensions of the BSI. Correlations were calculated for all participants, and for younger and older people; these are reported in Table 7.10.

Table 7.10 - Pearson correlations between SCS and other dimensions of the BSI

SCS	BSI	All participants	Younger people	Older people
SCS	Interpersonal Sensitivity	0.44**	0.71***	-0.04
SCS	Phobic Anxiety	0.41**	0.56**	0.28
SCS	Paranoid Ideation	0.24	0.48*	-0.14
SCS	Hostility	0.18	0.20	0.03
SCS	Psychoticism	0.34*	0.48*	0.06
SCS	Obsessive - Compulsive	0.38*	0.70***	0.04

* $p < .05$ (one-tailed). ** $p < .01$ (one-tailed). *** $p < .001$ (one-tailed)

As shown in Table 7.10, the results were very different for the two age groups. In younger people, scores on the Self-Concealment Scale were significantly correlated with the Global Symptom Index and with all symptom dimensions but one, the exception being the Hostility Dimension. In contrast, for older people none of the dimensions of the BSI or the GSI correlated with scores on the SCS.

The data were explored further for each subsample, by separating gender as well as age. Pearson correlations between the SCS and dimensions of the BSI for each subsample are presented in Table 7.11.

Table 7.11 - Pearson correlations between SCS, GSI and BSI dimensions for each subsample

SCS	BSI	Younger Men	Younger Women	Older Men	Older Women
SCS	GSI	0.62*	0.73**	0.31	-0.05
SCS	Depression	0.73**	0.75**	0.04	-0.06
SCS	Anxiety	0.47	0.68*	-0.02	0.08
SCS	Somatization	0.62*	0.48	0.35	0.27
SCS	Interpersonal Sensitivity	0.58*	0.85**	0.06	-0.10
SCS	Phobic Anxiety	0.65*	0.41	0.09	0.38
SCS	Paranoid Ideation	0.36	0.65*	0.43	-0.63(*)
SCS	Hostility	0.12	0.33	0.31	-0.11
SCS	Psychoticism	0.28	0.68*	0.34	-0.18
SCS	Obsessive - Compulsive	0.66*	0.82**	0.16	-0.05

(*) $p < .05$ (two-tailed test). * $p < .05$ (one-tailed test). ** $p < .01$ (one-tailed test).

The results shown in Table 7.11 indicate that the greater self-concealment the younger men engaged in, the greater the psychological distress they experienced in terms of an aggregation of symptoms measured by the GSI, and in terms of some specific symptoms (Depression, Somatization, Interpersonal Sensitivity, Phobic Anxiety and Obsessive-Compulsive). For younger women, the greater their self-concealment, the higher their scores on the GSI and on all but three of the symptom dimensions of the BSI (Depression, Anxiety, Interpersonal Sensitivity, Paranoid Ideation, Psychoticism, and Obsessive-Compulsive). No significant relationships emerged for the older men. For the older women, one significant relationship existed in the opposite direction to that obtained in the younger samples. The greater the self-concealment, the less paranoid ideation the older women reported experiencing.

7.2 Within-subjects hypotheses

The testing of four hypotheses was replicated from previous research (Rossotti, 1995).

7.2.1 Trust and similarity between self and other elements.

This hypothesis predicted that people place more trust in people whom they see as more similar to themselves. Testing was done by correlating two measures: (i) the

distance between each element and the self element obtained from the print-out of the principal component analysis of the repertory grid, and (ii) each element's total trust score. This led to one correlation coefficient per participant. The correlations were transformed into Fisher's Z scores, from which a one-sample t test was calculated. "The goal in a one-sample t test is to test if the mean of a single sample differs from a hypothesized population value" (SPSS, 1997, p. 117). The value of the one-sample $t(39)$ test is 6.65 ($p < .001$, with a one-tailed test). As predicted, the value of the t test allowed the rejection of the null hypothesis which states that the mean of the population of correlations is zero. Therefore, the smaller the distance between themselves and particular other people, or the more similar to themselves people perceive particular other people to be, the more trust participants granted those people.

7.2.2 Trust and distance between elements and the participant's ideal self

The next hypothesis predicted that people grant more trust to people whom they like. This was tested by correlating the following measures: (i) the distance between each element and the ideal self obtained from the print-out of the principal component analysis of the repertory grid, and (ii) each element's total trust score. The distance between the elements and how the participant would like to be was taken as a measure of disliking. One correlation coefficient was obtained per participant. The correlations were transformed into Fisher's Z scores, from which a one-sample t test was calculated. The value of the one-sample $t(39)$ test was 17.56 ($p < .001$, with a one-tailed test). Again, the value of the t test allowed the null hypothesis to be rejected. Therefore, it provides evidence that people grant more trust to people whom they see as more similar to how they would like to be.

7.2.3 Trust and perceived understanding of other people's construing

This hypothesis predicted that people place more trust in people whose construing system they think they understand. Testing was done by correlating two measures: (i) the rating that the participant gave to each element on the first supplied construct of the repertory grid which read "I understand how this person sees himself/herself and other people versus I don't", and (ii) each element's total trust score. This led to one correlation coefficient per participant. The correlations were transformed into Fisher's Z scores, from which a one-sample t test was calculated. (It was possible to calculate

only 39 correlations as one participant used an identical rating for his understanding of all his elements' construing system.) The value of the one-sample $t(38)$ test is 9.67 ($p < .001$, with a one-tailed test). Therefore, it indicates that people placed greater trust in people whose construing system they thought they understood.

7.2.4 Trust and the elements' perceived understanding of each participant

This hypothesis predicted that people grant more trust to people who, they feel, understand their (the participants') construing system, and most specifically the way they see themselves. Testing was done by correlating two measures: (i) the rating that the participant gave to each element on the second supplied construct of the repertory grid, which read: "This person understands how I see myself and other people versus he/she does not understand" and (ii) each element's total trust score. This led to one correlation coefficient per participant. The correlations were transformed into Fisher's Z scores, from which a one-sample t test was calculated. The value of the one-sample $t(39)$ test is 10.99 ($p < .001$, with a one-tailed test). Therefore, it indicates that participants placed greater trust in people by whom their construing system was perceived to be understood.

7.3 Summary of results

This section provides a brief summary of the results, again with the between-subjects results being provided first, with the hypotheses which were supported being given prior to those which did not receive support. The within-subjects results are provided last.

7.3.1 Between-subjects results

As predicted, the results would tend to indicate that (i) trust and dependency constitute two psychological processes. (ii) A greater correspondence existed between the people who were trusted and those who were depended upon in the younger age group than in the older age group, although this difference was found only when the situations common to trust and dependency were taken into account. (iii) There is evidence that the higher the number of people that younger women depended on and also trusted,

the lower the level of psychological and interpersonal distress they experienced. No significant relationship existed for younger men. Older men experienced a positive relationship between psychological distress and the number of people they trusted and depended upon, as well as between interpersonal distress and the number of people they trusted and depended on. Unexpectedly, the higher the number of people older women trusted and depended upon, the more depression they experienced; however, this relationship was the result of the scores of two women which exerted much leverage on the data. Those scores are discussed in section 8.1.1.3.2. (iv) Younger women who felt less confident in their judgement about whom they could trust experienced more interpersonal distress than those who felt more confident in their judgement. No significant relationship existed between these two variables in the other subsamples. (v) Some preliminary evidence was obtained that the trust grid measures similar aspects of trust as the Specific Interpersonal Trust Scale - Short Form. However, this relationship needs to be tested further with a greater number of participants. In keeping with previous research, support was also found for the following hypotheses which had been previously tested. (vi) It was found that, as people construed more tightly, they tended to trust others less, but this was a weak effect. (vii) It was found that the more that younger people concealed about themselves the more symptoms they reported experiencing. For older men, there was no relationship between self-concealment and psychological symptoms, whilst, for the older women, a significant negative relationship was found between self-concealment and paranoid ideation.

Contrary to prediction, (i) older and younger people did not differ with regard to the level of psychological distress they experience. (ii) People who trust and/or mistrust people very much do not experience greater dissatisfaction in the interpersonal sphere than people who assign trust in a more differentiated way. (iii) People who experience greater difficulty in deciding whom to trust do not experience more dissatisfaction in the interpersonal sphere than people who find it easy to decide whom to trust.
A summary of the results of each subsample is presented in Figures 7.1 to 7.4.

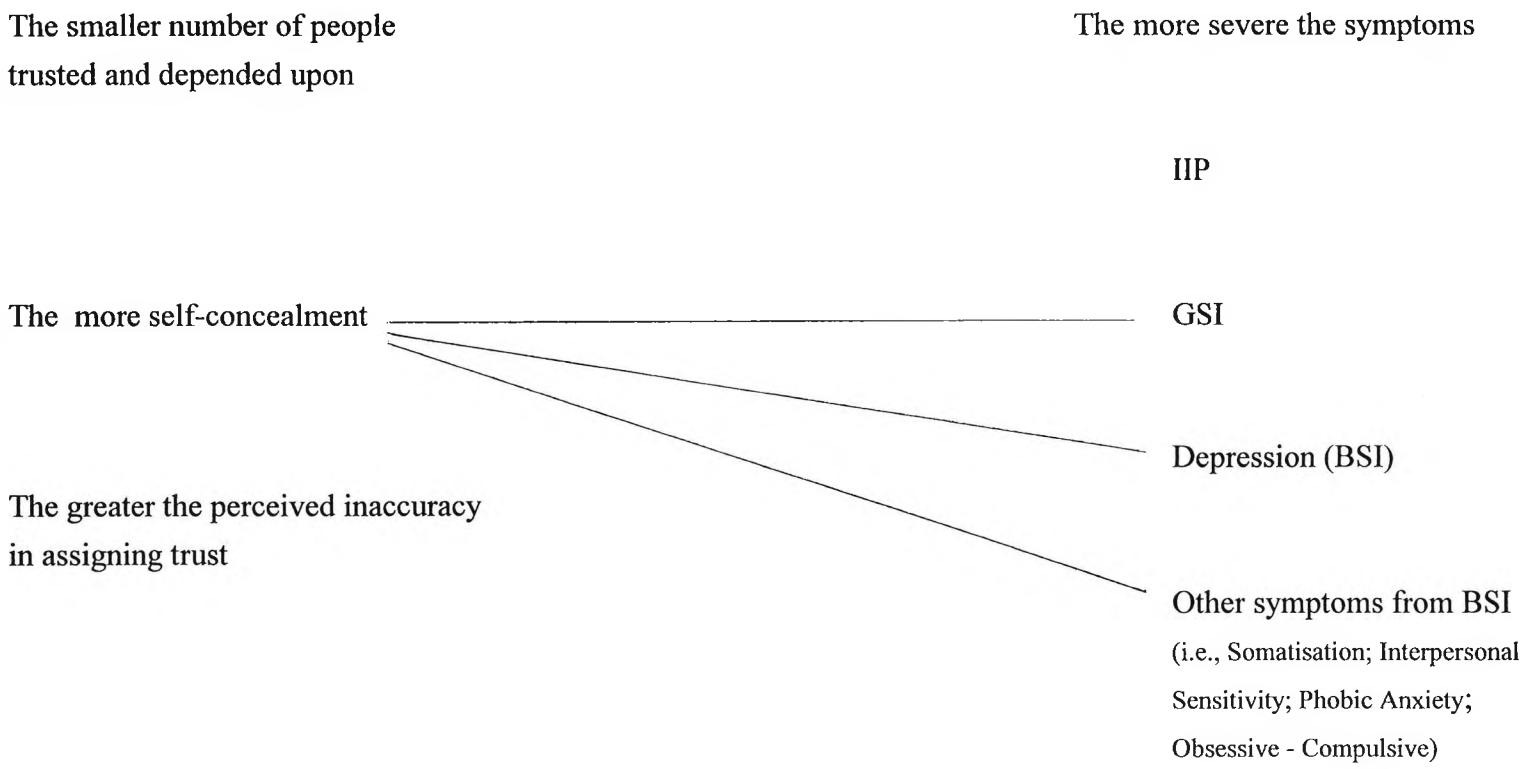
7.3.2 Within-subjects results

In keeping with predictions, it was found that people tend to grant more trust to people whom they construe as more similar to themselves, and/or people whom they like,

and/or people whose construing system they think they understand, and/or people who, they think, understand their construing system.

Figure 7.1 - Summary of results

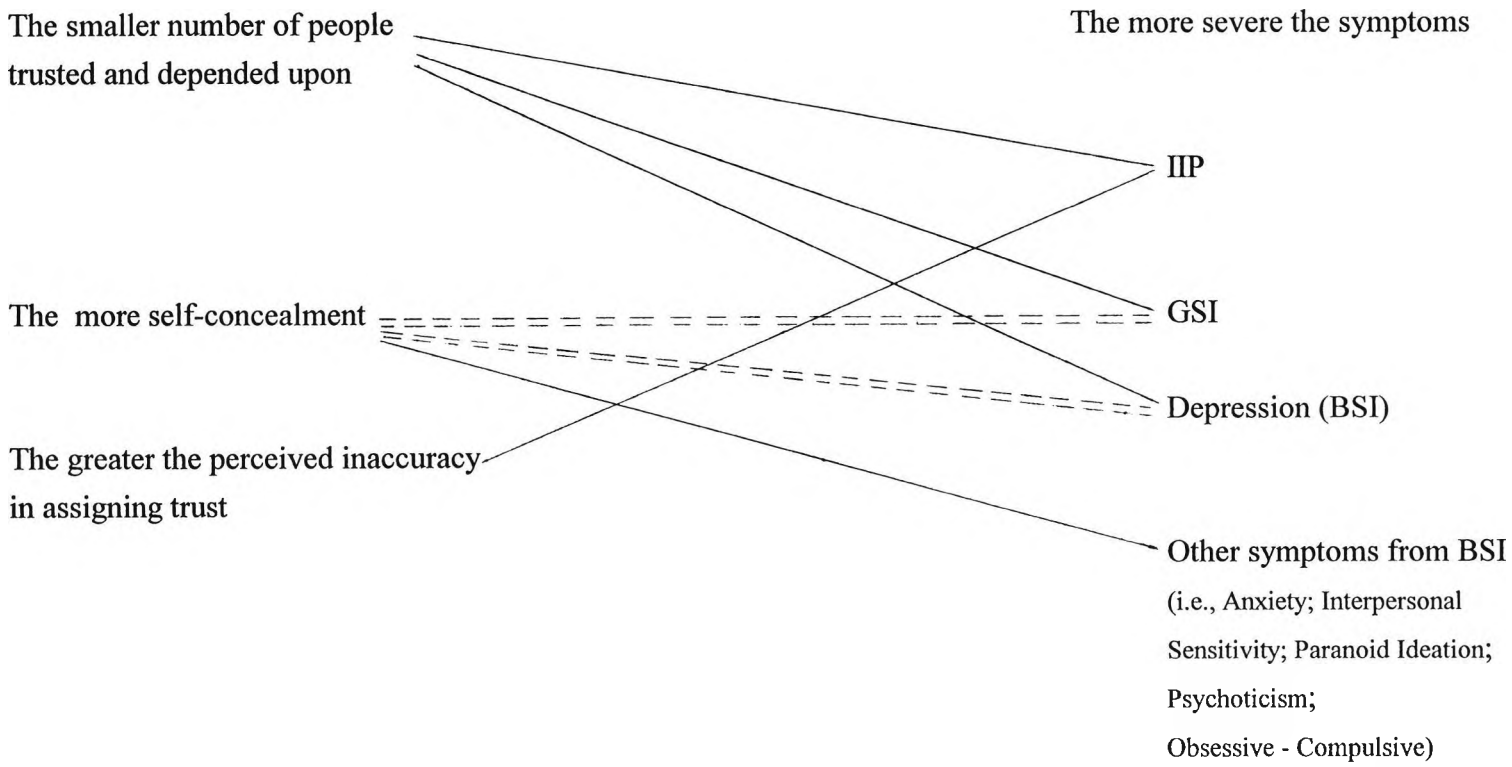
Younger men



_____ : $p < .05$ (one-tailed).

Figure 7.2 - Summary of results

Younger women



_____ : $p < .05$ (one-tailed). ===== : $p < .01$(one-tailed).

Figure 7.3 - Summary of results

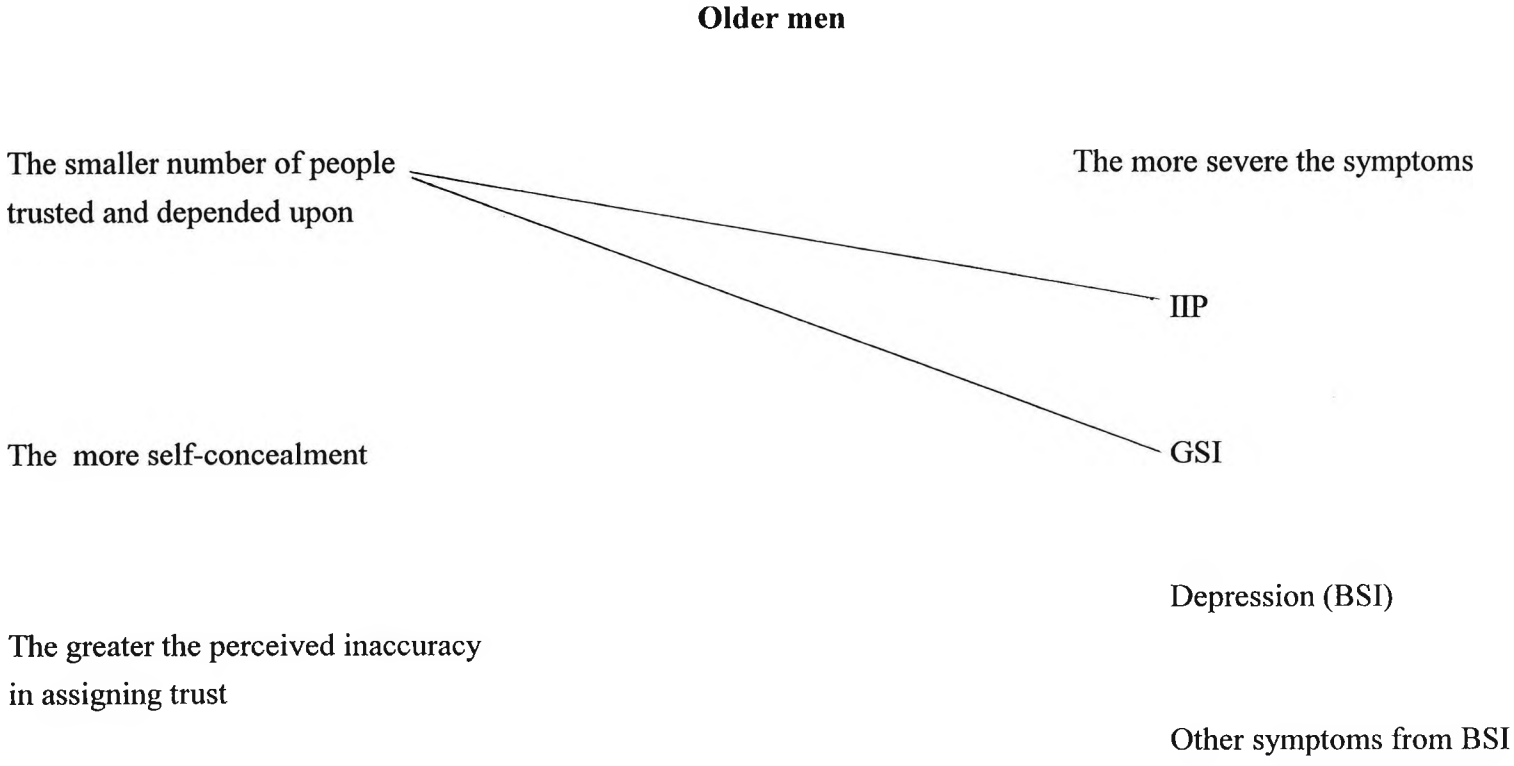
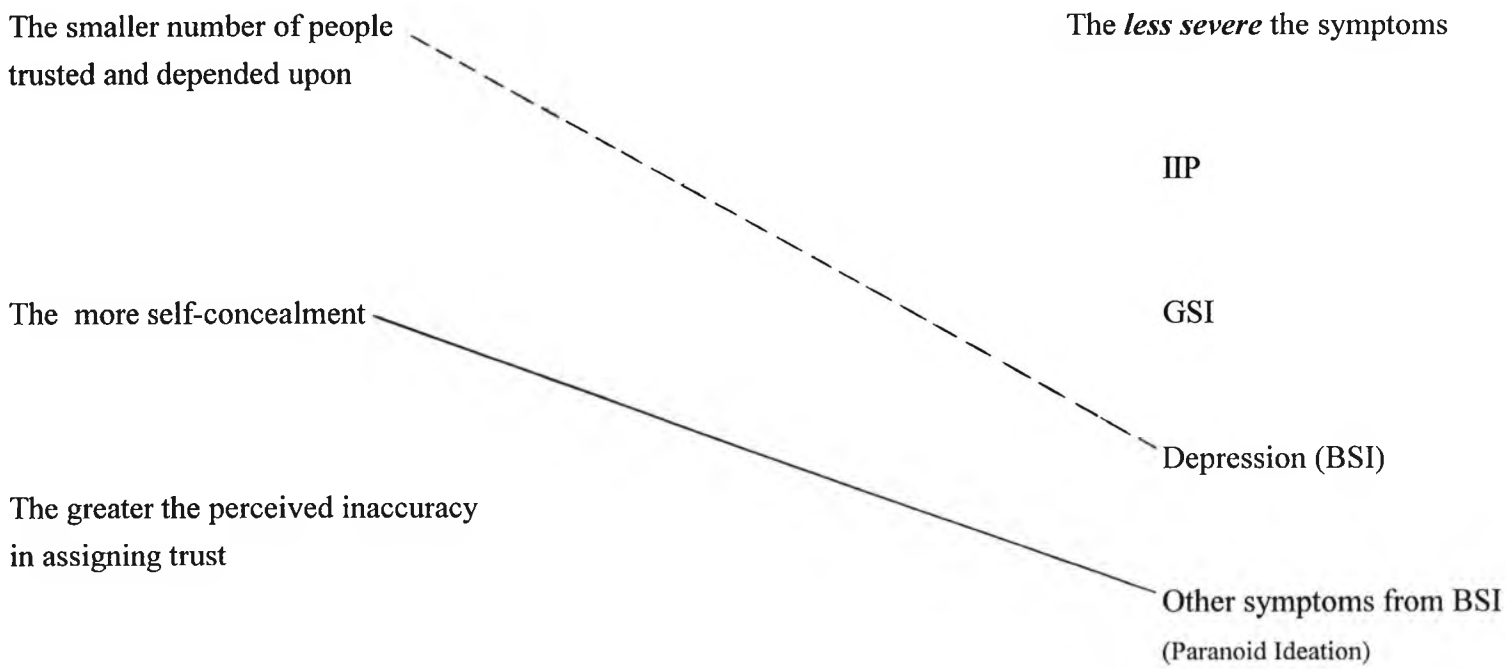


Figure 7.4 - Summary of results

Older women



------- : $p < .10$ (two-tailed). _____ : $p < .05$ (two-tailed).

CHAPTER 8

DISCUSSION

The main purpose of this research was to study trust and dependency in young mature adults and older people. Chapter 1 provided the background to the study. Most of the literature relevant to this research was reviewed in Chapters 2, 3 and 4, starting with trust, followed by dependency, and then succeeded by an exploration of the relationship between trust and dependency. Although the chapters included reviews from several theoretical standpoints, an emphasis was placed, whenever possible, upon personal construct psychology. Chapter 5 started with a review of literature relevant to this particular study but outside the scope of the first three chapters. The focus of the study, the hypotheses and their operationalisations were then introduced. Chapter 6 provided a description of methods and procedures, and Chapter 7 the results of data analyses. This chapter focuses on several areas: the discussion and interpretation of the results, methodological issues, directions for future research and clinical implications.

8.1 Interpretations of the results

This section will not follow the order previously established in the Hypotheses and the Results Chapters. Discussion of the between-subjects results once again precedes that of the within-subjects results, beginning with the consideration of the validity of the trust grid and followed by an examination of the relationship between trust and dependency. Next are presented all the results in which age and gender were taken into account. These include the relationships between trust, dependency, self-concealment and distress, as well as between perceived accuracy in trusting and interpersonal dissatisfaction. Then, the results in which the relationships between variables had been studied for the whole sample are discussed: these comprise some relationships between trust and interpersonal dissatisfaction and the relationship between trust and tightness/looseness of construing. Subsequently, methodological considerations are reviewed. These include issues regarding participants, grids and questionnaires, as well as statistical considerations. Clinical illustrations drawn from participants who were also clients have been included in

order to illuminate some of the results. The researcher is aware of some aspects of the life stories of most of the older participants, as most were either her clients or clients of colleagues whom she supervised. The younger people were not known and no clinical information will serve to illustrate their data. Finally, directions for future research and clinical implications are considered.

8.1.1 Between-subjects results

8.1.1.1 Trust grid and Specific Interpersonal Trust Scale - Short Form

A positive relationship was found between the trust grid and the SITS-SF on the basis of 15 participants' questionnaires. Even though the correlation coefficient was high (r = .71), much leverage was exerted by two participants. This calls for a replication of the findings with a greater number of participants. Nevertheless, there is some indication thus far that the trust grid and the SITS-SF might measure the same kind of trust. It is possible that a methodological consideration which might have influenced the results is that the two tests (grid and questionnaire) were not completed on the same day by any of the participants. In view of the length of the interviews, participants took their questionnaires to complete at home. The time that elapsed between the completion of the grid and the questionnaires varied from a week to a month. Though the effect of a delay between the completion of the grid and the SITS-SF is not known, it is assumed that the shorter the time between the completion of the two tests, the greater the correspondence between the two measures.

8.1.1.2 Trust and dependency

It was predicted that trust and dependency would emerge as separate psychological processes. Thirteen of the 24 correlations (six common trust and dependency situations for each of four subsamples) proved to be significant. Even though this relationship seemed to indicate that the higher the trust scores, the higher the dependency scores, examination of the raw scores revealed that, overall, trust and dependency were construed differently by participants. A pattern emerged which showed that people reported that they would trust others more than they would be prepared to turn to them. However, there were two exceptions. The first of these was construct 8 (feelings of sexual inadequacy or

sexual habits), on which most participants within the younger subsamples obtained a negative trust score and a negative dependency score, with lack of trust and lack of dependency being correlated, and the second was construct 12 (obtaining a large lottery win). Here, positive trust and dependency scores were obtained by most younger women within their subsample.

The discrepancy between trust and dependency scores can be explained in terms of the differing nature of trust and dependency. Trusting in the context of this research was operationalised as an internal process, independent of and uncontaminated by self-disclosure, whereas dependency or "turning to" people requires action. Trust may or may not lead to self-disclosure, but dependency is always actively interpersonal, as the grammatical use of the preposition "upon" or "on" after the verb "depend" indicates.

Moreover, it might be postulated that another difference exists between the number of people trusted and the number of people depended upon. Though one may be doomed if one trusts all or none (Stack, 1978), there does not seem to be an optimal number of people one can trust in the course of one's life. Depending upon the degree of dilation or constriction in a person's social life, the number of 'new' people in his or her life can vary greatly from individual to individual. 'New' acquaintances might become trusted to a varying extent.

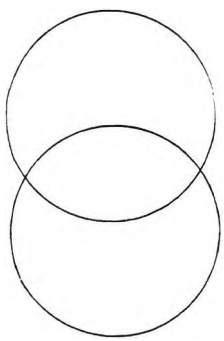
The number of trusted people increases over a lifetime, and includes deceased people, as well as people with whom relationships have lapsed. Yet, past trusting relationships remain as a memory, and for some people a powerfully living memory, with unbetrayed trust informing their construing of recently-known people, opening the possibility of developing new trust relationships. In contrast, persistently betrayed trust or a perception of persistently betrayed trust is likely to induce the development and maintainance of construing familiar to clinicians whose clients explain that they do not trust anyone, or sexually abused clients who declare that they do not trust men. So the number of trusted people at any moment in one's life can vary greatly from person to person.

Where the act of sharing, defined in this research as psychological dependence, is concerned, Stokes (1983) found a curvilinear relationship between the number of confidants and the degree of satisfaction with social support, with seven as the optimum number of confidants. No further benefit is accrued from a much greater number of

confidants, and disadvantages arise from the emotional cost of providing reciprocal support. Therefore, it is thought that one might change the actual person(s) one might turn to, but the number of people one turns to ideally does not keep increasing.

Ideally, trust and dependency can be intimately related and can be separate, as shown in Figure 8.1 below, whereby one of the circles represents trust and the other represents dependency. There is an intersected section made up of the two circles, in which trust and dependency are closely related, but there are also sections where the two are separate. One still trusts a deceased parent or partner whilst dependence upon this person might be non-existent or minimal. In this sense, following Ainsworth (1969), trust and attachment (or love) have much in common, in so far as the feelings remain untouched by geographical separation or death. The size of the two circles and that of the intersecting section only serve to illustrate the thinking delineated above. It is assumed that their proportion will vary between people and within the same people across their own life cycle.

Figure 8.1 - Illustration of separateness and relatedness of trust and dependency



8.1.1.3 Age and gender in relation to trust, dependency, and distress

8.1.1.3.1 Trust, dependency and psychological distress

As predicted, there was a greater correspondence between trust and dependency for the younger age group than the older group. However, this difference between the two age groups only occurred when the situations which were used to calculate the correlations

were the situations common to trust and dependency, as opposed to all situations. In the latter case, there was no significant difference between the two groups. Even though both analyses yielded different results, it is thought that the analysis based on common situations is the more meaningful as it is the only one which permits a true comparison of the way trust and dependency are granted to the elements.

8.1.1.3.2 Number of people trusted and depended upon, and distress

It had been predicted that people who trusted and depended upon very few people experienced more psychological distress. Even though the prediction did not differentiate between the four subsamples, the analysis indicated that both age and gender were important factors in the mediation of the relationship between these two variables.

For younger men, no relationship existed between the two variables. Younger women, in contrast, experienced increasing psychological distress (as measured by the GSI), interpersonal distress (as measured by the IIP) and depression (as measured on the appropriate dimension of the BSI) as the number of people whom they trusted and depended on decreased. Older men experienced more interpersonal distress as the number of people they trusted and depended upon (on six constructs only) diminished, and more psychological distress as the number of people they trusted and depended upon on all constructs decreased. In contrast to the younger group, there was no significant relationship in the older women sample between distress and the number of people whom they trusted and depended upon. One correlation approached significance: the higher the number of people whom older women trusted and depended on, the higher their reported level of depression (BSI).

These results are now discussed in turn. This study provides further evidence of the importance of confiding and trusting relationships for younger women. In their research, Brown & Harris (1978) had found that women who experienced severely stressful events and difficulties were protected from developing clinical depression by the presence of a confiding relationship with their husbands or boyfriends.

The gender difference between the two younger groups might be explained in terms of men and women gaining satisfaction from different sources. Arieti & Bemporad (1980)

stated that men and women aspire to different dominant goals. Many women seek the pursuit of romantic love, whereas many men's dominant aim is their career. Although this research does not focus particularly on either of these dominant goals, its focus is much closer to the reported preoccupation of women, with its emphasis on close relationships, than it is to the putative goal of men. Furthermore, gender differences in relation to same sex relationships were researched by Caldwell & Peplau (1982), who found that men and women differed in the ways they preferred to pass time with their friends. Fifty-seven per cent of women preferred 'just talking' rather than 'doing some activity', in contrast to only 16 per cent of the men expressing the same preference. However, 84 per cent of men rather than only 43 per cent of women favoured doing some activity. Therefore, if men's core constructs (or self-image) are less predicated upon relationships and more upon activities, it would seem to follow that the number of people they trust and depend upon is less relevant to them and therefore less closely related to psychological or interpersonal distress. Even though this assumption might be convincing for a representative population of men, it might not seem persuasive for this subgroup of younger men who chose to attend this research because they were interested in trust and dependency. Yet, an interest in this topic, and even an acknowledgement that they do not trust others, might not necessarily imply that they would suffer distress because of it.

Though it was not the case for younger men, there were two significant correlations for older men, between the number of people they trusted and psychologically depended upon and their scores on the IIP on the one hand, and between the number of people trusted and depended upon and their scores on the GSI on the other. The difference between the two subsamples of men might be explained by the change in life orientation in men as they grow older, from the prominence of their career to developing warm nurturing relationships (Lowenthal, Thurnher & Chiriboga, 1975).

There is also a striking difference amongst younger women and older women in the quantity of significant correlations between the number of people trusted and depended upon and psychological distress. A possible explanation may be that, when younger women knew few people whom they depended on and trusted, they might have attributed this low number of confiding relationships to an internalised failure in establishing and maintaining such relationships. In contrast, a number of older people may externalise this as being attributable to circumstances and the harshness of the increasing number of bereavements associated with ageing. It might be also that a difference between the two

age groups might be related to self-esteem. Clinical material is presented as an illustration of the difference in self-esteem between two of the older women participants who differed markedly in terms of the number of people they trusted, and the number of people depended upon and their level of psychological distress.

Mrs A was very lonely because of having been bereaved of her husband, a close male friend and several women friends. Her loneliness was all the more acute as her main contact with the outside world was telephonic because her severe arthritis precluded her from participating in much of life outside of her maisonette. In her grids, there were seven people whom she trusted and only one whom she depended upon. Her level of psychological distress on the GSI (1.06) was below the average for psychiatric patients (1.32). In contrast Miss B, whose positive self-image in the past had been based upon a successful and fulfilling career, retreated post-retirement to a previously held self-construction, borrowed from a close relative who, early in her life, had said that "there was nothing to her". In retirement, she viewed herself as someone who no longer had anything to offer, and she was very lonely and socially isolated. This, she attributed to her very great personal shortcomings rather than to circumstances. She felt she could neither trust nor depend upon anyone. She experienced a high level of psychological distress (1.62).

As it appeared difficult to understand and explain the trend towards a significant *positive* relationship between the number of people whom older women trusted and depended upon and depression, which contradicts much clinical evidence, the raw data were examined for leverage being exerted by some participants. Indeed, two of the women's data were very different from the rest of their subgroup, and thus unduly influenced the size of and direction of the correlation coefficient. They obtained very high mean scores on the Depression dimension, with scores of 3.83 and 4. (The range of mean scores attainable on the dimensions of the BSI is between 0 and 4.) The average score on that dimension for their subsample was 1.95. Both trusted and psychologically depended upon more people than the average for their group. The woman whose depression score was 3.83 trusted and psychologically depended upon six people, and the person whose depression score was 4 trusted and psychologically depended upon four people. The average number of trusted and psychologically depended upon people for their subsample was 2.3. Both of these women were very unusual in some ways compared to the other people. It appeared that the former person's depressive presentation was caused largely by a very high number of

'traumatic' deaths, from those of relatives and young friends dying in German camps during the war, to her husband's recent suicide. The trauma of his death remained alive as she was tormented by the fact that he did not leave a suicide note (as her father-in-law had done for his wife). She was seen for the research after only very few sessions of therapy. The other person was unusual in a different way. She was seen before commencing therapy. It seemed that, after an emotionally deprived and abusive childhood, she had compensated not only by being very dependent upon people, but also by doing her best to ensure that her dependency needs were met. For instance, she expected her two children to telephone her every day. Whilst doing the dependency grid she needed to give her son positive ratings on physical dependency even though he worked in a different country for weeks at a time, and was away from the UK at the time of testing. Both of these older women trusted and depended upon others in their grids; for one of them, the death and circumstances surrounding her husband's suicide prevented her from benefiting from the support of other people. For the other person, there were people whom she trusted and depended upon but it might be that she feared that her dependency needs were met only because of her being very insistent.

In order to seek confirmation or disconfirmation of the trend towards a significant *positive* relationship between the number of people whom older women trusted and depended upon and depression, correlations between other variables were calculated. These were correlations between all the symptom measures (IIP, GSI, and symptom dimensions of the BSI) and the total psychological dependency score, as well as the sum of the scores on the last six trust situations. Only one symptom dimension (Interpersonal Sensitivity) was significantly correlated with trust scores ($p < -.68$, with a two-tailed test), indicating that the higher the trust score, the lower the interpersonal sensitivity. However, examination of the graph indicates that the points are wide-spread, and located in three clusters which are not placed in a linear relationship. Therefore, correlations of the trust scores based on the last six situations and of the psychological dependency scores with symptom measures do not indicate that a significant relationship exists between these variables for this sample of older women. This does not provide confirmatory evidence for a positive relationship between the number of people trusted and depended upon and the level of symptoms.

8.1.1.3.3 Ageing and distress

Contrary to prediction, older people did not experience more psychological distress than younger people. This prediction had been made on the basis of two hypotheses, also tested in this research. First, it had been hypothesised that there would be a lesser degree of correspondence between people who are trusted and people who are depended upon for older people than for younger people. This hypothesis received support. Secondly, it had been predicted that people who had fewer people whom they trusted and depended upon would experience more distress. However, as was seen in an earlier section, this prediction was upheld for younger women, slightly for older men, in so far as only one correlation out of six was significant, and not at all for older women. Participants' raw data on the IIP and GSI divided by subsamples revealed that, of the four subsamples, the younger men had the highest means on the GSI and on the IIP, and the older men had the lowest means on both the GSI and the IIP. (No statistically significant difference existed between the groups.) Descriptive statistics of the GSI and the IIP for the four subsamples are provided in appendix 15. Perhaps research findings on marriage might serve to explain this seeming anomaly. It has been acknowledged that marriage is a protective factor against depression in men, whilst it has a detrimental effect in women (Weisman & Klerman, 1977). All but one of the older men in this study were married, compared to five younger men who lived with a partner (married or unmarried). Furthermore, Cunningham & Brookbank (1988) found that, in most studies, marital satisfaction in older couples is high, as high as amongst the newly-wed, and men are likely to be more satisfied than their wives. It may be that marriage has protected older men from psychological distress.

Yet, these results may also be due to four other possibilities. First, it is possible that younger and older people come from different populations, in so far as the younger samples by definition have experienced psychological distress in young-mature adulthood, whereas a history of psychological treatment prior to the age of 46 was found in only five of the older people. Admittedly, people 20 years ago (and more) might have been less likely to seek help for their psychiatric and psychological symptoms than people are now. However, a cohort effect is not responsible for most of the difference in the treatment seeking behaviour of the two groups. A high number of the older people in the study experienced difficulties which arose as a result of their being older, including bereavement, chronic pain, loss of role and adverse effects of retirement. Although this provides only anecdotal evidence, severe depression accompanied by psychological

barrenness did not appear in the older sample but was found in the younger sample. One 40 year old man, whose despair was palpable, had no friends, and had never experienced an intimate and/or sexual relationship. Secondly, since older people were chosen from people who were on the waiting lists or from people already receiving therapy (because of the small number of older people awaiting psychotherapy), it may be that their level of distress had already diminished by the time the research was conducted. Thirdly, all the older women who were approached whilst in therapy readily agreed to participate. In contrast some of the most distressed older men refused. This gender difference amongst older people has been established in previous research. Woods (1996) reported that the most distressed women were very likely to agree to participate in research whereas the most distressed men were less likely to take part. Fourthly, the number or severity of symptoms might, in fact, not differ for younger or older people, and the null hypothesis was not rejected because it was correct. Owing to the number of extraneous variables aforementioned, this research does not shed light on whether there is a difference in the level of distress between younger and older people.

8.1.1.3.4 Self-concealment and psychological distress

The current findings appeared to be in keeping with previous research, confirming a positive relationship between self-concealment and a global measure of distress (GSI), and specific symptoms (depression, somatisation, and anxiety) when all participants' data were combined. However, a more complex picture emerged when the data were split according to age and gender. Larson & Chastain's (1990) research participants were undergraduates, post-graduate students and people attending professional conferences. Even though the age of these respondents is not known, it seems probable that most or all of them were under 65. Larson & Chastain's (1990) findings were not replicated with the two subsamples of older people. No relationship existed between self-concealment and psychological distress for older men and, unexpectedly, a significant negative relationship existed between self-concealment and paranoid ideation in older women, whereby the more self-concealment, the less paranoid ideation they reported experiencing.

A reminder of the definition of self-concealment might be useful at this point. "[S]elf-concealment involves the conscious concealment of personal information (thoughts, feelings, actions, or events) that is highly intimate and negative in valence"

(Larson & Chastain, 1990, p. 440). Younger women who concealed most about themselves experienced many symptoms, be they in terms of a global symptom measure, the Global Severity Index, or in terms of a variety of symptoms, including depression, anxiety, paranoid ideation, psychoticism, obsessive-compulsive and interpersonal sensitivity. As younger men concealed more about themselves, they also experienced a heightened level of symptoms as measured by the Global Severity Index, as well as more depression, more somatisation, more phobic anxiety, and more symptoms within both the interpersonal sensitivity and obsessive-compulsive dimensions. Larson & Chastain's research provided some evidence for the effects of self-concealment unavailable in this research as they controlled for "trauma incidence, trauma distress, trauma disclosure, social support and social network" (p. 451) as well as levels of self-disclosure. They concluded that "although the existence of trauma has a negative impact on health and although the existence of social support can ameliorate this impact, at least with psychological symptoms, it remains the case that self-concealment has a uniquely negative impact on mental and physical health" (p. 451).

Larson & Chastain (1990) reported that self-concealment and self-disclosure are "distinct and separate constructs" (p. 451) and that, unlike self-concealment, lack of self-disclosure was not, in their study, linked to an increased risk of physical and psychological symptoms. Some of the 10 statements which make up the Self-Concealment Scale (appendix 9) implicitly include the absence of trust as mediating self-concealment. In some of these items, mistrust is based either on assumptions seemingly based upon a combination of the nature of one's secrets, and friends' responses to these secrets ("If I shared all my secrets with my friends, they'd like me less") or upon constructions which, in the eyes of the self-concealer, have been validated* (for instance, "Telling a secret often backfires and I wish I hadn't told it"). Therefore, this supports the contention that the ability to discriminate between whom one can and cannot trust might be an important interpersonal factor in mediating the younger women's state of health. Supporting evidence in this research was provided by the significant relationship between the degree of confidence in one's judgement of whom to trust and interpersonal distress amongst younger women.

The difference between the two age groups in terms of self-concealment is very marked. For instance, regarding self-concealment and depression, the correlation coefficient for younger men is 0.73, for younger women 0.75, for older men 0.04 and for older women

-0.06. The correlations obtained by older men between the SCS and the GSI and the symptom dimensions are consistently low, with not even one correlation indicating a trend towards a relationship.

It may be that self-concealment produces somatic and psychological symptoms because it is also likely to be accompanied by guilt and shame. Guilt represents "an awareness of dislodgement of the self from one's core role structure" (Kelly, 1991, p. 391) whereas shame is an "awareness of dislodgement of the self from another's construing of your role" (McCoy, 1977, p.121). Dislodgement is present in both emotions, in the former from one's view of oneself in relation to others, and in the latter from one's assumption of others' expectations of one's behaviour. McCoy cited Janis, Mahl, Kagan & Holt (1969, p. 471) for their clear distinction between the two emotions (referred to within personal construct psychology as dimensions of transition rather than emotions). "The unpleasant feelings called shame are elicited by an expectation that *other people* will be disappointed in the fact that a standard has been violated. The unpleasant feelings called guilt are caused by expectations that the *self* will disapprove" (italics in the text).

One may choose to conceal past aspects of the self which provoked dislodgement at the time they were felt or displayed. Alternatively, past aspects of the self might provoke dislodgement much later, if one has evolved new ways of behaving or of seeing oneself *(new core constructs)*, or of being in relationship with others *(new core role)*, which are much at odds with the old self. Lack of trust (whether warranted or unwarranted) in others' understanding of one's past and current self-image (one's core construing and one's core role) might be one factor in deciding to engage in self-concealment, as might be inferred from one of the eight items of the Self-Concealment Scale which reads: "If I shared all my secrets with my friends, they'd like me less" (Larson & Chastain, 1990, p. 445). Furthermore, in order to view the opposite of self-concealment more positively, one would also need to trust that others would understand and respect one's views of oneself.

The question of why there is such a difference in association between self-concealment and psychological symptoms for the younger groups and the older groups remains. Possibly, in many younger people there is a close relationship between the need for self-concealment and being critical of oneself, or a close relationship between guilt and shame. In contrast, some of the older people who chose self-concealment might have adjusted to their negative secrets so that they no longer cause internal suffering, such that

the behaviour or feelings causing dislodgement from the self have been forgiven. They may still fear the shame but no longer experience the guilt. Therefore, while they might not trust other people with their secrets, they might nevertheless have developed trust in themselves. This would seem to correspond to Erikson's (1987; Erikson, Erikson & Kivnick, 1989) last phase of development, the positive pole of which is "integrity". Doubtless, many older people, including some of those in this research, do not reach this stage of development, or are still struggling to reach it. Yet, this possible explanation would seem to concord with the views expressed by Ryff (1991) that older people tend to show increased self-acceptance.

8.1.1.3.5 Perceived accuracy in trusting and interpersonal satisfaction

Younger women who felt less confident in their judgement of whom they can or cannot trust are more likely to experience greater interpersonal dissatisfaction than younger women who felt more confident in their judgement. As mentioned in an earlier section, younger women, unlike men, tend to have a greater need for relationships based on talking rather than on activities. One might assume that more risk is involved in talking about one's feelings than in sharing an activity and, in consequence, women may take more risks than men in order to gain these relationships and fulfil their needs. More risk may also entail greater disappointment. Rowe (1998) affirmed that women blame themselves for the negative consequences of events when men, in contrast, tend to blame others. This combination of factors might explain why invalidation of granting of trust may be related to interpersonal distress for younger women and not for men.

8.1.1.4 Trust and interpersonal dissatisfaction

8.1.1.4.1 Pattern of granting trust and interpersonal dissatisfaction

Contrary to prediction, people whose granting of trust seemed to be very undifferentiated did not experience more interpersonal dissatisfaction than people who granted trust in a more differentiated way. However, the findings are not easy to interpret as there appears to be a mismatch between the actual measure used and what it was purported to measure. Though differentiation of construing was viewed as fineness of discrimination between

elements when the hypothesis was formulated, it was operationalised in terms of the number of +3 and -3 ratings within the trust grid. These totals would be better conceptualised as a measure of extremity of construing. However, no suitable measure was found to replace it, as the Dispersion of Dependency Index (Walker et al., 1988) did not seem to differentiate sufficiently between seemingly distinct patterns of dispersion in the grids.

8.1.1.4.2 Ease of/difficulty in trusting and interpersonal satisfaction

Contrary to prediction, people who found it more difficult to decide in whom to place their trust did not experience more interpersonal dissatisfaction than people who found it easier to know whom to trust. Several hypotheses might explain this result. Perhaps ease or difficulty in knowing whom to trust is unrelated to interpersonal satisfaction. Perhaps the question seeking to measure ease of decision-making was unwittingly ambiguous. During the course of doing the research, a methodological problem emerged as it became clear that "ease in deciding whom to trust" was rated similarly by people who conceptualised this very differently. The researcher had construed this in terms of "ease in deciding to whom to assign trust or mistrust" on an individual basis, whereby a decision needed to be made over a more or less lengthy period of time. Yet, as one participant remarked, "[she] find[s] it easy to decide because [she] do[es] not trust anybody." (Out of 40 participants, 10 said that they find it "easy to decide whether to trust or not trust somebody".)

Finding it easy to decide would lead to two outcomes: placing one's trust in someone or not granting trust to this person. Placing one's trust might lead to acting upon the trust or trust remaining inactive. Whether one trusts someone or one does not, one can be validated or invalidated. If one finds it difficult to decide whom to trust, one may experience much indecisiveness, which may or may not lead to a decision, be it in terms of trusting or not trusting, which then loops into placing or not placing one's trust. But save in the most extreme cases, inaccurate prediction which has led to 'active trust' is likely to be more distressing than indeciseveness. Indecision is usually provisional whereas errors of judgement might be definitive.

Since many possibilities arise out of one question ("How easy or how difficult is it for you to decide whether to trust or not to trust somebody?"), the question itself was not

sufficiently discriminatory, and had not taken into account the fact that indecision and erring on the side of caution might have less serious consequences than repeated invalidation. It might be either that this process is unrelated to interpersonal satisfaction/dissatisfaction, or that a multifactorial understanding, including ease and difficulty in trusting people, frequency of invalidation, and superordinacy of the events/feelings that people feel invalidated by, was needed to account for a relationship.

8.1.1.5 Trust and tightness / looseness of interpersonal construing

It had been hypothesised that, over a very large population, the relationship between the amount of trust placed in others and rigidity of interpersonal construing was expected to be curvilinear, with very rigid and very loose construers trusting people less. Yet, in view of the small sample and the type of clients included in the research, a linear relationship had been predicted as few, if any, very loose construers were expected. It was surmised that, owing to the exclusion criteria of the research (as delineated in Section 6.2.1), most problems that participants presented with would lead to diagnoses fitting into the nosological categories of neurotic disorders. People presenting with such problems have been found to be characterised by tight construing (Winter, 1992). The size of the first principal component ranged from very tight (94.4 per cent of the total variance) to the looser range of normal (36.3 per cent). No one presented with very loose construing. A small negative relationship was found between the extent to which participants trusted other people in their grids and the rigidity of their interpersonal construing. The more participants construed tightly, the less they trusted other people. However, the correlation coefficient was only -.29, which indicates a weak relationship (Bryman & Cramer, 1997, p. 178).

8.1.2 Within-subjects results

Four hypotheses were tested and replicated from previous research, and support was lent to all of them. The findings indicated that people tend to trust people whom they like and/or whom they construe as similar to themselves and/or whose interpersonal construing system they understand, and/or people who, they think, understand their own (the participant's) construing system. Each of these hypotheses will be considered in turn.

(i) People trust people whom they construe as more similar to themselves rather than people who are seen as dissimilar. Similarity/dissimilarity was operationalised as the distance in the repertory grid between the self element and other elements as measured by the Flexigrid analysis of the grid (Tschudi, 1992). This distance was derived from the ratings that participants gave to themselves and the elements on all 12 constructs of the repertory grid. People who were rated in a similar way to the participants on these constructs were consequently more trusted than people whom they viewed as dissimilar to themselves. However, it appears that this finding might be an artefact of the research design. Several supplied constructs were chosen because they were thought to be related to trust. In addition to being asked to decide whether the elements were trustworthy, participants rated others on their degree of discreetness, and on the degree to which they confided in these people. Two other constructs were also included as they were shown in previous research to be related to trust (Rossotti, 1995). The first concerned the judgement participants made regarding the degree to which they understood other people's construing system and the degree to which others understood their own construing system. The ratings assigned by participants to themselves were more positive than expected on all these constructs. For instance, on the "trustworthy versus untrustworthy" dimension, only one person rated himself as untrustworthy. Similarly, only two people said that they would not confide in themselves, and only two other people described themselves as indiscreet. It seemed that the research design has produced a positive relationship between people who are trusted and the participants. As most participants rated themselves positively on most supplied constructs, and as trusted elements were also liked (as demonstrated in the validation of the second within-subjects hypothesis), it follows that participants and trusted elements were rated overall in a similar way.

(ii) People who were liked were more trusted than people who were not liked. Liking was operationalised as the distance in the repertory grid analysis between each element and the participant's ideal self. It is possible that the result may be a product of the methodology, whereby two of the elements were construed positively either for trust or for dependency, and two other elements were chosen for the opposite reason. Therefore, it may have created a polarisation in terms of trust and dependency making it more likely that a positive relationship between trust and liking would arise. Of course, at first glance, this result may also appear to reflect common sense. Yet, scrutiny suggests that it may not be so. Even though it is easy to conceive that people who are liked are also trusted, liked people may be better trusted in some ways but less in others. For instance, someone may

be "trust[ed] ... to accept and validate whatever version of our self should emerge in that relationship" (Butt et al., 1997, p. 25) but one may not trust him or her to keep a secret if he or she is construed as indiscreet. Conversely, someone may not be liked but they might be trustworthy, at least in some respects. The finding suggests, though, that people who are not liked are not given a chance to act in a trustworthy manner. It may be that there is a sense of safety in trusting people who are liked. Perhaps more emotional and intellectual effort is required to find out whether people who are not liked may or may not be trusted, as one would need to construe their construing system to gauge whether they would want to be trustworthy or untrustworthy in particular respects. Even though one can imagine that chosen social relationships, such as friendships, may not involve this dilemma, it is possible that other situations, such as work or imposed social relationships, such as familial ones, would involve making finer discriminations.

(iii) People were more inclined to trust others whose construing system they thought they understood rather than people whose construing system they did not understand. Despite this, it is possible to understand people's construing system and not trust them; therapists encounter clients who understand their mother or father's construing system but do not trust her or him. Yet, in this sample as in the previous research (Rossotti, 1995), trust and having an understanding of another's construing system were positively correlated.

(iv) Participants were more inclined to trust others who, they felt, understood their construing system. Having an understanding of people does not imply respect for that understanding, as, for example, successful psychopaths need to have an accurate understanding of their prey. In this research, in which participants had chosen known people for their grids, they placed their trust in people whom they felt understood by.

8.2 Synthesis of results

The most surprising result concerned the difference between younger and older people. Unlike in the younger group, there was no relationship in the older people between the number of people trusted and depended upon and their levels of reported distress, nor between self-concealment and distress. The most striking difference was between younger and older women whereby the younger women's results were most in keeping with the

hypotheses and the older women's least. Only one relationship in the older women's data reached significance, in the opposite direction to that predicted: self-concealment scores were negatively related to paranoid ideation.

One predicted difference between the two age groups was a greater correspondence between the people who are trusted and depended upon for younger people than for older people. This had been expected partly owing to the greater number of bereavements experienced by older people in general, including those in this research. However, the hypothesised difference in distress between the two age groups was not observed.

Younger women's results set them apart in a number of ways. Unlike for the other participants, the number of people younger women depended on and trusted was related to their level of psychological and interpersonal distress. Younger women who had fewer people to trust and to depend upon also obtained higher scores on the GSI, the IIP, and on the Depression dimension of the BSI than younger women who placed their trust and dependency in a greater number of people. Also, the greater their perceived inaccuracy in assigning trust to other people, the more interpersonal dissatisfaction younger women experienced. Again, this relationship was not present for the other subsamples. Within each younger group, participants who reported high levels of self-concealment experienced higher levels of psychological distress than people who concealed less about themselves. The number of dimensions on the BSI that were correlated with their scores on the SCS was much higher for younger women than younger men. In contrast, only one relationship was significant for the older samples and, it was in the opposite direction to what had been predicted.

A number of hypotheses were drawn from two separate lines of enquiry; these concerned the relationship between trust and dependency. The research findings indicated that trust and dependency are not only theoretically different constructs but were assigned to people in different ways, with trust tending to be higher than dependency.

As a new grid was used in this study, it was tested against a shortened version of an already validated questionnaire, the SITS. Even though only 15 participants filled out both the grid and the questionnaire, these preliminary results indicate that the trust grid might indeed measure the same kind of trust as that measured by the SITS-SF. The trust grid will be discussed in detail in section 8.3.3.

8.3 Methodological considerations

8.3.1 Participants

All participants in the research were people whose psychological symptoms were sufficiently distressing for them to be referred to the clinical psychology department. It is not known whether their results are similar to or different from those which would be obtained from a 'normal' population.

As mentioned in the Methods Chapter, the recruitment of older people to the research needed to be much more flexible than the recruitment of younger people, resulting in three quarters of the older people already being in therapy at the time they participated in the study. Thirteen months were needed to obtain all 40 participants. Trust and dependency had not been targeted in the therapy but, as mentioned in the previous section (8.2), it is likely that a reduction in the number and severity of their symptoms had occurred amongst some of these 15 people.

Similarly, it could not be ascertained whether the participants receiving therapy answered questions differently, possibly more openly, than people who had never met the researcher previously. It is hoped that, as people knew the broad foci of the research and had agreed to participate, they were willing to be open and engage 'trustingly' in the process. Individual differences will always exist, and will include variables such as participants' degree of self-knowledge, their willingness to reveal their view of themselves to the interviewer, and their ability/willingness to be open with themselves.

Lastly, one older man who participated in the research prior to therapy had been inappropriately referred (but this only became clear when he was seen for therapy). Had his psychological difficulties, which arose as a result of medical treatment, been listened to attentively in his GP surgery, they could have been assuaged within that setting. It was only post-hoc and after therapy finished that the researcher contemplated the possibility that his having slot-rattled* from not being trusting to being very open with people might have been related to his panic about dying from cancer. The threat of death might have prompted him to experiment with a different self-image (another core role).

8.3.2 The repertory grid

Only two of the supplied constructs used in the repertory grid were used to test the hypotheses in the present research. Therefore, it might be thought that fewer supplied constructs would have permitted the eliciting of a greater number of 'personal' constructs reflecting participants' own construing of their elements. Even though this might have been better, it appeared that four of the supplied constructs were used meaningfully by the participants. One of the measures which is obtained from the principal component analysis is the amount of the total variance accounted for by each construct. This is thought to reflect the importance that the construct holds for people. As there were 12 constructs, 12 rankings were available to quantify the relative importance accorded each construct. Appendix 16 provides, for each participant, rankings from one to 12 for the six supplied constructs. The rankings are derived from the percentages of the total variance each construct accounted for in participants' repertory grid. Table 8.1 below gives the number of times supplied constructs ranked from first to sixth in terms of the amount of the total variance they accounted for in participants' repertory grids. The table groups the rankings by subsamples. The supplied constructs are listed below in the same order as they appeared in the repertory grid.

1. I understand how this person sees himself/herself, other people versus I don't understand.
2. This person understands how I see myself, other people versus they don't understand.
3. Discreet versus indiscreet.
4. Trustworthy versus not trustworthy.
5. Somebody I confide in now versus somebody I don't confide in now.
6. I depend on this person now versus I don't depend on him/her now.

Table 8.1 - Number of times each supplied construct ranked 1st to 6th (out of a total of 12) for each of the subsamples

Participants	1st supplied construct	2nd supplied construct	3rd supplied construct	4th supplied construct	5th supplied construct	6th supplied construct
YM	2	7	4	7	9	10
YW	1	5	4	6	9	9
OM	3	7	2	3	10	9
OW	4	5	3	4	9	9
All participants	10	24	13	20	37	37

Note. YM = younger men, YW = younger women, OM = older men, OW = older women.

As can be seen, all constructs did not appear equally meaningful to the participants. The difference in high rankings obtained by the first and second supplied constructs were reflected in the degree of ease or difficulty that participants, regardless of age, experienced in understanding the meaning of the first construct. Whilst some people appeared to understand or at least stopped communicating confusion regarding its meaning, others seemed to have difficulty throughout. Yet, the meaning was illustrated, as required, with an example in order to emphasise that the statement did not focus on whether participants understood the other person, but whether they understood or knew how each element saw himself or herself (the element). In contrast, the second supplied construct presented no difficulty to the participants. Should both of these constructs be used in future research, it would be sensible to reverse the order as the second idea seemed very easily understandable and might lead to an easier understanding of the meaning of the first. In respect of the fourth supplied construct, some participants expressed confusion as to whether somebody was judged to be trustworthy in general or whether they, themselves, trusted this person. Therefore, it is highly possible that it was conceptualised differently by different people. As the last two constructs are written in the personal form with "I" as the subject, the same form would have been preferable, not only for consistency but, more importantly, because it is less open to differing interpretations.

8.3.3 Trust grid

8.3.3.1 Comparability of situations across participants

The formulation of the trust situations (and also the psychological dependency situations) had been chosen in an attempt to increase the importance (superordinacy) of the situations and thus to minimise individual variations in construing. For instance, the situation was not 'feeling jealous' but 'feeling very jealous'. 'One's secret' was 'one's darkest secret', and so on. However, and perhaps not surprisingly, in spite of the care that had been taken in amplifying the problems, individual variations appeared to flourish. It seemed that, for the grids to be comparable across people, the examples chosen by participants needed to be of a similar degree of importance to them. The researcher did not ask each participant about the importance of the examples they chose as it would have considerably lengthened the already protracted and demanding interviews; furthermore, personal individual understanding and construing would also have been one of the relevant factors. Perhaps this constitutes one of the ineluctable difficulties of psychological research. It remains likely that differing amounts of trust were required by different participants with regard to the same construct description. For instance, one person said that the most serious mistake she had made was to marry her former husband. Yet, it became clear that it was a mistake about which she was open to everyone. It is very doubtful that most of the other participants' most serious mistake would have been something that they would have revealed indiscriminately to others. Another example of seeming diversity of importance in the way the descriptions were concretised concerns the construct about having been involved in something illegal; in the absence of personal experience, most people imagined an illegal event or activity. These fictitious events were varied in seeming gravity, including buying the wrong train ticket, taking drugs, stealing, fiddling income tax, committing a murder. (As mentioned in Chapter 6, participants were told to chose an example, real when available or imagined otherwise, which best fitted the description. They were also told that the interviewer would not ask them to divulge their choice.)

It is the researcher's view that diversity of importance attached to the examples chosen (whether real or imagined) varied considerably. It seems inevitable that this might have influenced the results but also that diversity is inescapable. This presumed diversity of importance in the examples could have arisen for different reasons. It may be that the importance is indeed very different across participants, or even within each participant,

whereby an emotion like jealousy might be so threatening that it is out of bounds and he or she had to imagine a minor event to 'please' the researcher and complete the study.

Diversity of construing was also noticed in the context of one other situation, the meaning of which was interpreted in one of two ways by different participants. Some people understood "feeling very jealous" as envy and others as jealousy. Undoubtedly, it created less comparability for that situation. Jealousy rather than envy had been the piloted situation and it is unknowable whether the panel of expert judges would have considered envy as requiring as much trust in another person as jealousy.

8.3.3.2 Conceptualisation of trust

Trust had been used in the research to mean trust in the abstract, without disclosure. This distinction had not been made in the pilot project (Rossotti, 1995) and this failing had been rightfully pointed out to the researcher. Trust without self-disclosure presented difficulty of a different order, as for some people conceptualising trust without this added component was very difficult to understand, even though it was illustrated with examples. For instance, throughout the completion of his trust grid, one older man found the concept of trust without the behavioural concomitant of "telling" very puzzling. It is assumed that, even though different degrees of understanding might have influenced the results, they reflected the inevitable diversity of meaning attached to the construct by different people.

8.3.4 Dependency grid

8.3.4.1 Rating scale for dependency grid

Ratings for the dependency grid were on a seven-point scale, unlike those for the trust grid, which were on a six-point scale. The assumption had been made that trust does not cease with bereavement but that, by and large, dependency does. The seventh point on the dependency scale was the mid-point of zero, reserved for deceased elements. However, the usage of this point had been reconsidered after the first older person interviewed said that she still relied on, and spoke to her late husband, giving him positive ratings on psychological dependency. From then on, it was decided that people who did not wish to

give a zero rating to deceased elements would be asked to specify the ways in which they depended upon the deceased persons. However, this situation did not arise again. The older woman previously mentioned who had given positive ratings to her late husband on psychological dependency situations was asked a month later by the researcher in her role as therapist, in the context of discussion about being lonely and having no one to talk to, how much support she gained from confiding and speaking to her husband. She answered confidently that she did not confide in him and only spoke to him when she could not find a parking place. The positive ratings on psychological dependency did not correspond to her actual behaviour towards him.

8.3.4.2 Physical dependency

Difficulties in rating also occurred in the case of two older women, who gave positive ratings in terms of physical dependency to their sons, even though both of them lived abroad. Despite explanations that they needed to consider whether they would be turning to the people in their grids if these situations happened now, they wanted to rate these situations according to what would happen if their sons did not live away. Even though the ratings were "incorrect" they were retained because the ratings reflected the wishes of the participants, and because with other participants who were neither known nor open, the researcher would not have been aware of the discrepancy between ratings and behaviour. One of these women would have considered a negative rating in terms of physical dependency as carrying a connotation of negativity, even though it was explained that negative ratings only reflected the elements' inability to be present physically to do certain things. The other participant was referred for depression, the trigger of which had been her son writing to her that he was not coming back from New Zealand. Perhaps, she could only have given him "negative" ratings on physical dependency once she had accepted his staying away from England.

8.3.5 Comparability of ratings across participants

Comparatibility of ratings across participants would be highly desirable so that similar ratings would reflect similar degrees of trust or lack of trust, as well as dependency or lack of dependency. However, it is unlikely that ratings are comparable as they are subject to a

number of factors, such as participants' degree of self-knowledge, their ability/willingness to be open with themselves, and their willingness to reveal aspects of themselves to the interviewer. This would not be an issue in a within-subjects design, or in research which also included a qualitative component, as the meaning of the ratings for the various participants would be highlighted in their oral elaboration of their construing. Including a qualitative approach would have been outside the scope of the present research.

Questions arose about the validity of some people's ratings of the trust grid. First, one younger man said that he chose to participate in the research because he did not trust anyone, yet his total trust score was positive and the third highest amongst people in his subsample. Secondly, some of the participants made comments about some of the situations and their reactions to them. Once again, their oral reactions were contradicted by the ratings they gave. Yet, this lack of consistency was never questioned, so as not to influence those people who disclosed their construing while completing the grids. In the case of "feeling very jealous", one older man spontaneously exclaimed that he would not trust anybody with this feeling. Yet, he then proceeded to give positive ratings to eight out of 10 people in his grid. Such ratings meant that he would trust eight out of 10 people with the knowledge that he was feeling very jealous.

Thirdly, the researcher also wondered whether the possible reluctance of some people in rating the trust and dependency grids "accurately" is that honesty with self, in terms of not trusting or not depending upon people, might provoke anxiety, guilt, and/or repeated invalidation* in terms of one's views of other people or one's relationship with them. A possible explanation seems predicated upon the difference between the more ephemeral quality of spoken words, be they in therapy or within the research setting, and the permanence of having one's construing committed to paper. A related point concerns the brevity of the spoken word, as opposed to the repetitiveness of rating people in the course of two grids, and being faced with the possibility that one might be less open or less trusting than previously thought, or that one might confide in people without trusting them, or trust people but not confide. Although none of these discrepancies would be problematic in and of themselves, it is predicted that from the point of view of the psychology of personal constructs such discoveries would lead to "transitions" or changes, whether short-lived or long-term, within one's construing system.

An older man said that he used to be very secretive, but he added that he was changing, now being willing to "say anything to anybody". He experienced difficulty in fitting the role title list with two particular elements, namely someone he did not trust and someone he would not want to depend on. For the former, he chose one person who was indiscreet and, for the latter, one person who was always late for appointments. Both of these elements' total trust and total dependency scores were positive, unlike the comparable elements in other participants' grids, who had obtained overall negative trust and dependency scores. Needless to say, it was possible that this man might have been genuinely different from the other people, with all the people in his grids being construed positively. However, he was seen for therapy very shortly after his research interviews were conducted, and in the course of therapy, his construing of the trusted person was sought. He contradicted his previous position, saying that he did not trust this person, and that it went much beyond her being indiscreet. What might have caused this discrepancy? It may be that, in the intervening few weeks, he had undergone a change of heart about this person. Or it may be explained not so much by his having changed radically, but having slot-rattled from the position of not confiding and not trusting, to telling everything to everybody and completely trusting. Having changed from one position to its opposite, he appeared to be giving ratings in an automatic fashion in keeping with his newly developed construing of himself. His trust score was unusually high, 150 points higher than the older man whose trust score was second highest, and also considerably higher than that of any of the other participants.

8.3.6 Questionnaires

Even though Woods (1996, p. 200) stated that it was not acceptable to use the same diagnostic instruments for younger and older people, it was not possible to employ different instruments for the two age groups as people's responses could not have been compared. The suitability of the questionnaires used in this research for older people is, therefore, discussed below.

Of the three questionnaires used, the BSI is discussed first because two dimensions are at first glance not equally relevant to both age groups. These are the Somatization and the Obsessive-Compulsive dimensions, as the number or severity of symptoms within those dimensions could be related to actual physical problems, or to memory problems in the

case of the Obsessive-Compulsive dimension in the older group. Yet, sensitivity in making deductions from the results would have been exercised, had some variables been significantly related to these dimensions in the older subsamples. Such results would not have been viewed as valid for the older people. The Depression dimension of the BSI, which has been mentioned separately from other dimensions in the Results Chapter, is more relevant to older people than another depression instrument, such as the BDI, as it does not include sleep difficulties or somatic symptoms. The BDI is a better indicator of depression in younger people than in older people.

No psychometric properties for the Interpersonal Symptom Inventory and the Self-Concealment Scale are available for the older age group. However, examination of the items based on clinical knowledge of and experience with the older population would lead the researcher to surmise that the relevance of the items remains unaffected by ageing.

8.3.7 Statistical considerations

The use of multiple tests in a study is a weakness because of the increased risk of type 1 error, which consists in finding a significant difference between two (or more) variables when it does not exist. To compensate for this risk, more stringent levels of significance are usually considered. Discounting hypothesis 7.1.1 which had predicted that trust and dependency would not be correlated, 17 out of the total of 42 significant correlations (or 40.48 per cent) were significant at least at the .01 level. None of the correlations regarding the older groups was significant at the .01 level. In contrast, amongst the younger sample, seven of the 11 correlations (or 63.64 per cent) reached at least the .01 level of significance. One of the six correlations from younger men's data (or 16.67 per cent) and five out of 13 correlations calculated from the younger women's data (or 38.46 per cent) were significant at least at the .01 level. Thus, a proportion of the significant effect was at a high level of significance. Nevertheless, in future research, it would be avantageous to use much larger samples to be able to perform multivariate statistics.

8.4 Directions for future research

Throughout the process of conducting this study, the researcher experienced a tension between what she regarded as 'good science' and being a constructivist. In order to gain meaningful results from quantitative data one seeks to achieve comparable results and thus tries to iron out individual differences, whereas being a constructivist is seen as involving a celebration of individual differences. One way of lessening the tension between these two seemingly contradictory aspirations is to have a large number of participants so that one can be better assured of the validity of one's conclusions, whilst carrying out qualitative research with some individuals in order to understand more fully their personal construing. Neither of these options was within the scope of this study.

Age and gender have been identified as important variables in terms of trust and dependency and in terms of the need for trusting and confiding relationships. Even though the current findings are consistent with other research in younger people, such as the importance of confiding relationships in younger women, and the greater importance of relationships based on activity for younger men, explanations about the results obtained by older people were largely speculative. Future research could concentrate on replicating these results, using the same instruments and also carrying out qualitative interviews with older people, including people who live in different settings. It would be ideal to include several older subgroups, including non-clients, outpatients, and people in residential homes. Naturally, such a project would be very time-consuming and would involve considerable resource implications.

This research started with the premise that trust and dependency are differentially affected by death. For this reason, in the dependency grid deceased people were to be given a rating which distinguished them from the living. Remarks made by the first bereaved person about depending upon her late husband led to a modification of the rating system, so that participants who wished to give positive ratings to their deceased elements could do so. Even though the issue did not come up with any of the other participants, trust and dependency upon the deceased would be a very valuable area of study, including the effect that length of bereavement has upon these two aspects of interpersonal relationships.

As the concomitants of self-concealment appear to be so different in the younger and older groups, it would be interesting to look at this again alongside other variables, such as

anxiety, guilt and shame. It would be an advantage if the design allowed for more sophisticated analyses than relying on correlations.

Some of the data obtained in this research have not been considered as they did not form the basis of the hypotheses of the study. It will be of interest to explore these data, in particular the total raw scores concerning trust, physical dependency and psychological dependency, and their potential relationships to distress.

Finally, it may be useful to test whether the trust and dependency grids could be fruitfully used together as instruments to evaluate therapy outcomes and to measure changes in trust and in dependency over the course of therapy.

8.5 Clinical implications

The results differentiated between men and women at different stages of life. Despite some methodological shortcomings, and in the absence of further studies, some implications can be drawn from this research in terms of younger women and younger men. Research on younger women consistently points to the importance of trust and dependency and the detrimental effects of self-concealment, indicating that these psychological constructs need to be given much attention in the course of therapy. For younger men the number of people whom they trust and depend on seems unrelated to psychological well-being. It was surmised that this was because of the emphasis they place at this time of life on their career. Yet, the awareness in younger men that they conceal negative information about themselves appears related to psychological distress. This finding would seem to concord with the much higher rate of suicide amongst younger men than women, and their acknowledgement that talking about problems with male friends is not part of their culture for fear of being seen as "soft" (Morris, BBC: Panorama, Dec. 1998). It is suggested that younger men might be asked to fill out the Self-Concealment Scale, which is not time-consuming, as it might illuminate significant areas of interpersonal insecurity which can be explored within the psychotherapeutic setting.

Older men's results showed a negative relationship between the number of people they trusted and depended upon and their scores on the Inventory of Interpersonal Problems, as

well as their scores on the Global Severity Index of the BSI. It would seem therefore that, for older men, trust and dependency are important interpersonal dimensions, which need exploring alongside their perceived interpersonal difficulties as measured by the Inventory of Interpersonal Problems.

Findings relating to older women were more difficult to interpret and require further research. No suggestions regarding therapeutic foci are suggested in the absence of further evidence, as the lack of a positive relationship in the case of older women between the number of people trusted and depended upon and psychological distress does not correspond to the writer's clinical experience.

This research presented the development of a grid, the trust grid, for measuring the extent to which other people are trusted and for differentiating between people and between situations. As with the repertory and dependency grids, the elements and the situations chosen can be tailored to meet the needs of individual clients. The trust grid is a very useful tool for people who wish to explore their construing of trust, or who wish to consider difficulties in forming close relationships. It can be used also very fruitfully in conjunction with the dependency grid. In the case of people who present with difficulty in confiding in others, the completion of both grids with the same people and the same situations would highlight not only the similarities and differences in the people they trust and depend on, but would also provide the basis for elaborating their construing of trust, mistrust, dependency or lack of dependency vis a vis significant others. The understanding of their construing and of their difficulties would be expected to lead to directions for change.

In addition to its usage within individual therapy, it is suggested that the trust grid, either on its own or in association with the dependency grid, could also be used fruitfully in couple therapy and in groups, such as in the Interpersonal Transaction Group, which is a type of group therapy elaborated by Landfield & Rivers (1975) and used extensively by personal constructs psychotherapists (e.g., Button, 1987; Neimeyer, 1988).

8.6 Conclusion

This research presented the development of a new instrument, the trust grid, the design of which was based upon personal construct theory and methodology. This study sought to provide some empirical evidence that trust and dependency can be regarded as two separate psychological processes. The results suggest that this is the case. For the purpose of the design, trust was regarded as an abstract construct, that is to say, unattached to specific behaviour, in contrast to dependency which was measured in terms of real or imagined behaviour in specific situations. The results indicate that, by and large, participants experienced trust in others to a greater extent than they depended on them.

Even though the findings of this study are based on small subsamples, they provide some empirical evidence for suggesting that age and gender may influence the way people assign trust and dependency. They point to differences between younger men and younger women in terms of the relationship between the number of trusting and depending relationships they enjoy and their mental health. The results for younger women indicate a strong positive relationship between lack of trusting and confiding relationships and psychological distress. The results for younger men were much less conclusive, although a relationship was found between self-concealment and interpersonal distress. Findings that there was little relationship for older men and no relationship for older women between the number of trusting and depending relationships and psychological distress were surprising, as they appeared to contradict clinical evidence. Since in their clinical practice therapists repeatedly meet older clients with depression who are lonely, have few people to confide in, and who long for meaningful relationships, future research could valuably investigate further the relationship of trust and dependency to mental health in the lives of older people.

REFERENCES

Ainsworth, M. D. S. (1969). Object relations, dependency, and attachment: a theoretical review of the infant-mother relationship. *Child Development, 40,* 969- 1025.

Ainsworth, M. D. S. (1972). Attachment and dependency: A comparison. In J. L. Gewirtz (Ed.), *Attachment and dependency* (pp. 97-137). New York: Wiley.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Ainsworth, M. D. S. (1979). Infant-mother attachment. *American Psychologist, 34,* 932-937.

Alden, L. E., Wiggings, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment, 55,* 521-536.

Altman, I., & Taylor, D. A. (1973). *Social penetration: The development of interpersonal relationships.* New York: Holt, Rinehart and Winston, Inc.

Arieti, S., & Bemporad, J. (1980). *Severe and mild depression.* London: Tavistock.

Baier, A. (1986). Trust and antitrust. *Ethics, 96,* 231-260.

Baltes, M. M. (1988). The etiology and maintenance of dependency in the elderly. *Behavior Therapy, 19,* 301-319.

Baltes, M. (1996). *The many faces of dependency in old age.* Cambridge: Cambridge University Press.

Bannister, D. (1981). Personal construct theory and research method. In P. Reason & J. Rowan. *Human Inquiry: A sourcebook of new paradigm research* (pp. 191-199). Chichester: John Wiley & Sons.

Beail, N., & Beail, S. (1985). Evaluating dependency. In N. Beail (Ed.), *Repertory grid technique and personal constructs: Applications in clinical and educational settings* (pp. 207-217). London: Croom Helm.

Bernath, M. S., & Feshbach, N. D. (1995). Children's trust: Theory, assessment, development, and research directions. *Applied and Preventive Psychology, 4,* 1-19.

Birtchnell, J. (1984). Dependence and its relationship to depression. *British Journal of Medical Psychology, 57,* 24-36.

Birtchnell, J. (1988). Defining dependence. *British Journal of Medical Psychology, 61,* 111-123.

Birtchnell, J. (1991). The measurement of dependence by questionnaire. *Journal of Personality Disorders, 5*, 281-295.

Birtchnell, J. (1996). *How humans relate: A new interpersonal theory*. East Sussex: Psychology Press.

Birtchnell, J., & Kennard, J. (1983). What does the MMPI Dependency scale really measure? *Journal of Clinical Psychology, 39*, 532-543.

Bok, S. (1978). *Lying: Moral choice in public and private life.* Sussex: The Harvester Press Limited.

Boon, S. B., & Holmes, J. G. (1991). The dynamics of interpersonal trust: Resolving uncertainty in the face of risk. In R. A. Hinde & J. Groebel (Eds.), *Cooperation and Prosocial Behaviour* (pp.190-211). Cambridge: Cambridge University Press.

Bornstein, R. F. (1992). The dependent personality: Developmental, social, and clinical perspectives. *Psychological Bulletin, 112*, 3-23.

Bornstein, R. F. (1993). *The dependent personality.* New York: The Guildford Press.

Bornstein, R. F. (1994a). Adaptive and maladaptive aspects of dependency: An integrative review. *American Journal Of Orthopsychiatry, 64*, 622-635.

Bornstein, R. F. (1994b). Construct validity of the interpersonal dependency inventory: 1977-1992. *Journal of Personality Disorders, 8*, 64-76.

Bornstein, R. F., Masling, J.M. & Poynton, F. G. (1987). Orality as a factor in interpersonal yielding. *Psychoanalytic Psychology, 4*, 161-170.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis, 39*, 350-373.

Bowlby, J. (1973). *Attachment and loss: Separation, anxiety and anger (Vol. 2).* London: The Hogarth Press and the Institute of Psychoanalysis.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Bowlby, J. (1991). *Attachment and loss: Attachment (Vol. 1).* London: Penguin Books. Original publication: London: The Hogarth Press and the Institute of Psychoanalysis, 1969.

Bowling, A. (1988-9). Who dies after widow(er)hood? A discriminant analysis. *Omega, 19* (2), 135-153.

Breckenridge, J. N., Gallagher, D., Thompson, L. W., & Peterson, J. (1986). Characteristic depressive symptoms of bereaved elders. *Journal of Gerontology, 41*, 163-168.

Brown, G. W., & Harris, T. (1978) *Social origins of depression: A study of psychiatric disorder in women.* London: Tavistock.

Brown, J. S., & Rawlinson, M. (1975). Relinquishing the sick role following open heart surgery. *Journal of Health and Social Behavior, 16,* 12-27.

Bryman, A., & Cramer, D. (1997). *Quantitative data analysis with SPSS for Windows: A guide for social scientists.* London: Routledge.

Buber, M. (1937). *I and thou.* New York: Scribners.

Butler, J. K., Jr. (1991). Toward understanding and measuring conditions of trust: Evolution of a Conditions of Trust Inventory. *Journal of Management, 17,* 643-663.

Butt, T., Burr, V., & Bell, R. (1997). Fragmentation and the sense of self. *Constructivism in the Human Sciences, 2,* 12-29.

Button, E. J. (1987). Construing people or weight?: An eating disorders group. In R. A. Neimeyer & G. J. Neimeyer (Eds.), *Personal construct therapy casebook* (pp. 230-244). New York: Springer Publishing Company, Inc.

Button, E. (1996). Validation and invalidation. In J. W. Scheer & A. Catina (Eds.) (1996). *Empirical constructivism in Europe: The personal construct approach* (pp. 142-148). Giessen: Psychosocial Verlag.

Cadwell, M. A., & Peplau, L. A. (1982). Sex differences in same-sex friendship. *Sex Roles, 8,* 721-732.

Chambers 20th Century Dictionary (1983). E. M. Kirkpatrick (Ed.), Edinburgh: W. & R. Chambers Ltd.

Chiari, G., Nuzzo, M. L., Alfano, V., Brogna, P., D'Andrea, T., Di Battista, G., Plata, P., & Stiffan, E. (1994). Personal paths of dependency. *Journal of Contructivist Psychology,* 7, 17-34.

Chun, K., & Campbell, J. B. (1974). Dimensionality of the Rotter Interpersonal Trust Scale. *Psychological Reports, 35,* 1059-1070.

Clark, S. (1991). The relation of social support networks and dependency to loneliness. Unpublished Honours thesis, University of Wollongong.

Clarkson, P. (1989). *Gestalt counselling in action.* London: Sage Publications.

Cohran, C. D., & Hale, W. D. (1985). College students norms of the Brief Symptom Inventory. *Journal Of Clinical Psychology, 41,* 777-779.

Cunningham, W. R., & Brookbank, J. W. (1988). *Gerontology: The psychology, biology and sociology of aging.* New York: Harper and Row.

Davis, M. S., & Eichorn, R. L. (1963). Compliance with medical regimens. *Journal of Health and Human Behavior, 4,* 240-249.

Derlega, V. J., Metts, S., Petronio, S., & Margulis, S. T. (1993). *Self-disclosure.* Newbury Park, CA: Sage Publications, Inc.

Derogatis, L. R. (1977). *The SCL-90 manual I: Scoring, administration and procedures for the SCL-90.* Baltimore: Clinical Psychometric Research.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: An introduction report. *Psychological medicine, 13,* 595-605.

Derogatis, L. R. (1993). *Brief symptom inventory (BSI): Administration, scoring, and procedures manual.* Minneapolis: National Computer Systems, Inc.

Deutsch, M. (1958). Trust and suspicion. *Conflict Resolution, 2,* 265-279.

Deutsch, M. (1960). Trust, trustworthiness, and the F scale. *Journal of Abnormal and Social Psychology, 61,* 138-140.

Doherty, M. A. (1973). Sexual bias in personality theory. *The Counselling Psychologist, 4,* 67-74.

Earl, W. L. (1987). Creativity and self-trust. *Adolescence, 22,* 419-432.

Eliot, G. (1871-1872; 1965). *Middlemarch.* Edited by W. J. Harvey. London: Penguin Books Ltd.

Erikson, E. H. (1987). *Childhood and society.* Aylesbury, Bucks: Paladin Books. Original publication: W.W. Norton, 1950.

Erikson, E. H. (1994). *Identity: Youth and crisis.* New York: W.W. Norton & Company. Original publication: W. W. Norton, 1968.

Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1989). *Vital involvement in old age.* New York: W. W. Norton & Company.

Fransella, F., & Bannister, D. (1977). *A manual for repertory grid technique.* London: Academic Press.

Freud, S. (1953). An outline of psychoanalysis. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 141-279).

Geller, J. D. (1966). Some personal and situational determinants of interpersonal trust. Unpublished doctoral dissertation, University of Connecticut.

Greenberg, R. P., & Bornstein, R. F. (1988). The dependent personality: 1. Risk for physical disorders. *Journal of Personality Disorders, 2,* 126-135.

Greenberg, R. P., & Bornstein, R. F. (1989). Length of psychiatric hospitalization and oral dependency. *Journal of Personality Disorders, 3,* 199-204.

Greenberg, R. P., & Dattore, P. J. (1981). The relationship between dependency and the development of cancer. *Psychosomatic Medicine, 43,* 35-43.

Guntrip, H. (1992). *Schizoid phenomena, object relations and the self.* London: Karnac Books and The Institute of Psychoanalysis. Original publication: The Hogarth Press, 1968.

Gurtman, M. B. (1992). Trust, distrust, and interpersonal Problems: a circumplex analysis. *Journal of Personality and Social Psychology, 62*, 989-1002.

Hammen, C., Ellicott, A., & Giltin, M. (1989). Vulnerability to specific life events and prediction of course of disorder in unipolar depressed patients. *Canadian Journal of Behavioral Science*, *21*, 377-388.

Hamsher, J. H., Jr. (1968). Validity of personality inventories as a function of disguise of purpose. Unpublished doctoral dissertation, University of Connecticut.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52,* 511-524.

Herbert-Lowe, I. (1990). Dependency, development and self-esteem in late adolescents: A personal construct exploration. Unpublished Honors thesis, University of Wollongong, NSW, Australia.

Hindy, C. G., & Schwarz, J. C. (1984). Individual differences in the tendency toward anxious romantic attachments. Paper presented at the Second International Conference on Personal Relationships, Madison, WI.

Hirschfeld, R. M. A., Klerman, G. L., Gouch, H. G., Barrett, J., Korchin, S. J., & Chodoff , P. (1977). A measure of interpersonal dependency. *Journal of Personality Assessment*, *41*, 610-618.

Horney, K. (1937). *The neurotic personality of our time.* New York: Norton.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S. (1988) Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, *56*, 885-892.

Hosmer, L. T. (1995). Trust: The connecting link between organizational theory and philosophical ethics. *Academy of Management Review*, *20*, 379-403.

Into, E. C. (1969). *Some possible childrearing antecedents of interpersonal trust.* Unpublished master's thesis, University of Connecticut.

Jacobs, M. (1986). *The presenting past: An introduction to practical - psycho dynamic counselling.* Milton Keynes: Open University Press.

Janis, I. L., Mahl, G. F., Kagan, J., & Holt, R. R. (1969). The period of identification: 3 to 6 years. In I. L. Janis, (Ed.), *Personality: Dynamics, development, and assessment* (pp. 457-491). New York: Harcourt, Brace & World, Inc.

Johnson-George, C. & Swap, W. C. (1982). Measurement of specific interpersonal trust: Construction and validation of a scale to assess trust in a specific other.

Journal of Personality and Social Psychology, 43, 1306-1317.

Jourard, S. M. (1971). *The transparent self.* New York: Van Nostrand Reinhold.

Kagan, J., & Moss, H. A. (1960). The stability of passive and dependent behavior from childhood through adulthood. *Child Development, 31*, 577-591.

Katz, H. A., & Rotter, J. B. (1969). *Interpersonal trust scores of college students and their parents*. Child Development, *40*, 657-661.

Kelly, G. A. (1955). *The psychology of personal constructs*: *Vol. 2. Clinical diagnosis and psychotherapy*. New York: W. W. Norton.

Kelly, G. A. (1969a). In whom confide: On whom depend for what? In B. Maher (Ed.), *Clinical Psychology and Personality: The selected papers of George Kelly* (pp. 189-206). New York: Krieger Publishing Company.

Kelly, G. A. (1969b). Humanistic methodology in psychological research. In B. Maher (Ed.), *Clinical Psychology and Personality: The selected papers of George Kelly* (pp. 133-146). New York: Krieger Publishing Company.

Kelly, G. A. (1991). *The psychology of personal constructs*: *Vol. 1. A theory of personality*. London: Routledge. Original publication: New York: W. W. Norton, 1955.

Lagace, R. R., & Rhoads, G. K. (1988). Evaluation of the MacDonald, Kessel, and Fuller Self-Report Trust Scale. *Psychological Reports, 63*, 961-962.

Lagace, R. R., & Gassenheimer, J. B. (1989). A measure of global trust and suspicion: replication. *Psychological Reports*, *65*, 473-474.

Landfield, A. W., & Rivers, P. C. (1975). An introduction to interpersonal transaction and rotating dyads. *Psychotherapy: Theory, Research, and Practice*, *12*, 366-374.

Larson, D. G., & Chastain, R. L. (1990). Self-Concealment: Conceptualization, measurement, and health implications. *Journal of Social and Clinical Psychology*, *54*, 438-446.

Larzelere, R. E., & Huston, T. L. (1980). The dyadic trust scale: Toward understanding interpersonal trust in close relationships. *Journal of Marriage and the Family*, *42*, 595-604.

Lewis, J. D., & Weigert, A. J. (1985). Trust as social reality. *Social Forces*, *63*, 967-985.

Livesley, W. J., Schroeder, M. L., & Jackson, D. N. (1990). Dependent personality disorder and attachment problems. *Journal of Personality Disorders*, *4*, 131-140.

Lowenthal, M. F., & Haven, C. (1968). Interaction and adaptation: Intimacy as a critical variable. *American Sociological Review*, *38*, 20-31.

Lowenthal, M. F., Thurnher, M., & Chiriboga, D. (1975). *Four stages of life*. San Francisco: Jossey-Bass.

Luce, R. D., & Raiffa, H. (1957). *Games and decisions: Introduction and critical survey*. New York: John Wiley & Sons.

Luhman, N. (1979). *Trust and power*. Chichester: John Wiley & Sons.

Lund, D. A., Caserta, M. S., & Dimond, M. F. (1986). Gender differences through two years of bereavement among the elderly. *The Gerontologist, 26*, 314-320.

MacDonald, Jr., A. P., Kessel, V. S., & Fuller, J. B. (1972). Self-disclosure and two kinds of trust. *Psychological Reports, 30*, 143-148.

Mahrer, A. R. (1956). The role of expectancy in delayed reinforcement. *Journal of Experimental Psychology, 52*, 101-106.

Masling, J. M., Rabie, L., & Blondheim, S. H. (1967). Obesity, level of aspiration, and Rorschach and TAT indices of oral dependence. *Journal of Consulting Psychology, 31*, 233-239.

McCoy, M. M. (1977). A reconstruction of emotion. In D. Bannister (Ed.), *New perspectives in personal construct theory* (pp.93-124). London: Academic Press.

McKiernan, F. (1996). Bereavement and attitudes to death. In R. T. Woods (Ed.), *Handbood of the clinical psychology of ageing* (pp.159-182). Chichester: John Wiley & Sons.

McNemar, Q. (1955). *Psychological statistics* (2nd ed.). New York: John Wiley & Sons, Inc..

McWhirter, B. T. (1990). Loneliness: A review of current literature, with implications for counseling and research. *Journal of counseling and Development, 68*, 589-595.

Mills, J. K., & Cunningham, J. (1988). Oral character and attitudes and behavior related to food and eating. *Psychological Reports, 63*, 15-18.

Mischel, W. (1961a). Father-absence and delay of gratification: Cross-cultural comparisons. *Journal of Abnormal and Social Psychology, 63*, 116-124.

Mischel, W. (1961b). Preference for delayed reinforcement and social responsibility. *Journal of Abnormal and Social Psychology, 62*, 1-7.

Morris, J. (Reporter) (1998). BBC: Panorama, 14th December.

Murray, H. A. (1938). *Explorations in personality*. New York: Oxford University Press.

Neimeyer, R. A. (1988). Clinical guidelines for conducting Interpersonal Transaction Groups. *International Journal of Personal Construct Psychology, 1*, 181-190.

Neimeyer, G. J., & Neimeyer, R. A. (1993). Defining the boundaries of constructivist assessment. In G. J. Neimeyer (Ed.), *Constructivist assessment: A casebook* (pp. 1-30). Newbury Park, California: Sage Publications, Inc..

Oskamp. S., & Perlman, D. (1966). Effect of friendship and disliking on cooperation in a mixed-motive game. *Journal of Conflict Resolution, 10*, 221-226.

Parkes, C. M., & Weiss, R. S. (1983). *Recovery from bereavement*. New York: Basic Books.

Pistole, M. C. (1993). Attachment relationships: Self-disclosure and trust. *Journal of Mental Health Counseling, 15*, 94-106.

Rawlins, W. K. (1983). Openness as problematic in ongoing friendships: Two conversational dilemmas. *Communication Monographs, 50*, 1-13.

Rempel, J. K., & Holmes J. G. (1986). How do I trust thee? *Psychology Today*, February, 28-34.

Rempel, J. K., Holmes, J. G., & Zanna M. P. (1985). Trust in close relationships. *Journal of Personality and Social Psychology, 49*, 95-112.

Roberts, M. D. (1972). Changing patterns of college student trust (Doctoral dissertation, University of Connecticut). *Dissertation Abstract International, 32*, 5457-B--5458-B. (University Microfilms No. 72-8901).

Rosenthal, D. A., Gurney, R. M., & Moore, S. M. (1981). From trust to intimacy: A new inventory for examining Erikson's stages of psychosocial development. *Journal of Youth and Adolescence, 10*, 525-537.

Rossotti, N. G. (1995). An elaboration on the theme of trust. Paper presented at the Xlth International Congress on Personal Construct Psychology, Barcelona.

Rotenberg, K. J. (1990). A measure of the trust beliefs of elderly individuals. *International Journal of aging and human development, 30*, 141-152.

Rotenberg, K. J. (1994). Loneliness and interpersonal trust. *Journal of Social and Clinical Psychology, 13*, 152-173.

Rotter, J. B. (1967). A new scale for the measurement of interpersonal trust. *Journal of Personality, 35*, 651-665.

Rotter, J. B. (1971). Generalized expectancies for interpersonal trust. *American Psychologist, 26*, 443-452.

Rotter, J. B. (1980). Interpersonal trust, trustworthiness, and gullibility. *American Psychologist, 35*, 1-7.

Rowe, D. (1998) A lecture: Friends, enemies and refugees. Barnet Healthcare Trust, Edgware, Middlesex, 9th December.

Rubin, Z. (1970). The measurement of romantic love. *Journal of Personality and Social Psychology, 16*, 265-273.

Russell, D. (1982). The measurement of loneliness. In L. A. Peplau & D. Perlman (Eds.), *Loneliness: A sourcebook of current theory, research and therapy* (pp. 81-104). New York: John Wiley & Sons.

Russell, D., Peplau, L. A., & Cutrona, C. E. (1980). The revised UCLA loneliness scale: Concurrent and discriminative validity evidence. *Jounal of Personality and Social Psychology*, *39*, 472-480.

Ryff, C. D. (1991). Possible selves in adulthood and old age: A tale of shifting horizons. *Psychology and Aging*, *6*, 286-295.

Sanders, C. M. (1980-81). Comparison of younger and older spouses in bereavement outcome. *Omega, 11*(3), 217-232.

Schlenker, B. R., Helm, B., & Tedeschi, J. T. (1973). The effects of personality and situational variables on behavioral trust. *Journal of Personality and Social Psychology*, *25*, 419-427.

Seneca, L. A. (1917 Edition). *Ad Lucilium epistulae morales*, III, 4. Translation: R. M. Gunmere. London: William Heineman.

Sheehan, M. J. (1985). A personal construct study of depression. *British Journal of Medical Psychology*, *58*, 119-128.

Siegel, R. J. (1988). Women's dependency in a male-centered value system. *Women and therapy, 7*, 113-123

Simmel, G. (1978). *The philosophy of money*. London: Routledge & Kegan Paul Ltd.

Singh, R. R., & Ojha, S. K. (1987). Sex difference in dependence proneness, insecurity and self-concept. *Manas*, *34*, 61-66.

Sinha, J. B. P. (1968). A test of dependence-proneness. *Journal of Psychological Research*, *12*, 66-70.

Smith, W., & Grassle, J. F. (1977). Sampling properties of a family of diversity measures. *Biometrics*, *33*, 283-292.

Solano, C. H., Batten, P. G., & Parish, E. A. (1982). Loneliness and patterns of self-disclosure. *Journal of Personality and Social Psychology*, *43*, 524-531.

Soldz, S., Budman, S., Demby, A., & Merry, J. (1995). A short form of the inventory of interpersonal problems circumplex scales. *Psychological Assessment, 2*, 53-63.

Sorrentino, R. M., Holmes, J. G., Hanna, S. E., & Sharp, A. (1995). Uncertainty orientation and trust in close relationships: Individual differences in cognitive styles. *Journal of Personality and Social Psychology*, *68*, 314-327.

SPSS (1997). *SPSS Base 7.5 Applications guide*. Chicago: SPSS Inc.

Stack, L. C. (1978). Trust. In H. London & J. E. Exner, Jr. (Eds.), *Dimensions of personality* (pp. 561-599). New York: John Wiley & Sons.

Steel, J. L. (1991). Interpersonal correlates of trust and self-disclosure. *Psychological Reports*, *68*, 1319-1320.

Stein, K. B., Soskin, W. F., & Korchin, S. (1974). Dimensions of the Rotter trust scale. *Psychological Reports*, *35*, 999-1004.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Stinnett, N., & Walters, J. (1977). *Relationships in marriage and family*. New York: Macmillan.

Stokes, G. (1992). *On being old: The psychology of later life*. London: The Falmer Press.

Stokes, J. P. (1983). Predicting satisfaction with social support from network structure. *American Journal of Community Psychology*, *11*, 141-152.

Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss*. Cambridge: Cambridge University Press.

Stuewe-Portnoff, G. (1988). Loneliness: Lost in the landscape of meaning. *Journal of Psychology*, *122*, 545-555.

The Compact Oxford English Dictionary (2nd Edition) (1993). Complete text reproduced micrographically. (By arrangement Oxford University Press).

Tribich, D., & Messer, S. (1974). Psychoanalytic character type and status of authority as determiners of suggestibility. *Journal of Consulting and Clinical Psychology*, *42*, 842-848.

Tschudi, F. (1992). *Flexigrid 5.2: Programs for analyses of repertory grids*. Tschudi System sales, P.O. Box 279, 1322 Hovik, Norway.

Vaillant, G. E. (1978). Natural history of male psychological health, IV: What kinds of men do not get psychosomatic illness. *Psychosomatic Medicine*, *40*, 420-431.

Viney, L. L. (1988). Which data-collection methods are appropriate for a constructivist psychology? *International Journal of Personal Construct Psychology*, *1*, 191-203.

Viney, L. L. (1992). Social Science research in the 1990's: The contribution of constructivism. *International Journal of Personal Construct Psychology*, *5*, 295-305.

Walker, B. M. (1990). Construing George Kelly's construing of the person-in-relation. *International Journal of Personal Construct Psychology, 3,* 41-50.

Walker, B. M. (1993). Looking for a whole "Mama": Personal construct psychotherapy and dependency. In L. M. Leitner & N. G. M. Dunnett (Eds.),

Critical issues in personal construct psychotherapy (pp. 61-81). Florida: Krieger Publishing Company.

Walker, B. M. (1995). Dispersion of dependency and its relationships: Recent research. Paper presented at the Xlth International Congress on Personal Construct Psychology, Barcelona, Spain.

Walker, B. M. (1997). Shaking the kaleidoscope: Dispersion of dependency and its relationships. In G. J. Neimeyer & R. A. Neimeyer (Eds.), *Advances in personal construct psychology*, Vol. 4. Connecticut: JAI Press, Inc.

Walker, B. M., Ramsey, F. L., & Bell, R. C. (1988). Dispersed and undispersed dependency. *International Journal of Personal Construct Psychology, 1*, 63-80.

Weisman, M. M., & Klerman, L. (1977). Sex differences and the epidemiology of depression. *Archives of General Psychiatry, 34*, 98-111.

Whetman, P. (1996, March 20). Predicting loneliness and dispersion of dependency in clergy. Paper presented at the Personal Construct Research Group, University of Wollongong.

Whittingham, J. M. (1990). Sex differences in perceived social support. Unpublished honours thesis, University of Wollongong, NSW, Australia.

Winter, D. A. (1985). Repertory grid technique in the evaluation of therapeutic outcome. In N. Beail (Ed.), *Repertory grid technique and personal constructs: Applications in clinical and educational settings* (pp. 154-170). London: Croom Helm.

Winter, D. A. (1992). *Personal construct psychology in clinical practice: Theory, research and applications*. London: Routledge.

Winter, D. A., & Gournay, K. (1987). Constriction and construction in agoraphobia. *British Journal of Medical Psychology, 60*, 233-244.

Woods, R. T. (1996). Mental Health problems in late life. In R. T. Woods (Ed.), *Handbook of the clinical psychology of ageing* (pp. 197-218). Chichester: John Wiley & Sons.

Wortman, C. B., & Silver, R. C. (1990). Successful mastery of bereavement and widowhood: a life-course perspective. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences*. Cambridge: Cambridge University Press.

Wright, T. L. (1972). Situational and personality parameters of interpersonal trust in a modified Prisoner's Dilemma Game. Unpublished doctoral dissertation, University of Connecticut.

Wrightsman, L. S., Jr. (1964). Measurement of philosophies of human nature. *Psychological Reports*, *14*, 743-751.

Wrightsman, L. S. (1966). Personality and attitudinal correlates of trusting and trustworthy behaviors in a two-person game. *Journal of Personality and Social Psychology*, *4*, 328-332.

Wrightsman, L. S. (1974). *Assumptions about human nature: A social-psychological analysis.* Monterey. CA: Brooks/Cole.

Wrightsman, L. S. (1991). Interpersonal trust and attitudes toward human nature. In J. P. Robinson, P. Shaver & L. S. Wrightsman (Eds.), *Measures of Personality and Social Psychological Attitudes. Volume 1 of Measures of Social Psychological Attitudes* (pp. 373-412). San Diego, Ca: Academic Press, Inc.

Zand, D. E. (1972). Trust and managerial problem solving. *Administrative Science Quarterly*, *17*, 229-239.

Appendices

Appendix 1

Glossary of some personal construct terms in alphabetical order

Anxiety: "is the awareness that the events with which one is confronted lie outside the range of convenience of one's construct system." (Kelly, 1991, p. 391). It is the awareness that one's construing system does not allow one to make sense of the "events" at hand.

Fragmentation corollary: "A person may successively employ a variety of construction subsystems which are inferentially incompatible with each other" (Kelly, 1991, p. 58).

Guilt: " is the awareness of dislodgment of the self from one's core role structure" (Kelly, 1991, p. 391). In other words, it refers to the awareness that one is being dislodged from how one see oneself in relation to other people.

Invalidation: "represents incompatibility (subjectively construed) between one's prediction and the outcome he [or she] observes" (Kelly, 1991, p. 110).

Slot-rattling: is a process which describes the wide-arcing pendulum-like movement from one pole of a construct to the other.

Threat: "is the awareness of an imminent comprehensive change in one's core structure" (Kelly, 1991, p. 391). It involves the invalidation of a large and important portion of one's self image.

Validation: "represents the compatibility (subjectively construed) between one's prediction and the outcome that he [or she] observes" (Kelly, 1991, p. 110).

Appendix 2

2a: Copy of a letter to Consultant Psychiatrists and General Practitioners

2b: Copy of a letter to clients inviting them to participate

2c: Copy of consent form

Silk Stream Unit
Colindale Hospital
Colindale Avenue
London NW9 5HG
Tel: 0181-200-1555
Fax: 0181-205-8911

Barnet Healthcare NHS TRUST

Silk Stream Unit

Dr
Address

10th May 1997,

Dear Dr .....,

I am writing to request your permission to write to Mr/Mrs/Miss/Ms [name] (d.o.b. 03. 02. 19) of [address], whom you have referred for psychological therapy, asking him/her whether he/she might be willing to participate in my doctoral research project. I shall be pleased to see him/her at home if needed. I have enclosed a copy of the letter and of the consent form I would send to him/her. If I do not hear from you I shall assume that I may write to him/her, and to other patients you refer in the future who fulfil the criteria of the research. Of course, I shall be pleased to ask you about the suitability of each of your patients if you so wish.

The research project was approved by the Barnet Research Ethics Committee in July 1996; I shall be pleased to send you a copy of the protocol if you so request.

If I do not hear from you, I shall assume that you have no objection to my writing to your patients.

Thank you very much for your consideration in this matter.

Yours sincerely,

Nicole G Rossotti
Consultant Clinical Psychologist

Silk Stream Unit
Colindale Hospital
Colindale Avenue
London NW9 5HG

Tel: 0181-200-1555
Fax: 0181-205-8911

Barnet Healthcare NHS TRUST

Silk Stream Unit

Mr/ Mrs/Ms/Miss
Address

22nd June 1997,

Dear Mr/Mrs/Ms/Miss

I am a chartered clinical psychologist employed by Barnet Healthcare Trust. I am carrying out a research study on how people choose to trust others and to depend on others; I am seeking prospective research participants from clients on the waiting list of the Department of Clinical Psychology.

I am writing to ask whether you may wish to participate in my research. If you agree to take part in the study, I would like to see you over one or two meetings. Overall, I will have three questionnaires and three other techniques focusing on your relationship with some people who are or have been important to you.

I hope that you will find our meetings interesting; I envisage that they will elicit useful material for your therapy.

Should you wish to contact me in between our meetings or after your participation in the study, you can telephone Mrs M. Ridout on 01727-823333, extension 2815 and leave a message for me. I would contact you without delay.

If you would like to participate in the research, I would be grateful if you would return to me the enclosed sheet dated and signed in the stamped, addressed envelope.

With very best wishes,

Yours sincerely,

Nicole G Rossotti
Consultant Clinical Psychologist

Silk Stream Unit
Colindale Hospital
Colindale Avenue
London NW9 5HG
Tel: 0181-200-1555
Fax: 0181-205-8911

Barnet Healthcare NHS TRUST

Silk Stream Unit

Ms N. Rossotti, Consultant Clinical Psychologist, has explained to me the nature and the procedures for her research. I have agreed to participate; I understand that I can withdraw from the research at any time. I know how to contact her in between sessions or afterwards if the need arises.

Name: .....

Signed: .....

Date: .....

I would be grateful if you could let me know whether I may telephone you. Please indicate your preference below:

I am willing / not willing to be contacted by telephone.

My telephone number is .....

Do feel free to specify, if you wish, the times when telephoning is most convenient for you.

Appendix 3

Second list of items piloted for the trust grid
consisting of 33 items,
rated by 22 younger people and 7 older people

Raters were asked to consider the following list of situations or feelings according to the instructions below. Bold writing was in the original text. Some of the situations are followed by one or more stars (*), the meaning of which is explained on page 181.

Thank you very much for kindly participating in the development of this list seeking to measure interpersonal trust. For each item, the answer I am seeking is whether confiding about the feelings/ situations/ events listed below would require trust prior to talking about this event. **I am not focusing on your degree of willingness to disclose such information or your experience of having done so, but on the degree of trust you imagine you would need to feel in another person before doing so.**

I would appreciate your rating the situations on a scale from 1 to 6 according to the following criteria:

1 = no trust would be required to confide about this
2 = a little trust would be required
3 = some trust would be required
4 = a lot of trust would be required
5 = complete trust would be needed

6 = I would never reveal this under any circumstances

1. Feeling extremely guilty about something you have done*
2. Feeling very ashamed about something you have done**
3. Telling a joke against yourself
4. Discussing with another person an important problem within a close relationship**
5. Having been involved with something illegal (excluding minor traffic offences, and breaking copyright!)**
6. Discussing sexual habits or feelings of sexual inadequacy***
7. Recounting a powerful (night) dream
8. Recounting in depth a time when you felt very hurt or angry as a child
10. Disclosing a large lottery win
11. Sharing your deepest feelings about having children or not having children

13. Disclosing your fantasy about your ideal occupation
14. Being unsure about how to behave and wanting to explore your views without being told what to do
15. Expressing an opinion which you know is alien to the other person
16. Broaching an important area (other than sexuality) in which you feel you are not coping very well
17. Disclosing something you don't like about yourself which you consider as important
18. Discussing your feelings regarding an important problem within the relationship with the person you're talking to***
19. Opening up in depth the positive and negative influences which have made you the person you are
20. Revealing the details of your finances*
21. Being open about a time in your life when you might have lost your will to live
22. Revealing to the person you're talking to that you feel hurt as a result of what he/she said
26. Your feelings about your own death and dying
27. Sharing in depth an experience of joy, serenity or beauty
28. The complexity of your feelings (positive and negative) towards someone who is important to you (not your partner)
30. Sharing in depth your political views and affinities
31. Sharing in depth your views and feelings about religion
32. Sharing your deepest thoughts about life, and its meaning for you
33. Sharing your darkest secret***

The next set of statements refers to behaviour that you might engage in with someone, or requests you might ask of other people. For each item, the answer I am seeking is how much trust you would need to feel in another for you to engage in this behaviour with the other or for you to make a request of another. **I am not focusing on your degree of willingness to do these things or your experience of having done so, I am focusing instead on the degree of trust you imagine you would need to feel in another person before doing so.**

I would appreciate your rating the situations on a scale from 1 to 6 according to the following criteria:

1 = no trust would be required in another for me to do this/or to make this request
2 = a little trust would be required
3 = some trust would be required
4 = a lot of trust would be required
5 = complete trust would be needed

6 = I would never do this *or* I would never let someone else do this

9. Behaving in a completely different way from your normal way of behaving (e.g. "letting your hair down", being uninhibited)
12. Going on holiday with someone
23. Allowing someone to look after your child or grandchild, your cat or your dog***
24. Accepting tuition or instruction from someone
25. Sharing an aspect of your work, present or past, which is very dear to you and which has involved you in endless toil and could be open to possible abuse or ridicule by others (e.g. writing, painting, etc).
29. Lending a belonging which is very precious to you***

* indicates that the mean rating for these items was between 3.5 and less than 4 in both samples.
** indicates that the mean rating for these items was between 4 and less than 4.5 in both samples.
*** indicates that the mean rating for these items was 4.5 and over in both samples.

Appendix 4

Third list of items piloted for the trust grid
comprising 30 items,
rated by 44 people under the age of 55
and seven people over 65

Raters were asked to consider the following list of situations or feelings according to the instructions below. Bold writing was in the original text.

Thank you very much for kindly participating in the development of this list seeking to measure interpersonal trust. For each item, the answer I am seeking is whether confiding about the feelings/ situations/ events listed would require trust prior to talking about this event. **I am not focusing on your degree of willingness to disclose such information or your experience of having done so, but on the degree of trust you imagine you would need to feel in another person before doing so.**

I would appreciate your rating the situations on a scale from 1 to 6 according to the following criteria:

1 = no trust would be required to confide about this

2 = a little trust would be required
3 = some trust would be required
4 = a lot of trust would be required
5 = complete trust would be needed

6 = I would never reveal this under any circumstances

1. Feeling extremely guilty about something you have done
2. Feeling very ashamed about something you have done
3. Discussing with another person an important problem within a close relationship
4. Having been involved with something illegal (excluding minor traffic offences, and breaking copyright!)
5. Discussing sexual habits or feelings of sexual inadequacy
6. Disclosing a large lottery win
7. Broaching an important area (other than sexuality) in which you feel you are not coping very well
8. Disclosing something you don't like about yourself which you consider as important

9. Discussing your feelings regarding an important problem within the relationship with the person you're talking to
10. Revealing the details of your finances
11. Being open about a time in your life when you might have lost your will to live
12. Sharing your darkest secret
13. Opening up in depth the positive and negative influences which have made you the person you are
14. Feeling very perplexed about how to spend your time (eg what sort of job, or activity, hobby you may engage in)
15. Having very much difficulty getting on with the opposite sex
16. Revealing that things seem to be going against you
17. Admitting that someone took advantage of you because you did not know what you were doing
18. Having made one of the most serious mistakes of your life
19. Having failed to accomplish something you tried very hard to do
20. Being very lonely
21. Feeling very discouraged about the future
22. Feeling very misunderstood by others
23. Having got very angry
24. Having hurt someone's feelings
25. Feeling very frightened
26. Disclosing about a time when you acted very childishly
27. Feeling very jealous
28. Feeling very mixed up or confused about things in general

I would now like you to gauge how much you would need to trust someone else before making the decisions involving the two items listed below. Again, I am not focusing on your degree of willingness to do these things or your experience of having done so, **I am focusing instead on the degree of trust you imagine you would need to feel in another person before doing so.**

I would appreciate your rating the situations on a scale from 1 to 6 according to the following criteria:

1 = no trust would be required in another for me to do this/or to make this request
2 = a little trust would be required
3 = some trust would be required
4 = a lot of trust would be required
5 = complete trust would be needed

6 = I would never do this *or* I would never let someone else do this

29. Allowing someone to look after your child or grandchild, your cat or your dog
30. Lending a belonging which is very precious to you

Your answers are **anonymous** and **confidential.**
I would appreciate your ticking the lines below corresponding to your age:

Under 65 _____ 65 and over _____

Many Thanks

Nicole G Rossotti

Appendix 5

Kelly's situation list for the dependency grid

Kelly's list of general problems that people may encounter in their life is as follows:

The writing in square brackets and in italics indicate whether the items were included, modified, or excluded.

"1. [T]he time in your life when you were most perplexed about what kind of job or vocation you ought to go into. [*This item was excluded as it was not relevant to the current lives of older people*]

2. [T]he time in your life when you had the greatest difficulty understanding how to get along with the opposite sex. [*This item was modified and included in the third list as item number 15*]

3. The time when things seemed to be going against you - when your luck was particularly bad. [*This item was modified and included in the third list as item number 16*]

4. The time when you were the most hard up financially [*This item was not included in the list as it was deemed too ambiguous as it could be related to trust and to dependency*]

5. The time when you were in poorest health or had a long period of sickness. [*This item was not included because it appeared to concern dependency at least as much as trust*]

6. The time when someone took advantage of you because you did not know what you were doing. [*This item is number 17 in the third list*]

7. The time when you made one of the most serious mistakes in your life. [*This is included as number 18 in the third list*]

8. The time when you failed to accomplish something you tried very hard to do. [*This is included as number 19 in the third list*]

9. The time when you were most lonely. [*This item was modified slightly and was included as number 20 in the third list*]

10. The time when you felt most discouraged about the future. [*This item was modified slightly and was included as number 21 in the third list*]

11. The time when you wondered if you would not be better off dead or when you came nearest feeling that way. [*An equivalent of this item existed as number 11 in the third list]*

12. The time when you felt most misunderstood by others or when it seemed as if people were ganging up on you. [*This item was shortened to number 22*]

13. The time when you lost your temper or got very angry. [*This was included as item number 23*]
14. The time when you hurt someone's feelings in a way he or she did not deserve. [*This item was shortened and included as item 24*]
15. The time when you felt most ashamed of yourself. [*This feeling was already included as item number 2*]
16. The time when you were most frightened or fearful about what might become of you. [*This item was shortened and included as item 25*]
17. The time in recent years when you acted childish or like a 'panty-waist'. [*This item was modified and included as number 26 in the third list*]
18. The time when you felt jealous of someone's affection. [*This item was shortened slightly and included as number 27 in the third list*]
19. The time in your life when you felt most mixed up or confused about things in general. [*This item was included as number 28*]
20. The time when you had serious trouble with your parents or came nearest to having trouble with them. [*This and the following two items were excluded because they were very specific; a more general item already existed as number 3 in the third list*]
21. The time when you had trouble with your brother, sister, or a close relative - or the time when you came nearest having trouble with one of them.
22. The time when you had trouble with your wife (husband) or girl(boy) friend - or the time when you came nearest having trouble with one of them." (1991, pp. 233-234)

Appendix 6

Rankings of the trust situations from third piloted list which satisfied inclusion criteria for the trust grid on the basis of younger people's responses

The following list provides the rankings based on the means of younger people's ratings for situations from the third piloted trust list which satisfied the criteria for inclusion in the trust grid. Rankings based on the means of older people's ratings of trust situations are provided in parentheses.

Ranking 1: Sharing your darkest secret (ranked first by older people)

Ranking 2: Allowing someone to look after your child or grandchild, or your pet (ranked fifth by older people)

Ranking 3: Lending a belonging which is very precious to you (ranked second by older people)

Ranking 3: Feeling very ashamed about something you have done (ranked seventh by older people)

Ranking 5: Discussing sexual habits or feelings of sexual inadequacy (ranked ninth by older people)

Ranking 6: Feeling extremely guilty about something you have done (ranked third by older people)

Ranking 6: Having made one of the most serious mistakes of your life (ranked 13th by older people)

Ranking 8: Being open about a time in your life when you might have lost your will to live (ranked 26th by older people)

Ranking 9: Having been involved with something illegal (excluding minor traffic offences and breaking copyright) (ranked fifth by older people)

Ranking 10: Discussing your feelings regarding an important problem within your relationship with the person you're talking to (ranked 30th by older people)

Ranking 11: Disclosing a large lottery win (ranked eighth by older people)

Ranking 12: Discussing with another person an important problem within a close relationship (ranked 10th by older people)

Appendix 7

The Brief Symptom Inventory
(Derogatis, 1993).

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
10	0	1	2	3	4	Feeling that most people cannot be trusted
11	0	1	2	3	4	Poor appetite
12	0	1	2	3	4	Suddenly scared for no reason
13	0	1	2	3	4	Temper outbursts that you could not control
14	0	1	2	3	4	Feeling lonely even when you are with people
15	0	1	2	3	4	Feeling blocked in getting things done
16	0	1	2	3	4	Feeling lonely
17	0	1	2	3	4	Feeling blue
18	0	1	2	3	4	Feeling no interest in things
19	0	1	2	3	4	Feeling fearful
20	0	1	2	3	4	Your feelings being easily hurt
21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
22	0	1	2	3	4	Feeling inferior to others
23	0	1	2	3	4	Nausea or upset stomach
24	0	1	2	3	4	Feeling that you are watched or talked about by others
25	0	1	2	3	4	Trouble falling asleep
26	0	1	2	3	4	Having to check and double-check what you do
27	0	1	2	3	4	Difficulty making decisions
28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
29	0	1	2	3	4	Trouble getting your breath
30	0	1	2	3	4	Hot or cold spells
31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
32	0	1	2	3	4	Your mind going blank
33	0	1	2	3	4	Numbness or tingling in parts of your body
34	0	1	2	3	4	The idea that you should be punished for your sins
35	0	1	2	3	4	Feeling hopeless about the future
36	0	1	2	3	4	Trouble concentrating
37	0	1	2	3	4	Feeling weak in parts of your body
38	0	1	2	3	4	Feeling tense or keyed up
39	0	1	2	3	4	Thoughts of death or dying
40	0	1	2	3	4	Having urges to beat, injure, or harm someone
41	0	1	2	3	4	Having urges to break or smash things
42	0	1	2	3	4	Feeling very self-conscious with others
43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
44	0	1	2	3	4	Never feeling close to another person
45	0	1	2	3	4	Spells of terror or panic
46	0	1	2	3	4	Getting into frequent arguments
47	0	1	2	3	4	Feeling nervous when you are left alone
48	0	1	2	3	4	Others not giving you proper credit for your achievements
49	0	1	2	3	4	Feeling so restless you couldn't sit still
50	0	1	2	3	4	Feelings of worthlessness
51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
52	0	1	2	3	4	Feelings of guilt
53	0	1	2	3	4	The idea that something is wrong with your mind

Appendix 8

The Inventory of Interpersonal Problems - Short Form
(Soldz et al., 1995)

DATE:_____ SUBJECT ID:_____

INVENTORY OF INTERPERSONAL PROBLEMS - SC

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that item has been a problem for you with respect to *any* significant person in your life. Then select the number that describes how distressing that problem has been, and circle that number.

Part I. The following are things you find hard to do with other people.

It is hard for me to:	Not at all	A little bit	Moder-ately	Quite a bit	Extremely
1. join in on groups	0	1	2	3	4
2. keep things private from other people	0	1	2	3	4
3. tell a person to stop bothering me	0	1	2	3	4
4. introduce myself to new people	0	1	2	3	4
5. confront people with problems that come up	0	1	2	3	4
6. be assertive with another person	0	1	2	3	4
7. let other people know when I am angry	0	1	2	3	4
8. socialize with other people	0	1	2	3	4
9. show affection to people	0	1	2	3	4
10. understand another person's point of view	0	1	2	3	4
11. be firm when I need to be	0	1	2	3	4
12. experience a feeling of love for another person	0	1	2	3	4
13. be supportive of another person's goals in life	0	1	2	3	4
14. feel close to other people	0	1	2	3	4
15. feel good about another person's happiness	0	1	2	3	4
16. ask other people to get together socially with me	0	1	2	3	4
17. attend to my own welfare when somebody else is needy	0	1	2	3	4
18. be assertive without worrying about hurting the other person's feelings	0	1	2	3	4

Part II. The following are things that you do too much.

19. I am too easily persuaded by other people	0	1	2	3	4
20. I open up to people too much	0	1	2	3	4
21. I am too aggressive toward other people	0	1	2	3	4
22. I try to please other people too much	0	1	2	3	4
23. I want to be noticed too much	0	1	2	3	4
24. I try to control other people too much	0	1	2	3	4
25. I put other people's needs before my own too much	0	1	2	3	4
26. I am too suspicious of other people	0	1	2	3	4
27. I tell personal things to other people too much	0	1	2	3	4
28. I argue with other people too much	0	1	2	3	4
29. I keep other people at a distance too much	0	1	2	3	4
30. I let other people take advantage of me too much	0	1	2	3	4
31. I am affected by another person's misery too much	0	1	2	3	4
32. I want to get revenge against people too much	0	1	2	3	4

Appendix 9

The Self-Concealment Scale
(Larson & Chastain, 1990)

Self-Concealment Scale

		1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree	
1	2	3	4	5			I have an important secret that I haven't shared with anyone.
1	2	3	4	5			If I shared all my secrets with my friends, they'd like me less.
1	2	3	4	5			There are lots of things about me that I keep to myself.
1	2	3	4	5			Some of my secrets have really tormented me.
1	2	3	4	5			When something bad happens to me, I tend to keep it to myself.
1	2	3	4	5			I'm often afraid I'll reveal something I don't want to.
1	2	3	4	5			Telling a secret often backfires and I wish I hadn't told it.
1	2	3	4	5			I have a secret that is so private I would lie if anybody asked me about it.
1	2	3	4	5			My secrets are too embarrassing to share with others.
1	2	3	4	5			I have negative thoughts about myself that I never share with anyone.

Larson, D. G., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement, and health implications. *Journal of Social and Clinical Psychology*, *9*, 439-455.

Appendix 10

The Specific Interpersonal Trust Scale
(Johnson-George & Swap, 1982).

The Specific Interpersonal Trust Scale (short form):

1	2	3	4	5	6	7	8	9
Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree

1 2 3 4 5 6 7 8 9	I could expect _____ to tell the truth.
1 2 3 4 5 6 7 8 9	I could talk freely to _____and know _____would want to listen.
1 2 3 4 5 6 7 8 9	_____ would never intentionally misrepresent my point of view to others.
1 2 3 4 5 6 7 8 9	If _____knew what kinds of things hurt my feelings, I would never worry that he/she would use them against me, even if our relationship changed.
1 2 3 4 5 6 7 8 9	If my alarm clock was broken and I asked _____ to call me at a certain time, I could count on receiving the call.
1 2 3 4 5 6 7 8 9	If _____couldn't get together with me as we planned, I would believe his/her excuse that something important had come up.
1 2 3 4 5 6 7 8 9	If _____promised to do me a favor, he/she would follow through.
1 2 3 4 5 6 7 8 9	If _____were going to give me a ride somewhere and didn't arrive on time, I would guess there was a good reason for the delay.

Specific Interpersonal Trust Scale (short form)
Adapted from: Johnson-George, C. & Swap, W. C. (1982). Measurement of specific interpersonal trust: Construction and validation of a scale to assess trust in a specific other. *Journal of Personality and Social Psychology,* **43**, 1306-1317.

Appendix 11

Raw trust scores and raw dependency scores based on non-deceased elements for all participants on situations seven to 12

	Younger Men	Younger Men	Younger Women	Younger Women
Situation 7	Dependency	Trust	Dependency	Trust
Participant 1	4	6	-16	-17
Participant 2	-6	1	-22	1
Participant 3	13	10	-6	6
Participant 4	-13	2	-21	-2
Participant 5	-13	-5	-22	9
Participant 6	-11	1	-21	-12
Participant 7	-19	-23	1	0
Participant 8	-4	-5	-21	-8
Participant 9	-8	15	-13	7
Participant 10	0	4	-18	-13

	Younger Men	Younger Men	Younger Women	Younger Women
Situation 8	Dependency	Trust	Dependency	Trust
Participant 1	1	5	-30	-30
Participant 2	-4	-5	-17	-1
Participant 3	-9	4	-8	0
Participant 4	-23	-20	-9	-2
Participant 5	-18	-10	-8	15
Participant 6	-18	1	-2	-4
Participant 7	-22	-21	-2	1
Participant 8	-14	-11	-16	-9
Participant 9	-11	-9	-9	-6
Participant 10	-11	-7	-13	-4

	Younger Men	Younger Men	Younger Women	Younger Women
Situation 9	Dependency	Trust	Dependency	Trust
Participant 1	6	7	-16	-10
Participant 2	-2	-1	-4	6
Participant 3	8	17	-8	2
Participant 4	-5	-9	-4	-1
Participant 5	-15	-3	-2	20
Participant 6	-18	5	-1	4
Participant 7	-20	-21	1	5
Participant 8	-10	3	5	9
Participant 9	-2	13	-4	5
Participant 10	3	9	-2	-3

	Younger Men	**Younger Men**	**Younger Women**	**Younger Women**
Situation 10	Dependency	Trust	Dependency	Trust
Participant 1	6	6	-11	-10
Participant 2	-7	3	-11	3
Participant 3	13	11	-16	-2
Participant 4	-7	6	-7	1
Participant 5	-17	-8	-2	12
Participant 6	-6	-4	3	-13
Participant 7	-24	-21	2	1
Participant 8	10	7	-9	-7
Participant 9	-2	14	-6	-2
Participant 10	-4	0	-1	2

	Younger Men	**Younger Men**	**Younger Women**	**Younger Women**
Situation 11	Dependency	Trust	Dependency	Trust
Participant 1	6	6	-24	-18
Participant 2	-12	-4	-12	-1
Participant 3	-27	11	-17	-11
Participant 4	2	6	-12	4
Participant 5	-12	-3	-3	16
Participant 6	-4	1	-20	-16
Participant 7	-24	-21	-4	-1
Participant 8	-18	-17	1	10
Participant 9	-9	-5	-9	15
Participant 10	-7	3	-18	-10

	Younger Men	**Younger Men**	**Younger Women**	**Younger Women**
Situation 12	Dependency	Trust	Dependency	Trust
Participant 1	6	6	-10	-14
Participant 2	-2	-15	10	21
Participant 3	21	10	3	1
Participant 4	-6	6	21	27
Participant 5	14	-8	18	20
Participant 6	6	16	11	4
Participant 7	-7	-3	7	6
Participant 8	3	2	11	11
Participant 9	21	27	5	15
Participant 10	12	17	8	6

	Older Men	**Older Men**	**Older Women**	**Older Women**
Situation 7	Dependency	Trust	Dependency	Trust
Participant 1	-8	3	-6	4
Participant 2	-10	8	-6	10
Participant 3	-4	0	-9	-10
Participant 4	-12	10	-21	-2
Participant 5	14	17	10	4
Participant 6	-24	-24	-11	-6
Participant 7	-8	6	-12	8
Participant 8	-24	-11	-7	8
Participant 9	0	1	-2	6
Participant 10	14	15	9	10

	Older Men	**Older Men**	**Older Women**	**Older Women**
Situation 8	Dependency	Trust	Dependency	Trust
Participant 1	-20	-19	-12	6
Participant 2	-24	4	-18	-1
Participant 3	-5	0	-14	-7
Participant 4	-13	-7	-21	-11
Participant 5	-18	-18	7	12
Participant 6	-14	-3	-9	-5
Participant 7	-8	1	-24	-12
Participant 8	-18	-3	-14	9
Participant 9	2	2	-8	0
Participant 10	16	14	-21	-21

	Older Men	**Older Men**	**Older Women**	**Older Women**
Situation 9	Dependency	Trust	Dependency	Trust
Participant 1	-14	1	-2	7
Participant 2	-10	12	-10	13
Participant 3	-4	8	-19	-26
Participant 4	-14	7	-17	-6
Participant 5	-12	6	10	4
Participant 6	-15	-2	-15	-5
Participant 7	-10	-1	-11	8
Participant 8	-3	6	-3	15
Participant 9	-5	0	-8	0
Participant 10	18	14	-5	-21

	Older Men	Older Men	Older Women	Older Women
Situation 10	Dependency	Trust	Dependency	Trust
Participant 1	-6	0	-1	-5
Participant 2	-10	12	-4	6
Participant 3	3	6	-2	-13
Participant 4	11	17	-16	-5
Participant 5	-6	6	17	10
Participant 6	3	-2	-15	-6
Participant 7	-7	2	-12	-7
Participant 8	2	11	-5	8
Participant 9	-2	2	-1	7
Participant 10	21	21	15	0

	Older Men	Older Men	Older Women	Older Women
Situation 11	Dependency	Trust	Dependency	Trust
Participant 1	-14	-2	-6	-14
Participant 2	-24	3	-6	-2
Participant 3	2	10	-7	-11
Participant 4	-15	-18	-21	-21
Participant 5	-13	4	10	9
Participant 6	-24	-24	-15	-7
Participant 7	-7	-1	-18	3
Participant 8	-10	-12	-5	11
Participant 9	-2	2	-11	0
Participant 10	21	21	-21	3

	Older Men	Older Men	Older Women	Older Women
Situation 12	Dependency	Trust	Dependency	Trust
Participant 1	-18	-19	-5	6
Participant 2	-18	11	5	18
Participant 3	12	24	-16	0
Participant 4	16	18	-17	-2
Participant 5	0	0	8	-3
Participant 6	10	4	-3	-4
Participant 7	-10	-2	-6	0
Participant 8	9	-11	-13	16
Participant 9	7	9	0	3
Participant 10	21	21	3	9

Appendix 12

Correlations between total trust score and total dependency score based on all 12 situations and on the six common situations for all participants

Participants	Trust and Dependency 12 situations	Trust and Dependency 6 situations	Participants	Trust and Dependency 12 situations	Trust and Dependency 6 situations
YM1	0.42	1.00**	OM1	0.46	0.45
YM2	0.59	0.53	OM2	0.42	0.21
YM3	0.85**	0.91**	OM3	0.68*	0.63
YM4	0.96**	0.93**	OM4	0.85**	0.90**
YM5	0.80*	0.86**	OM5	0.62	0.93**
YM6	0.90**	0.92**	OM6	0.55	0.84**
YM7	0.33	0.10	OM7	0.89**	0.88**
YM8	0.84	0.96**	OM8	0.76**	0.47
YM9	0.65*	0.74*	OM9	0.83**	0.84**
YM10	0.68*	0.72*	OM10	0.42	0.45
YW1	0.97**	1.00**	OW1	0.73*	0.73*
YW2	-0.33	0.12	OW2	0.42	0.55
YW3	0.79**	0.73*	OW3	0.20	0.41
YW4	0.46	0.55	OW4	0.82**	0.82**
YW5	0.48	0.68*	OW5	0.83**	0.94**
YW6	0.80**	0.77*	OW6	0.91**	0.95**
YW7	0.97**	0.98**	OW7	0.76*	0.82**
YW8	0.88**	0.95**	OW8	0.59	0.63*
YW9	0.72*	0.83**	OW9	0.78**	0.59
YW10	0.87**	0.95**	OW10	0.69*	0.69*

Note. YM = younger man, YW = younger woman, OM = older man, OW = older woman.
* $p < .05$ ** $p < .01$

Appendix 13

Number of people trusted and depended upon
(based on all situations (12),
and on the common situations (6))
correlated with all the dimensions of the BSI

	All people	All people	Younger people	Younger people	Older people	Older people
	12 situations	6 situations	12 situations	6 situations	12 situations	6 situations
Depression	-0.20	-0.11	-.60**	-0.41*	0.10	0.10
Anxiety	-0.02	0.09	-0.02	0.05	0.00	0.17
Somatisation	0.03	0.09	-0.23	0.05	0.28	0.20
Interpersonal Sensitivity	-0.17	-0.05	-0.31	-0.06	-0.17	-0.18
Phobic Anxiety	-0.08	-0.07	-0.16	-0.14	-0.06	-0.05
Paranoid Ideation	-0.13	-0.12	-0.21	-0.31	-0.12	-0.04
Hostility	-0.07	0.00	-0.17	-0.02	-0.11	-0.12
Psychoticism	-0.03	0.00	-0.35	-0.33	0.18	0.18
Obsessive - Compulsive	-0.18	-0.12	-0.15	0.00	-0.17	-0.20

* $p < .05$ (one-tailed). ** $p < .01$(one-tailed).

Appendix 14

Sizes of the first principal components and total trust scores for all participants

Participants	Size of first principal component*	Total trust score	Participants	Size of first principal component*	Total trust score
YM1	66.30%	171	YW1	74.30%	-132
YM2	60%	14	YW2	43.30%	75
YM3	63.10%	191	YW3	81.90%	75
YM4	67.50%	48	YW4	56.20%	158
YM5	68.40%	-46	YW5	47.40%	236
YM6	75.90%	80	YW6	61.60%	-29
YM7	50.60%	-143	YW7	92%	99
YM8	63.90%	41	YW8	62.50%	103
YM9	49.40%	144	YW9	56.40%	153
YM10	74.80%	138	YW10	55.30%	30
OM1	60.30%	-46	OW1	76.40%	53
OM2	46%	157	OW2	61.80%	251
OM3	44.60%	205	OW3	42.60%	-91
OM4	42.70%	200	OW4	44.20%	28
OM5	94.40%	89	OW5	49%	72
OM6	64.70%	15	OW6	57.70%	191
OM7	35.50%	112	OW7	77.50%	91
OM8	54.70%	64	OW8	36.30%	230
OM9	51.60%	114	OW9	41.70%	178
OM10	44.30%	351	OW10	45.90%	127

Note. YM = younger men; OM = older men; YW = younger women; OW = older women.

* The numbers under the heading "Size of first principal component" refer to the percentage size of the total variance accounted for by the first principal component.

Appendix 15

Descriptive statistics
for the GSI and the IIP
by subsample

GSI/IIP	Descriptive statistics	Younger men	Younger women	Older men	Older women
GSI	Minimum score	0.26	0.34	0.57	0.30
GSI	Maximum score	2.62	2.66	1.98	2.55
GSI	Mean	1.47	1.27	1.23	1.35
GSI	Standard deviation	0.91	0.85	0.53	0.69
IIP	Minimum score	15	18	20	30
IIP	Maximum score	90	95	68	78
IIP	Mean	56.20	52.30	46.30	50.30
IIP	Standard deviation	22.75	23.44	18.3	15.38

Appendix 16

For each participant, rankings from one to 12 obtained by the supplied constructs in the repertory grid

Rankings from one to 12 obtained by the supplied constructs in the repertory grid of younger people

Participants	First supplied construct	Second supplied construct	Third supplied construct	Fourth supplied construct	Fifth supplied construct	Sixth supplied construct
YM1	9	11	1	6	4	3
YM2	1	2	9	4	3	6
YM3	9	4	5	6	2	3
YM4	4	8	3	9	7	2
YM5	10	4	7	5	1	3
YM6	10	6	4	2	2	1
YM7	7	11	12	10	4	3
YM8	7	6	11	8	3	3
YM9	12	5	8	3	4	1
YM10	11	1	12	4	2	3
YW1	10	4	8	5	6	2
YW2	7	7	2	5	6	9
YW3	10	8	12	11	1	3
YW4	6	4	5	10	2	3
YW5	11	4	8	11	7	5
YW6	9	8	6	3	5	2
YW7	8	10	11	4	1	2
YW8	9	3	11	9	1	2
YW9	12	6	7	5	2	1
YW10	12	11	6	4	3	1

Note. YM = Younger men, YW = Younger women.

First supplied construct: I understand how this person sees himself/herself, other people versus I don't understand.

Second supplied construct: This person understands how I see myself, other people versus they don't understand.

Third supplied construct: Discreet versus indiscreet.

Fourth supplied construct: Trustworthy versus not trustworthy.

Fifth supplied construct: Somebody I confide in now versus somebody I don't confide in now.

Sixth supplied construct: I depend on this person now versus I don't depend on him/her now.

Rankings from one to 12 obtained by the supplied constructs in the repertory grid of older people,

Participants	First supplied construct	Second supplied construct	Third supplied construct	Fourth supplied construct	Fifth supplied construct	Sixth supplied construct
OM1	8	5	10	6	2	1
OM2	n/a*	3	11	1	6	4
OM3	6	5	8	11	2	1
OM4	4	5	11	9	2	1
OM5	12	4	5	8	5	8
OM6	12	10	3	7	2	1
OM7	11	8	10	12	3	1
OM8	6	5	10	11	1	2
OM9	10	12	11	3	1	1
OM10	10	3	8	7	1	2
OW1	7	10	12	8	2	1
OW2	4	5	10	1	7	3
OW3	1	6	9	7	5	2
OW4	8	2	3	5	1	11
OW5	11	2	3	9	1	4
OW6	4	9	10	7	1	2
OW7	5	10	4	3	1	2
OW8	11	11	10	9	2	1
OW9	12	10	11	5	2	1
OW10	7	1	8	12	4	3

Note. OM = older men; OW = older women.

* No ranking is available as this construct was not used in the analysis. The participant gave a rating of 7 to all the elements.

First supplied construct: I understand how this person sees himself/herself, other people versus I don't understand.

Second supplied construct: This person understands how I see myself, other people versus they don't understand.

Third supplied construct: Discreet versus indiscreet.

Fourth supplied construct: Trustworthy versus not trustworthy.

Fifth supplied construct: Somebody I confide in now versus somebody I don't confide in now.

Sixth supplied construct: I depend on this person now versus I don't depend on him/her now.

SECTION C : CASE STUDY

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SECTION D : LITERATURE REVIEW

Attitudes of professionals

towards older people

TABLE OF CONTENTS

ATTITUDES OF PROFESSIONALS TOWARDS OLDER PEOPLE

1. Introduction

This literature review focuses on the attitudes of various professional groups towards older people. Its purpose is to examine the current state of knowledge in order to assess the value of carrying out a research project with clinical psychologists-in-training. Such a study would aim to measure their attitudes toward older people, prior to and following their clinical placement in this specialism and to investigate the role of interpersonal factors, particularly attitudes towards grandparents and older relatives or friends, which might influence trainees' attitudes. Although much has been written about the attitudes of various professionals towards older people, most has focused upon one discrete professional group, be they, for example, physicians or nurses. In contrast to most of the extant literature, the present study considers five health care professions.

The review consists of successive sections on ageism, societal attitudes towards older people, attitudes of five professional groups towards older people and their desire to work with this client group. This is followed by consideration of professionals' perceptions of older people compared to how they see themselves, professionals' attitudes towards their own ageing and fear of death, their contact with older people, ways of counteracting ageism within the professions, the putative future project and finally by a conclusion.

Working with older people presents a challenge which is not encountered in most other specialisms. It is one area within the mental health professions in which one can find oneself thinking as one sees someone affected, for instance, by dementia: "One day, it could be me or a loved one". This musing would not occur in such specialims as work with children, adolescents, clients with learning disabilities or with long-term mental illness, or clients with forensic problems. Becoming old is not an inevitability as an early death might curtail life. Ideally, it could be a joy and a privilege; yet, in our western societies it might be considered as the lesser of two evils. Prejudice against older people, devaluation of old age and older people, and worship of youth is plain for all to see. Prior to looking at attitudes toward older people, the concept of ageism is considered. This is

followed by attitudes towards old age, ageing, and older people within the population at large.

2. Ageism

As attitudes and stereotypes are concepts relevant to this review, definitions of both are provided. Seltzer & Atchley (1971) defined attitudes as "predispositions to respond toward a person or thing in either a positive or negative way. Stereotypes are sets of beliefs which purport to describe typical members of a category of people, objects, or ideas. These beliefs are then acted upon as if they were true, regardless of the empirical facts" (p. 226).

"Age-ism" as a term was coined by Butler (1969, p. 243), who viewed it as a form of bigotry and as a particular example of stereotyping. The definitions and elaboration of the concept provided by three writers are considered. Doty (1987) wrote that ageism "is thinking or believing in a negative manner about the process of becoming old or about old people" (p. 213). He stated that the term ageism could be applied to people of any age, but that typically it is used to refer to attitudes towards older people. Butler (1975) considered ageism as "a process of systematic stereotyping of and discrimination against people because they are old" (p. 12). Slevin (1991) also emphasised that an important component of ageism is that the views held about older people are stereotypical, shared by society as well as devaluing in content. The fact that ageing is regarded in "diminishing" terms has been expanded by Doty (1987) who provided a list of the diminishing connotations of ageing: "deterioration, disease, disability, distance, disengagement, and dependency" (p. 213). Butler (1996, p. 12) offered a psychological explanation for the existence of this process. "Underlying ageism is the awesome dread and fear of growing older and, therefore, the desire to distance ourselves from older persons who are a proxy portrait of our future selves". Two other consequences of negative stereotypes are cultural institutionalisation and discrimination (Slevin, 1991). From the perspective of personal construct psychology (PCP), stereotypes are characterised by preemptive and constellatory thinking. Preemptive thinking refers to an "all or nothing" thinking, whereby somebody is an old person and 'nothing but' an old person. Constellatory thinking refers to a pattern whereby one description is associated with other fixed characteristics. In the case of the stereotype of an older person, these other constructs are negative and diminished. Thus

somebody is not only old but also mentally slow, unable to learn, rigid, set in his or her ways, sad, depressed, and has nothing to look forward to. A more fruitful way of construing people is by using propositional thinking, whereby describing someone with one characteristic does not imply that he or she is seen in other predetermined ways. This allows an older person to be what he or she can or wants to be, such as a scientist and/or a photographer and/or a wind-surfing enthusiast and/or a student of ancient Greek, and/or an affectionate parent.

Language can be important in shaping thinking. Use of "the elderly" rather than "elderly people" encourages the denial of personhood rather than the consideration of older people as diverse individuals. The terms "the elderly", which for many conveys images of frailty, and "old age pensioner", with its connotations of dependence upon the state, contrast unfavourably with the Spanish "personas mayores" (which at least to a non-Spaniard conveys connotations of importance). However problematic the introduction of new terminology, the novel concept of being a "senior citizen" seems to be an attempt not only to enhance the status of older people but also to suggest that they are integral members of the civic fabric rather than that they have become redundant to it.

Prior to considering the views of professionals towards elderly people, the age range referred to by the terms older or elderly will be reviewed. This will be followed by societal attitudes toward older people.

3. Attitudes of society at large towards older people

Within the health services, older people are generally viewed as being 65 and over. Exceptions exist. The writer was surprised, when attending a conference in North London in the autumn of 1998 on the Health of Older People, that the group under discussion started at 50. In society at large, this broader definition of older can be found, for instance, amongst organisations such as SAGA (which provides insurance exclusively for people aged 50 and over). However, it has been pointed out that the terms "older" and "elderly" cover such a wide range of people as to be misleading. It seems to render homogeneous a very heterogeneous population even when age alone is the only variable taken into account. In her work with older people, the writer has seen individuals whose age ranged from 65 to 93. Within the health service one reads infrequently of another distinction,

such as the young old and the old old, the latter demarcation being considered to be 75 and over. Still, this takes no account of individual circumstances (such as mental and physical health, involvement in social life and range of activities) of people of that age group. Unless stated otherwise, this review focuses upon attitudes toward people aged 65 and older.

Having delineated the population described by the term older, the discussion now refocuses on attitudes. One of the ways that attitudes can be learned is through socialisation. Socialisation influences the young and old alike. It provides the young with a stereotype and is described by Jones (1976, p. 9) as "pernicious". Unfortunately, it might also affect the perception some older people have of themselves and create a self-fulfilling prophecy.

Negative attitudes towards older people have been documented from the time of ancient Greek civilisation (Minois, 1989 in Glendenning, 1997) to contemporary life. Negative attitudes can also be found in literature from Hamlet's mockery of Polonius (Shakespeare, c. 1600, *Hamlet*, 2.ii) on the basis of age on the one hand, to contemporary satirical work involving older people such as Kingsley Amis's *The Old Devils* and Muriel Spark's *Memento Mori*, on the other. Gibson (1992) affirmed that the positive portrayal of the protagonist in Hemingway's *The Old Man and The Sea* provides an unusually positive depiction of an ageing person. Even though no recent research has been found regarding the portrayal of different age groups on television, the discrepancy between the number and variety of televisual situations portraying young and older people is clearly discernible. What is more, older people are less visible in the media than young adults or worse still, they are the target of unkind humour which would be viewed as politically incorrect if directed towards other minority groups, be they black people, disabled people or women. Older people have been also the targets of ageist and aggressive advertisement (Bytheway, 1995, pp. 65-67).

Extreme ageist attitudes have been expounded in the second half of the twentieth century by Sir Peter Medawar, a biologist, and Donald Gould, a medical journalist, who respectively recommended killing people over the age of 70 and 75 (cited in Laslett, 1996, p. 126). Genocide of the old has indeed existed in some societies, for instance amongst the Eskimos, and amongst some tribes in the Caucasus and in India. Our own current

western form of age discrimination is not so violent but it might gnaw at the psychological being of older people, making some feel valueless and invisible.

In 1975 Butler considered the difficulties associated with ageing which arise out of society's attitudes. His words are quoted in full as he brings together the despair and the life enhancing potential of ageing:

> The tragedy of old age is not the fact that each of us must grow old and die but that the process of doing so has been made unnecessarily and at times excruciatingly painful, humiliating, debilitating and isolating through insensitivity, ignorance and poverty. The potentials for satisfactions and even triumphs in late life are real and vastly underexplored. (pp. 2-3)

Finally, even though the review thus far has focused on older people without any separation of gender, it is important to acknowledge the double prejudices, ageism and sexism, that older women encounter (e.g., Stevenson, 1989; Arber & Ginn, 1991; Greer, 1991; Friedan, 1993). The existence and consequences of sexism towards older women within the American health system have also been acknowledged (Sharpe, 1995). Yet, sexism in old age has not been encountered throughout the ages in every society. Other sociological developments have been known: "Even in male-dominated societies, like the Comanche of North America, the Mundurucu of South America, and the Ewe of West Africa, women who ha[d] reached menopause fill[ed] important decision-making roles otherwise restricted to men" (Silverman, 1987, p. 335).

4. Attitudes of professionals towards older people

As members of society, professionals might be expected to be influenced by the prevailing views and prejudices of the society in which they live and work (e.g., Litwin, 1994; Schaie, 1993; Stevens & Crouch, 1995). For this reason, one of the aims of providing training to health care workers might be to counteract negative constructions. In this section, the attitudes towards older people of several types of professional are reviewed, as well as the consequences those attitudes might engender. These include the influences bearing upon a wish to work (or not to work) with this age group and, when available, the quality of care provided to older people. The professionals under study are medical doctors, nurses, social workers, physiotherapists and clinical psychologists. Occupational

therapists are unfortunately not represented as no relevant literature was found. Reviewing the groups of professionals according to the same critera has not been possible, owing to marked differences in the quantity of available research and in the issues covered. The emphasis within each profession has been dictated by the areas which have been studied and also by the quantity of data available. As the writer is a clinical and counselling psychologist and she envisaged the possibility of carrying out a research project with her professional group, results of studies of clinical psychologists have been considered in greater depth regarding both attitudes and desire to work with older people. No studies were available on attitudes of counselling psychologists towards older people, presumably because it is a relatively new profession.

4.1 Medical students and doctors

4.1.1 Attitudes towards older people

A review of the literature up to the late 1980's concerning the attitudes of medical students towards older people has been provided by Adelman & Albert (1987). They reported some inconsistencies in the findings, which might be attributable to differences between samples, differences between measurement, and the small sizes of the samples. Nevertheless they found that some relationships appeared to be repeated across studies, such that more positive attitudes towards older people were associated with increased knowledge of geriatrics and also with female respondents. In a large study of beginning medical students, Reuben, Fullerton, Tschann & Croughan-Minihane (1995) concluded that, males and students of younger age expressed more negative attitudes than did female students or older students. It appears that these attitudes are not specific to young men who choose medicine as a career as their finding is consistent with the results of a study by Slevin (1991) who found that secondary school male pupils aged 15 to 17 expressed significantly more negative attitudes towards older people than their female counterparts did. Deary, Smith, Mitchell & MacLennan (1993) investigated attitudes towards older people of medical students at three different stages of training. Their findings were less clear-cut as their results indicated that women only "tended" to have "lower negative attitudes scores" (p. 402). The authors sought to understand the nature of the negative attitudes and found two factors. The first was named "negative attitudes" and the second "medical intervention". The first factor was composed of two types of items and when

specific items were considered, the items loading most heavily on the first component concerned those related to the lack of patience and lack of empathy which students felt towards older people, rather than "statements which expressed a direct negative attitude" (Deary et al, 1993, p. 404). Items which indicated specific negative attitudes toward older people (such as "Conversations with older people are usually dull", p. 402) loaded on the same component as items reflecting possible awareness of some inadequacy in the students (e.g., "I feel impatient and uneasy with the elderly", p. 402).

Wilderom et al. (1990) investigated the attitudes towards older people of six successive intakes of first year medical students between 1979 and 1984. They found that their respondents had a "positive stereotypical outlook on the aged" (p. 436). Wilderom et al. were concerned about the potential for bias in scales which measure stereotypes, and they expected that they might have obtained different results had valid nonstereotypical measures existed. Similar findings to those obtained by Wilderom et al. (1990) were reported by McAlpine, Gilhooly, Murray, Lennox & Caird (1995). Their results showed "little evidence of negative attitudes at the start of the course; the students disagreed with ten of the 13 'negative' statements". The two statements they agreed with - 'working with elderly patients is often frustrating' and 'the thought of growing old worries me' (p. 749) do not reflect, in the view of the authors, negative attitudes towards older people.

Carmel, Galinsky & Cwikel (1990) investigated the attitudes of four groups of medical students and three groups of physicians. No difference was found in the groups' level of general knowledge about older people but all groups reported more negative attitudes towards older people than they did towards young people. No statistically significant difference in attitude existed between the groups of respondents.

Physicians' attitudes towards older people have also been investigated, and have in some cases included demographic characteristics. Marshall's (1981) review of studies suggested that older physicians were more sympathetic towards older patients. Ray, Raciti & Ford's (1985) results were dissimilar as they found that older psychiatrists held more negative attitudes towards older people than younger psychiatrists and "female psychiatrists rated the prognoses for older patients [significantly] more poorly than did male psychiatrists" (p. 497). With only a small sample of older physicians in an otherwise large study, Hellbusch, Corbin, Thorson & Stacy's (1994) results were similar to those obtained by Ray et al., (1985) as "the oldest group of physicians (70 and older) ... were found to be the least

positive toward old people" (p. 61). A survey of physicians in various specialities showed that psychiatrists had the most positive attitudes towards older people (Ahmed, Kraft & Porter, 1986). This finding was not replicated in Hellbusch et al.'s (1994) research as they found no difference between different specialists, although many specialities were represented by only few physicians.

As Reyes-Ortiz (1997) thought that a relationship might exist between attitudes towards older people and the quality of treatment provided, this is the focus of the next section.

4.1.2. Effects of attitudes on the quality of treatment provided

Comparisons are made within this section between the medical treatment received by older and younger people, and by older people living in different settings. Research findings (e.g., Keeler, Solomon, Beck, Mendelhall & Kane, 1982; Wetle, 1987) have suggested that older people might obtain worse treatment than younger people and that this discrepancy might be explained by ageism. Two examples of this are provided here. Though many doctors assume that the care of older patients requires more time as their histories are longer and the conditions to consider are more numerous (Globerman, 1991), findings by Keeler, Solomon, Beck, Mendelhall & Kane (1982) and by Radecki, Kane, Soloman, Mendenhall & Beck (1988a) provided evidence that doctors in the United States spent less time with older people than with younger patients. Also, Radecki, Kane, Solomon, Mendenhall & Beck (1988b) found that diagnostic testing for people over 75 was used significantly less often than for people under that age. Similar results were also reported by Black, Sefcik & Kapoor (1990). People over 65 were prescribed much more anxiolytic and hypnotic medication than younger people (King, Griffiths, Reilly & Merrett, 1982) in spite of the risk involved in their usage for older people (Jarvis, 1981; Cook, 1986; Kruse, 1990) which is higher than for younger people (Higgitt, 1992). For Grant (1996), this finding indicates that when it comes to older people, the emphasis is on "disease management as opposed to proactive intervention" (p. 11).

Other studies have focused upon the quality of care received by seemingly different groups of older people. Campion, Mulley, Goldstein, Barnett & Thibault (1981) compared admissions to specialist units amongst two categories of older people and found that

admissions to intensive care units and to coronary care units were more frequent for people who lived at home than for those who lived in nursing homes.

In his letter to the editor of *Academic Medicine*, Reyes-Ortiz (1997) expressed similar concerns to those already revealed in this section. He spoke of the danger that "many negative responses toward the elderly are incompletely recognized by physicians" (p. 831). He also expressed concern that these negative attitudes may result in inadequate treatment owing to a reduction in the breadth of medical examinations and to the lack of consideration of some non-medical factors (such as psychosocial concerns) used to reach an understanding of the problems and a diagnosis. He also warned about approaching the treatment of older people "with a sense of futility or therapeutic nihilism" (p. 831).

4.1.3 Desire to work with older people

Both medical students' and qualified doctors' desire to work with older people has been measured. Research with medical students was carried out by Wilderom et al. (1990). They found that, even though students' attitudes towards older people were not negative, only three per cent expressed an "interest in specialising in geriatric medicine" (p. 429). Factors which affected the desire to work with older people were familiarity with older people prior to entering medical school as well as the perceived attitudes of practising physicians towards older patients. Negative role models were found to have a negative impact on students' views.

Saarela & Viukari (1995) found that psychiatric residents expressed the view that doctors have a limited interest in taking care of elderly patients. No data were provided regarding the populations with whom these psychiatric residents worked. This might be an important omission as Carmel et al. (1990) found that practising physicians "who actually work with the elderly and have the orientation of family practice express significantly more willingness to work with the aged" (p. 103). This result was found in spite of more negative attitudes towards older people than younger people amongst all of the samples in Carmel et al.'s research, regardless of the age of the population with whom they worked. Weiler, Orgren & Olafson's (1989) investigations revealed that willingness to seek out older patients in the future and to specialise in geriatrics was found in a greater number of women than men. It was also positively influenced by taking undergraduate gerontology

courses and spending quality time with healthy, independent older people. It was also found that there was "a significant and positive relationship between a ... role model in [the] geriatrics [faculty] and interest in geriatric patients and in specializing in geriatrics" (p. 447). Nonetheless, in spite of demographic variations, it has been shown that the desire to work with older people is weak.

4.1.4 Effects of medical and geriatric training

Geriatric and gerontological curriculum in medical schools has not been shown to have a uniform effect on the attitudes of medical students towards older people. Two of the studies reviewed showed no change in attitude. These included an investigation by Gardner, Kuder & Rich (1995) who found no attitude change towards older people after a one-week long interdisciplinary rotation during the third year of medical school. The other such study was conducted by Fields, Jugatir, Adelman, Tideiksarr & Olson (1992). Seventy per cent of the fourth year students who participated in a four week clinical geriatric rotation found it valuable, but attitude scores did not change significantly pre- and post-rotation.

In contrast, five recent studies showed an improvement in attitudes. (i) Sachs, McPherson & Donnerberg (1985) investigated the effect of personal experience with healthy older persons on first year medical students and found improved attitudes towards older people. (ii) Deary et al.'s (1993) study indicated that medical students' negative attitudes were reduced after a four-week training block in geriatric medicine in either their fourth or fifth year. (iii) In Adelman, Fields & Jutagir's (1992) study, those medical students who were exposed to older people living in the community developed more positive attitudes towards older people than their counterparts who spent time with nursing home residents. (iv) Medical students who underwent a gerontology training programme displayed more positive attitudes and were more socially skilled during an interview with older adults than a comparable control group (Intreri, Kelly, Brown & Castilla, 1993). (v) Burke & Duthie (1997) found that the internal medicine residents (second and third years) who participated in a one month block geriatric rotation "expressed more comfort and confidence regarding the care of older persons than did residents who did not have a geriatrics rotation" (p. 29). At the end of the rotation, only one resident did not have a positive attitude towards older people.

A completely different type of training experience which brought about positive results has been reported. Pretending to live as an elderly person at different stages of independence/dependence, through an ageing simulation workshop, the Aging Game, improved medical students' empathy and attitudes towards caring for older patients (Pacala, Boult, Bland & O'Brien, 1995).

Overall, it would seem that geriatric training during medical school can have a beneficial effect upon attitudes. It has been suggested that it needs to include "some exposure to healthy, vigorous elderly as well as the frail" (Adelman et al., 1992, p. 972). The next section considers the literature relevant to nurses.

4.2 Nurses

4.2.1 Attitudes toward older people

Attitudes towards older people amongst nurses have been measured in several ways. These have included comparisons between secondary school students, student nurses and qualified nurses (Slevin, 1991), student nurses from different stages of training (Stevens & Crouch, 1995, for instance) with post-registered nurses (Melanson & Downe-Wanboldt, 1985), and student nurses at different stages of their own training (Haight, Christ & Dias, 1994).

Following their review of the existing literature, Melanson & Downe-Wamboldt (1985) indicated that the controversy about whether student nurses hold positive or negative attitudes towards older people remains. Their own study, with nurses at different stages of training, indicated that their samples of nursing students had favourable attitudes towards older people (Downe-Wamboldt & Melanson, 1985).

Slevin (1991) studied the attitudes of secondary school pupils, student nurses early in their training and qualified nurses working with older people. He found that, although no difference existed between the group of secondary school female pupils and women nursing students, qualified nurses held significantly more negative attitudes towards older people than the student nurses. This led Slevin to conclude that "professional socialization influences may lead to more negative attitudes" (p. 1201).

Stevens & Crouch (1995) studied attitudes of student nurses (at entry into the course, midway and prior to completion) towards ten areas of nursing over the course of a three year training. The proportion of students expressing a negative attitude towards older people and the type of work (attitudes and work constituted one type of response) dropped from 65 per cent on entering the course to 49 per cent at the end of their training.

DePaola, Neimeyer, Lupfer & Fiedler (1992) investigated attitudes of nursing home personnel and of a control group towards older people. They found that the "nursing personnel displayed significantly fewer positive attitudes" (p. 537) towards older people than did the control group (whose jobs were unrelated to death and dying). DePaola, Neimeyer & Ross (1994) studied nursing assistants and qualified nurses. Nursing assistants had significantly more negative attitudes towards older people than did qualified nurses; however, overall, attitudes towards older people were positively correlated with length of time working in the nursing homes.

Differences in attitudes towards different types of older persons has been found by Kahana et al. (1996). They measured attitudes of staff working in nursing homes towards well older people, physically ill older people and older people with Alzheimer's disease. The most positive evaluations were made towards well people and the least positive towards people with Alzheimer's disease. They also studied the effect of a number of variables on the staff's evaluations of older people. Generally, "Greater feelings of self-efficacy amongst staff resulted in more positive evaluations for each of the three target groups" (p. 44), and this was the only factor which had an effect in terms of attitude towards people with Alzheimer's disease. With regard to well elderly people, years of education had a negative effect and contact with grandparents a positive effect on positive evaluation (p. 45). Kahana et al. (1996) suggested that overall, "interventions designed to increase staff members' feelings of self-efficacy may lead to more positive evaluation of elderly clients and, ultimately, improve quality of care" (p. 27).

In summary, it appears that it is difficult to draw conclusions from studies which have been carried out in countries as disparate as Northern Ireland, Canada and the United States, as length of training and curriculum are unlikely to be homogeneous. Furthermore, the attitudes have been measured by different instruments, such as Attitudes toward Old People (Kogan, 1961), Opinions about People (Ontario Welfare Council, 1974), Facts of Aging (Palmore, 1977). So the evidence is still inconclusive and Melanson &

Downe-Wamboldt's (1985) assessment that it remains unknown whether nurses' attitudes towards older people are negative or positive is still valid today.

4.2.2 Desire to work with older people

This section deals with the relationship between attitudes and desire to work with older people and reviews findings relating to the latter topic. McCracken, Fitzwater, Lockwood & Bjork (1995) found no relationship between attitudes towards older people as measured by Kogan's (1961) scale and desire to work with older people in a Norwegian sample, whereas a significant relationship between attitudes towards older people and expressed likelihood of working with them was found in their American sample. They stated that 18.3 per cent of the American students would choose to work with older people. The figure does not indicate the proportion of students coming from second, third and final years of their study. The present writer considers that caution should be exercised in interpreting this result, since research done with other professional groups (Mount, 1993; Scott, 1997) suggests that expressing the likelihood of working with older people in the future may be different from actually going into geriatric nursing at the end of training.

In a study by Stevens & Crouch (1995), significant improvement in attitude towards older people from beginning of training to completion did not foster a desire in students to work with older people. Compared with other areas of nursing, working with older people ranked 9th out of 10 at the end of training compared to 7th at the beginning. Only five per cent of the students rated 'working with older people' most highly as a post graduation career prospect at the end of their training. The reason people gave for choosing this speciality was their "positive regard for older people in general" (p. 238). Stevens & Crouch explained the lack of appeal of work with older people in terms of the difference between "basic nursing" and "technical nursing". They found that the latter with its aim of curing conditions, unlike that of basic nursing, exercises no less allure for nurses than for doctors. The lack of attraction in working with older people was confirmed by Haight et al. (1994) and by Giardina-Roche & Black (1990). Haight et al. (1994) reported that only one student (or two per cent of the graduating class) at the end of the three year training (which included a gerontological curriculum during each year of the training) chose to work in geriatrics, compared to 22 per cent in paediatrics, and 34 per cent in surgery. Giardina-Roche & Black's (1990) study indicated that even students with experience of

and positive attitudes towards older people preferred not to work with older people after graduation.

4.2.3 Effect of nursing and specific gerontological training

Slevin (1991) noted that the training of nurses in working with older people is inadequate both in the UK and in the USA. Slevin (1989) found that a large proportion of nurses working with older people had not attended any study days in the care of elderly people in the previous two years. Slevin (1991) also stated that Project 2000, a recently developed training programme for nurses in the UK, does not include a curriculum in elderly nursing, even though the largest groups of in-patient and out-patient populations come from this age group. Slevin said that it had been suggested that the decision not to include geriatric nursing in Project 2000 was due to a fear of negative labelling or a fear that specific training in gerontology might promote ageism.

In 1985, Melanson & Downe-Wamboldt stated that the question of the relationship between the amount of geriatric and gerontological teaching and attitudes towards older people and ageing has not been resolved. Evidence about the effect of different types of educational experiences in the training of nurses is provided by Haight et al. (1994). Following their first year of training, including by some trainers who were very interested in gerontological studies, American student nurses showed an improvement in their attitudes. There was an additional enhancement of attitude at the end of the second year, in spite of secondary health care teaching by lecturers who were not particularly interested in ageing. This trend had subsequently reversed as "by the time the students graduated they were holding fewer positive attitudes towards older people" (p. 386). Positive attitudes "decreased as the students' clinical experiences with more and more critically ill older adults increased" (p. 386). McCracken et al.'s (1995) research did not provide a breakdown on years of study but they also found that "as clinical and lecture time increased [amongst their American sample], positive attitudes toward the elderly decreased" (p. 173). Stevens & Crouch (1995) asked Australian nursing students to rank "ten nursing specialties in their order of preference" (p. 236). Their findings indicated that "nurses' negative attitudes towards the elderly are consolidated rather than dissolved in the course of their training" (p. 233).

Evidence providing different results to those described above came from studies by Aday & Campbell (1995) and Huber, Reno & McKenney (1992). Aday & Campbell (1995) found that a gerontological curriculum combined with practical experience led to student nurses holding fewer negative stereotypical views of older patients at the end of their gerontological training than they had at the beginning. One advantage of this study is that students' responses were matched pre- and post-training whereas in some other studies no matching occurred (for example, McCracken, et al., 1995). Similar evidence is also available from Huber, Reno & McKenney (1992) in a study about the usefulness of training amongst nursing staff in a long term care centre. Amongst registered nurses, they found a reduction in negative bias. Amongst licenced practical nurses, increased knowledge and reduction in negative bias followed formal educational sessions.

The effects of training appear difficult to judge because studies have measured heterogeneous components of training, from general nursing training with a small gerontological component (McCracken, et al., 1995; Stevens & Crouch, 1995) to well planned gerontological training (Haight et al., 1994). Haight et al. suggest that "exposure to older people who are well, happy and thriving is a definite plus for positively influencing student nurses' attitudes" (p. 388).

Again, it would seem that the studies reviewed have gathered data leading to conflicting evidence regarding the value of gerontological training to student nurses. It seems, though, that offering training to staff already working with older people might be helpful. Such training needs to be aimed at increasing their sense of competence and self-efficacy as a greater sense of self-efficacy has been related to improved attitudes towards older people (e.g., Kahana et al., 1996).

4.3 Social workers

4.3.1 Attitudes towards older people

Very little literature was found regarding attitudes of social workers towards older people. This dearth of literature on attitudes of social workers towards older people was noted by Gibson (1992). He wrote that Biggs (1989), a psychologist, has "produced an excellent manual of exercises designed to explore the attitudes of social workers to the elderly"

(Gibson, p. 105). However, no research based on this instrument was identified. Perhaps the unavailability of studies evaluating the attitudes of social workers towards older people is due to a "considerable scepticism about the value of social work with the elderly" (Crosbie, 1983, p. 123). Possible reasons for this attitude are examined in the next section dealing with social workers' desire to work with older people.

4.3.2 Desire to work with older people

Litwin (1994) reviewed previous research concerning social workers' attitudes to working with older people and concluded that studies have consistently shown that work with older people has been viewed as a "relatively low priority" in the United States (e.g. Abell & McDonell, 1990; Butler, 1990) as well as in Israel (Aviram & Katan, 1991). Litwin looked for possible explanations for this reluctance, which he divided into three areas: first, perceptions of elderly clients; secondly, the professional task; and finally, the rewards and accomplishments. He feels that the marginalisation of older people as a group "may impact upon professionals' own perceptions of work with elderly people" (p. 55). As it forces people to consider the difficulties of ageing, including those which may await the professionals themselves, the work may also "constitute a personally threatening undertaking for many social workers, and may thus reduce their willingness to engage in gerontological practice" (p. 55). Furthermore, since social workers are also seen as products of the societal norms which devalue ageing and older people, they, too, may hold a negative stereotype of elderly people. Secondly, where the professional task is concerned, Litwin considered that the care of frail elderly people is devalued and is seen as "work of poor quality and lower status" (p. 56) because it can be also done by volunteers and home helps. Moreover, many tasks involved in social work with older people are indirect work, with its emphasis on resource co-ordination and case management. According to Crosbie (1983), status in work is attached to the nature of the work carried out and the skills demanded. Direct clinical work is seen as requiring more skill and having higher status. The last area of influence in choosing the population with whom to work is that related to "rewards and accomplishments" (p. 57). A further factor which appears to mitigate against working with older people is that the work is seen as "ameliorative in nature" (p. 57) rather than aimed at producing "long lasting changes". Some evidence is provided by O'Connor, Dalgeish & Khan, (1984) who found that social work students in Australia expressed a preference for effecting change over helping. Their

results also indicated that students placed a higher value on the achievement of personal growth than on helping other people.

However, in Litwin's (1994) study with social work trainees in Israel, respondents did not evaluate working with older people as negatively as had been reported in earlier research. The results of a stepwise regression showed that several factors influenced the professional standing of work with older people. " [A] relatively positive evaluation of practice with older persons was explained most, it seems," (p. 67) by several factors: (i) "a traditional value orientation to the role of the elderly in society on the part of the respondents" (p. 67), (ii) assuming that work with older people carried prestige amongst peers and (iii) to a small degree, a practical field practicum had a positive effect. In contrast (iv) seeing work with older people as indirect had a negative effect. Interestingly, he found that "the greater the professional standing of social work in the eyes of the respondents, the lower the perception that work with elderly persons is limited to indirect intervention, and vice versa" (p. 63).

Litwin's work shed light on the factors which may influence a desire by social workers to work with older people. A similar tension between the needs of older people and the development of the profession is also seen amongst physiotherapists, the next group being considered.

4.4 Physiotherapists / physical therapists

Two different job titles have been including in one heading. As comparisons are made in studies like Mount's (1993) between attitudes of physical therapists in the USA and physiotherapists in Australia, the present reviewer assumed that both titles represent similar professional groups in different countries. Within this section, the use of the titles of physical therapist and physiotherapist follows the tradition of the country within which particular research took place. The literature search brought to light rather little relevant research on this professional group. As attitudes towards older people were only considered in the context of understanding the intention of physical therapists and physiotherapists to work with older people, their desire to work with older people is the only section for their professional group.

4.4.1 Decision to work with older people

According to Coren, Andreassi, Blood & Kent (1987) important factors for physical therapists in deciding not to work in geriatric practice related to the characteristics assigned to the client group (such as their motivation and the chronicity of the difficulties to be addressed) and how depressing the working environment was construed to be. Morris & Minichiello (1992, p. 25) also found that the construing of "less desirable working conditions" was a significant factor in discouraging practice with older people.

Attitudes towards older people did not predict physical therapist students' choice of specialisation. Mount (1993) found that, within the first two years of training in physical therapy, students' attitudes towards older people and intention to work with them correlated significantly. Attitudes of third year students towards older people and intention to work with this age group were not correlated, even though their attitudes towards older people were more positive at the end of a gerontological practicum than prior to its beginning. Taking into account the views of Wong (1990) and Pruessner, Hensel & Rasco (1992) about the "dichotomy between scientific and humanistic approaches to health care" (Mount, 1993, p. 21), Mount surmised that students experienced a tension between the need to view clients holistically (and therefore taking into account not only disease process but psychological and social conditions) and their requirement to assess the value of treatments in a reductionist way. She did not think that reductionist thinking was useful in working with older people. Mount proposed that "In order to attract health professionals into geriatrics, it is not enough to encourage a positive attitude towards the elderly" (p. 22). In her view, geriatric practice would suit best those students who "enjoy the complexity of dealing with humans in multiple dimensions" (p. 22).

Regarding the effect of training on students, Mount (1993) investigated the effect of a course with a didactic component about life span and a practical component involving the provision of health promotion to members of senior centres on physical therapy students. She found that there was a significant improvement in attitudes towards older people of the students participating in the course. However, this improvement was no greater than the improvement in a control group also made up of physical therapy students who did not participate in the course.

4.5 Clinical Psychologists

4.5.1 Attitudes

James & Haley (1995) investigated the type of clients seen by doctoral-level clinical psychologists in private practice in the US and their attitudes towards older people. Over 10 per cent of the case loads of the respondents surveyed consisted of people over the age of 60. Attitudes were investigated by means of a vignette which described a widowed woman of either 35 or 70 years of age, either in good health or suffering from a congenital heart disease. Descriptions of symptoms and difficulties resulting from the symptoms and physical condition were provided. The clinicians were asked to rate one client described in a vignette on such measures as treatment recommendations, suitability for psychotherapy, interpersonal characteristics. Older people "were seen as being less appropriate candidates for therapeutic intervention", and older persons "were viewed a[s] having a poorer prognosis than were their younger counterparts" (p. 612). However, regardless of age, people "in poor health were rated as less able to develop an adequate therapeutic relationship, ... as being less appropriate for therapeutic intervention, ... as more likely to have their presenting complaint related to an organic mental disorder, ... as having a poorer diagnosis ... and as being more likely to commit suicide" (p. 612). This health bias might be explained by the fact that "Psychologists rated themselves as less competent and comfortable in treating the [vignetted client] in poor health" (p. 613); it may be that their assessment of feeling less skilled with this client group might arise from a lack of experience owing to working in private practice. James & Haley's discovery of healthism as being even more prevalent than ageism was of concern to them. They felt that this might influence the treatment of older people as a number of older people may seek help for "depression in the context of chronic physical illness" (p. 614), with the danger that some older people might be the target of twin prejudices, ageism and healthism. It is also unfortunate that clinical psychologists' unwitting healthism and feeling deskilled might undermine their "ability to form a strong therapeutic alliance with the patient" (p. 614), which might bring about a self-fulfilling prophecy.

4.5.2 Desire to work with older people

Vacancies within clinical psychology departments in the UK are commonplace as the demand for clinical psychologists has so far exceeded the number of people being trained. Gilleard, Askham, Biggs, Gibson & Woods (1995) attributed the high number of vacant posts in the older people's specialty to ageism. Unlike other age groups, older people are not referred to clinical psychologists at a rate commensurate with their total population. Only 10 per cent of those referred are older people whereas they constitute 16 per cent of the population. In contrast, children are referred in a proportion consistent with their number and adults aged between 16 and 65 in excess of their number (Britton & Woods, 1996). Clinical psychologists cannot be held solely responsible for the low number of referrals to their service; yet, the number of vacant posts within the older people speciality limits the breadth of the service provided and publicity for the benefits of clinical psychology services to potential referrers.

As early as 1980, Liddell & Boyle reported that working with older people was a low priority for prospective students applying for training in clinical psychology. Little appears to have changed subsequently. Scott (1997) investigated career choices of trainee clinical psychologists. Her research findings confirm the estimate of the British Psychological Society (1995) that only six per cent of newly qualified clinical psychologists go on to work with older people. This small number contrasts markedly with the 75 per cent who affirmed that they had enjoyed their placement with older people and the 57 per cent who said that they would consider a job in the specialty.

Scott's (1997) research revealed an unexpected factor: half of the trainees who responded to her questionnaires had decided upon their area of work prior to starting their clinical training. Of the trainees who had pre-training work experience with older people, 15.6 per cent found it the most rewarding specialism encountered. "However ... the pre-course experiences that trainees adjudged to be the most rewarding, *did not* necessarily dictate their choice of career [italics in text]. Indeed only 7 per cent of trainees suggested that this played a factor in career choice" (pp. 15-16). In her investigation of the reasons for trainees not choosing to work with older people, 14 per cent of respondents indicated that poor recruitment might be due to the specialty being seen as under-resourced and to the expectation that less supervision and support would be available for newly-qualified staff compared to that available in the larger specialties.

Another recent survey by Thomas & Cook (1995) of clinical psychologists working in North Wales indicated that working with older people was seen as less attractive than the other three main specialisms of Adult Mental Health, Child and Learning Disability. Shmotkin, Eyal, & Lomranz (1992) studied the motivation of Israeli trainees and qualified clinical psychologists to work with older people. They reported that "Consistent with previous studies, the subjects showed much lower motivation for work with the elderly than with any other age group" (p. 186). Fifty-five per cent of the clinical psychologists in the sample preferred not to work with this age group. Motivation to work was positively influenced by previous experience in professional work with older people, by training in geropsychology, and by the number of years spent in the profession. Positive attitude towards psychotherapy with older people had a high predictive power on professionals' motivation. Attitude towards ageing in general was also an important factor. The study suggested "the presence of ageism in the sense that a tendency to avoid work with the elderly was evident on the basis of age alone" (p. 187). Yet, they made the point that a charge of ageism cannot be made without reservations as one fourth of the sample displayed interest in working with older people. Twenty-three per cent of people had had experience in the field, and 29 per cent showed an interest in gaining knowledge. Their "results suggest that subjects were seriously troubled by the assumed difficulties of the elderly in responding to therapeutic change" (p. 188). The intrapersonal characteristics which were the most frequently viewed as potentially hindering the psychotherapeutic treatment with older people were the following: mental rigidity (63.5 per cent), difficulty in changing habits (46 per cent), apathy (38.1 per cent), difficulties of memory (36.3 per cent), intolerance (33.9 per cent), stubborness (32.8 per cent) and passivity (31.2 per cent). This list has included those characteristics which were mentioned by at least 30 per cent of the respondents. Despite the weight attributed by James and Haley (1995) to healthism, only 20.1 per cent of Shmotkin et al.'s respondents referred to "impaired physical health" (p. 187). In their sample, personal issues, such as attitudes towards one's own ageing and death, did not relate to motivation to work with older people. However, attitude towards ageing in general was a factor. Synthesising the factors involved in not wanting to work with older people, they concluded that, generally, professional issues were more important than personal issues.

Searle's (1991) earlier research with trained clinical psychologists provided a different analysis of recruitment to the speciality and the reasons given for choosing it. In her sample, the majority of clinical psychologists working with older people made their

decision after having worked at least two years post qualification. Thirty-two of 70 clinical psychologists whom she surveyed returned their questionnaires. Of those, 15.6 per cent had made the decision to work with older people prior to their post-graduate training and another 15.6 per cent had decided during their clinical training. Six per cent decided within two years after qualifying, whilst 59.3 per cent chose to go into that specialty two years or more after qualifying. Searle's respondents provided the following reasons for choosing to work with older people: "Career advancement (11), Convenience/availability of post (9), Generally attractive post (13), Deliberate decision to work with older people (13), Only job available (1), Best job available but wouldn't have been first choice (4), It wasn't a decision, the job evolved (2), Research interests (3)" (p. 20). (The number following each reason represents the number of people who provided this answer.) The aspects of working with older people they most liked ranged from clinical and existential issues, such as the variety of problems and "Contact with real issues - death, meaning of life" (p. 20), to management issues like the possibility of influencing service development. Some of the answers provided ran counter to an ageist attitude: "Challenge of working with a neglected group"; "The people, more interesting as they get older"; "Learning from older people and sharing their wisdom". Some of the responses alluded to the complexity of working with older people: "Exciting, challenging". Others clearly spelled out that other avenues had been tried and set aside: "Fed up working with young people who expect miracles, older people are so much more grateful" (p.21).

4.6 Summary

Overall, the review of the literature on attitudes of five groups of professional towards older people does not provide any unequivocal answers. Perhaps, it cannot be anything but complex. In clinical psychology, which is the profession within the NHS best known to the writer, working with older people represents highly varied work not only because of the multiplicity of presenting problems but also owing to the range of settings in which clients live. Unfortunately, this variety is masked by the designation "long-term need" in the context of clinical training placements, with its implication that the service deals mostly with long-term residential care. The desire to work with older people within all the professions remains quite low, and it is suspected that the number of professionals wishing to work with this age group will not meet the requirements of a growing ageing population.

Following the reviewing of the literature on the attitudes towards and desire to work with older people within the main professions, the focus now changes to an attempt to provide a synthesis of the issues which have been posited to affect professionals' attitudes towards older people. These are: (i) perceptions and misperceptions of older people compared to how they see themselves, (ii) existential issues, including professionals' attitudes towards ageing and death, (iii) the effect of contact with known and/or healthy older people. (iv) Ways to counter ageism will be discussed prior to focusing on the possible measures which have been expounded in the literature in order to increase professionals' interest in and willingness to work with older people.

5. Perceptions and misperceptions of older people compared to how they see themselves

Comparisons of ratings provided by professional groups and their patients are available only for nurses and physicians. Generally, it would seem that there is a discrepancy between professionals' views of patients compared to patients' own assessment of their well-being. Herbert & Salmon (1994) found that there was no agreement between ratings assigned by non-psychiatrically trained nurses and by patients regarding patients' well-being and level of depression. Furthermore, the patients that nurses rated as more lonely rated themselves as more satisfied with their lives. Nurses and day hospital patients seemingly construed well-being on the basis of different behavioural styles. Nurses' ratings of patients' well-being were correlated with overt engagement, and their ratings of patients' increasing depression with greater behavioural impairment. By contrast, "patients' well-being correlated with their estimates of the time they spent in solitary activity" (Herbert & Salmon, 1994, p. 485). Pearlman and Uhlmann (1988) investigated physicians' perceptions of older patients with five chronic diseases. They found that the older patients gave more positive ratings to their quality of life than did their doctors. This research indicated that quality of life is multifactorial, including psychological, environmental and socioeconomic elements.

Carmel (1998) investigated perceptions of the will to live of two groups of Israeli people (first year medical students and a large random sample of older people). The students were also asked to rate the will to live of older people. The will to live of the younger

people was stronger than that of the older group. However, the older group had a stronger will to live than young people assumed they had.

The self-esteem of older people seems more secure than is sometimes assumed. George (1987) suggested that no difference in self esteem between younger and older people has been convincingly demonstrated, although a trend for a higher self-esteem amongst older people has been suggested. The factors which contribute to self-esteem in older adults are similar to those in the younger population: "measures of personal achievement, ... interpersonal success in family and peer relationships, and participation in meaningful activities. In addition, health and attitudes toward ageing emerge as unique correlates of self-esteem among older adults" (p. 593). Stokes (1992) has reviewed studies regarding personality and adjustment in old age and concluded that "If a generalization is to be made it is that self-concept of most aged adults is not characterized by self-deprecatory attitudes and low self-esteem" (p. 97). This is in sharp contrast with a Spanish study in which older participants described ageing mostly in terms of multifaceted decline (Triado & Villar, 1997). However, sociodemographic variables might have partly given rise to the negative characteristics associated with ageing in this research. The low educational achievement in the sample (most people having only received primary education) might have been a confounding variable which influenced the degree of psychological changes and lack of adjustment reported by people in the sample. Very different findings were obtained by Ranzijn, Keeves, Luszcz & Feather (1998) who found that self-esteem in Australian older people (aged 70 and over) was related to positive self-regard and a feeling of usefulness and competence. Self-esteem in their sample was quite high with an overall mean of 4.14, with the highest possible self-esteem score being five. Results from the two studies were obtained by dissimilar means, with Bachman's (1970) revised Self-Esteem Scale (Rosenberg, 1965) in the case of the Australian sample and with semi-structured interviews in the case of the Spanish sample. Spanish respondents were asked two questions: (i) What is ageing for you? and (ii) What are the changes which, in your view, define ageing? Results were based on the content analyses of the responses.

6. Professionals' attitudes towards their own ageing and fear of death

Attitudes to ageing in general and towards older people have been considered in earlier sections of this review. Where attitudes towards one's own ageing are concerned, DePaola et al. (1994) found that anxiety about one's own ageing was associated with negative views towards older people. DePaola et al. (1992) found that a high level of death anxiety was associated with greater anxiety about ageing.

What is meant by fear of death requires careful definition. Neimeyer (1988) expressed a view that attitudes towards death need to be separated into death fear or death anxiety (which are construed as conceptual equivalents) and death threat. The former refers to "the negative emotional reactions" to aspects of death and dying whereas the latter "refers to a more cognitive predisposition to view one's own death as fundamentally incompatible with one's identity as a living being" (p. 100). Studies such as Vickio & Cavanaugh (1985) and Eakes (1985) have investigated death anxiety, whereas other investigators (e.g., DePaola, et al., 1992; DePaola et al., 1994) also included a measure of death threat.

It would appear that some variables, such as age, influence an individual's level of death anxiety. Age has been found to be negatively correlated with "fear of personal death" (Neimeyer, 1985, p. 242). When large samples have been used, however, a trend towards a curvilinear relationship has sometimes been established with death anxiety highest in the middle-aged group (mean age = 41.4), lower in young people (mean age = 21.4) and lowest in the older group (mean age = 74.3) (Gesser, Wong & Reker, 1987-88).

Several studies have found that staff in nursing homes who experience a high level of death anxiety tend to hold more negative attitudes towards older people than their counterparts who feel low levels of death anxiety (Vickio & Cavanaugh, 1985; Eakes, 1985). Similar results were found by DePaola et al. (1994) using the Multidimensional Fear of Death Scale (MFODS). They found that three subscales (fear of the unknown, fear of being conscious when dead, and fear for the body after death) correlated with attitudes towards older people but a regression analysis indicated that only fear of the unknown "contributed significantly to the prediction of participants' negative attitudes toward the elderly" (p. 243). There was no association between death threat and attitudes towards older people.

One further finding appears highly relevant for staff working in nursing homes and in professions related to death and dying. Vickio & Cavanaugh (1985) found that, even though increased anxiety about death was positively correlated with greater personal anxiety about ageing, staff who had experienced a greater number of deaths amongst residents were more comfortable with thinking about and discussing dying and death with patients.

7. Contact with older people

The effect of contact with older people has been investigated by Melanson & Downe-Wamboldt (1985), Knox, Geroski & Johnson (1986), Murphy-Russell, Die & Walker (1986) with undergraduate students, Wilderom et al. (1990) with medical students and Mount (1993) with physical therapy students.

Melanson & Downe-Wamboldt's (1985) findings showed that there was no significant relationship between nursing contact with older people and attitudes towards this age group. However, they stressed that their study measured quantity of time rather than quality of time spent with older people. Other studies have measured quality of contact. Knox, et al. (1986) measured knowledge about older people, attitudes, and types and quality of contact with older people and with the most familiar older person. Quality of contact with a variety of older people, rather than quality of contact with the most familiar older person, was the most significant variable governing attitudes towards older people. Mount (1993) sought to measure physical therapy students' closeness of contact with anyone over 65. "Students who had a close relationship with an older person were found to have a significantly more positive attitude toward older people" (p. 19) than students who did not enjoy such a close relationship. Murphy et al. (1986) tested the effects of direct exposure (with an older, nonstereotypic couple) and of two types of indirect experience of older people on the attitudes of undergraduates towards older people. The attitudes of these young people were slightly positive before the educative programme started. Of the three experimental conditions, contact with the older couple was the most effective in improving attitudes. Further evidence for the value of contact with well older people was found by Thomson (1991). He reviewed the effect of contact with well older people and found that such contact had value in nearly all studies (e.g., Ross, 1983; Garrett, 1987; Howden & Baggaley, 1989). The results of Haight et al.'s study (1994)

with 118 baccalaureate nursing students indicated that "grandparents had a strong positive influence on the student attitudes" towards older people (p. 388). In their view "Exposure to older people who are well, happy and thriving is a definite plus for positively influencing student nurses' attitudes" (p. 388). One exception was found in a study by Greenhill & Baker (1986) in which two groups of students' attitudes and knowledge of older people improved over time regardless of whether the group had contact with well older people.

Work contact prior to training has also been researched in groups of medical and nursing students with dissimilar results. In their survey of the attitudes of medical students towards the geriatrics specialty, Wilderom et al. (1990) found that voluntary work with older people before medical school produced a positive effect on students' attitudes towards specialisation in geriatrics. This contrasts with a study of first year baccalaureate nursing students (Hart, Freel & Crowell, 1976). Prior experience of working with this age group had a significantly deleterious effect on attitudes towards older people. However, the results obtained by Wilderom et al. (1990) and Hart et al. (1976) are different without being necessarily contradictory as no evidence is available that the type of employment obtained pre-training by the two groups of prospective students is comparable.

8. Counteracting negative attitudes towards older people within the professions

The need to counter ageism is evident, because the population of western countries is growing older and ageist attitudes make it less likely that older people obtain good care on a basis that is equitable with the rest of the population. The old adage of "you are only as old as you feel" seems irrelevant when the world appears to behave according to the assumption that "you are as old as you look". The purpose of countering ageism is to free people from erroneous and injurious stereotypes.

Levin & Levin (1980) suggested that the gerontological literature with its emphasis on multifaceted decline contributes to ageism. Grant (1996) suggested that "health care professionals need to move away from using ... age as an explanatory variable and [from] the assumption that after enough time certain "things" will happen to people" (p. 13). She recommends that "health professionals ... focus on the causes of functional impairment" (p. 13) even in those conditions or impairments that are more frequent amongst older

people. Reuben et al. (1995) emphasised the importance of the provision of high quality care to older people. He suggested that this might be achieved by choosing future physicians with positive attitudes towards older people, or by providing experiences within medical school which foster positive attitudes. In previous sections, some evidence of the value of having quality relationships with older people, or being exposed to healthy older people either pre-training or during medical training has been demonstrated as being related to better attitudes towards older people (Sachs et al., 1985; Murphy et al., 1986; Weiler et al., 1989; Wilderom et al. 1990; Adelman et al., 1992; Deary et al., 1993). It was also noted that "brief, direct experience with healthy elderly [people brought] about positive attitudinal changes" in a group of dietetic students (Rasor-Greenhalgh, Stombaugh & Garrison, 1993, p. 60). More knowledge about ageing was predictive of more positive attitudes (e.g. Intrieri et al., 1993; Edwards & Aldous, 1996; Reuben et al., 1997), although contrary findings were reported by Carmel et al. (1990) whose research indicated that greater knowledge does not necessarily lead to more positive attitudes. Greater feelings of self-efficacy were found to predict more positive evaluations of older people by staff members (Kahana et al, 1996).

For Reyes-Ortiz (1997), gerontological training, learning about healthy ageing, and about the myths and realities of ageing is insufficient in training physicians. He advocates that "Self-awareness ... is the key. Physicians must begin to look closely at their reactions to older patients, and be willing to discuss their feelings openly with colleagues" (p. 831). Of all the writers whose research was reviewed, he appeared to be the only one to consider that self-exploration and frank discussion were necessary in rooting out ageist attitudes.

Ellis (1996) provided a personal construct analysis of the genesis of nurses' views of their role in a hospital or residential home environment and of their views of older people. She affirmed that the "anticipation of caring for older people will have complicated connections to childhood constructions of caring and constructions of what it means (to the nurse) to be an older person" (p. 2). As children develop, they are very likely to develop their construing system around what it means to them to be caring and uncaring, and where older people, including those whom they know, fit on this continuum. Ellis analysed the possible mismatch between the views of caring and being cared for held by older people and by nurses. The mismatch might be attributed to the type of construing of caring held by both types of people. Nurses' view of caring and being cared for might not have altered much since childhood and might be 'constellatory', such that one construct is

linked to others. Thus, for a nurse whose construing has not evolved since childhood 'being cared for' might also imply "a state of dependency, with lack of personal control and competence" (p. 3). The older person's view of caring and being cared for might have evolved since their own childhood to include more propositional thinking (whereby one construct does not automatically imply others), such that being cared for means to be provided with that which one cannot do oneself, but being left to make decisions about many other aspects of one's physical and psychological existence. In such an old person, the nurse's attitude of patronising care "will cause anxiety and confusion, and surprise at being treated in such a childish manner. This anxiety and confusion is likely to be the cause of the withdrawal which occurs in many elderly residents admitted to nursing homes for reasons other than dementia" (p. 3). Ellis went on to surmise that much of the excessively dependent behaviour displayed in nursing homes might be a form of adaptation to the construction of the nurses of older patients as dependent whilst attempting to retain some sense of control. She argued that change would come from nurses being encouraged to examine their own construction processes. The current writer considers that Ellis' analysis of nurses' construing might usefully be incorporated in any form of training, such as that advocated by Reyes-Ortiz (1997).

9. Future project

The purpose of this review was to assess whether it would be useful to carry out a research project on attitudes towards older people in one group of professionals. The aim of the future research would be to assess the attitudes towards older people of clinical psychologists-in-training (and, when available, counselling psychologists-in-training pre- and post-placement) as well as the influence of their construing of their grandparents. Scott's (1997) research provided data on the usefulness and enjoyment of a placement with older people to clinical psychologists-in-training. Attitudes towards grandparents, elderly relatives and other older people have also already been measured by several studies. The results are positive, showing that quality of contact with older people who are preferably in good health can contribute to positive attitudes towards older people in general (Adelman, et al, 1992; Haight et al, 1994). Since the proposed project would be more likely to replicate existing findings than to contribute new information, it will probably not be executed.

10. Conclusion

Despite the difficulties in comparing research literature across cultures, on account of the very different assumptions that are made even about such fundamental tenets as the chronological age at which old age begins, it remains evident that working with older people presents a very important challenge. Growing old is a universal aspect of the human journey for all those who do not die prematurely. That older people tend to be the least preferred group for professionals to work with might be distressing, but it is also understandable. Working with older people might act as an inescapable mirror for profound existential issues such as the meaning of life, fear of ageing, dying and death anxiety. The amount of literature on the subject reflects the deep concern of the writers and the need they perceive for radical social changes. It has, for the most part, been written with a view to making work with older people more attractive. Most clinical psychologists do not come into the specialty following training. However, it would seem essential to provide trainees with a varied placement, to include experience with people who are able and keen to participate in psychotherapeutic work, in an attempt to make it more likely that they might choose older people as a specialism later in their career. The researcher suggests that specific training for all professionals working with older people is not only extremely important but also needs to include an attempt to reduce threat, to enhance understanding of one's construing in relation to older people, and to increase feelings of efficacy, the importance of which has been stressed within three professions. These are difficult aims to achieve, but it is hoped that their successful accomplishment would benefit older people and professionals alike.

REFERENCES

Abell, N., & McDonell, J. R. (1990). Preparing for practice: Motivations, expectations and aspirations of the MSW class of 1990. *Journal of Social Work Education, 26*, 57-64.

Aday, R. H., & Campbell, M. J. (1995). Changes in nursing students' attitudes and work preferences after a gerontology curriculum. *Educational Gerontology, 21*, 247-260.

Adelman, R. D., & Albert, R. C. (1987). Medical student attitudes toward the elderly: A critical review of the literature. *Gerontology & Geriatrics Education, 7*, 141-155.

Adelman, R. D., Fields, S. D., & Jugatir, R. (1992). Geriatric education part II: The effect of a well elderly program on medical student attitudes toward geriatric patients. *Journal of the American Geriatrics Society, 40*, 970-973.

Ahmed, S. M., Kraft, I. A., & Porter, D. M. (1986). Attitudes of different professional groups toward geriatric patients. *Gerontology & Geriatrics Education, 6*, 77-86.

Anastasi, A. (1974). Individual differences in aging. In W. C. Bier (Ed.), *Aging* (pp. 84-95). New York: Fordham University Press.

Arber, S., & Ginn, J. (1991). *Gender and later life*. London: Sage.

Aviram, U., & Katan, J. (1991). Professional preferences of social workers: Prestige scales of populations, services and methods in social work. *International Social Work, 34*, 37-55.

Bachman, J. G. (1970). *Youth in transition II: The impact of family background and intelligence on tenth-grade boys*. Ann Arbor, MI: The Institute for Social Research.

Biggs, S. (1989). *Confronting ageing: A groupwork manual for helping professionals*. London: Central Council for Education and Training in Social Work.

Black, J. S., Sefcik, T., & Kapoor, W. (1990). Health promotion and disease prevention in the elderly: Comparison of house staff and attending physician attitudes and practices. *Archives of Internal Medicine, 150*, 389-393.

Britton, P. G., & Woods, R. T. (1996). Introduction. In R. T. Woods (Ed.), *Handbook of the clinical psychology of ageing* (pp. 1-19). Chichester: John Wiley & Sons Ltd.

Burke, R., & Duthie, E. H. (1997). Focus group evaluation of physician training in geriatric medicine: Does a geriatrics rotation make a difference? *Gerontology & Geriatrics Education, 17*, 29-38.

Butler, A. (1990). A reevaluation of social work students' career interests. *Journal of Social Work Education*, *26*(1), 45-56.

Butler, R. N. (1969). Age-Ism: Another form of bigotry. *The Gerontologist*, *9*, 243-246.

Butler, R. N. (1975). *Why survive being old in America?* New York: Harper Row.

Butler, R. N. (1996). Global ageing: Challenges and opportunities of the next century. *Ageing International*, *23*,12-32.

Bytheway, B. (1995). *Ageism*. Buckingham: Open University Press.

Campion, E. W., Mulley, A. G., Goldstein, R. L., Barnett, G. O., & Thibault, G. E. (1981). Medical intensive care for the elderly: A study of current use, costs, and outcomes. *Journal of the American Medical Association*, *246*, 2052-2056.

Carmel, S. (1998). Medical students' attitudes regarding the use of life-sustaining treatments for themselves and for elderly persons. *Social Sciences & Medicine*, *46*, 467-474.

Carmel, S., Galinsky, D., & Cwikel, J. (1990). Knowledge, attitudes, and work preferences regarding the elderly among medical students and practicing physicians. *Behavior, Health, and Aging*, *1*, 99-104.

Cook, P. J. (1986). Benzodiazepine hypnotics in the elderly. *Acta Psychiatrica Scandinavica*, *Suppl. 332*, *74*, 149-158.

Coren, A., Andreassi, M., Blood, H., & Kent, B. (1987). Factors related to physical therapy students' decisions to work with elderly patients. *Physical Therapy*, *67*(1), 60-65.

Crosbie, D. (1983). A role for anyone? A description of social work with the elderly in two area offices. *British Journal of Social Work*, *13*, 123-148.

Deary, I. J., Smith, R., Mitchell, C., & MacLennan, W. J. (1993). Geriatric medicine: Does teaching alter medical students' attitudes to elderly people? *Medical Education*, *27*, 399-405.

DePaola, S. J., Neimeyer, R. A., Lupfer, M. B., & Fiedler, J. (1992). Death concern and attitudes toward the elderly in nursing home personnel. *Death Studies*, *16*, 537-555.

DePaola, S. J., Neimeyer, R. A., & Ross, S. K. (1994). Death concern and attitudes toward the elderly in nursing home personnel as a function of training. *Omega*, *29*, 231-248.

Downe-Wamboldt, B., & Melanson, P. M. (1985). A descriptive study of attitudes of baccalaureate student nurses toward the elderly. *Journal of Advanced Nursing, 10*, 369-374.

Doty, L. (1987). *Communication and assertion skills for older persons*. Washington: Hemisphere Publishing Corporation.

Eakes, G. C. (1985). The relationship between death anxiety and attitudes toward the elderly among nursing staff. *Death Studies, 9*, 163-172.

Edwards, M. J. J., & Aldous, I. R. (1996). Attitudes to and knowledge about elderly people: A comparative analysis of students of Medicine, English and Computer Science and their teachers. *Medical Education, 30*, 221-225.

Ellis, J. M. (1996). Nurses' anticipations of caring for elderly patients. Paper presented at the European Personal Construct Association Conference, University of Reading, April 1996.

Fields, S. D., Jutagir, R., Adelman, R. D., Tideiksarr, R., & Olson, E. (1992). Geriatric education part I: Efficacy of a mandatory clinical rotation for fourth year medical students. *Journal of the American Geriatrics Society, 40*, 964-969.

Friedan, B. (1993). *The fountain of age.* London: Jonathan Cape.

Gardner, C. S., Kuder, L. C., & Rich, E. C. (1995). Medical students' attitudes: Effect of an interdisciplinary geriatrics rotation. *Gerontology & Geriatrics Education, 15*, 75-84.

Garrett, G. (1987). Caught and not taught. *Nursing times, 24* Oct, 48-51.

George, L. K. (1987). Self-esteem. In G. L. Maddox (Ed.), *The Encyclopedia of Aging* (p. 593). New York: Springer Publishing Company.

Gesser, G., Wong, P. T. P., & Reker, G. T. (1987-88). Death attitudes across the life-span: The development and validation of the Death Attitude Profile (DAP). *Omega, 18*, 113-128.

Giardina-Roche, C., & Black, M. E. (1990). Attitudes of diploma student nurses toward adult clients. *Journal of Nursing Education, 29*, 208-214.

Gibson, H. B. (1992). *The emotional and sexual lives of older people: A manual for professionals*. London: Chapman & Hall.

Gilleard, C., Askham, J., Biggs, S., Gibson, H. B., & Woods, R. (1995). Psychology, ageism and health care: A DCP symposium. *Clinical Psychology Forum, 85,* 14-15.

Glendenning, F. (1997). Attitudes to older people. In P. Decalmer & F. Glendenning (Eds.), *The mistreatment of elderly people*. London: Sage Publications.

Globerman, J. (1991). Treating older patients: Who treats and why? *Canadian Journal on Aging, 10*, 232-253.

Grant, L. D. (1996). Effects of ageism on individual and health care providers' responses to healthy aging. *Health & Social Work, 21*, 9-15.

Greer, G. (1991). *The change: Women, ageing and the menopause*. London: Hamish Hamilton.

Greenhill, E. D., & Baker, M. F. (1986). The effects of a well older adult clinical experience on students' knowledge and attitudes. *Jounal of Nurse Education, 25*, (4), 145-147.

Haight, B. K., Christ, M. A., & Dias, J. K. (1994). Does nursing education promote ageism? *Journal of Advanced Nursing, 20*, 382-390.

Hart, L. K., Freel, M. I., & Crowell, C. M. (1976). Changing attitudes toward the aged and interest in caring for the aged. *Journal of Gerontological Nursing, 2*, 10-16.

Hellbusch, J. S., Corbin, D. E., Thorson, J. A., & Stacy, R. D. (1994). Physicians' attitudes towards aging. *Gerontology & Geriatrics Education, 15*, 55-65.

Herbert, C., & Salmon, P. (1994). The inaccuracy of nurses' perception of elderly patients' well-being. *Psychology and Health, 9*, 485-492.

Higgitt, A. (1992). Dependency on prescribed drugs. *Reviews in clinical gerontology, 2*, 151-155.

Howden, C., & Baggaley, S. (1989). Learning from the experts. *Nursing Times, 85*(25), 42-44.

Huber, M., Reno, B., & McKenney, J. (1992). Long-term care personnel assess their attitudes and knowledge of the older adult. *Journal of Advanced Nursing, 17*, 1114-1121.

Intreri, R. C., Kelly, J. A., Brown, M. M., & Castilla, C. (1993). Improving medical students' attitudes toward and skills with the elderly. *The Gerontologist, 33*, 373-378.

James, J. W., & Haley, W. E. (1995). Age and health bias in practicing clinical psychologists. *Psychology and Aging, 10*, 610-616.

Jarvis, E. (1981). Drugs and the elderly patient. *Adverse Drug Reaction Bulletin, 86*, 312-315.

Jones, S. (1976). Education for the elderly. In F. Glendenning & S. Jones (Eds.), *Education and the over-60s* (pp. 9-20). Stoke-on-Trent: Beth Johnson Foundation and Keele University Adult Education Department.

Kahana, E., Kinney, J. M., Kercher, K., Kahana, B., Tinsley, V. V., King, C., Stuckey, J. C., & Ishler, K. J. (1996). Predictors of attitudes toward three target groups of elderly persons. *Journal of aging and health, 8*, 27-53.

Keeler, E. B., Solomon, D. H., Beck, J. C., Mendenhall, R. C., Kane, R. L. (1982). Effect of patient age on duration of medical encounters with physicians. *Medical Care, 20*, 1101-1108.

King, D. J., Griffiths, K., Reilly, P. M., & Merrett, J. D. (1982). Psychotropic drug use in Northern Ireland 1966-80: Prescribing trends, inter- and intra-regional comparisons and relationship to demographic and socio-economic variables. *Psychological Medicine, 12*, 819-833.

Knox, V. J., Gekoski, W. L., & Johnson, E. A. (1986). Contact with and perceptions of the elderly. *The Gerontologist, 26*, 309-313.

Kogan, N. (1961). Attitudes toward old people: The development of a scale and an examination of correlates. *Journal of Abnormal and Social Psychology, 62*, 44-54.

Kruse, W. H.-H. (1990). Problems and pitfalls in the use of benzodiazepines in the elderly. *Drug Safety, 5*, 328-344.

Laslett, P. (1996). *A fresh map of life: The emergence of the third age* (2nd ed.). London: Weidenfeld and Nicolson.

Levin, J., & Levin, W. (1980). *Ageism: Prejudice and discrimination against the elderly.* Belmont, California: Wadsworth.

Liddell, A., & Boyle, M. (1980). Characteristics of applicants to the MSc. in Clinical Psychology at North East London Polytechnic. *Newsletter of the Division of Clinical Psychology, 30*, 20-25.

Litwin, H. (1994). The professional standing of work with elderly persons among social work trainees. *British Journal of Social Work, 24*, 53-69.

Marshall, V. W. (1981). Physician characteristics and relationships with older patients. In M. R. Haug (Ed.), *Elderly patients and their doctors* (pp. 94-118). New York: Springer.

McAlpine, C. H., Gilhooly, M. L. M., Murray, K., Lennox, I. M., & Caird, F. I. (1995). Medical student and geriatric medicine. *Academic Medicine, 70*, 749-750.

McCracken, A., Fitzwater, E., Lockwood, M., & Bjork, T. (1995). Comparison of nursing students' attitudes toward the elderly in Norway and the United States. *Educational Gerontology, 21*, 167-180.

Melanson, P. M., & Downe-Wamboldt, B. L. (1985). Antecedents of baccalaureate student nurses' attitudes toward the elderly. *Journal of Advanced Nursing, 10*, 527-532.

Minois, G. (1989). *History of old age*. Cambridge: Polity Press.

Morris, M., & Minichiello, V. (1992). Why choose to work in geriatrics? Factors which affect physiotherapists' decision to work with older people. *Australian Physiotherapy*, *38*(1), 21-28.

Mount, J. (1993). Effect of a practicum with well elderly on physical therapy students' attitudes towards older people and their intention to work with the elderly. *Gerontology & Geriatrics Education*, *13*, 13-24.

Murphy-Russell, S., Die, A. H., & Walker, Jr, J. L. (1986). Changing attitudes toward the elderly: The impact of three methods of attitude change. *Educational gerontology*, *12*, 241-251.

Neimeyer, R. A. (1985). Actualization, integration, and fear of death: A test of the additive model. *Death Studies*, *9*, 235-244.

Neimeyer, R. A. (1988). Death anxiety. In H. Wass, F. M. Berardo & R. A. Neimeyer (Eds.) (2nd edition), *Dying: Facing the facts* (pp. 97-136). New York: Hemisphere Publishing Corporation.

O'Connor, I., Dalgeish, L., & Khan, J. (1984). A reflection of the rising spectre of conservatism: Motivational accounts of social work students. *British Journal of Social Work*, *14*, 227-240.

Ontario Welfare Council (1974). *Opinions about people: Guidelines and Manual.* Toronto: Ontario Welfare Council Section on Ageing.

Pacala, J. T., Boult, C., Bland, C., & O'Brien, J. (1995). Aging game improves medical students' attitudes toward caring for elders. *Gerontology & Geriatrics Education*, *15*, 45-57.

Palmore, E. (1977). Facts on Aging: A short quiz. *The Gerontologist*, *17*, 315-320.

Pearlman, R. A., & Uhlmann R. F. (1988). Quality of life in chronic diseases: Perceptions of elderly patients. *Journal of Gerontology*, *43*, M25-M30.

Pruessner, H., Hensel, W., & Rasco, T. (1992). The scientific basis of generalist medicine. *Academic Medicine*, *67*, 79-82.

Radecki, S. E., Kane, R. L., Solomon, D. H., Mendenhall, R. C., & Beck, J. C. (1988a). Do physicians spend less time with older patients? *Journal of the American Geriatrics Society*, *36*, 713-718.

Radecki, S. E., Kane, R. L., Solomon, D. H., Mendenhall, R. C., & Beck, J. C. (1988b). Are physicians sensitive to the special problems of older patients? *Journal of the American Geriatrics Society*, *36*, 719-725.

Ranzijn, R., Keeves, J., Luszcz, M., & Feather, N. T. (1998). The role of self-perceived usefulness and competence in the self-esteem of elderly adults: Confirmatory factor

analyses of the Bachman Revision of Rosenberg's Self-Esteem Scale. *Journal of Gerontology, 53B*, P96-P104.

Ray, D. C., Raciti, M. A., & Ford, C. V. (1985). Ageism in psychiatrists: Associations with gender, certification, and theoretical orientation. *The Gerontologist, 25*, 496-500.

Rasor-Greenhalgh, S. A., Stombaugh, I. A., & Garrison, M. E. (1993). Attitude changes of dietetic students performing nutritional assessment on healthy elderly. *Journal of Nutrition for the Elderly, 12*, 55- 64.

Reuben, D. B., Fullerton, J. T., Tschann, J. M., & Croughan-Minihane, M. (1995). Attitudes of beginning medical students toward older persons: A five-campus study. *Journal of the American Geriatrics Society, 43*, 1430-1436.

Reyes-Ortiz, C. A. (1997). Physicians must confront ageism. *Academic Medicine, 72*, 831.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Ross, M. M. (1983). Learning to nurse the elderly: Outcome measures. *Journal of Advanced Nursing, 8*, 373-378.

Saarela, T., & Viukari, M. (1995). Attitudes of health care professionals towards care of the elderly. *International Journal of Geriatric Psychiatry, 10*, 797-800.

Sachs, L. A., McPherson, C., & Donnerberg, R. (1985). Influencing medical students' attitudes toward older adults: A curriculum proposal. *Gerontology & Geriatrics Education, 4*, 91-96.

Schaie, K. W. (1993). Ageist language in psychological research. *American Psychologist, 48*, 49-51.

Scott, A. (1997). Career choices and attitudes to the older adult specialty: Results of a national survey of trainee clinical psychologists. Paper presented at PSIGE Conference (Psychologists' Special Interest Group for the Elderly), Edinburgh, July 1998.

Searle, R. (1991). Choices & decisions: Starting work with elderly people. *Psychologists' Special Interest Group for the Elderly (PSIGE) Newsletter*, 19-24.

Seltzer, M. M., & Atchley, R. C. (Autumn 1971). The concept of old: Changing attitudes and stereotypes. *The Gerontologist, Part 1*, 226-230.

Shakespeare, W. (c.1600). Hamlet. In H. Jenkins (Ed.), (1982). *The Arden Shakespeare*. London: Methuen.

Sharpe, P. A. (1995). Older women and health services: Moving from ageism toward empowerment. *Women & Health*, *22*, 9-23.

Shmotkin, D., Eyal, N., & Lomranz, J. (1992). Motivations and attitudes of clinical psychologists regarding treatment of the elderly. *Educational Gerontology*, *18*, 177-192.

Silverman, P. (1987). Comparative studies. In P. Silverman (Ed.), *The elderly as modern pioneers* (pp. 312-344). Bloomington and Indianapolis: Indiana University Press.

Slevin, O. D'A. (1989). Communicating with the elderly: Social and educational influences in nurse-patient interactions. Unpublished PhD thesis. The Queen's University of Belfast.

Slevin, O. D'A. (1991). Ageist attitudes among young adults: Implications for a caring profession. *Journal of Advanced Nursing*, *16*, 1197-1205.

Stevens, J., & Crouch, M. (1995). Who cares about care in nursing education? *International Journal of Nursing Studies*, *32*, 233-242.

Stevenson, O. (1989). *Age and Vulnerability: A guide to better care*. London: Edward Arnold.

Stinnett, N., Walters, J., & Stinnett, N. (1991) (3rd Ed.). *Relationships in marriage and the family*. New Jersey: Prentice-Hall, Inc..

Stokes, G. (1992). *On being old: The psychology of later life*. London: The Falmer Press.

Thomas, C., & Cook, F. (1995). An investigation into the factors determining the choice of specialism in clinical psychology. *Clinical Psychology Forum*, 13-17.

Thomson, H. (1991). Attitudes to old people: A review (part 2). *Nursing Standard*, *5*(31), 33-35.

Triado, C., & Villar, F. (1997). Modelos de envejecimiento y percepcion de cambios en una muestra de personas mayores. *Anuario de Psicologia*, *73*, 43-55.

Vickio, C. J., & Cavanaugh, J. C. (1985). Relationships among death anxiety, attitudes toward aging, and experience with death in nursing home employees. *Journal of Gerontology*, *40*, 347-349.

Weiler, P. G., Orgren, R. A., & Olafson, L. (1989). Medical education and interest in geriatrics. *Educational Gerontology*, *15*, 441-451.

Wetle, T. (1987). Age as a risk factor for inadequate treatment. *Journal of the American Medical Association*, *258*, 516.

Wilderom, C. P. W., Press, E. G., Perkins, D. V., Tebes, J. A., Nichols, L., Calkins, E., Cryns, A. G., & Schimpfhauser, F. (1990). Correlates of entering medical students' attitudes toward geriatrics. *Educational Gerontology*, *16*, 429-446.

Wong, R. (1990). Negative attitudes toward chronic care intervention: Overview of a growing challenge. *Geri-topics*, *13*(2), 11-14.