Patient care: Is interpersonal trust missing?

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Abstract

Background: Health statistics and studies in the Caribbean have omitted interpersonal trust in their investigations. Aims: This study will examine the effect of interpersonal trust and other conditions on psychosocial subjective wellbeing and self-reported health, in order to assess the significance of interpersonal trust, as well as other socio-demographic factors on health. Materials and Method: The current study utilized primary data commissioned by the Centre of Leadership and Governance, Department of Government, the University of West Indies, Mona, Jamaica, between July and August 2006. It was a nationally representative probability sampling survey. A sample of 1,338 respondents was interviewed with a detailed 166-item questionnaire. Results: Generally, the psychosocial subjective wellbeing of Jamaicans was high (mean = 6.8 ± 1.8), and self-reported health was moderately high (mean = 6.3 ± 2.6). The current study has revealed that income, political system, subjective social class, employment status, and interpersonal trust determine psychosocial subjective wellbeing as well as self-reported health. Interpersonal trust accounted for between 9.4 to 10.4% of the explanatory power of the wellbeing and self-reported health of Jamaicans. Conclusion: The current study highlights that the determinants of health include interpersonal trust. It is critical to point out here that trust must be taken into consideration in any evaluation of health statistics, as it is a factor of subjective wellbeing and health. It is within this context that clinicians need to incorporate interpersonal trust along with other conditions, as it is a part of the psychosocial determinants of health, subjective wellbeing, and health treatment.

Keywords: Interpersonal trust, self-reported health, psychosocial subjective wellbeing, patient care, Jamaica.

Introduction

In the developing nations, and particularly in Jamaica, an extensive review of the health literature has revealed that there is a paucity of information in clinical studies on the effect of interpersonal trust on health, subjective wellbeing or quality of life, in reference to patient care. In the 1950s, Engel warned clinicians against the overemphasis of biological variables in treating ill patients, as he noted that the causes of morbidity were owing to multidimensional conditions [1-5]. Prior to the postulations and works of Engel [1-5], the WHO in its 1948 Constitution had broadened the conceptual definition of health, accentuating the importance of non-biological variables in the image of health and its treatment [6]. The WHO’s definition of health highlighted the need to have an image of health that goes beyond illness (injury), which was later seen as negative health or minimization of health [7]. Health, according to the WHO, is social, physical and psychological wellbeing, which speaks to the maximization (positive nature) of health [7, 8] and not merely the absence of disease (dysfunction) or infirmity.

Health is not merely the absence of disease-causing pathogens; psychologists refer to this as ill-health (or negative health) and not health in its broad context [7, 8], but exactly what constitutes health? Much of health statistics continue to measure ill-health and not health. This is a part of the rationale for the use of morbidity
statistics to evaluate health. In addition to illnesses, mortality, which is widely used in health research, embodies life expectancy but not healthy life expectancy. Some psychologists argue that ill-health does not speak to what causes ‘good’ health (or positive health). This is in keeping with the broad definition outlined by the WHO in 1948. Bok [9] and Crisp [10] opined that the conceptual framework outlined by WHO is elusive, as it is too broad to measure. They believed that positive health, which includes what constitutes ‘good’ health, is indefinite, and that the WHO failed to provide a listing of the items that are included (and not included) in the framework. Both scholars provided the health discourse with some potent arguments, but their postulations can to a certain extent be answered in this paper.

According to Bok and Crisp, the WHO definition is too broad, but they have not put forward an alternative that would capture the positive aspects to health. Grossman [11], however, established a theoretical framework in 1972 that approximates the determinants of ‘good’ health. He used econometric analysis to establish the predictors of health using the principle of positive health. This was later modified by Smith & Kington [12] who were able to expand on the variables. Those scholars identified socio-demographic and economic variables that determine the health of people. One of the limitations of their work is their use of functional limitation to proxy health, and another is that not all the socio-demographic and psychological conditions were included at the time of their studies. The use of functional limitation is still equivalent to using diseases or ill-health (or disease-causing pathogens), as functional limitation speaks to the biological state of the individual.

Other scholars have used happiness to proxy health (or wellbeing) [13-27]. Diener did pioneer work [13] when he established that happiness is a good proxy for wellbeing. He called the area subjective wellbeing, as it was self-reported happiness. Since then some economists such as Easterlin [22-26] and DiTella and MacDonald [23] have begun using happiness to measure subjective wellbeing. Recently a Caribbean scholar (26-28) expanded on the proxy for wellbeing by constructing an index to coalesce economic wellbeing (proxied by material possessions) and an individual’s health conditions. This means that instead of speaking of health, using the positive health approach, it has been replaced by wellbeing in health research.

Grossman [11], Smith & Kingston [12], Easterlin [22-26] and Hambleton and colleagues [28] have established the socio-demographic and economic predictors of wellbeing (or health). Michael Pacione has extensively researched quality of life and the role played by the environment in determining people’s wellbeing [12, 29], indicating that one more determinant of health is the environment. Using multivariate analysis, Bourne [25-27] concurred with the findings of the aforementioned scholars but added to the discourse. The latter scholar found that physical environment accounted for 3.4% out of a 39.3% variability in the wellbeing of Jamaicans [27] – it ranked 11th of 14 predictors, and when the elderly population (ages 60 years and older) was used this same variable was ranked 3rd of 13 determinants [25]. Embedded in this finding is the importance of the effect of the physical milieu on the wellbeing of different age cohorts, and the fact that the environment does influence wellbeing.

The current study bridges the gap in the literature, by answering a number of questions in regard to general health and trust, and the different components of psychosocial wellbeing and trust. Recently a nationally representative probability survey, conducted by Powell, Bourne & Waller [30] found that 14.1% of Jamaicans revealed that they trusted other persons, and approximately 47.5% less respondents indicated trusting the government. Fukuyama [31] in a seminal work established that trust is a crucial component of cooperation, which is a pivotal factor in determining production, a healthy democracy, and family. This suggests that interpersonal trust (trust) is primary to business transactions, democracy, family, production, and economic growth, which begs the question, ‘What about trust and wellbeing?’ Should a clinician take interpersonal trust into account in health treatment? These questions will be answered in this paper.

Materials and Methods

Analytic Model

It is well established in the literature that wellbeing is determined by socio-demographic, economic, psychological and environmental conditions [11, 12, 25-29]. The current study seeks to ascertain the predictor factors of wellbeing, and so we will use the analytic theoretical model utilized by Bourne [27].

Using a sample of 1,147 respondents which was extracted from one of the 2002 Jamaica Survey of Living Conditions datasets, Bourne [27] developed a linear model that captured some explanatory factors of the wellbeing of Jamaicans. He found that 10 factors accounted for 39.3% of the variability of wellbeing of Jamaicans. Those factors are embodied in the linear model below:

\[
\text{Wellbeing} = \alpha + \beta_1 \text{Gender} + \beta_2 \text{Area of Residence} - \beta_3 \text{Environment} + \beta_4 \text{Marital Status} + \beta_5 \text{Age} + \beta_6 \text{InCrowding} + \beta_7 \text{Psychological conditions} + \beta_8 \text{Educational level} + \beta_9 \text{Social support} + \beta_10 \text{Landownership} + \epsilon \]

Eq (1)

For the purpose of this study, given that the dependent variable (psychosocial wellbeing) is a normally distributed metric variable, the analytic model used by Bourne can be utilized for this paper. A new set of variables will be used for the current research. These include trust, confidence in socio-political institutions, religiosity, income, extent of welfare system of the state and social class.

\[
\text{Psychosocial Subjective Wellbeing} = \alpha + \beta_1 \text{Gender} + \beta_2 \text{Age} + \beta_3 \text{Social Class} + \beta_4 \text{Confidence} + \beta_5 \text{Extent of welfare system} + \beta_6 \text{Political governance of nation} + \beta_7 \text{Interpersonal trust} + \beta_8 \text{Governmental trust} + \beta_9 \text{Religiosity} + \beta_10 \text{Income} + \epsilon \]

Eq (2)
Self-reported Health status = \( a + \beta_1 \text{Gender} + \beta_2 \text{Age} + \beta_3 \text{Social Class} + \beta_4 \text{Confidence} + \beta_5 \text{Extent of welfare system} + \beta_6 \) 

\text{Political governance of nation} + \beta_7 \text{Interpersonal trust} + \beta_8 \text{Governmental trust} + \beta_9 \text{Religiosity} + \beta_{10} \text{Income} + \varepsilon

The current study used primary data from a survey which was commissioned by the Centre of Leadership and Governance, Department of Government, the University of the West Indies (UWI). The survey was conducted between July and August 2006, and was sponsored by the Office of the Principal, UWI, the Department of Government, UWI, Mona, and the Mona School of Business, UWI, Mona, Jamaica. It was a nationally representative probability sampling of 1,338 Jamaicans. The sampling frame was an adaptation of the sample design used by the Statistical Institute of Jamaica. Jamaica was divided into 14 parishes and each parish was further sub-divided into enumeration districts, which effectively compartmentalizes each geographical zone. Respondents were then randomly selected based on enumeration district, parish of residence, gender, and marital status.

The instrument that was used to collect the data was a 166-item questionnaire which covered the socio-demographic characteristics of the sampled population: democracy, trust and confidence in socio-political institutions, crime, corruption, and the unequal treatment of individuals, leadership, party and electoral preferences and subjective psychosocial wellbeing. The interviewers were selected from the trained data collectors of the Statistical Institute of Jamaica and the Social Development Commission. Despite that fact, all the selected interviewers were trained to address the concerns of the interviewees.

The instrument consisted of questions taken from national political polls conducted by Professor Carl Stone; Latinobarometer and Eurobarometer cross-sectional series; the American National Election Studies; Harvard/Washington Post Leadership surveys, the New Zealand Election Surveys, and the Cross-cultural Variations in Distributive Justice Perception Survey. On completion of the instrument, the questionnaire was vetted by scientists in the various related fields. Two hundred questionnaires were pilot-tested in the field (Jamaicans), after which another set of corrections was made.

**Measures**

The Psychosocial Subjective Wellbeing Index (PSWI) variable measures the self-reported wellbeing of an individual taken from Abraham Maslow’s 5-Need Items. Each of the 5 Items is measured on a 10-point Likert Scale, ranging from 0 to 10. The 5-Item Scale includes (i) state of health, (ii) basic necessities, (iii) social needs (a life full of love, warmth, friendship and family relations), (iv) self-esteem and recognition, and (v) self-actualization. The PSWI is the average summation of the 5-Item Scale, in which low values indicate low psychosocial subjective wellbeing, and higher scores represent greater PSWI, with the minimum score being 0 and the maximum 10. The reliability of the measure was tested, and the Cronbach alpha was 0.762. Thus, the W index is interpreted as: from 0 to 3.9 low; 4.0 to 6.9 moderate; 7.0 to 8.9 high and 9.0 to 10 very high.

The Confidence in Socio-political Institutions Index (CSPII) measures the degree of an individual’s confidence in public, private and social institutions in Jamaica. The CSPII is the summation of 22 questions. The questions read “And now for a similar question… I am going to read to you a list of major groups and institutions in our society. For each, tell me how much CONFIDENCE you have in that group or institution”. For each, do you have from 0 (no confidence) to 4 (a lot of confidence) – Police, Family, Political Parties, Churches, Large Companies and Corporations, Government, Universities, the Private Sector, Banks, the Prime Minister, the Judiciary, the Armed Forces, Parliament, the Governor General, Local Government, Newspapers, Television, Radio, the People’s National Party and the Jamaica Labor Party. The final index is the summation of 22 items, with a minimum score of 0 and a maximum of 87. Reliability testing was done on this measure, which was 0.896 (Cronbach alpha). Thus, the confidence index is interpreted as: from 0 to 34 representing very little confidence, 35 to 61 low confidences, 62 to 78 moderate confidence and 79 to 88 most confidence.

Interpersonal Trust: The question which was asked is “Generally speaking would you say that most people are essentially good and can be trusted; or that most people are not essentially good and cannot be trusted?” The two options are 1) Can be trusted, and 2) Most people not essentially good and cannot be trusted. This variable is a dummy variable where 1 = can be trusted and 0 = otherwise (cannot be trusted).

Trust in government: This is a dummy variable where 1 = can be trusted and 0 = otherwise (never be too careful). The question that was asked is ‘Would you say most persons in the Jamaican government can be trusted to keep their promises, or that you can never be too careful in dealing with people in government?’

Extent of the Welfare system: This is the summation of 14 items in which each option is a 10-point Likert Scale question. For each item, 1 indicates that the person should take full responsibility and 10 means the government must take the responsibility for providing the item. Lower scores mean that the individual is responsible for the various issues, and higher scores indicate governmental assistance. The reliability testing of the construct was 0.847.

Self-reported Health Status is based on the single question “How do you rate the state of your health?” with 10 possible responses (ranging from 0 to 10). It accounted for the self-rated health status of each person.

**Statistical analyses**

For this paper, the researcher will test (1) the hypothesis
that psychosocial subjective wellbeing is a function of some predisposed explanatory variables (socio-demographic conditions, political governance of the nation, extent of the welfare system of the nation, interpersonal and governmental trust, confidence in socio-political institutions and (2) self-reported health status as a function of the aforementioned explanatory conditions. In each of the analyses, using the principle of parsimony, those variables that had no statistical difference \((P > 0.05)\) were omitted from each equation (2 or 3). Hence, for those variables that were statistically significant \((P < 0.05)\), the explanatory power of each model was disregarded to provide the contribution of each factor.

Results

Socio-demographic characteristics

Of the sample of 1,338 respondents, the general response rate was 96.9% \((N = 1,297)\). Of those who responded, 44.3% were males \((N = 574)\) compared to 55.7% females \((N = 723)\). The mean age of the sample was 34.95 years \((\pm 15.6\) years). In addition, 59% of the sample classified themselves as being in the lower class \((N = 766)\), 74% \((N = 984)\) were employed, 18.5% had post-secondary level education and 26.4% indicated having tertiary and professional education. Generally, the mean psychosocial subjective wellbeing of Jamaicans was high \((6.8\) out of 10), with the mean self-reported health status being 6.3. Respondents indicated moderate confidence in socio-political institutions \((56.5\) out of 87) (Table 1).

| Variable          | Number | %  |
|-------------------|--------|----|
| **Gender**        |        |    |
| Male              | 574    | 44.3|
| Female            | 723    | 55.7|
| **Subjective social class** |        |    |
| Working (lower) class | 766  | 59.0|
| Middle class      | 476    | 36.6|
| Upper class       | 57     | 4.4 |
| **Educational level** |        |    |
| Primary and below | 60    | 4.6 |
| Secondary         | 653    | 50.5|
| Post-secondary    | 239    | 18.5|
| Tertiary and professional | 339 | 26.4|
| **Employment Status** |       |    |
| Employed          | 984    | 74.0|
| Other             | 345    | 26.0|

Age \((\text{mean} \pm \text{SD})\) 34.95 \pm 13.57; Range: 16 to 85 years. Psychosocial wellbeing \((\text{mean} \pm \text{SD})\) 6.8 \pm 1.8; Range: 0 to 10; Median = 7, Mode=7.8

Self-reported health status 6.3 \pm 2.6; Range: 0 to 10; Median =7, Mode=8.0. Extent of welfare system \((\text{mean} \pm \text{SD})6.8 \pm 1.5;\) Range: 1.3 to 10Confidence in institutions \((\text{mean} \pm \text{SD})56.5 \pm 11.3;\) Range: 3 to 87.

Analytic Model

The psychosocial subjective wellbeing of Jamaicans is influenced by 6 explanatory factors. These factors (income, subjective social class, political system, interpersonal trust, employment status, and religiosity) accounted for 16.3% of the variability in psychosocial subjective wellbeing (Table 2). Income accounted for 7.7% of the explanatory variability in psychosocial subjective wellbeing, which was 3.2 times more than the second most influential factor, subjective social class \((2.4\%\), middle class with reference to lower class). Following the two aforementioned factors, the political system accounted for 2.0% of the explanatory power, with interpersonal trust accounting for 1.7%.

Decomposing those 4 factors revealed that interpersonal trust was 10.4% of the 16.3% explanatory power of psychosocial subjective wellbeing of Jamaicans (Table 3).

### Table 1: Socio-demographic characteristics of sample (n: 1,297)

| Variable          | Number | %  |
|-------------------|--------|----|
| **Gender**        |        |    |
| Male              | 574    | 44.3|
| Female            | 723    | 55.7|
| **Subjective social class** |        |    |
| Working (lower) class | 766  | 59.0|
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| **Employment Status** |       |    |
| Employed          | 984    | 74.0|
| Other             | 345    | 26.0|

### Table 2: Multiple regressions: Psychosocial subjective wellbeing and explanatory variable

| Explanatory Variable | Coefficient | Std. Error | Beta | 95% CI |
|----------------------|-------------|------------|------|-------|
| Constant             | 6.018       | 0.207      | 5.612| -6.424|
| Income               | 0.062       | 0.013      | 0.172| -0.037|-0.087*** |
| Middle class         | 0.707       | 0.126      | 0.190| 0.460|0.954*** |
| Lower class          | 0.853       | 0.368      | 0.093| 0.250|1.457*** |
| Political system     | -0.505      | 0.134      | -0.123| -0.786|-0.243*** |
| (1=Benefits most)    | 0.480       | 0.120      | 0.130| 0.244|0.715*** |
| (1=Trust)            | 0.580       | 0.157      | 0.127| 0.272|0.888*** |
| Employed             | -0.064      | 0.027      | -0.077| -0.116|-0.011*** |

### Table 3: Disaggregating the r-square change in the psychosocial subjective wellbeing model

| Explanatory Variable | R square change (%) | Std. Error |
|----------------------|---------------------|------------|
| Income               | 7.7                 | 1.71       |
| Social class – middle class | 2.4       | 1.69       |
| Political system of governance | 2.0       | 1.67       |
| Interpersonal trust  | 1.7                 | 1.66       |
| Employed             | 1.1                 | 1.65       |
| Social class – upper class | 0.8       | 1.64       |
| Religiosity          | 0.6                 | 1.64       |

### Table 4: Multiple Regression: Self-reported health status and explanatory variable

| Explanatory Variable | Coefficient | Std. Error | Beta | 95% CI |
|----------------------|-------------|------------|------|-------|
| Constant             | 4.838       | 0.294      | 4.260| 5.415 |
| Income               | 0.043       | 0.020      | 0.079| 0.003|0.082*** |
| Middle class         | 0.817       | 0.199      | 0.146| 0.427|1.207*** |
| Upper class          | 1.228       | 0.485      | 0.089| 0.275|2.181*** |
| (1=Lower class)      | 0.885       | 0.250      | 0.128| 0.394|1.376*** |
| (1=Trust)            | 0.452       | 0.189      | 0.081| 0.082|0.823*** |
| Male                 | 0.451       | 0.185      | 0.084| 0.088|0.813*** |
| Dummy political system | -0.461       | 0.211      | -0.074| -0.874|-0.047*** |

Of the 10 identified variables in this case, 6 of them accounted for 8.5% of the variability in self-reported health status (Table 4). Those factors are income, subjective social class, employment status, interpersonal trust, gender of respondents and political system. Income,
which is 3.1% of the model, accounted for 36.5% of the explanatory variability of the self-reported health status of Jamaicans (Table 5).

Table 5 Disaggregating the r-square change in the health status model

| Explanatory Variable | R Square change (%) | Std. Error |
|----------------------|---------------------|------------|
| Income               | 3.1                 | 2.65       |
| Middle class         | 1.2                 | 2.63       |
| Employed             | 1.4                 | 2.62       |
| Upper class          | 0.9                 | 2.61       |
| Interpersonal trust  | 0.8                 | 2.60       |
| Male                 | 0.6                 | 2.59       |
| Political system     | 0.5                 | 2.58       |

Discussion

The use of prevalence study to aid clinicians has a fundamental limitation, as it does not provide causation, which is frequently used by health practitioners in patient care. It is well established in the literature that health can be assessed using cross-sectional data [1-28]. Another important element within this discussion is the use of self-assessment of one’s health status [12, 18] instead of the use of disease-causing pathogens [7]. The WHO’s conceptual definition of health has long established that using ill-health to evaluate health is unidirectional, an idea which was supported by Engel [1-5]. Therefore, when Grossman [11] and other scholars [12, 25-28], using cross-sectional data, examined the factors that influence health (or wellbeing), these were in keeping with potent research that provides health research with a better understanding of how patient care can be used, and by extension treated by health practitioners.

Using psychoanalytic theories, Saddock and Saddock [32] remarked that the absence of symptoms as a single factor is not sufficient for a comprehensive outlook on normality. Among the challenges with this method (biomedical model), is its emphasis only on curative care. Such an approach omits the importance of life style and preventative care. There, health is measured based on experiences with illnesses and/or ailments, with limited recognition being placed on approaches that mitigate against sickness and/or diseases. The biomedical approach is somewhat biased against an understanding of multi-dimensional people, which is not in keeping with the holistic conceptualization of health as offered by the WHO.

Individuals comprising the middle class do not have the same degree of wealth as those in the wealthy classes, but their educational attainment is such that they are clearly more health conscious, which accounts for their healthier lifestyle behavior. Income affords the purchase of particular commodities and services which include health practitioners and better physical milieu, but the lifestyle of the wealthy erodes this reality. Middle class individuals, on the other hand, do not possess the riches of the wealthy, but they are able to add more healthy years to their lives by their health consciousness. The literature has shown that income [11, 12] and employment do improve wellbeing, and that it is accomplished through the purchase of particular material goods [23, 33-35]. The current research concurs with this. Sen, however, was quick to point out, in rebuttal, that data analyzed have shown that some countries (i.e. Sri Lanka, China and Costa Rica) have had reduced mortality without a corresponding increase in economic growth [36,37], and that this was attained through other non-income factors such as education, nutrition, immunization, expenditure on public health and poverty eradication. Hence, this explains the rationale for the middle class exhibiting a higher non-economic wellbeing than the affluent classes, as education is a good predictor of wellbeing through knowledge, options, choice and self efficacy of the individual. The lower class (poor) has the least self-reported health status, as the lack of money deprives them of the opportunity to purchase particular goods and afford certain health care services. A group of scholars in a study opined that low income is associated with poor health, as they found that people from the bottom 25 percent of the income distribution self-reported poorer subjective health by 2.4 times more than people in the fifth quintile [38]. This is supported by the present research, as the study revealed that the poor had the least self-reported health and psychosocial subjective wellbeing.

Trust appears secondary to many Caribbean scholars in health studies. Fukuyama has postulated that trust is crucial to family, co-operation, business transactions, democracy and production, but ‘what about trust and wellbeing?’ In this study, it has been revealed that interpersonal trust is positively associated with self-reported health and psychosocial wellbeing, suggesting that low interpersonal trust lowers health status.

Psychological conditions are well established in the health or health psychology literature as being correlated with wellbeing or health [8, 13-18]. People’s psychological states are considered to be a good indicator of their general health status. Some psychologists such as Diener and Lyubomirsky [39] have extensively examined happiness, which is one of the components of the psychological state of the individual in capturing subjective wellbeing. They argue that happiness is a good proxy of subjective wellbeing, as it captures people’s life satisfaction and thereby assesses their general quality of life.

In seeking to unearth why some people are happier than others, Lyubomirsky [39] approached the study from the perspective of positive psychology. She noted that to comprehend the disparity in self-reported happiness between individuals, “one must understand the cognitive and motivational processes that serve to maintain, and even enhance, happiness and transient mood” [39]. Using positive psychology, Lyubomirsky [39] identified comfortable income, robust health, supportive marriage, and lack of tragedy or trauma in the lives of people as factors that distinguish happy from unhappy people,
something which was discovered in an earlier study by Diener, Suh, Lucas and Smith [40]. In an even earlier study by Diener, Horwitz and Emmon [41], they were able to add value to the discourse of income and subjective well-being. They found that the self-reported wellbeing (personal happiness) of the wealthy (those earning in excess of US 10 million, annually) was marginally more than that of the lower wealthy.

It has been found that happier people are more optimistic, and as such they conceptualize life's experiences in a positive manner. Self-fulfilment and self-esteem will transform the individual into a happier person who in the long run views life's challenges and situations as experiences, and thereby makes decisions in a completely different way from someone who is negative or pessimistic. Thus, goal achievement and self-actualization are critical components in positivistic affective conditions, and they do directly influence people's wellbeing [42, 43, 44]. Studies reveal that positive moods and emotions are associated with well-being [45] as the individual is able to think, feel and act in ways that foster resource building and involvement with particular goal materialization [46]. This situation is later internalized, causing the individual to be self-confident, from which follow a series of positive attitudes that guide further actions [47]. Positive mood is not limited to active responses by an individual, but a study showed that "counting one's blessings", "committing acts of kindness", "recognizing and using signature strengths", "remembering oneself at one's best", and "working on personal goals" all positively influence well-being [46, 48]. Happiness is not a mood that does not change with time or situation; hence, happy people can experience negative moods [49].

Trust is a psychological phenomenon. It is built around cognitive responses [50] to past performances, accountability and character, which explains other psychological responses to events such as cooperation, cohesiveness, togetherness, acceptance of weaknesses and strengths, acceptance of the fact that people can make mistakes and that they should be forgiven. Those conditions are all responses to the stimulus called trust. Hence, low trust can be compared to negative psychological conditions which correlate negatively to health or subjective wellbeing. High trust, on the other hand, is comparable to positive affective psychological conditions, and thereby justifies the relationship with increased health or subjective wellbeing. A group of scholars examining social capital found that the lack of social capital provides a greater risk of poor self-rated health than greater social capital [50]. In that study social capital was proxied by civic trust, political trust, political participation and civic participation. Unlike this study, which examines interpersonal trust as it relates to general self-reported health or overall wellbeing, Engstrom, Mattsson, Jarleborg & Halldqvist's work [50] coalesces civic and political trust to proxy cognitive social capital, and therefore does not deconstruct how the civic (interpersonal) trust is associated with self-rated health.

In this study, it was found that a positive statistical association exits between trust and health as well as subjective wellbeing, suggesting that low trust is directly related to lower health, and that high trust is positively associated with better health. Hence, when Fukuyama [31] opined that trust was crucial to democracy, production, co-operation, family, social relationships and economic growth, he stopped short of saying that trust is equally critical to wellbeing. The literature as well as the current study concurs on the finding that income is positively associated with wellbeing, and when Sen argued that income is directly associated with economic growth, and by extension standard of living (or wellbeing), it should not be surprising that trust, which is a sub-tenet of economic growth, production, productivity, co-operation and positive affective psychological conditions should be directly related to health or subjective wellbeing.

Mistrust, which is synonymous with low trust, is therefore related to low health and subjective wellbeing. Mistrust relates to cynicism, apprehension, withdrawal of the individual from unfettered involvement in activities with other people, hostility and suspicion, and these are all elements of negative affective psychological conditions as well as low subjective wellbeing. Among the crucial components of mistrust is suspicion, which is responsible for people's reservations about willingly participating with other persons, as they believe that the next person only seeks to advance his/her personal interest. Within this context, mistrust makes people unresponsive to welcoming the contributions of other persons, as they are continuously analyzing people's actions, attitudes and behavior for their own selfish motives. However, this behavior negatively correlates with subjective wellbeing, and can result in paranoia and thence low health status of the individual; it may also result in a greater tendency to commit suicide.

Culturally, Caribbean men are socialized to be macho, which accounts for their failure to appreciate weakness, as it is interpreted to be feministic [51]. One of the indicators of weakness is ill-health, and this goes to the core of the rationale for their choosing not to report health conditions. Studies have shown that there is a disparity between gender and health [52], an idea with which the current research concurs. Hence, within the context that women report and seek more health care than men, it should not be surprising that they outlive men, and in Jamaica by as much as 6 years. Women do not only outlive men in Jamaica, but they do in other nations as well [53, 54].

Biomedical studies have shown that there are gender specific diseases. The examples here are prostate cancer (affecting only men) and uterine cancer (affecting only women). Rice believed that this health difference between the sexes is due to social support. According to Rice [52], it can be explained by epidemiological trends. Lifestyle practices may justify the advantages that women enjoy compared to men concerning health status. However, a survey done by Rudkin found that women have lower levels of wellbeing (i.e. economically) than men [55]. This finding is further sanctioned by Haveman et al. [56] whose
study revealed that retired men’s wellbeing was higher than that of their female counterparts, because men usually received more material resources, and more retirement benefits compared to women aged 65 years and over. Thus, with men receiving more than women, and having more durable possessions than women, their material wellbeing is higher in later life. This study contradicts other studies that have shown that females had greater health status than males [57]. However, the finding of this work concurred with a study that was done in 2002 on the elderly population by a group of scholars, which revealed that men reported less dysfunction compared to women, suggesting that they had greater health status, which was also the finding in the Jamaica Survey of Living Conditions [56]. That study [57] noted that despite greater self-reported health conditions by females than males, there were particular diseases that the latter reported more than the former, such as heart disease, neoplasm, viral diseases, tuberculosis, and respiratory conditions.

Conclusion
In summary, the current study highlights that the determinants of health (or wellbeing) include interpersonal trust. It is critical to point out here that trust must be taken into consideration in any evaluation of health statistics, as it is a factor of subjective wellbeing and health.

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