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Attachment and eating disorders: a research update

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Prominent models of eating disorders tend to focus on cognitive and behavioral features, but tend not to consider important developmental issues related to affect regulation, interpersonal style, self concept, and mentalization — all of which are well conceptualized within attachment theory. Higher levels of attachment insecurity across diagnoses are related to greater eating disorder symptoms. Low parental care and early trauma may lead to attachment insecurity that then might lead to greater eating disorder symptoms. The association between insecure attachment and eating disorder severity is likely mediated by affect dysregulation and perfectionism. Recent research using the Adult Attachment Interview highlights the importance of reflective functioning in predicting treatment response and therapeutic processes, and on the utility of therapies that increase mentalization.

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Attachment research in eating disorders is a relatively small yet important field of inquiry. Research recent indicates that attachment theory may speak to potential reasons for the development of eating problems, potential maintenance of eating disorder symptoms in adults, and mechanisms of change in psychological treatment [1]. This paper is a review and update of the most recent research, with special emphasis on newly published work using the Adult Attachment Interview (AAI) [2].

Eating disorders

Eating disorders confer substantial personal, economic, and health burden on individuals. Those with AN tend to cognitively over-evaluate their weight and shape, and their self-worth is dependent upon their appearance evaluation [3]. Behaviourally, individuals with AN severely restrict their food intake so that they are often severely malnourished and underweight. Those with bulimia nervosa (BN) also over-evaluate their weight and shape. In addition to this cognitive component, individuals with BN engage in binge eating followed by inappropriate compensatory behaviors such as dietary restriction or excessive exercise, or purging such as self-induced vomiting or laxative misuse in order to prevent weight gain [4]. Binge-eating disorder (BED) include binge eating without inappropriate compensatory behaviors, and marked distress related to the binges. Individuals with an eating disorder of clinical severity that did not meet specific diagnostic criteria for AN, BN, or BED are classified in version five of the Diagnostic and Statistical Manual of Mental Disorders [4] with an other specified or unspecified feeding and ED.

Attachment

Attachment theory is a potentially important framework to help to understand and treat the eating disorders [1]. Yet, in the most prevalent psychological models of eating disorder, symptoms are largely seen as maintained by cognitions related to weight and shape concerns, and dietary restriction that may in turn result in binge eating [5]. These factors may operate within a cultural context that idealizes a thin female body shape that is internalized from exposure to media images [6]. This cognitive-behavioral model mainly addresses cognitions and behaviors related to eating disorders, but it largely ignores that the impact of affect regulation and the quality of relationships that can have on symptoms and quality of life. Recently, Fairburn [5] suggested an 'enhancement' to the basic cognitive-behavioral model, in which additional maintenance factors that may be important for some were specified: interpersonal problems, mood intolerance, clinical perfectionism, and low self-esteem. These additional maintenance factors are purported to operate transdiagnostically to maintain eating disorder symptoms for some. However, even with these additions, this model does not take a developmental perspective when considering individuals and the emergence of eating disorder symptoms, nor does it speak to the role of internal working models or introjects in determining the quality of affect regulation and relational style, and it only indirectly suggests the impact of trauma on one's functioning. For that reason, some researchers have turned to attachment theory [7] to fill the gaps in the conceptualization of eating disorders and to inform treatment choices.

Attachment theory posits that repeated interactions based on attachment behaviors with caregivers become encoded within memory and result in internal working models of attachments [8], which are the basis for individual differences in adult attachment styles (typically conceptualized as variability along two dimensions — attachment anxiety

and avoidance) or mental states (i.e. coherence of narrative regarding early attachment experiences grouped into patterns of secure, preoccupied, dismissing, and disorganized). In terms of attachment mental states, securely attached individuals are able to engage in satisfying and safe relationships, moderate their affective experiences during times of stress, and reflect on their internal experiences and those of others. Preoccupied individuals tend to be overly concerned with relationship loss or conflict that impedes their sense of security, and maladaptively up-regulate their emotional experiences, which in turn interferes with their ability to reflect on their own and others mental states. Individuals with dismissing attachments tend to defensively downplay the importance of relationships and so cannot draw a sense of security from them. They often maladaptively down-regulate their emotional experiences, which limits their access to emotions and attachment-related memories, which in turn can severely limit their ability to reflect on their internal experiences and those of others. A pattern of disorganized attachment refers to mental states that become disorganized (i.e. mental states characterized by overriding guilt, absorption, or dissociation) in relation to the experience of trauma or loss of an attachment figure [9]. Disorganized mental states are associated with childhood adversity, including abuse or neglect, and tend to be associated with post-traumatic symptoms. Preoccupied, dismissing, and disorganized attachments are related to higher levels of psychopathology and functional impairment [9].

Another important development in attachment theory and research is the role of mentalization or reflective functioning on human functioning and development [10]. Reflective functioning is 'the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons' [10] (p. 21). Low reflective functioning is associated with difficulty in discerning mental states and the impact of one's own and others' mental states on behavior. Higher reflective functioning indicates a capacity to think reflectively, have increased ability to regulate affect, and have better interpersonal functioning. As I report below, some recent treatment research for BED suggests that reflective functioning plays a role in symptom expression and treatment outcomes.

Attachment and eating disorders

Much of the research on attachment and eating disorders has relied on the use of self-report questionnaires that assess dimensions of attachment insecurity including attachment avoidance (a parallel to dismissing mental states) and attachment anxiety (a parallel to preoccupied mental states). This research has shown a moderate and significant association between attachment insecurity with general eating disorder psychopathology [11–15]. In particular, need for approval, an aspect of attachment anxiety, is most consistently associated with body image dissatisfaction [11,13,15,16••]. The research however is inconsistent about whether types of attachment insecurity are associated with specific eating disorder diagnoses. In a review of this research, Tasca and Balfour [1] concluded that attachment insecurity is associated with higher eating disorder symptoms and is a factor that operates transdiagnostically to confer greater risk for an eating disorder.

Several studies of clinical samples have considered potential mechanisms by which attachment insecurity leads to greater eating disorder symptoms. Tasca and colleagues [14] found that hyper-activation of emotions mediated the relationship between attachment anxiety and eating disorder symptoms. Keating and colleagues [17] found that alexithymia, a concept related to the down-regulation of emotions, mediated the relationship between insecure attachment and body dissatisfaction. These studies suggest maladaptive affect regulation associated with attachment insecurity may play a key role in the expression and maintenance of disordered eating and cognitions related to eating disorders symptoms. That is, eating disorder symptoms may be conceptualized as a means of coping with the effects of affect dysregulation.

In a similar vein, Dakanalis and colleagues [18] found that maladaptive perfectionism mediated the relationship between insecure attachment patterns and eating disorder symptoms. The authors argued that attachment anxiety or avoidance may sensitize one to the negative effects of maladaptive perfectionism which is a known risk for developing and maintaining an eating disorder [5].

Two studies have looked at retrospective accounts of childhood experiences in order to take a more developmental approach to understanding eating disorders from an attachment perspective. In a study looking specifically at the role of parental bonding, Grenon and colleagues [16••] asked a large adult clinical sample with eating disorders to retrospectively assess mother and father care, and to report current levels of attachment insecurity, media internalization of an ideal body image, and body dissatisfaction. The authors found that experiencing lack of affection from mothers appears to have a direct effect on body dissatisfaction. However, lack of affection from fathers may have indirect effects on body dissatisfaction mediated by greater attachment anxiety and media internalization. That is, lower father care may lead to greater attachment anxiety that in turn may make one more vulnerable to media internalization that leads to body dissatisfaction.

Using a similar approach, Tasca and colleagues [19] asked an adult clinical sample with eating disorders to report retrospective accounts of childhood abuse and trauma,