Attachment Patterns in Eating Disorders: Past in the Present

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Abstract: Objective: There is a wide literature suggesting abnormal mother-daughter and familial attachment patterns in individuals with eating disorders. We surmised that this insecurity would extend to adult attachment relationships. Methods: The Reciprocal Attachment Questionnaire (RAQ) was administered to all inpatients and outpatients at a tertiary referral eating disorders unit over a given period of time, and to controls. The RAQ operationalizes the key components of reciprocal attachment, and is in close theoretical agreement with the Adult Attachment Interview. Results: Patients scored significantly higher than controls on most scales of the RAQ, most notably on Compulsive Care-Seeking and Compulsive Self-Reliance. We did not find any associations between eating disorder diagnoses and particular attachment profiles. Conclusions: A basic “pull-push” dilemma was demonstrated in the reciprocal attachment relationships of eating-disordered subjects. This dilemma be-devils attempts at therapy and may illuminate the strong feelings elicited by these patients in their therapists. The association of attachment style with particular disorder subgroup diagnoses is complicated. Childhood attachment insecurity may provide a vulnerability whose symptomatic manifestation is colored by later events. © 2000 by John Wiley & Sons, Inc. Int J Eat Disord 28: 370–376, 2000.

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“Preoccupation with food may appear as helpless, dependent clinging to parents, or as hostile rejection of them” (Bruch, 1974a, p. 44).

INTRODUCTION

Eating Disorders

The emergence of bulimia nervosa (BN) is a late 20th century phenomenon in Westernized societies (Russell, 1979) suggesting a significant cultural influence. Anorexia ner-
vos (AN), on the other hand, has been systematically described since the mid-19th century. The relatively consistent incidence rates (Fombonne, 1995) together with twin studies (Treasure & Holland, 1995) suggest a larger genetic component. However, both cultural and genetic influences may be expressed in familial interactions. Families have appeared as important etiological/maintaining agents since the earliest case descriptions of AN: “it is indispensable . . . to entrust the patient to the care of strangers” (Marce, 1860). The concept of pathogenic/anorexogenic families continued intermittently, with greater or lesser emphasis, and reached its influential peak in the 1970s (Selvini-Palazzoli, 1974; Minuchin, Rosman, & Baker, 1978). Around this time, Hilde Bruch proposed more specific dyadic difficulties as she focused on early mother-daughter interactions (Bruch, 1974b). She described a mother who superimposes on her infant daughter her own concept of the infant’s needs such that the infant’s needs and impulses remain poorly differentiated. This results in a lack of a sense of separateness and a pervasive sense of ineffectiveness that underlie the development of the eating disorder.

Attachment Theory

Attachment theory developed from the work of John Bowlby. Bowlby (1969, 1973, 1980, 1982) brought together ideas from psychoanalysis, ethology, and learning theory and applied them to the mother-infant relationship. He postulated a drive, separate from and more powerful than hunger in its effect on the mother-child relationship, the drive toward attachment. Adult attachment representations are believed to be internalized working models of the infantile drives and associated behaviors. Various measures have been devised to tap into these, in particular the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), which is currently regarded as the gold standard.

Current Study

We were interested in a particular aspect of attachment, the ability to form reciprocal adult attachments, that is, those that would typically be embodied in partner or spousal relationships. Such attachments reflect both the internal working models derived from childhood and subsequent experiences with important attachment figures, and also demonstrate how these are displayed in current life. We chose an instrument that was directly grounded in Bowlbian theory, the Reciprocal Attachment Questionnaire (RAQ; West & Sheldon-Keller, 1994a, 1994b). Our hypothesis was that reciprocal attachment relationships in an eating-disordered population would be insecure.

METHODS

Subjects

Subjects included all new outpatients attending the Eating Disorders Unit at the Bethlem and Maudsley NHS Trust over a 1-year period. They were sent the questionnaire with the assessment appointment, together with a stamped addressed envelope. Subjects also included all inpatients at the Gerald Russell Eating Disorders Unit over a one-year period, as part of a larger family study. Diagnoses were generated by a questionnaire (BITE (Bulimic Investigatory Test, Edinburgh); Henderson & Freeman, 1987) and, where these were not available, from clinical knowledge of the patient by the consultant (J.T.).
Questionnaire

The RAQ is a 43-item self-report questionnaire designed to operationalize the key components of reciprocal attachment. Each item is rated on a 5-point Likert-type scale and questions are grouped to form nine subscales. Three subscales (Separation Protest, Feared Loss, and Proximity Seeking) describe criteria of attachment that distinguish it from other social relationships. Two subscales (Use and perceived Availability of the attachment figure) relate to the unique provisions provided by attachment. Four subscales (Compulsive Self-Reliance, Compulsive Care-Giving, Compulsive Care-Seeking, and Angry Withdrawal) describe the four identified dysfunctional patterns of adult attachment relationships. The validity and reliability of the RAQ have been established in both clinical and nonclinical adult populations (West & Sheldon-Keller, 1994a). For the purposes of the RAQ, our cover letter defined an attachment figure as “(i) most likely, the person you are living with or romantically involved with, (ii) the person you’d most likely expect to turn to for comfort, help, advice, love or understanding, (iii) the person you’d be most likely to depend on, and who may depend on you for some things. Your attachment figure may be your husband or wife, boyfriend or girlfriend, or another special friend . . . The person you feel closest to right now.” Our covering letter added that “the attachment figure should ideally be outside the immediate family,” by which we meant an immediate blood relative.

Statistics

The statistical package SPSS (Version 6.1.3 for Windows) was used to analyze the data. Parametric and nonparametric tests were used as appropriate to compare demographic data between subjects and controls. Multivariate analysis of variance (MANOVA) was used to compare questionnaire data between the two groups.

RESULTS

Subjects

Of the 151 respondents, in total across the inpatient and outpatient studies, 127 replies were usable. Response rates were 56.1% for the outpatients and 55.6% for the inpatients. A number of outpatients were admitted during the study; therefore, there is some overlap in the figures (n = 16). Of the responders, 50 had AN, 52 had BN, 30 had anorexia with bulimic features (ANBN), 12 were obese (OB), and 9 had an eating disorder not otherwise specified (EDNOS). There was insufficient information to make a diagnosis in 9 patients.

Controls were recruited by advertisement (n = 80). They were slightly younger than patients (mean [SD] age: 25.7 [7.0] vs. 27.9 [9.2]; p = .6, two-tailed t test). Because of the trend toward age difference, we entered age as a covariate in the analysis of variance (ANOVA). One control and 7 patients were male (p = .27, Fisher’s exact test).

Despite the instruction that “the attachment figure should ideally be outside the immediate family,” 22 patients chose a parent as their attachment figure (mostly mother), compared to 3 controls. Twenty patients with eating disorders recorded “none” for their attachment figure, compared to 0 controls, but a number of them went on to answer the RAQ, presumably thinking of a previous attachment figure. In no controls but in 20 patients, the attachment figure was unknown (i.e., not given) and typically the RAQ was
left unanswered. These differences between patients and controls were significant ($\chi^2 = 28.0; p < .0001$).

**RAQ**

A MANOVA, using age as a covariate, showed a significant difference between patients and controls (Wilks’s lambda = .80; $p < .001$). Follow-up univariate tests showed these significant differences were on the scales Angry Withdrawal, Availability, Compulsive Care-Seeking, Compulsive Self-Reliance, Feared Loss, and Use. In all cases, patients scored higher than controls (Table 1). There were no significant differences on the RAQ between the different diagnostic subgroups of patients. This remained true when the subgroups were confined to the core eating disorders, AN, BN, and ANBN.

Among the eating-disordered patients, a multivariate analysis, using attachment figure as the defining factor and age as a covariate, showed a significant difference between the attachment figure subgroups (Wilks’s lambda = .67; $p = .012$). Follow-up univariate tests showed these differences were on the scales Compulsive Care-Seeking, Feared Loss, and Use (Table 2). Thus, patients with an appropriate attachment figure had the highest scores for Feared Loss, whereas those who listed “none” scored highest on the Use subscale.

**DISCUSSION**

Our hypothesis was confirmed, in that there were significant differences in reciprocal adult attachment status between patients and controls. However, we recognize the limitations of our study. It has the same problems as any self-report questionnaire study. We

<p>| Table 1. Reciprocal Attachment Questionnaire: Multivariate analysis of variance (patients vs. controls) using age as a covariate (Wilks’s lambda = .80; $p &lt; .001$) |
|-------------------------------------|----------------|----------------|----------------|----------------|</p>
<table>
<thead>
<tr>
<th>Scale</th>
<th>$M$ (SD) Patients</th>
<th>$M$ (SD) Subjects</th>
<th>$F$</th>
<th>Significance of $F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry Withdrawal</td>
<td>17.4 (5.7)</td>
<td>15.8 (5.4)</td>
<td>4.38</td>
<td>0.038*</td>
</tr>
<tr>
<td>Availability</td>
<td>7.3 (2.9)</td>
<td>6.4 (2.4)</td>
<td>4.98</td>
<td>0.027*</td>
</tr>
<tr>
<td>Compulsive Care-Seeking</td>
<td>23.2 (4.3)</td>
<td>23.1 (4.4)</td>
<td>0.02</td>
<td>0.902</td>
</tr>
<tr>
<td>Compulsive Care-Giving</td>
<td>23.2 (4.3)</td>
<td>23.1 (4.4)</td>
<td>0.02</td>
<td>0.902</td>
</tr>
<tr>
<td>Compulsive Self-Reliance</td>
<td>19.1 (5.5)</td>
<td>16.4 (4.6)</td>
<td>13.86</td>
<td>0.000***</td>
</tr>
<tr>
<td>Feared Loss</td>
<td>19.5 (4.9)</td>
<td>16.5 (4.1)</td>
<td>18.17</td>
<td>0.000***</td>
</tr>
<tr>
<td>Proximity Seeking</td>
<td>8.6 (3.2)</td>
<td>8.7 (3.2)</td>
<td>0.20</td>
<td>0.653</td>
</tr>
<tr>
<td>Separation Protest</td>
<td>7.1 (3.2)</td>
<td>7.0 (2.7)</td>
<td>0.36</td>
<td>0.547</td>
</tr>
<tr>
<td>Use</td>
<td>6.9 (2.7)</td>
<td>6.0 (2.7)</td>
<td>4.57</td>
<td>0.034*</td>
</tr>
</tbody>
</table>

*Significant at $p < .05$ level. **Significant at $p < .01$ level. ***Significant at $p < .001$ level.
might have used the AAI, a semistructured interview that elicits internal working models of past attachment figures. It is currently regarded as the gold standard in attachment work. However, it is cumbersome to administer and rate, and therefore unsuitable for large numbers of subjects. However, we are in the process of using it with a smaller group of patients. In addition, we lacked a measure for subjects who simply did not have an attachment figure, and so do not know how many of our RAQ nonresponders may have been in this category. A questionnaire measure for those with no attachment figure (West & Sheldon-Keller, 1994c) could be added to further studies. In addition, our study would have benefited from the addition of a psychiatric control group.

In terms of adult reciprocal attachments, our patients were most characterized by the apparently contradictory attachment styles of compulsive care-seeking (anxious) and compulsive self-reliance (avoidance). Interestingly, clinicians working with these patients often experience both messages simultaneously, the overt verbal “leave me alone” and the covert somatic “you can’t leave me, I’m dying,” resulting in a characteristic frustrated and helpless response in the clinician. The scores did not correlate significantly for individual patients. This is perhaps not surprising, given that ambivalence may be sequential rather than simultaneous.

Another apparent contradiction arose from the analysis of attachment scales by attachment figure. Those with none who nevertheless filled in the questionnaire scored highest on the use of an attachment figure, whereas those with an appropriate attachment scored highly on feared loss. One might surmise that the avoidant individual, perceiving herself as a potential high User, denies the fear of loss by not engaging. Overt ambivalence was reflected in the correlation between compulsive care-seeking and angry withdrawal (Pearson’s $r = .32, p < .001$ for patients; $r = .25, p = .03$ for controls), both of which were described by Bowlby in his anxious/ambivalent group. It is interesting to note that the correlation, although higher and more significant in subjects, is also present in controls, reflecting perhaps a universal ambivalence about relationships.

These findings echo Bruch’s description of a mother-daughter relationship in which the mother does not respond to the baby’s needs, but rather superimposes her own (1974b). The child grows up unable to differentiate her own impulses, reliant on her mother to interpret her wants. Thus, mother is both unbearably intrusive and vitally necessary. One can also see this relationship played out with food, which is both intensely desired and feared. Our results reflect this “pull-push” pattern, not just with mother, but in other adult attachment relationships.
In a study of borderline personality disorder (BPD) using the RAQ, West and Sheldon-Keller (1994d) found that feared loss of attachment figure, compulsive care-seeking, and angry withdrawal were significantly related to BPD. It is interesting that these are three of the scales that discriminated our patients from controls, suggesting borderline features among the patient group. In addition, our patients were significantly more fearful than controls of losing their attachment figures, supporting the idea of unresolved loss as a relevant concept in eating disorders.

The various attachment patterns/dimensions did not differentiate the different diagnostic subgroups of eating disorders, suggesting that similar attachment difficulties may underlie both AN and BN. This is in keeping with the larger literature on attachment and eating disorders, which largely fails to differentiate subgroups on the basis of attachment profile (O'Kearney, 1996), suggesting that attachment insecurities may cut across eating disorder diagnosis. Insecurity may provide the template, with later events coloring the precise presentation.

We have shown significant differences in reciprocal adult attachment patterns between eating-disordered patients and controls. The eating-disordered patients displayed a mixed pattern of insecurity, reflecting both anxious/ambivalent and avoidant patterns. Returning to Bruch, it is of interest to consider the generational and transgenerational aspects of these attachment styles. In normal populations, parents’ own attachment status has been shown to predict the attachment security of their infant (Fonagy, Steele, & Steele 1991). We are currently analyzing the AAIs of a small group of inpatients with AN and their mothers, and will report our findings in future publications.

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REFERENCES

Marce, L.V. (1860). On a form of hypochondriacal delirium occurring consecutive to dyspepsia, and characterized by refusal of food. Journal of Psychological Medicine and Mental Pathology, 13, 264–266.


