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The relation between anorexic symptoms in women and their reports of trustworthiness in interactions with close persons

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ABSTRACT

The study examined the relation between women's anorexic symptoms and their reports of trustworthiness in interactions with close persons. Ninety-eight females (mean age = 24 years-10 months) completed the anorexic symptom subscale of the SEDS and reported (ascribed) the extent to which they showed reliability, emotional, and honesty trustworthiness behaviors in interactions with their mother, father, and close friend. Negative linear relations were found between anorexic symptoms and ascribed: (a) trustworthiness with close friends; (b) reliability trustworthiness; and (c) at a trend level, honesty trustworthiness. These were qualified by curvilinear relations and by elevated anorexic vs normative group comparisons. It was found that women with elevated anorexic symptoms ascribed lower trustworthiness than did women with the normal range of anorexic symptoms. The findings were interpreted as supporting the conclusion that women with elevated levels of anorexic symptoms are inclined to believe that they are deceptive in their interactions with close persons, primarily friends.

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1. Introduction

Anorexia Nervosa (AN) poses serious psychosocial and health problems for women (see Ng, Cheung, & Chou, 2013a, 2013b) including an increased risk of mortality (Hoek & van Hoeken, 2003a, 2003b; Mustelin et al., 2015). It has been estimated that between 3% to 10% of females between 15 and 29-years of age show AN (Polivy & Herman, 2002; also see Hoek & van Hoeken, 2003a, 2003b). Research has shown that AN is the result of neurological problems (Hatch et al., 2010), interpersonal problems (Keel & Forney, 2013), and dysfunctional emotion regulation (Oldershaw, Lavender, Sallis, Stahl, & Schmidt, 2015).

Some research has shown that women with AN engage in secretive food consumption, hide their eating pathology, misrepresent themselves to others, and experience being fraudulent and living a lie (Bruch, 1973; Dalzell, 2000; Minuchin, Rosman, & Baker, 1978). These conclusions have been drawn, though, from interviews and case studies which have questionable replicability and generalizability. There is scarcity of quantitative research that has examined whether not those are attributes of women with AN. The purpose of the current study was to fill-in that gap in our knowledge. The study was designed to examine whether or not AN in young women, as indexed by anorexic symptoms, is associated with their reports of behaving is an untrustworthy fashion in interactions with close persons.

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1.1. Conceptualization and measurement of trust

The current investigation of trustworthiness was guided by the Bases, Domains, and Domains (BDT) interpersonal trust framework developed by Rotenberg, and his colleagues (see Rotenberg, 2010; Rotenberg et al., 2008), The BDT comprises 3 Bases (reliability, emotional, and honesty) × 3 Domains (cognitive-affective, behavior-dependent trust, and behavior-enacting) × 2 Target Dimensions of interpersonal trust (specificity and familiarity). The reliability basis pertains to keeping a word or promise. The emotional basis pertains to refraining from emotional harm. Finally, the honesty basis pertains to telling the truth as opposed to lying. Those span three domains: (1) cognitive-affective which comprises attributions/beliefs and accompanying affect, (2) behavior-dependent trust which comprises the reliance on others to be trustworthy and (3) behavior-enacting which comprises engaging in trustworthy behaviors. The bases and domains are further differentiated by dimensions of: (a) specificity which ranges from general trust to a specific person and (b) familiarity which ranges from slightly unfamiliar to very familiar. The framework posits that individuals show reciprocity and tend to match the trust of others, notably in dyadic interaction. This process results in a shared common social history.

The BDT framework has guided the development of a number of scales to assess trust. These have assessed the three bases (reliability, emotional, and honesty) of trust beliefs in a range of target persons such as mother, father, teacher, peers, and physician (Betts, Rotenberg, & Trueman, 2009a; Rotenberg et al., 2005; Rotenberg et al., 2008). Rotenberg (1994, Study 3) modified those scales to assess the extent

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to which individuals believe that they are trusted by others in social interaction. (These judgments will be referred to as *ascribed trustworthiness*.) Rotenberg (1994, Study 3) found that young adults' loneliness was negatively correlated with their ascribed trustworthiness in interactions with close friends. The research showed that, in contrast, there was a lack of an appreciable correlation between young adults' loneliness and their trustworthiness in those interactions as reported by their close friends themselves. Overall, the findings were interpreted as showing that close friends do not share lonely individuals' view that they are untrustworthy in social interaction. The ascribed trustworthiness employed by Rotenberg (1994, Study 3) were used the current study to investigate whether AN symptoms in women are negatively associated with reports of trustworthiness (reliability, emotional and honesty) in interactions with close persons: mother, father, and close friend.

1.2. Dysfunctional family and peer relationships of women with AN

Researchers have found that women (and men) with AN experience atypical family relationships. There is evidence that an array of family problems, notably parenting factors, are associated with AN in women such as: (a) parents' attitudes to their own and their children's eating and weight; (b) insecure attachment and unresolved loss in the patient and her parents; (c) family difficulties in resolving conflict; (d) parental psychological control and (e) parental expectations of conformity (for a review see Dring, 2015). Dalzell (2000) summarized reports of cases and interviews in previous research (Bruch, 1973; Minuchin et al., 1978) to arrive at the conclusion that women with AN have highly secretive family relationships which caused them to conceal their activities (including their atypical eating behaviors). It was argued that that undermined trust among family members and caused women with AN to develop false-self organizations. Guided by these reports and conclusions, the current study was guided by the hypothesis that AN symptoms in women would be negatively associated with their ascribed trustworthiness in social interactions with family members, notably mother and father.

Having inadequate peer relationships also appears to play a role in AN for women. Research indicates that females learn eating-related attitudes and behaviors from peers (e.g., the desirability of slimness and dieting) during the course of adolescence and that this leaning contributes to AN (see Polivy & Herman, 2002). Also, it has been found that women with AN have fewer close friends during childhood than women without that disorder (Mangweth et al., 2005). The current study examined whether AN symptoms in women would be negatively associated with their ascribed trustworthiness in their social interactions with close friends.

1.3. Discontinuous vs continuous models of psychopathology

Practitioners and researchers have been concerned with the issue of discontinuity versus continuity in the nature and assessment of psychopathology from the beginning of clinical psychology. According to a continuous formulation, psychopathology represents a continuum of symptoms which differ only in their severity. According to the discontinuous formulation, psychopathology is a qualitative phenomenon that comprises a unique set of symptoms – a diagnostic category identified by the DSM-V for example. Researchers guided by the discontinuous formulation while using self-report scales, assess the psychopathology from scale scores exceeding established “cut-off points” (see Connell et al., 2007). The practice of using cut-off points to assess AN is exemplified by Allan and Goss (2014).

A statistical technique of distinguishing between the continuous and discontinuous approaches to psychopathology entails the identification of a given quadratic relation between symptoms of psychopathology and criterion measures. If observed, the quadratic curve demonstrates a point of inflexion (an abrupt shift) in the relation between the symptoms of psychopathology and the criterion measures which serves to identify the cut-off point. As an example of this statistical technique, Lahey et al. (1990) found a quadratic relation between the number of DSM-III-R symptoms in boys and their antisocial behavior as indexed by police contacts and disciplinary contacts. DSM-III-R symptoms only statistically predicted elevated antisocial behavior when the symptoms exceeded the cut-off point corresponding to the abrupt shift on the quadratic curve. This is also exemplified by Qualter, Rotenberg, Barrett, and Henzi (2013) who found quadratic relations in the relation between children's loneliness and their hypersensitivity to rejection. Only children who exceeded a given level of loneliness, as indexed by the abrupt shift in the quadratic curve, showed evidence of hypersensitivity to rejection.

The current study examined whether or not there was a quadratic relation between anorexic symptoms in women and their ascribed trustworthiness to close persons. The observation of a quadratic relation would yield support for a discontinuous approach. The abrupt shift in the quadratic curve would serve to identify the cut-off point for anorexic symptoms.

1.4. Hypotheses guiding the current study

The current study was guided by the hypothesis that there would be a negative association between anorexic symptoms in women and their ascribed trustworthiness in interactions (reliability, emotional, and honesty) with close persons: mother, father, and close friend. It was hypothesized that there would be quadratic relations between anorexic symptoms and ascribed trustworthiness in interactions with close persons which included abrupt shifts – as cut-off points – in the relation between the two variables. It was anticipated that women with elevated levels of anorexic symptoms (i.e., those who exceeded those cut-off points) would report lower ascribed trustworthiness with close persons than would women with the normal range of anorexic symptoms. The study included a test of differences in women's ascriptions of trustworthiness in interactions with the three close persons. Observed differences in ascribed trustworthiness to the three persons could provide a frame of reference from which to understand the potential deficits in ascribed trustworthiness for women with elevated levels of anorexic symptoms.

2. Method

2.1. Participants

The participants were 98 females who were enrolled in a mid-sized university in the UK. They had a mean age of 24 years-10 months (*SD* = 10 years – 6 months) which ranged from 18 years to 63 years. The participants were solicited by advertisements on campus and on campus web sites.

2.2. Measures

2.2.1. Ascribed trustworthiness.

This was assessed by the modification of the 12 reliability and emotional trustworthiness scenarios (items) from Specific Interpersonal Trust scale (SITS; Johnson-George & Swap, 1982) in the form used by Rotenberg (1994; study 3). An additional 6 structurally similar scenarios were constructed to assess honesty trustworthiness. These items were used in the construction of the Specific Ascribed Trustworthiness Scale: SATS. For the SATS, the participant was asked to imagine that he or she was the person (*perpetrator*) in the scenarios which depicted him or her as potentially showing reliability, emotional, or honesty trustworthiness behaviors in interactions with a given close person (the *recipient*). The participant was present the18 scenarios and was asked to write the initials in the spaces designating the recipient as either his or her: Mother, father, or close friend. The participant judged on 5-point Likert scales the likelihood that he or she would exhibit the

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