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Attachment insecurities, maladaptive perfectionism, and eating disorder symptoms: A latent mediated and moderated structural equation modeling analysis across diagnostic groups

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ABSTRACT

Although 96–100% of individuals with eating disorders (EDs) report insecure attachment, the specific mechanisms by which adult insecure attachment dimensions affect ED symptomatology remain to date largely unknown. This study examined maladaptive perfectionism as both a mediator and a moderator of the relationship between insecure attachment (anxiety and avoidance) and ED symptomatology in a clinical, treatment seeking, sample. Insecure anxious and avoidant attachment, maladaptive perfectionism, and ED symptomatology were assessed in 403 participants from three medium size specialized care centres for EDs in Italy. Structural equation modeling indicated that maladaptive perfectionism served as mediator between both insecure attachment patterns and ED symptomatology. It also interacted with insecure attachment to predict higher levels of ED symptoms – highlighting the importance of both insecure attachment patterns and maladaptive aspects of perfectionism as treatment targets. Multiple-group comparison analysis did not reveal differences across diagnostic groups (AN, BN, EDNOS) in mediating, main and interaction effects of perfectionism. These findings are consistent with recent discussions on the classification and treatment of EDs that have highlighted similarities between ED diagnostic groups and could be viewed through the lens of the Trans-theoretical Model of EDs. Implications for future research and intervention are discussed.

1. Introduction

Over the past three decades, attachment theory (Bowlby, 1973, 1988) has received increasing interest from those seeking a cognitive-affective and relational understanding of eating disorders – EDs – (Ward et al., 2000; O'Shaughnessy and Dallos, 2009; Kuipers and Bekker, 2012). Attachment theory states that infants develop beliefs about one's lovability and expectations regarding one's caregivers' responsiveness and emotional availability based on the quality of their initial interactions with the caregiver, internalized as "working models" (Bowlby, 1988). These cognitive-affective representations of the self and of others are proposed mechanisms underlying continuity and stability of attachment patterns across the life-span; they influence personality development, psychological functioning, behavior, and affect regulation in later relational contexts (Mikulincer and Shaver, 2012).

The most appropriate method for assessing individual differences in adult attachment is via the assessment of two independent dimensions (see Mikulincer and Shaver, 2007): attachment anxiety (i.e., excessive need for others' approval and fear of interpersonal rejection) and avoidance (excessive need for self-reliance and fear of interpersonal dependence). Individuals who have either high levels of attachment avoidance or attachment

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anxiety are considered to be insecurely attached; whereas those with low levels of both dimensions are described as having secure attachment (Brennan et al., 1998).

A significant body of research links insecure attachment to psychopathology (Mikulincer and Shaver, 2012); both insecure-avoidant and insecure-anxious attachment can be construed as general risk factors for ED psychopathology (O'Shaughnessy and Dallos, 2009; Cavanna et al., 2012). Additionally, a growing body of empirical research and the success of interpersonal psychotherapy in treatment trials for EDs support the role of long-term interpersonal difficulties (i.e., attachment insecurities) in the maintenance process of EDs (see Murphy et al., 2012). Although 96–100% of the samples with clinical levels of EDs report attachment insecurity, the nature of the connection between attachment insecurity and ED symptomatology remains largely unexplored (Zachrisson and Skarderud, 2010; Kuipers and Bekker, 2012). One approach that can be used by researchers to gain insight into the specific mechanisms by which insecure attachment affects ED symptoms is to shift from a simple examination of linear bivariate relationships to multivariate interactional models examining the roles of mediators and moderators (Kraemer et al., 2001).

Although this type of research is necessary, only two studies have examined empirically the indirect influence of attachment insecurity on disordered eating. These studies used undergraduate (Dakanalis et al., 2013) and twin samples (Eggert et al., 2007) and found that the anxious attachment–disordered eating relationship was fully mediated by neuroticism; whereas narcissism fully mediated the relationship between attachment avoidance and disordered eating regardless of gender. These findings suggest that personality characteristics of anxious or avoidant-attached individuals may play a major role in the expression of disordered eating behaviors (Cavanna et al., 2012). However, other personality variables linked to EDs, may act as potential mediators and/or moderators of the bivariate relationship between both insecure attachment patterns and ED symptomatology (Kuipers and Bekker, 2012; Mikulincer and Shaver, 2012). Perfectionism, particularly its maladaptive aspects, is a personality trait that seems involved in the onset, course, and maintenance of ED symptoms (Stice, 2002; Franco-Paredes et al., 2005; Bardone-Cone et al., 2007; Cooper and Fairburn, 2011; Egan et al., 2011). Consistently, in the current study we focused on maladaptive perfectionism as a potential intervening and moderating variable within a clinical, treatment seeking, sample.

1.1. Maladaptive perfectionism

Perfectionism is a multidimensional construct with both adaptive and maladaptive aspects (Flett and Hewitt, 2002; Franco-Paredes et al., 2005). Adaptive perfectionism includes high but achievable standards for oneself, a preference for organization and order, and feeling of self-satisfaction and accomplishment when tasks are completed (Enns and Cox, 2002). Conversely, maladaptive perfectionism involves unrealistically high standards accompanied by critical evaluation tendencies (i.e., debilitating self-doubt of one's actions, intense ruminative concern over mistakes, and feelings of failure due to the mistakes; Boone et al., 2010). From an attachment theory perspective, maladaptive perfectionism can arise via one of two following different pathways. When insecure-anxiously attached, the child needs acceptance from a caregiver who sets elevated standards and is never satisfied with the child's efforts. The child internalizes the caregiver's disappointment and continues to strive for perfection in an attempt to gain the caregiver's love and approval (Flett et al., 2002). On the other hand, in an insecure-avoidant attachment situation, the child perceives its primary attachment figure as rejecting or unavailable and strives to achieve perfectionism in order to avoid rejection from others and to manage his or her own feelings of imperfection and lack of self-worth (Hewitt et al., 2003). In cross-sectional and longitudinal studies, secure attachment was strongly related to adaptive perfectionism; whereas both insecure-anxious and insecure-avoidant attachment strongly predicted maladaptive perfectionism (Rice and Mirzadeh, 2000; Wei et al., 2006; Ulu and Tezer, 2010).

Moreover, extensive reviews of the literature (Lilenfeld et al., 2006) revealed that maladaptive perfectionism is strongly associated with eating and body-related disturbances, and its levels "differ minimally across ED subtypes, defined diagnostically according to DSM-IV-TR categories" (Bardone-Cone et al., 2007, p. 390). In longitudinal studies maladaptive perfectionism has been linked to body image concerns and restrictive and binging behaviors over time (Tyrka et al., 2002; Boone et al., 2011). Because there are direct positive relations between attachment insecurities and maladaptive perfectionism, and maladaptive perfectionism and ED symptoms (MacKinnon, 2011), it is possible that individuals with high insecure avoidant or anxious attachment are likely to develop higher maladaptive perfectionistic levels, which could, in turn, experience significant ED symptomatology. From a practical standpoint, if maladaptive perfectionism does serve as an intermediate link in the chain leading from insecure attachment styles to ED symptoms, then interventions could be targeted to reduce the effects of this mediating variable in order to reduce ED symptomatology.

Research has also suggested that in addition to mediating effects (Tasca et al., 2011a, 2011b) maladaptive perfectionistic tendencies may interact with interpersonal stress in the prediction or maintenance of symptom severity (Hewitt and Flett, 2002; Stice, 2002; Bardone-Cone et al., 2007). As attachment-related anxiety or avoidance could be regarded as a source of chronic interpersonal stress (Schmidt and Treasure, 2006; Tasca et al., 2011a, 2011b; Murphy et al., 2012), it is possible that maladaptive perfectionism could also serve as moderator such that individuals with higher combined levels of maladaptive perfectionism and insecure attachment patterns have greater ED symptomatology. This hypothesis is consistent with the trans-theoretical theory of EDs (Fairburn et al., 2003; Dakanalis et al., 2014) that guides the enhanced cognitive-behavioral treatment of EDs (Fairburn, 2008; Dakanalis et al., 2014). While the examination of the potential mediating effects would lead to a deeper understanding about how attachment insecurities influence ED symptoms, the examination of the interaction (moderating) effects would qualify this association, exploring how its strength may vary for different levels of maladaptive perfectionism. This would ultimately inform tailored treatments that may address particular maintaining mechanism(s) operating in the individual patient's case (Bardone-Cone et al., 2007; Cooper and Fairburn, 2011; MacKinnon, 2011).

1.2. Objectives and hypothesis

The purpose of the current study was to examine maladaptive perfectionism as mediator and moderator between both insecure attachment dimensions and ED symptoms within a clinical sample of individuals with a diagnosis of Anorexia Nervosa (AN), Bulimia Nervosa (BN), or Eating Disorder Not Otherwise Specified (EDNOS). We hypothesized that maladaptive perfectionism would serve as intervening variable between insecure attachment style (anxious and avoidant) and ED symptoms and that these relationships would also be amplified as a function of maladaptive perfectionism. The hypothesized mediating and moderating