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Title Page

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RUNNING HEAD: Anorexic Symptoms and Trustworthiness

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.

Key Words: Anorexic Symptoms, Trustworthiness, Close Persons, Women, Linear, and Curvilinear.

The Relation Between Anorexic Symptoms in Women and Their Reports of Trustworthiness in Interactions with Close Persons

1.0 Introduction

Anorexia Nervosa (AN) poses serious psychosocial and health problems for women (see Ng, Cheung, & Chou, 2013) including an increased risk of mortality (Hoek & van Hoeken, 2003; 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 & Hernan, 2002; also see Hoek & van Hoeken, 2003). Research has shown that AN is the result of neurological problems (Hatch, Madden, Kohn, Clarke, Touyz, & Williams, 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.

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 of 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 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 unfamiliar to very familiar. The framework posits that individuals show reciprocity and tend to match the trust of others, notably in dyadic interaction, which 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 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, Rosman, & Baker, 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 leaning contributes to AN (see Polivy & Hernan, 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 is 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 main differences in women's ascriptions of trustworthiness in interactions with the three close persons in order to provide a frame of reference from which to understand the potential deficits in ascribed trustworthiness for women with elevated levels of anorexic symptoms.

2.0 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

2.21 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 behavior depicted in the scenario with the given target. The SATS was designed to assess the participants reports of the extent to which they demonstrate reliability trustworthiness (i.e., keeping a promise or word), honesty trustworthiness (e.g., tell the truth), and emotional trustworthiness (e.g., maintaining confidentiality of personal information) in interactions with each of the three close persons (mother, father, and close friend).

The items for the final of the SATS were the result of the following statistical procedure. Some items were removed because they detracted from internal consistency of the three hypothesized bases (reliability, emotional, and honesty). This selection process was qualified by the principle that an equal number of items were needed to assess each of the expected three bases of trustworthiness. The final SATS (shown in Table 1) was composed of 9 items that contained 3 per trust basis (i.e., latent factor). The SATS was subjected to a confirmatory factor analysis using Structural Equation Modelling (SEM). It was hypothesized that the scale would be composed of three latent factors (reliability, emotional, and honesty bases) which had direct paths from 3 items (one from each close person per latent factor). The hypothesized model included covariances between each of the three latent factors and covariances between error terms that attained significance (see Byrne, 2001).

The SEM analyses of the hypothesized model showed that it was an adequate fit of the data with, $\chi^2(19) = 29.40$, $p = .06$, NFI = 95, CFI = .98 and RMSEA = .075. As expected, all

the paths between the raw items and their intended latent factors attained significance at $p <$ .05 and were of desirable weight (Standardized Betas $\geq$ .49). As expected, the covariances between the three latent factors attained statistical significance ($p < .05$). Furthermore, SEM analyses showed that two-factor and one-factor models of the scale were not adequate accounts of the data, confirming that the hypothesized three-factor model was the best fit.

The final SATS items were summed to construct subscales for ascribed trustworthiness with each of the three target persons (mother, father, and close friend) and for each of three bases (reliability, emotional, and honesty). There was acceptable internal consistency for the ascribed trustworthiness subscales: mother, $\alpha = .83$, father $\alpha = 88$, close friend $\alpha = .79$, reliability, $\alpha = 90$, and emotional, $\alpha = .77$, honesty, $\alpha = .77$. It was anticipated that the subscales scores would be skewed because of the social desirability of ascribed trustworthiness. The data confirmed that expectation and therefore the subscale scores were subjected to a log10 transformation in order normalized the distribution for the analyses.

2.2.2 Anorexic Symptoms. This was assessed by the cognitive and behavioural anorexic subscales of the Stirling Eating Disorder scale (SEDS). Each item of the Anorexic subscales is scored according to its endorsement by patients who had been clinically diagnosed as having AN. The Anorexic subscales from SEDS have demonstrated acceptable internal consistency (αs from .56 to .89) and test-retest reliability (r's . 90 to .97, $ps < .001$) (Campbell et al., 2002; Gamble et al., 2006; Williams et al., 1994). As evidence for validity of the SEDS, researchers have found that the anorexic subscales on the SEDS successfully differentiate between individuals clinically diagnosed with Anorexia Nervosa from those diagnosed with Bulimia Nervosa, eating disorders otherwise not specified or no eating disorders (Campbell et al., 2002; Gamble et al., 2006; Williams et al., 1994).

In the current study the Anorexic cognition subscale was correlated with the Anorexic behavior subscale, $r(96) = .56$, $p < .001$. Therefore the two subscales were summed to yield a

total Anorexic symptom scale score which showed acceptable internal consistency α =.71. Greater values denoted greater Anorexic symptoms. As expected, the scores were not normally distributed and therefore the scale scores were transformed (lgnama) for use in the analyses. The raw score of the Anorexic scale is presented in the Tables for clarification of the findings. Although transformed data were used in the analyses for statistical reasons, the patterns reported are highly similar to those found in the analyses of the raw scores.

3.0 Results

3.1 Differences in ascribed-trustworthiness by target person. ANOVAs with repeated measures were carried out to examine the extent to which ascribed trustworthiness varied by close person. This yielded an effect of close person, $F(2,194) = 13.29$, $p < .001$, $\eta^2 = .121$. Tukey *a posteriori* comparisons showed that ascribed trustworthiness was, in the order from highest to lowest: close friend, $M = 1.603$, $SD = .004$, mother, $M = 1.586$, $SD = .006$, and father, $M = 1.570$, $SD = .008$. The differences between the ascribed trustworthiness for each of three persons attained statistical significance at $p < .05$.

3.2 Correlations between the measures. The correlations between the measures (with *M*s and *SD*s) are shown in Table 2. The correlations between the ascribed trustworthiness by close person and ascribed trustworthiness by basis were carried out separately because of the inherent link between the two (i.e., the close persons and bases had common items). As expected, there were positive correlations between ascribed trustworthiness between: (1) each of the three targets; and (2) each of the three bases. As expected, anorexic symptoms was negatively correlated with ascribed trustworthiness with close friend, and with ascribed reliability trustworthiness, and (at a trend level) ascribed honesty trustworthiness. Contrary to expectation, anorexic symptoms were not appreciably correlated with ascribed trustworthiness with mother and father and ascribed emotional trustworthiness.

3.3 Test of the discontinuity vs continuity by regression analyses. Tests of linear and curvilinear relations were carried out to address the discontinuity vs continuity issue. Anorexic symptoms served as the predictor and each of the ascribed trustworthiness bases and close persons subscales served as the dependent measure (see Cohen, Cohen, West, & Aiken, 2003). The results that attained statistical significance are shown in Figures 1, 2, and 3. The figures show standardized Betas and *p* values for tests of linearity and quadratic (curvilinear) relations. Linear relations were found between anorexic symptoms and ascribed: (1) trustworthiness with close friend, (2) reliability trustworthiness; and (3) honesty trustworthiness (at a trend level). Those effects were qualified by a quadratic relation for each measure. Although there was a slightly depressed level of ascribed trustworthiness for participants with very low anorexic symptoms, the curve was the product of very depressed levels of ascribed trustworthiness for participants with very elevated anorexic symptoms.

3.4 Testing the discontinuity vs continuity issue by group analysis. The participant sample was divided into two groups guided by the inflexion points (an abrupt upward shift) in curves depicted in the three figures. Participants who exceeded 60 (raw anorexic scale score > 20) on the anorexic symptoms scale were categorized as the elevated sample and participants who showed 60 or less on the anorexic symptoms scale were classified as the normative sample. The elevated anorexic group comprised 7% of the sample and normative sample comprised 93% of the sample. The elevated anorexic group showed 25.00 raw mean anorexic symptoms score and the normative group showed a 10.00 raw mean anorexic symptoms score. The mean for the former group was highly similar to the average anorexic subscale scores for patients diagnosed with AN found by Williams et al. (1994), specifically $M = 27.55$, and by Gamble et al. (2006), specifically $M = 24.42$. The elevated anorexic group were very similar on anorexic symptoms to those patients who have been diagnosed with AN.

MANOVAs with group as the between variable was performed on the ascribed trustworthiness for (1) each of the three close persons (mother, father, and close friend) and (2) each of the three bases of trustworthiness (reliability, emotional, and honesty). The MANOVA yielded an effect of group on ascribed an effect of trustworthiness across the three close persons, $F(3, 94) = 3.52$, $p = .018$ (Wilk's Lambda), $\eta^2 = .10$. Univariate analyses showed that ascribed trustworthiness with close friend attained statistical significance only, $F(1,96) = 7.94$, $p = .006$, $\eta^2 = .08$. The elevated anorexic group demonstrated lower ascribed trustworthiness with close friend ($M = 1.56$ and $SD = .016$) than did the normative group ($M = 1.60$ and $SD = .004$).

The MANOVA yielded an effect of group across the three bases of trustworthiness, $F(3,94) = 4.21$, $p = .008$ (Wilk's Lambda), $\eta^2 = .12$. The univariate ANOVAs yielded effects of group on ascribed reliability trustworthiness, $F(1,96) = 10.47$, $p = .002$, $\eta^2 = .10$, and, at a marginally significant level, on ascribed honesty trustworthiness, $F(1,96) = 3.77$, $p = .055$, $\eta^2 = .04$. The elevated anorexic group demonstrated lower ascribed reliability trustworthiness ($M = 1.53$ and $SD = .022$) and lower ascribed honesty trustworthiness ($M = 1.55$ and $SD = .02$) than did the normative group ($M = 1.61$ and $SD = .006$.and $M = 1.59$ and $SD = .005$, respectively).

4.0 Discussion

The findings confirmed some of the hypothesized relations between anorexic symptoms in women and their ascribed trustworthiness in interactions with close persons. As hypothesized, anorexic symptoms were negatively correlated with ascribed: (a) trustworthiness with close friends; (b) reliability trustworthiness; and (c) at a trend level, honesty trustworthiness. As anticipated, quadratic relations and corresponding group differences were found. Women with elevated anorexic symptoms reported lower ascribed trustworthiness on those measures than did women with the normal range of anorexic

symptoms. Some of the hypotheses were not confirmed, though. There were no appreciable relations between anorexic symptoms and ascribed trustworthiness with mothers and fathers nor with ascribed emotional trustworthiness.

Broadly, the findings yielded by the current study converges with case and interview research showing that women with AN misrepresent themselves to others, experience being fraudulent, and experience living a lie (Bruch, 1973; Dalzell, 2000; Minuchin, Rosman, & Baker, 1978). The current study contributes to that line of investigation by demonstrating statistical relations between standardized scales of anorexic symptoms and standardized measures of reported trustworthiness in interactions with close persons. Furthermore, the findings yield evidence for some very specific aspects of the relation between anorexic symptoms and reported trustworthiness. For example, anorexic symptoms were negatively associated with reports of reliability and honesty trustworthiness but not emotional trustworthiness in interactions with close persons. The findings may be taken to suggest that women with AN do not extend their perceptions of self-deception to a lack of acceptance and insurance of confidentiality in interactions with close persons. Furthermore, women with elevated anorexic symptoms reported low trustworthiness in interactions with close friends but not with mothers and fathers. Because it was found that women reported optimally trustworthiness in interactions with close friends then the findings indicate that women with elevated anorexic symptoms report depressed trustworthiness in their most trustworthy relationships –their close friends.

One reason why anorexic symptoms in women were not associated with reports of trustworthiness with mothers and fathers may be due to the emotional problems in their relationships with parents. According to some studies (e.g., Bruch, 1973, Dalzell, 2000) women with AN are raised in highly enmeshed families and, as a consequence, develop intense experiences of guilt. There are two possibilities that warrant consideration regarding

the role of guilt as an account of the findings. First, women with AN may be disinclined to perceive that they are untrustworthy in interactions with their mothers and fathers because of the intense guilt they feel in holding those perceptions. The women would deny those behavioural patterns. Second, it is possible that the women's proclivity to experience guilt undermines their tendency to be untrustworthy in interactions with parents. In future, researchers could examine both potential accounts of the findings.

In a related vein, it remains to be determined whether women with AN do demonstrate untrustworthiness in their interactions with close others. The current findings show that women with elevated anorexic symptoms perceive that they are (relatively) untrustworthy in interactions with close persons. There is evidence that there is an appreciable discrepancy between individuals' perceptions of their trustworthiness and perceptions of their trustworthiness by others (Betts, Rotenberg, & Trueman, 2009; Rotenberg, 1986). Because of the lack of correspondence, caution needs to be exercised in generalization from women's reports of their untrustworthiness in interactions with close persons to actual trustworthiness in those interactions.

There are some implications if women with AN actually do show low trustworthiness in social relationships. This relation could account for some findings that AN is associated with having fewer close friends during childhood (Mangweth, et al., 2005). In that vein, it has been found that untrustworthiness, as reported by peers, is concurrently and prospectively associated with having few close friends during childhood (Rotenberg et al., 2004).

Even if women's reports of trustworthiness in interactions with close persons are not veridical then the findings have important implications for the psychosocial functioning of women with AN. The tendency for women with AN to perceive themselves as untrustworthy in interactions with close persons would increase their experiences of social isolation and loneliness –which are part of the Social Withdrawal Syndrome– and therefore could promote

their eating disorder (see Rotenberg et al., 2013). In particular, women with AN would be unlikely to seek help from close persons because the women believe that they are (relatively) not trusted by them. Furthermore, as reported by various authors (e.g., Dalzell, 2000), these women would be inclined to develop false personal identities and thus demonstrate personality disorders. This issue warrants further investigation.

One important question that needs to be addressed is whether the report of untrustworthiness in interactions with close persons by women with elevated anorexic symptoms are attributable to their deception regarding their eating behavior. The current findings do not yield an affirmative answer to that question because the interactions with close persons presented to the women in the study did not including eating or eating behaviors. As a consequence, deception regarding eating would not appear to be directly responsible for the observed relation. Nevertheless, it is possible that deceptive eating behaviors could contribute to the relation between anorexic symptoms and reported trustworthiness in interactions with close persons in an indirect fashion. This could be the subject of future investigation.

The findings yielded by the current study yield further support for the discontinuous approach to psychopathology, specifically AN, as confirmed by quadratic relations between anorexic symptoms and the measures of ascribed trustworthiness in interactions with close persons. The abrupt shift -in the relation between the anorexic symptom and ascribed trustworthiness served to identify the cut-off points for the eating pathology. This statistical technique complements those employed by Lahey et al. (1990) and Qualter, Rotenberg, Barrett, and Henzi, (2013) with other forms of psychopathology.

The current study examined only women and it would worthwhile to examine whether the observed relations are evident in men. Also, given the developmental emerges of AN across adolescence (see Stice, Marti, & Rohde, 2013), it would be worthwhile to examine if

and when those relations emerged during that period. In summary, the current study yielded support for the conclusion that women with elevated anorexic symptoms, and thus likely AN, are inclined to believe that they are deceptive in their interactions with close persons, primarily friends

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Table 1: *Specific Ascribed Trustworthiness Scale: SATS* (by Basis)

Reliability

1. If _____'s alarm clock was broken and I promised to wake them up I would trust myself to do so. (Reliability)

2. If I promised to do _____ a favour I would always follow through. (Reliability)

3. If I promised to do _____ I know I would do it for them. (Reliability)

Honesty

1. If I were to sell a piece of used furniture to _____ I would be honest about the estimation of what it is worth. (Honesty)

2. I would always tell _____ the truth (Honesty)

3. If I borrowed something of value from _____ and returned it broken, I would be honest about what happened and offer to pay for the repairs. (Honesty)

Emotional

1. I believe _____ would feel comfortable confiding in me (Emotional)

2. I believe _____ would feel in talking to me freely (Emotional)

3. I am good at keeping secrets that I was told by _____ (Emotional)

Table 2

Correlations Between the Measures (with Means and SDs)

Measure	M	SD	TWTM	TWTF	TWTCF
Anorexic Symptoms	11.42	14.47	-.06	-.12	-.28**
Ascribed Trustworthiness by Close Person					
Mother (TWTM)	38.86	4.68		.68***	.55***
Father (TWTF)	37.76	5.75			.42***
Close Friend (TWTCF)	40.28	3.90			

Measure	Mean	SD	RelTWT	HonTWT	EmotTWT
Anorexic Symptoms			-.20*	-.18ŧ	-.07
Ascribed Trustworthiness by Basis					
Reliability (RelTWT)	40.23	4.97		.69***	.56***
Honesty (HonTWT)	39.08	4.38			.59***
Emotional (EmotTWT)	37.58	4.80			

Note: ŧ p < .10, * $p < .05$, ** $p < .01$ and ***$p < .001$, $df = 96$.

Figure Captions

Figure 1: Linear and Curvilinear Relations Between Anorexic Symptoms and Ascribed Trustworthiness with Close Friend

Figure 2: Linear and Curvilinear Relations Between Anorexic Symptoms and Ascribed Reliability Trustworthiness

Figure 3: Linear and Curvilinear Relations Between Anorexic Symptoms and Ascribed Honesty Trustworthiness

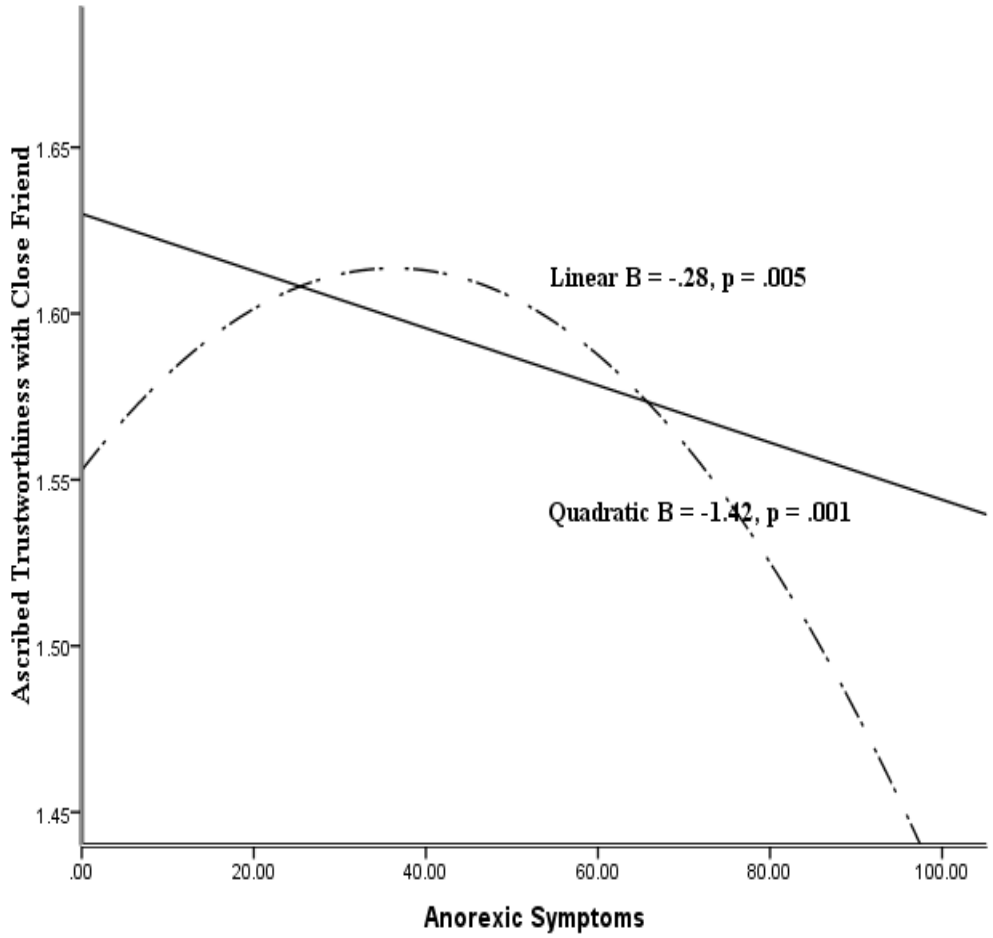

Figure 1

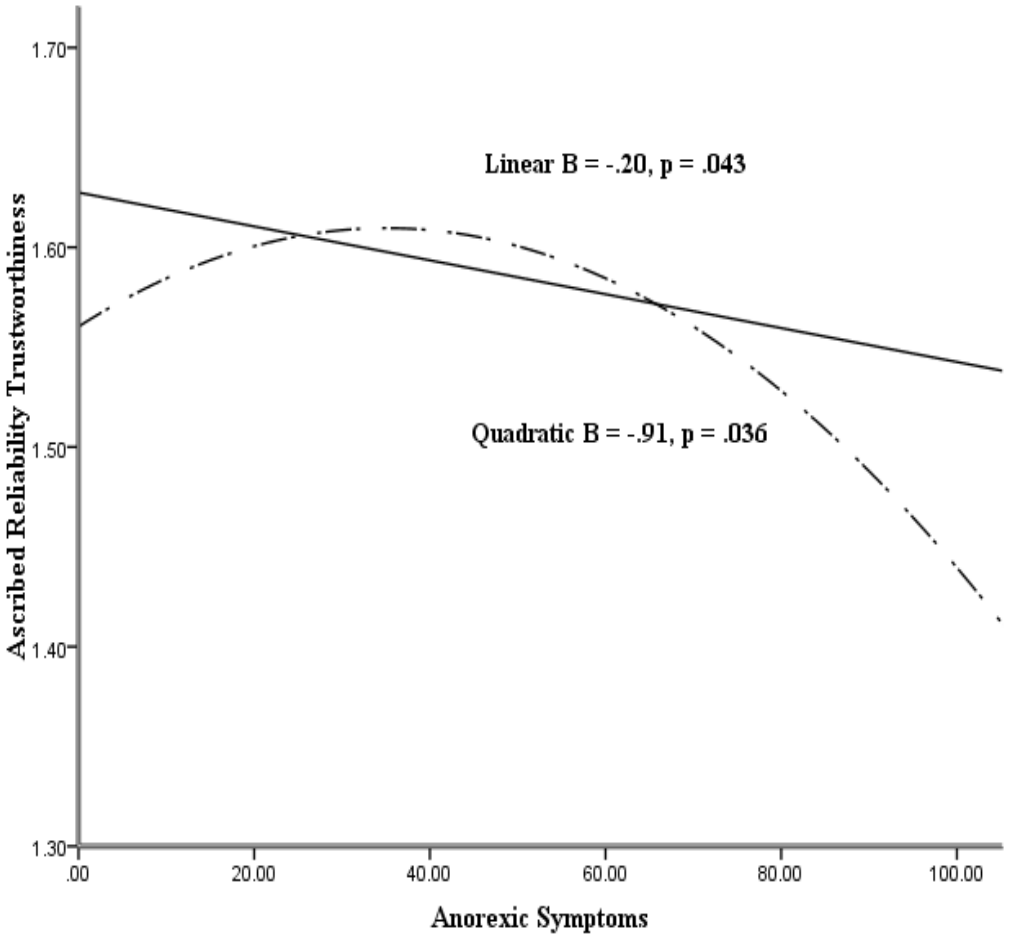

Figure 2

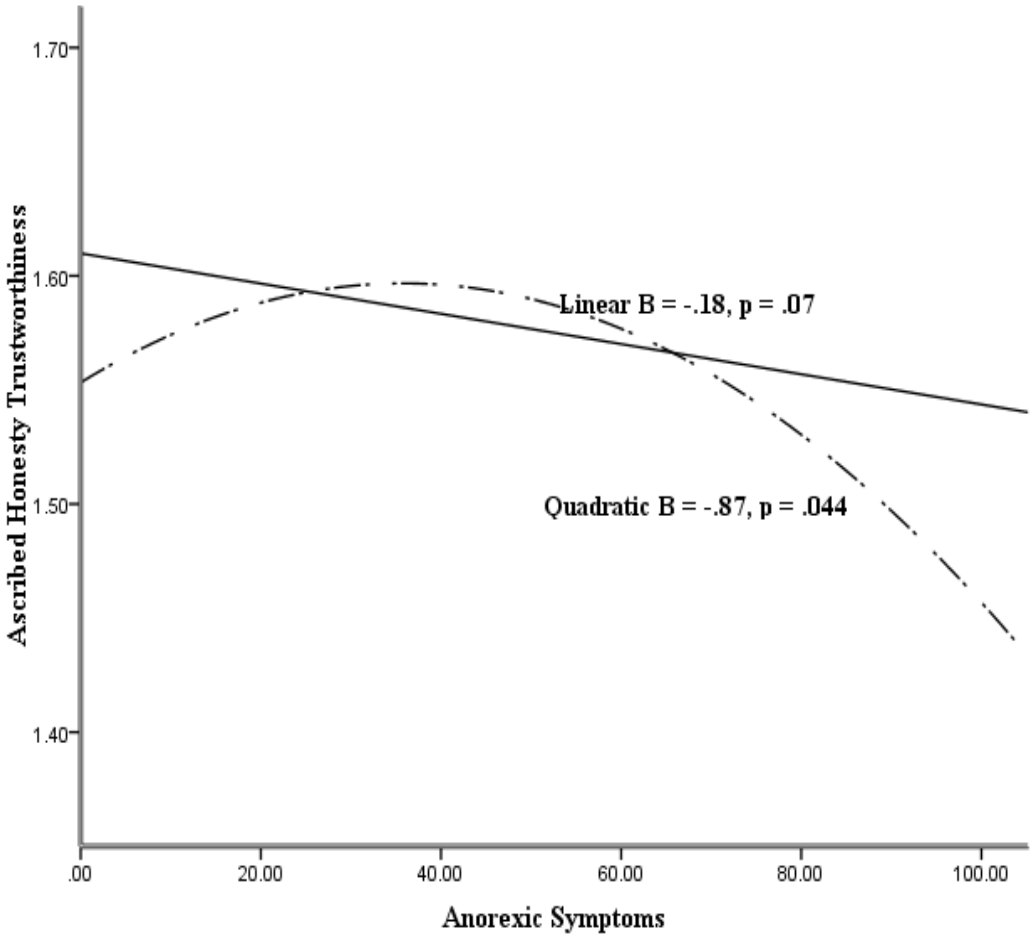

Figure 3

Authors' Disclosure

Statement 1: No funding source was involved in the study design, collection, analysis or interpretation of the data, writing the manuscript, or the decision to submit the paper for publication.

Statement 2: All authors contributed to the manuscript and all have approved its submission. Each author contributed to the research (literature search, design, analyses) described in the final manuscript and to the writing of the manuscript.

Statement 3: There is no conflict of interest.

Highlights

- Women's anorexic (AN) symptoms and reports of trustworthiness with close persons.
- 96 women completed an AN symptom subscale and ascribed trustworthiness scales.
- Women with elevated AN symptoms ascribed lower trustworthiness than other women.
- Women with AN believe that they are deceptive in interactions with close persons.