



Adult attachment, depression, and eating disorder symptoms: The mediating role of affect regulation strategies

Giorgio A. Tasca^{a,b,c,*}, Leah Szadkowski^a, Vanessa Illing^a, Anne Trinneer^a, Renee Grenon^c,
Natasha Demidenko^b, Valerie Krysaniski^{a,b}, Louise Balfour^{a,b}, Hany Bissada^{a,b}

^aUniversity of Ottawa, 75 Laurier Avenue, East, Ottawa, ON, Canada K1N 6N5

^bThe Ottawa Hospital, 501 Smyth Road, Box 400, Ottawa, ON, Canada K1H8L6

^cCarleton University, 1125 Colonel By Drive, Ottawa, ON, Canada K1S 5B6

ARTICLE INFO

Article history:

Received 13 February 2009

Received in revised form 21 May 2009

Accepted 1 June 2009

Available online 21 June 2009

Keywords:

Attachment

Eating disorders

Affect regulation

Structural equation modeling

ABSTRACT

The study examined the role of affect regulation strategies in mediating the relationship between attachment dimensions and both depressive and eating disorder (ED) symptoms. Participants were 310 women seeking treatment for an ED. Structural equation modeling indicated that attachment anxiety contributed to both depressive symptoms and ED symptoms through emotional reactivity. In contrast, only the association between attachment avoidance and depressive symptoms was mediated by emotional deactivation; whereas attachment avoidance had a direct relationship with ED symptoms not mediated by emotional deactivation. The results suggest tailored clinical interventions that take into account attachment style and accompanying affect regulation strategies. Treatment of patients who experience attachment anxiety may emphasize impulse regulation, whereas treatment of ED patients with attachment avoidance could focus on gradual exposure to affective expression.

© 2009 Elsevier Ltd. All rights reserved.

1. Introduction

During the past 30 years, attachment theory (Bowlby, 1973) has become one of the most important conceptual frameworks for understanding affect regulation and human relationships (Mikulincer & Shaver, 2007). Attachment is an inborn system that motivates an infant to seek proximity to a care-giving adult. The attachment system results in systematic patterns of interpersonal expectations, emotions, and behaviours that are associated with specific attachment-related strategies to regulate affect (Shaver & Mikulincer, 2002). Brennan, Clark, and Shaver (1998) argued that attachment can be characterized in terms of two orthogonal dimensions of attachment anxiety and attachment avoidance. *Attachment anxiety* may develop when attachment figures are inconsistent or unpredictable. In an attempt to maintain an engagement with inconsistent caregivers, these children “hyper-activate” their attachment systems. This involves excitatory pathways that intensify negative emotional responses by keeping them active in working memory resulting in an up-regulation of emotion (Shaver & Mikulincer, 2002). *Attachment avoidance* may develop when individuals perceive their primary attachment figure as rejecting or unavailable. In response, these individuals “deactivate”

their attachment systems and defensively devalue their need for relationships. Thus, affective experiences are cut off from working memory, and this is accompanied by a down-regulation of emotion (Shaver & Mikulincer, 2002).

Researchers link these attachment dimensions to psychological distress, including depression (e.g., Wei, Vogel, Ku, & Zakalik, 2005) and eating disorders (e.g., O’Kearney, 1996). In a recent study, Tasca et al., 2006 tested a structural equation model of the association between attachment insecurity and eating disorder (ED) symptoms. Attachment insecurity was directly related to body dissatisfaction and negative affect among a clinical sample of eating disordered women.

EDs are considered to be among the most difficult to treat, and they have the highest rate of mortality among mental disorders (Agras, 2001). Treatments are not effective for 40% for those with bulimia nervosa (BN) in terms of reducing binge eating and purging (Stice, 1999), and recovery from anorexia nervosa (AN) tends to be even lower due to very high attrition rates (Tasca, Taylor, Bissada, Ritchie, & Balfour, 2004). AN restricting subtype (ANR) is often characterized by severe food restriction, body dissatisfaction, body image distortion, and very low body weight. Binge eating and/or purging also occur in the binge or purge subtype of AN (ANB). BN symptoms include body dissatisfaction and binge eating followed by inappropriate compensatory behaviours (e.g., vomiting). Individuals with an ED often suffer from current or lifetime history of depression (Pike & Striegel-Moore, 1997).

* Corresponding author. Address: The Ottawa Hospital, 501 Smyth Road, Box 400, Ottawa, ON, Canada K1H8L6. Tel.: +1 613 737 8035; fax: +1 613 737 8085.

E-mail address: gtasca@toh.on.ca (G.A. Tasca).

Problems with autonomy and separation from parents may be factors in the development and maintenance of an ED (O’Kearney, 1996). In their review, Laliberte, Boland, and Leichner (1999) concluded that patients with bulimic symptoms consistently reported their families to be less cohesive, less nurturing, less expressive, less communicative, and to have experienced more conflict. Clinton (2006) stated that difficulties with identifying, expressing, and regulating emotions are also common in patients with EDs. All of these factors can be understood as different aspects of human attachment processes (Bowlby, 1973).

Researchers have become increasingly interested in the mechanisms by which attachment dimensions affect clinically relevant symptoms such as depression, anxiety and interpersonal problems (Mikulincer & Shaver, 2007). A number of studies have identified mediators between attachment and psychological distress. For example, Wei and colleagues (2005) found that affect regulation was a mediator between attachment dimensions and negative mood in a sample of college students.

Affect regulation may have a role in the expression of eating disordered attitudes and behaviours. In a sample of college students, Cole-Detke and Kobak (1996) found that hyperactivating strategies were related to symptoms of depression, and that deactivating strategies were related to ED symptoms when depressive symptoms were controlled. Perry, DiTommaso, Robinson, and Doiron (2007) found that emotion focused coping partially mediated the relationship between attachment anxiety and body image disturbances and problem eating among undergraduates. Hilbert and Tuschen-Caffier (2007) studied affect regulation in a clinical sample of eating disordered women. They found that binge eating was preceded by difficulty in regulating affect in women with BN.

One could argue that attachment insecurity may contribute to the development of maladaptive affect regulation strategies, which in turn may result in the expression of ED symptoms and depressive symptoms. For example, eating disordered patients with attachment anxiety may experience affect dysregulation that may result in symptoms such as purging behaviours. Conversely, those with attachment avoidance may cut off emotional experience, and this may aid extreme methods of dietary restriction. However, with the exception of the work by Wei and colleagues (2005), no studies have examined the mediating role of affect regulation to explain the relationship between attachment insecurity and distress. Further, no study has examined the mediating role of affect regulation in a sample of women with EDs. The purpose of this study was to examine the mediating role of affect regulation in a clinical sample of eating disordered women. We hypothesized that the association between attachment anxiety and both ED symptoms and depressive symptoms is mediated by emotional reactivity; and that the association between attachment avoidance and both ED symptoms and depressive symptoms is mediated by emotional deactivation.

2. Methods

2.1. Participants

Participants were 310 adult females (>17 years) referred for assessment and treatment of an ED to a Center for Eating Disorders at a general hospital in a medium size urban center. Of the 459 individuals referred to the center between 2006 and 2008, 439 were women, and of those 353 met diagnostic criteria for AN, BN, or an eating disorder not otherwise specified (EDNOS; APA, 2000). Of those, 312 had valid personality assessment inventory (PAI; Morey, 1991) profiles (see definition of a valid PAI profile below) and had complete data. Two participants were identified as multivariate outliers, so 310 participants were included in the

analyses. Of those, 74 were diagnosed with AN, 138 with BN, and 98 with EDNOS. Mean age was 26.31 ($SD = 8.76$), mean body mass index ($BMI = \text{kg}/\text{m}^2$) was 21.88 ($SD = 6.20$), and mean years with an ED was 7.46 ($SD = 7.60$). Most were Caucasian (91%), completed university (69%), and were never married (66%); and 34.5% had a comorbid affective disorder.

2.2. Instruments

2.2.1. Experiences in close relationships scale (ECR; Brennan et al., 1998)

Attachment dimensions were assessed with the ECR, a 36-item self-report measure with a 7-point Likert-type response format from 1 (disagree strongly) to 7 (agree strongly), with higher scores representing greater levels of attachment anxiety or avoidance. The *Attachment Anxiety* subscale (18 items) assesses concern with rejection and preoccupation with abandonment. The *Attachment Avoidance* subscale (18 items) assesses fear of intimacy and discomfort with closeness or dependence. The coefficient alphas in this sample were .92 and .94, respectively. To generate three observed indicators for the two latent variables (i.e., attachment anxiety, attachment avoidance), we created three parcels of 6 items from each of the two scales (Russell, Kahn, Spoth, & Altmeir, 1998). Exploratory factor analyses using the maximum likelihood method were conducted separately on the items from the two scales. Items were rank ordered by magnitude of the factor loadings and successive pairs of the highest and lowest loading items were assigned to each of three parcels.

2.2.2. Differentiation of self inventory – revised (DSI-R; Skowron & Friedlander, 1998)

The DSI-R contains 43 self-report items with two subscales of affect regulation used in this study, and two subscales of intimacy in relationships. Items have a 6-point Likert-type response format from 1 (not at all true of me) to 6 (very true of me). The *emotional reactivity* subscale (11 items) reflects the degree to which an individual responds with emotional flooding, emotional lability, or hypersensitivity. Lower scores represent greater emotional reactivity. The *emotional cutoff* subscale (12 items) reflects feeling threatened by intimacy, and isolating the self from others and emotions. Lower scores represent greater emotional deactivation. Coefficient alphas for this sample were .86 for each scale. The parcelling procedure described above for the attachment factors was also used to create indicator variables for the emotional reactivity and emotional deactivation factors.

2.2.3. Eating disorders inventory (EDI; Garner & Olmsted, 1984)

The EDI was used to assess ED symptoms. The EDI has 64 items making up 8 scales. Factor analysis indicated that three scales represent an ED symptom factor: *body dissatisfaction*, *bulimia*, and *drive for thinness* (Tasca, Illing, Lybanon-Daigle, Bissada, & Balfour, 2003). Participants responded to items on a 6-point Likert-type scale ranging from “always” to “never”. The three most symptomatic choices were recoded as 1, 2, and 3, and the three least symptomatic choices all recoded zero. Higher scores on the scales represented higher ED attitudes and behaviours. Coefficient alphas for an ED sample were .92 for body dissatisfaction, .92 for bulimia, and .86 for drive for thinness (Garner & Olmsted, 1984).

2.2.4. Personality assessment inventory (PAI; Morey, 1991)

The PAI has 344-items that make up 22 non-overlapping full scales measuring clinical constructs. Eleven of the full scales are made up of three or four subscales. The items are scored on a 4 point Likert-type scale ranging from 0 (not at all true) to 3 (very true). Total raw scores are converted to *T*-scores. Higher scores represent greater psychopathology. The three depression subscales

Download English Version:

<https://daneshyari.com/en/article/891942>

Download Persian Version:

<https://daneshyari.com/article/891942>

[Daneshyari.com](https://daneshyari.com)