

A Place for Eating Disorders within Attachment Theory's Frame

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"They turn to food instead to give them the pleasure they once got from singing. And the relationship with food becomes the most important relationship in their lives..." (1)

Attachment theory finds its origins in the work of John Bowlby who, with the assistance of Mary Ainsworth, proceeded to completely restructure the understanding of primary caregiver-child bonds (2). Only in recent decades has the concept been incorporated into research focused on development and treatment of eating disorders (EDs). When considering EDs as a reflection of issues within the entire family system, one can begin to understand how early attachment insecurities can profoundly impact pathology and treatment of the disease (3). Even for people without an ED, early attachment experiences set the "schemata" for, and perceived effectiveness in, all future interpersonal interactions and relationships - including those with food (4). Ward, et al. describes the attachment to the primary caregiver and food as both "unbearably intrusive and vitally necessary" (3).

Initial attachments influence future cognitive, emotional, and behavioral experiences, and may produce distorted perceptions of the external environment in the process (5). While there are three main categories of attachment patterns: secure, avoidant, and anxious, many measures recognize the sundry facets within these areas such as: affect intolerance, interpersonal problems, low self-esteem, and clinical perfectionism (4). Attachment styles tend to be an enduring personality factor that increase susceptibility to societal messages that prey on individual's insecurities (6). When personal identity is highly dependent on external sources, the potent fear of rejection from others only exacerbates a desperate need for approval and high body dissatisfaction (7). Very few individuals with EDs are securely attached, which leads to the "push-pull strategy" of vacillating between commitment to recovery and denying the need for specialized care (8).

Secure Attachment

This method is marked by autonomy and abilities such as effectively regulating affect, obtaining support from external sources, and actively seeking intimacy in relationships (4). This security prevents against unnecessary stress and anxiety, and fosters a healthy sense of self-efficacy (5). Unfortunately, this secure attachment is not what most registered dietitians (RDs) in the EDs field initially experience, since insecure attachment is a noted characteristic of the majority of patients with EDs.

Avoidant Attachment

The avoidant patient presents with a devaluing and cynical view, resulting from previous negative attachment experiences expecting that needs will be neglected and rejection likely. Over time, the attachment systems were "deactivated," and emotions down-regulated to prevent invalidation (5,4). Due to the client's low coherence of mind and physiological malnourishment and/or instability, treatment providers often experience some difficulty in accessing childhood attachment memories and experiences (4).

Tasca, et al. postulate that avoidant attachments are more likely to be found in patients with the restricting subtype of anorexia nervosa, but caution against assumptions based on a diagnoses (4). It is interesting to note that the restricting patient's interaction with food is also avoidant in nature, and through this style they may attempt to downplay the severity of experienced psychopathology. Their overwhelming desire to elude emotions and feelings of fullness can introduce difficulties such as adherence to treatment and/or interacting in a group setting. Despite the avoidant style, these individuals have enormous potential for reflective functioning and awareness, although others may initially feel they are overly critical and aloof (4).

Anxious Attachment

The anxious patient's interpersonal expectations tend to be defined by unreliable and unpredictable attachment figures in the past. The individual will often come across as "needy" because they seek constant validation from external sources (5). In contrast to the avoidant style, these patients constantly mull over previous unpleasant attachment experiences and memories, which maintains their agitated state. Due to a

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preoccupied internal dialogue, these individuals often have difficulty recognizing the needs and affects of others (4).

Research indicates that higher levels of attachment anxiety increase risk for severe ED manifestations and adverse treatment outcomes. Anxious attachment patterns are more likely to occur in patients with bulimic symptoms or binge eating disorder, due to personality interactions and the relationship with food. Hyperactivation of emotions and constant perceptions of relational stress can lead to a high state of reactivity, and attempts at coping such as bingeing or engaging in the binge-purge cycle (4,5). In this population, group therapy has the capacity to provide a safe and validating environment, which increases the likelihood of retaining the client in treatment (5).

A Family Matter

Insecure attachment patterns, much like disordered eating, are transgenerational, formed very early in life, and serve as a maladaptive coping skill (9). Thus, the patient's distorted beliefs of being unworthy of love and friendship are a red flag for family dysfunction and adverse experiences with primary caregivers (6). Further investigation might find a parent with an ED, enmeshment, triangulation, hostility, mistrust, an invalidating emotional atmosphere, some form of abuse, or markedly overprotective parenting styles (10). Whether innocent or malicious, comments and behaviors from primary attachment figures may figure prominently in the development and perpetuation of an ED. As Bulik points out in *The Woman in the Mirror*, a child's self-concept is initially shaped by others' perceptions simply because their brain has not yet developed to think abstractly or challenge a superior's expectations. Unfortunately, these early, deep-seated beliefs "get planted early, grow wild, and never get pruned" (11). Furthermore, by avoiding the issues within the family system, insecure attachment blueprints are prolonged and bequeathed to the next generation (12).

Discussion

It is not unusual to find that a patient seems both compulsively self-reliant and compulsively care-seeking, which can be a challenge for treatment providers (3). But, by using the attachment framework, one can recognize traits of ambivalence ED sufferers may hold towards food, treatment, recovery, and with their self-concept. Nutrition counseling and the role of the RD are vital components of ED recovery. Registered dietitians can explore how current relationships, with people and food, are a reflection of past attachment patterns, and could be a barrier to freedom from disordered eating. Registered dietitians have a unique opportunity to plant the seeds for healthy attachment - a relationship without abuse, abandonment, and inconsistency (5).. This aspect is within the RD's scope of practice because the maladaptive method of relating has severely impacted food intake, the client's relationship with food, and is a barrier to full recovery (13). The deep work of supporting the client to create healthy attachments will lie with the therapist. However all treatment team members can provide positive experiences to begin the reformation of secure connections as the client moves toward stability and health.

In addition to the relational role, the RD is primarily responsible for moving the client toward a more secure attachment with food. Dallos, et al. suggest that "mealtimes encapsulated and reaffirmed the emotional atmosphere of the family," which creates a complex puzzle for the RD to examine (12). By constantly reminding the patient that food is an object that will not reject or triangulate, but rather provides nourishment and care, trust can be developed with both food and the dietitian.

About the Author

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