Addiction, at an essential level, involves the substitution of a substance for the provision of mood alteration, affect regulation or anxiety assuagement which would, under optimal circumstances, be available in the form of internal coping mechanisms or, in cases when an individual’s internal resources are exceeded, an attuned attachment figure. To understand persistent reliance on: drugs, alcohol, compulsive eating, compulsive sex, compulsive risk taking, starving, binging, purging, obsessive compulsive rituals, self-mutilation as well as workaholism, or the need for unceasing activity - requires their identification contextually as methods of providing a sense of safety, equilibrium and an illusion of “control” when possibilities for finding these stabilizing elements within relationships have been deemed routinely unsafe or unsatisfying.

At first glance, eating disorders appear to be about preoccupation with food; but more centrally, the obsessive regulation of the intake of food is (1) a frantic attempt to cope with life’s stressors, particularly intense, dysregulated emotions; (2) which involves confusion regarding identity and self-esteem; and (3) expresses and seeks to quell a feeling of aloneness or disconnection from all people. This aloneness is related to a disorder of attachment. For example, anorexia is basically a phobia related to eating. Phobia, when traced back to its roots, is almost always an expression of the failure of the attachment figure to protect the individual
from the terror of trauma (Liotti, 1999). Eating disordered behavior, therefore, stems from the absence of and/or fear of the primary attachment figure.

Hilda Bruch (1973) was the first to suggest that attachment disruptions play a central role in the development of eating disorders. The attachment system is a biologically based, survival system for ensuring physical safety and metabolizing emotional stress, in which immature and vulnerable young seek proximity to an older, stronger, wiser caregiver for protection and care (Bowlby, 1980; Neborsky, 2001). The adequately functioning attachment dyad (e.g. mother/father and child) allows the infant to receive emotional support from a caregiver, which buffers him or her against extreme levels of fearful arousal. A dysfunctional, or failed attachment system exposes the infant to extreme levels of unmodulated stress, resulting in dysregulation of the adrenal-cortical system and the physical and mental side effects of high levels of stress hormone (Spangler & Grossman, 1993). Such unmodulated stress may be the basis of learned helplessness (Seligman, 1999) and post-traumatic stress (Yehuda, 2000) so common in the maintenance of addictive symptoms. When individuals experience the breakdown of their attachment system, they often report feeling disconnected, depersonalized, alone, overwhelmed, out of control, unsafe, abandoned, and longing to fill a profound inner emptiness – symptoms most often described by clients who restrict or compulsively overeat and undereat.

The purpose of this review is to examine eating disorder as an attachment disorder and suggest treatment strategies for adult amelioration of childhood attachment traumas with resultant eating disorder. Long-term recovery from eating disorder is distinguished from symptom control and involves understanding the functional roots of addictive behavior. In many
cases the attachment disorder leading to difficulties with adult intimacy must be adequately resolved before the eating disorder behaviors can reliably remit.

**Internal Working Models**

**Formation in Infancy and Early Childhood**

Bowlby (1980) hypothesized that children build mental models of self, others and relating based on their primary attachment relationships. Healthy internalized attachment models represent beliefs about the self as being worthy of love, being cared for and responded to, and the “other” as being available, caring and responsive (Hazen and Shaver, 1994). These models then serve as filters and guides for how new information is processed and how new relationships are perceived. Attachment templates - especially negative ones - created in early childhood can be so tenacious that they distort interpretation of information coming from the external world for a lifetime. A common example with eating disordered clients is “otherization;” the individual becomes over-focused on “not disappointing” others, so involvement with a partnership, or even parenting, becomes torturous. Such temperamentally disposed individuals often grew up with a narcissistic and/or overly critical (or conversely very emotionally fragile) parent, who demanded from the child attention and care to their own experience at the expense of seeing and nurturing their child’s internal world. The child in return may actively push the parent away becoming dismissive of attachment, thereby actively maintaining consistent the original Internal Working Model. These patterns influence the child’s, and later, the adult’s, view of others and define modes of affective experience. Their lives become dedicated to not causing others distress thereby impinging upon their own “self’s” unfolding.
The potency of early experiences to define an individual’s constructed reality cannot be viewed as on par with subsequent learning environments. For humans, the lack of a viable, attentive, attuned primary caregiver in infancy can mean death. Insulated from danger as we imagine ourselves by virtue of our construction of civilization, the reality of our infancy and childhood entails profound, inevitable dependency. Initially, as small, limited, vulnerable creatures, we cannot meet our own physical, psychological or emotional needs. Physical development of strength, coordination, orientation, psychological development of meaning making, sense of self, and emotional development of affect regulation capacities all unfold within the structure of first relationships. In addition, Schore (1994) has postulated that an infant’s right brain is actually hardwired by affectively charged interchanges within in the caregiver/baby dyad.

In early infancy, there are only basic sensations: soft/rough, warm/cold, comfort/discomfort, hunger/fullness, pressure/release, smell, taste, familiar/strange, rhythmic/discordant. Within the primary relational landscape, the child experiences and interprets these sensations and “learns” primitive lessons about whether he can inhabit his own body, tolerate discomfort, have needs met before they escalate to intolerability, find balance, lose and regain it, seek and find comfort. From repeated dynamic interactions with primary attachment figures, the child derives a subjective reality of self and other, through which lens the child interprets all subsequent relational/emotional experience.

When the attachment dyad functions in a “good enough” (Winnicott, 1965) manner, the result is a “secure attachment” (Main, 1995). The caregiver perceives and responds to the child’s needs with consistency and care, helping him/her to regulate intense negative affective states such as sadness, fear and anger, helps elaborate positive affect states, and co-enacts micro-
rupture, repair and recoordination sequences (Fosha, 2000). When the attachment relationship is disrupted, the impact on child development is marked and devastating. Insecure attachment injures the unfolding of the self-system, and can lead to fragmentation (Liotti, 1992). In one such example, protective parts or the self can create a false self, such that the individual denies crucial aspects of their emotional experience in order to maintain attachment at all costs (Masterson, 2000). As an example, maltreated toddlers display falsely positive affect which does not match their true feelings (Crittenden & DiLalla, 1988). In one scenario of adaptation, where there is misattunement with the caretaker, the child will actively anticipate the mother’s reaction and, while measurably agitated, inhibit or minimize their external expression of neediness, resulting in avoidance of intimacy and primary alexithymia (insecure-avoidant attachment style [Main, 2000]). Alternatively, other children respond by amplifying their expressions of neediness, hyperactivating the attachment system in an effort to capture the mother’s unpredictable attention (insecure-preoccupied/ambivalent attachment style [Main, 2000]). These inhibiting vs. amplifying expressions of neediness are the core of the anorexic-bulimic structure (i.e. “I have no needs, not even food.” vs. “I am so underweight I’m on the brink of death.”). In both of these scenarios, the child is put in a position of sacrificing true self experience in order to maintain loyalty and bonds with a selectively attentive caregiver (whose attachment style was, in turn, shaped by their own early relationships, hence the intergenerational transmission of attachment effect [Lyons-Ruth, et al., 2006]). Such patterns linger throughout the lifespan, as for example, the “absence of a self” is often described by addicts: not feeling real, feeling like an imposter, feeling like a chameleon who can do or say what they perceive others wanting to see or hear.
Attachment Styles

The quality of early caregiving leads to a child adopting one of various identifiable attachment strategies. Attachment quality during infancy is best ascertained utilizing the Strange Situation Procedure (Ainsworth, 1969), which creates a reliable index of infant behavior in response to stress (i.e. brief separation from mother), and provides a window into internal working models reflective of the relationship between infants and caregivers. The caregiver’s own unique internal working models of relationships are best reflected by their responses to the Adult Attachment Interview (Main & Hesse, 1992-1998). The patterns that emerge in the Strange Situation administered at 12 months appear to be reasonably stable over time (Lyons-Ruth, et al., 2006).

These internalized patterns are the “building blocks of emotional regulation,” that the infant incorporates into his or her own evolving system of self regulation, and they become anchored in the infant’s physiological and neurochemical make-up (Steele, et al, 2006). The mother’s degree of attunement to the child’s rhythms creates “inter-subjectivity”—“the interface of two minds” requisite for the maturation of the neurological hard wiring of the child’s brain (Trevarthen, 2001). This maturation occurs hierarchically, from the lower limbic emotional structures, through the midbrain and up to other cortical structures during this early critical period. Although internal working models tend to be resistant to change (Bowlby, 1973), in psychotherapy, activation of this limbic affect allows for state-dependent learning, and access to the “deep structures” in which the core schema and unconscious internal working models which have shaped the responsiveness to social interactions are stored. This argues for bottom-up, emotion-focused therapies that harness the transformative power of emotional experience in order to access IWM’s and transform insecure attachment styles (Fosha, 2000, 2006).
cognitive-based psychotherapies tend to be less useful (Young, 1999) as they instead tap into cerebral cortex structures. For the compliant eating disordered client, they can serve, in fact, to make the “false self” more false.

Table I is a summary of the empirically-based attachment patterns in infancy and adulthood (Ainsworth, 1969; Main, 2000). Secure attachment in the early years provides a child with the stable base needed to confidently explore the environment, to develop a feeling of empathy for others, to have positive self-esteem and subsequently, to have better adult affectional and love relationships as well as friendships. Children adapt to an unreliable attachment figure by either dismissing the need for attachment (avoidant) or becoming “preoccupied” with attachment: unstably hungering for love, while at the same time being hyper-anxious about rejection.

Of increased recent interest are individuals assessed with disorganized attachment (Main & Hesse, 1992-1998). Researchers originally identified children from lower income families who in the “strange situation” at 18 months of age both approached and avoided the returning parent, often appearing dazed, confused and apprehensive. It is as though circumstances in the structure of the primary attachment relationship prevented the child from devising or consolidating a coherent strategy for bonding with the caregiver. The researchers suggest that the child’s behavior may be consequent to a prior history of abuse, neglect, and/or the parent’s struggle with their own unresolved trauma and/or loss.

Ogawa and Sroufe (1997) also identified a link between disorganized attachment during the child’s first 29 months and later adult dissociation in a longitudinal study of a disorganized sample of children. Recent research has found that the disorganized pattern in infants was found
to coincide with maternal lack of involvement with the infant at 12 months, as observed in the home, and with disrupted maternal affective communication with the infant at 18 months as observed in the lab. It is likewise interesting to note the presence of concurrent maternal dissociative symptoms alongside the presence of dissociation in the adolescent, whereas maternal PTSD, depression and anxiety did not appear related.

When a parent exhibits unresolved fear, the baby can sense the emotion as early as 42 minutes after birth (Meltzoff & Repacholi, 2007). The arousal of fear related to the parent creates an irresolvable paradox for the infant, because the parent is then the source of fear, as well as safety and security. Lyons-Ruth and Jacobavitz (1999) examined the hypothesis that in disorganized attachment, the parent’s difficulty in regulating the infant’s fearful arousal is as important as the parent’s own confusing behavior and mixed signals. The children of mothers who were fearful, withdrawn, and inhibited, but appeared sweet and fragile, showed disorganized-ambivalent attachment patterns, in contrast to mothers who were outwardly abusive, whose children were disorganized-avoidant. Thus, two very different types of disorganized styles emerged, hostile-avoidant and helpless-fearful. The former children ordered their parents around, whereas the latter children were excessively solicitous at age six. These differences are similar to clinical observations of the restrictive anorexic vs. the binge-purge subtypes. Both appear disorganized, but the restrictive subtype is often anxious and fearful, while the binge-purge is more hostile-avoidant. In the next section, we examine in greater detail common attachment patterns and styles manifesting in eating disordered individuals.
**Attachment styles and eating disorders**

Eating disorder clients often embody aspects of both insecure attachment styles, with a simultaneous unawareness of needs (avoidant), manifest alongside exaggeration of needs (preoccupied). Life threatening starvation, obesity or purging, which, by definition, necessitates attention, co-exists with the client’s disavowal of severity or the need for intervention. Thus, an eating disorder is a ritualized method of both negating needs, while expressing extreme demand for attention, indirectly, but powerfully, through, at times, life-threatening symptoms.

Table II lists studies that focused on eating disorders and attachment. Chester (1997) compared a combined group of women with anorexia and bulimia to a non-matched control group without eating disorders. She found that those with an eating disorder had a higher incidence of insecure attachment. Ward et al. (2001) used the Adult Attachment Interview with 20 female inpatients with anorexia, binge-purge subtype and anorexia restricting type. Of these, 15 individuals were categorized as “dismissive” (avoidant), four as “preoccupied,” and only one was “secure.” Of the anorexics, 79% of the daughters and 70% of the mothers showed the dismissive pattern. Similarly, using the AAI with 14 anorexic and bulimic clients, Fonagy et al. (1996) reported that four were dismissive, nine were preoccupied (64%) and only one was secure. In our ongoing sampling of severely anorexic and bulimic clients, we are finding large numbers with the disorganized pattern.

Many eating disordered individuals’ symptoms, whether restricting, bingeing and/or purging, are the external behavioral manifestations of deeper underlying disturbances in attachment that were laid down by repeated relational exchanges with significant adults in childhood. These attachment disturbances lead to severe impairments in 1. The developing sense
of self of the child, adolescent and adult, and 2. Ability to relate, seek healthy intimacy and attach to others throughout the lifespan, and 3. Regulate affect, impulses and boundary-defining gestures.

The attachment disruptions common to anorexia nervosa can be summarized as (Dallos, 2004):

- Failure to develop autonomy from parents, especially the mother, due to parental intrusiveness and over-control.

- Perfectionistic home in which questioning of parental authority or diverging from parental values is negatively reinforced. Near obsessive attention to social appearance and protecting the outside image of the “perfect family.”

- Rewarding the dependency of the child so that she develops a compliant false self – “a good girl” – as a defense against parental intrusiveness.

- Parental control constantly redefining the children’s feelings and emotions to be congruent with the family’s values.

- A vulnerability and inability to express emotion, especially anger, which tends to surface in adolescence due to demands of that period.

- Unmourned issues in which everyone has ostensibly “moved on” and made the “best of it” through working or taking care of others.

Stemming from such family dynamics, the typical anorexic/bulimic client detests “weakness,” and wants to think her way out vulnerability. She despises her needs. She either envisions herself as “adult” even in childhood, or is detached from the child she was, with no
empathy for hardships faced. She longs to perfect herself through rituals around food, cleaning, achievement, caretaking others, self-deprivation, endurance or proving herself to another to whom authority status is imputed. It is never enough. She feels she is “too much” and takes up space and resources of which she is undeserving. She is so empty she could consume the world, but won’t allow what she takes in to nourish her, won’t “keep” what she takes in. Pleasure is anathema, or must be paired with pain or self-degradation. Others are viewed as competitors, would-be critics, potential sources of disappointment, who must not see what lies under the façade lest they feel reviled; thus relationships, like food – are not perceived as a source of nourishment or sustenance.

Looking through a lens of functional adaptation, the genesis of an eating disorder can be seen as providing a protective membrane around the beliefs and fears attendant upon a contradictory set of attachment needs, substituting a simplified version of “rules,” which aim to contain the client’s more profound existential anxieties. Simply, some clients deny unmet emotional needs by distracting themselves with food-related behaviors and rituals that relate to desperate attempts to “empty out” or stay empty (i.e., “If I don’t have needs I can’t be disappointed, abandoned, or lonely”). Still others may manifest utter preoccupation with their neediness and dependency, and rely heavily upon their eating disorder to force someone to care for them and to avoid growing up, with all the encoded terror of aloneness and inadequacy this imperative represents.

The eating disorder then ultimately functions to preserve unaltered internal working models of attachment laid down in the first two years of life. By overfocusing or underfocusing on the unreliable caretaker, the individual fails to develop self-agency, self-awareness, and self-cohesion. An eating disorder is used as an active survival strategy to cope with the inability to identify or articulate internal states and to turn to people for comfort. Clients unconsciously
deploy their attention to food to avoid anxiety in conjunction with preexisting expectations of unresponsive and unpredictable caregiving. They use eating obsessions to avoid potential rejection from friends and romantic partners, ironically creating in the process, unfortunate outcomes such as isolation, abandonment, engulfment, and/or high levels of conflict that lend further credibility to the original unrecognized, yet enacted, fears around attachment.

The inability to attach stably results in the unfolding of segregated, dissociated internal working models of self and of the attachment figure. The eating disordered individual states, “I don’t know who I am,” “I feel like an imposter” or “I’m really bad, but pretend to be good.” This confusion and dichotomy is exemplified in the commonly repeated history of being a “good girl,” who while making straight “A’s,” excelling in sports, or “never giving anyone a moment’s trouble,” who also compulsively steals, lies, or can’t say no to sex with men. Often, at the heart of this paradox lies the childhood experience of a mother who can be both safe and dangerous, and subsequently, adult intimacy with partners that is both desperately needed and distressing, leading to courtship ambivalence and the need to numb or insulate experiences of affection (Schwartz, 2008).

At the core of an individual’s capacity to bond, lie self-empathy and the related capacity for self-care. In the absence of validating caretakers (or an alternative), the individual does not internalize a caring relationship with self. Not surprisingly, a child who is rejected, neglected, abandoned or abused tends to develop negative core schema or beliefs about self. Yet core schema are likewise negatively impacted when a child is relied upon in excess of her capacities, or from whom perfection is expected, or where role reversals around dependency are maintained. These dynamics ultimately organize an individual’s range and type of interactions, driving relational and intra-relational re-enactments (Gleiser, 1998; Lamagna & Gleiser, 2007) and
constraining possibilities for new learning. Clients then feel stuck in relationships and emotional entanglements that mirror the original caregiver/child dyad. Such repetitive predicaments leave the client with feelings of shame, helplessness, and self-doubt like those they experienced in childhood or adolescence (a form of affective flashback), i.e., feeling “fat,” unlike, rejected, and believing that others will feel contempt for or hurt them, even when they have repeated examples in the present that contradict their old data. In the child’s mind, and in the eating disordered mindset that unfolds, the person falsely or accurately attributes the cause of their aloneness to being “fat,” or come to believe that only food, or the restriction thereof, will reliably offset the internal emptiness. Braun (1984) conceptualized the BASK model of dissociation (Behavior, Affect, Sensation, and Knowledge) to explain this phenomenon of a sensation such as stomach expansion being experienced as affect, “I feel huge” or knowledge, “I am so big as to be unlovable,” since affect is denied and is experienced primarily as anxiety.

One’s internal model of self comes to exist in the context of others, within an aggregation of experience of the “self-in-relationship.” The internal working models of eating disordered clients are filled with self-loathing, and the need to compensate by restricting or purging, thereby providing an illusion of control. The anorexic engaged in her disorder feels special and powerful and this sense further impels her toward perfectionistic mastery. However, when attempting abstinence from the eating disorder, the learned helplessness is so great that they are unable to do simple tasks such as paying bills or parking in new lots.

Eating disorders and the attendant disorders of self also impair the formation and dynamics of adult relationships, thereby perpetuating attachment dysfunction. The eating disorder client often experiences major difficulties with romantic liaisons and sexuality (see Table III). Many ED clients’ early histories include being highly sensitized to soothing and
mirroring the caretaker as a primary mode of engendering “safety;” however, this requires relinquishing the development and differentiation of the autonomous self, for which sufficient safety to individuate would be requisite. The result is an attempt to create safety and consistency in maladaptive ways, i.e. distorted survival strategies. With such an intimacy disorder, the individual repeatedly finds individuals who need care, thereby constructing an illusion of safety and control through caretaking. They become an extension of their partner’s identity and their boundaries become blurred, such that the other feels unduly vital to one’s self-survival. There is no separate sense of self, except in the eating disorder. The individual may then simultaneously experience a need to merge like a child might with a caretaker, and a need to run, for fear they will be engulfed or abandoned. They may also experience ambivalence related to the need to use others (binge) for self-soothing and prefer to “not need” (the hallmark of the restriction cycle). The eating disorder cycle can serve the function of mediating this dance of restriction and bingeing, distance and closeness, neediness, and autonomy-seeking.

The eating disorder client has difficulty self-soothing until they stumble onto eating or restricting as a substitute, though a poor one. They feel unlovable and use their preoccupation with food (the acquisition, ingestion, control of, avoidance of, and/or riddance of) to numb the pain of perceived existent and anticipated rejection. Food symbolically may become the self-object that allows them to feel safe – thus becoming both necessary while distressing, similar to the experience they had with their caretakers. The eating disorder client may require constant mirroring from others to maintain an accurate sense of self: “You are not fat.” “Fat isn’t bad.” They lack self-acceptance to the degree that their achievements never seem able to adhere internally, esteem cannot ensue. Thus, they tend to become a chronic human “doing” rather than “being” since they feel they are only as worthy as their last attempt at self-control or
perfectionistic attainment. Even pursuits that initially are undertaken for enjoyment or pleasure succumb to a narrowing of usage as a source of transient achievement or identification, eventually qualifying only as one more demand for excellence lest, “I disappoint others for which I will be disapproved of and rejected.”

**Eating Disorder as a Trauma Reenactment**

Trauma includes any event that is subjectively perceived as overwhelming an individual’s internal and external resources, thereby evoking states of terror, helplessness and fear of annihilation. Trauma, by its very nature, is difficult to consolidate into long-term memory. Discussion of the trauma may evoke state-dependent memory, strong emotions and avoidance defenses. The event is then remembered as a “re-episode” (as described by Weis, 2003), a memory that repeats itself over and over in affect, cognition and/or behavior while the actual memory is dissociated. An eating disorder represents one type of re-enactment or “re-episode,” which displaces the traumatic memories so that the person’s life becomes dedicated to reliving the trauma in disguised form.

Disruptive and overwhelming events (i.e. small “t” traumas) occur to everyone in normal development, such as changing schools or peer rejection, but sensitivity and resiliency for those experiences varies greatly depending on the early attachment environment, the child’s temperament, and the severity of the trauma. Two individuals can experience a similar trauma, for example, a rape during adolescence, but exhibit vastly different outcomes depending on their attachment histories. The adolescent with secure attachment to parents, access to social supports, and a resilient sense of self may resolve emotional reactions to the trauma without any long term psychopathology; whereas an adolescent who feels alone, alienated, silenced and ignored by
family members, will be more likely to go on to establish posttraumatic stress disorder and/or dissociative symptoms to cope with overwhelming emotions and helplessness. In the latter case, the adolescent experienced not only a discrete trauma event, but also suffered from attachment trauma in the inadequate responses of caregivers to soothe, protect and help process the event.

Horowitz (1993) studied adaptations to severe stressors in childhood, and suggested that the common “natural” result of severe trauma is repetition, which consists of flashbacks, intrusions and reenactment, until there is completion. If the stress response cycle is not successfully completed, erroneous schema become engraved into the internal working model of self. Relationships created by unresolved individuals are likely to reprise traumatic elements and schema by means of disguised repetitions, with accompanying numbing and intrusions, throughout their lives (Schwartz, 1996). Dissociative defenses resulting from both trauma and disorganized attachment interfere with completion and mastery and/or “working through” of the trauma. The result is that many victims of childhood abuse experience memory disturbances (van der Kolk, 1996), and are left to repeat the trauma in disguised form unaware of its origin. Compulsive reenactment often includes “acting-in” compulsions such as self-cutting or eating disorder, or “acting-out” compulsions such as hypersexuality or creating destructive relational reenactments, such as picking alcoholic partners repeatedly or battering relationships in which trauma related feelings repeat but are not resolved. These reenactments can become addictive, serving as distractions from the internal emptiness and constriction and giving the individual the illusion of temporary connectedness, power and control, as well as relief from loneliness and depression. This reliance is further potentiated by endorphin release (van der Kolk, 1996), extreme alterations in cortisol regulation and dopamine release from the median eminence, facilitating a state similar to “addiction.” Thus, any treatment of eating disorders, which aims to
truly heal the individual, to the point of flourishing, and engaging in enriching intimate relationships with self and others, must promote resolution of traumatic events and attachment traumas, in addition to restructuring insecure/disorganized attachment styles to secure attachment.

**Attachment as a Mediator of Eating Disorder: Part 2, Creating “Earned Secure Attachment”**

**Creating Secure Attachment**

According to Mary Main, one of the primary characteristics of “earned secure attachment” (Main, 1991) is metacognitional thinking, also called mentalizing (Fonagy et al., 1996) and integrative thinking. Distinct skills contribute to metacognitional capacity, such as the ability to reflect on and make meaning of one’s mental states (i.e. “I’m irritable because I didn’t sleep well last night.”), elaborate a theory of the other’s mind (i.e. “Mommy’s irritable because she’s tired.”), and decentralize, and therein establishing a sense of mastery and personal efficacy (Ardovini, 2002). Fonagy (2002) has identified the prefrontal area of the brain as a center for metacognitional thinking or mentalization - that is - thinking about another’s inner motives and contextualizing their behavior.

Building and enhancing this metacognitional ability is a central, though often implicit, aim in many psychotherapies. To lead eating disordered patients out of realms of fear, isolation and desperate reliance on symptoms, and into the hold of connection to self and others, trust and comfort in their own skin, requires explicit relational and emotional interventions that foster the metacognitional capacities named above. For many patients, this means giving them their first ever experience of secure attachment. In the following sections, we will draw from an eclectic
array of therapies to show how deep healing from attachment trauma is possible in eating disordered populations (Table III summarizes the methodology we are currently piloting).

**Restructuring Attachment in the Therapist/Client Dyad**

If we seek to access and transform deeply grooved patterns of disturbed attachment, laid down in the first, most susceptible years of life, we must have powerful tools at our disposal: tools that can awaken basic affiliative instincts thwarted by trauma, rejection and abandonment. These tools must engage not only cognitive parts of the brain, but also limbic and subcortical processes (van der Kolk, 1996); thus, experiential and emotion-focused interventions are crucial (Fosha, et al., 2009). However, the tools we seek must also transcend conventional notions of a “tool,” embodying a deep responsiveness on behalf of the therapist, a willingness to connect genuinely and humanely and share the exquisite pains that our clients bear and walk with through their suffering and out the other side. This is a hallmark of secure attuned attachment, whether in a mother/child or therapist/client dyad.

Diana Fosha has created an integrative therapy, called Accelerated Experiential Dynamic Psychotherapy (AEDP), rooted in attachment, emotion and developmental neuroscience theories, which inform its relational, meta-reflective, and emotion-focused interventions. AEDP was designed to heal attachment trauma (Fosha, 2002), and its dual focus on restoring secure connection to others (first with the therapist), and deep connection with the self (through the complete processing of warded off, feared emotions) makes it a well-tailored treatment for eating disordered individuals.

AEDP therapists aim to create a different and transformative emotional experience for patients from the get-go (Fosha, 2000). By micro-tracking and amplifying glimmers of emotions
as they arise in session, the therapist helps clients move beyond defensive, constricted, symptomatic functioning, through full waves of deep, bodily-felt emotion (e.g. grief, anger, fear, vulnerability) until they are processed to completion. This process, when supported and held in a spirit of felt safety, allows clients to feel deeply seen, deeply felt by another, guided safely through feared internal landscapes, and also fosters a sense of mastery, and authenticity (e.g. “I can feel the true me.”). So essentially, AEDP creates experiences of secure attachment, where the “older, wiser, stronger” (Bowlby, 1980) therapist attunes to, emotional regulates, and guides the client, who is encouraged to maintain simultaneous connection with self and therapist. This is in sharp contrast to the early environments of many eating disordered clients described above, in which they, as children had to sacrifice their self-experience to stay attached to disturbed caregivers, and as a result were left alone to deal with painful, intense emotions. Having an emotional experience that is shared, safe, and when processed to completion, results in clients feeling open, at peace, a sense of clarity, self-compassion and wisdom, further strengthens the bond to the therapist, which allows emotional processing to proceed to yet a deeper level.

Just as relational and emotional interventions are thickly intertwined, with each advancing the process of the other (e.g. intense shared emotional experience forging secure attachment, which then promotes deeper emotional processing), so too are experience and reflection synergistically linked in AEDP. Alternating waves of experience and reflection break new trails that open up into expansive vistas that uncover new trails. For example, the therapist notices a flicker of anger on a client’s face and interrupts her story to have her focus on the sensation of that feeling in her body (experience). The client is surprised, taken aback. The therapist perceives this, and asks what it’s like to have her anger recognized, accepted and encouraged (reflection). The client tears up (experience) and says that in her family, she was
always accused of being sulky, and no one wanted to be around her when she was like that, so she would just go off and binge. The therapist asks her if she can let in that the therapist still cares about her and stays present with her even when she’s angry. The therapist and client go on to work through the grief at being rejected and shut down when she was angry, and then the underlying anger, which was the first point of entry. Following this experiential work, the therapist helps the client reflect on the internal changes and sensations flowing from this work, and thus emerge feeling of relief, lightness, and vulnerability that are markers of deep emotional transformation.

Therefore, not only does AEDP intentionally and explicitly create an actual secure relationship within the therapeutic relationship, its alternating waves of experience and reflection elicit true self experiences that are deeply felt and inherently integrative, thus building much needed resources and resiliency in eating disordered clients. Finally, AEDP’s meta-reflective interventions emphasize the unfolding process of transformation, and become the crucible for the meta-cognitional skills enumerated above.

**Intra-Relational Interventions and Internal Family Systems**

As we have emphasized in the previous sections, a child’s sense of self, identity, affect regulation capacities and relational templates are forged in ongoing dyadic exchanges with caregivers. Severe attachment deficits in the first year of life typically lead to self-cohesion difficulties, leaving the individual vulnerable to identity fragmentation. As an example, one part of self can know they are think and starving, while another feels fat. This integrative deficit is most clearly characterized in adulthood as a dissociative disorder, since there is difficulty with integration of a coherent consistent sense of self.
Epstein (1995) has suggested that the result of internal self-fragmentation is the creation, metaphorically speaking, of “black holes” that absorb fear and create the defensive posture of isolated selves - unable to make satisfying contact with oneself or others. Without basic integration, the individual experiences identity as many “selves,” or feels like an imposter due to the inherent experience of contradiction. Each of these “selves” has unique emotional experiences, memories, the capacity to produce behavior and impulses for action. Thus, a client can binge or purge, and feel like the action was out of their control and outside of their capacity to access relapse prevention tools. In more severe cases of dissociation, the internal system of selves can be very alienated from one another, characterized by high levels of conflict, and even separated by amnestic barriers as in full blown Dissociative Identity Disorder.

Looking closely at the internal dynamics that characterize fragmented self systems reveals the specific mechanisms of internalization of caregiver/child dyadic interactions. The internal relationship and exchanges between dissociated parts of the self mirror relational patterns laid down in primary caregiver/child relationships (Lamagna & Gleiser, 2007; Lamagna, in press). For the child that experienced neglect and abandonment by their mother, for example, her internal system of self states will recapitulate that in patterns of internal abandonment and neglect. In eating disordered clients, this can manifest in ignoring hunger cues and neglecting basic needs for nourishment, essentially “abandoning” the parts of the self that hold those needs and thereby re-enacting cycles of deprivation by distancing from distressed and needy parts of the self. Likewise, a client who grew up with a critical and abusive father, may be haunted by critical, reflective parts of the self modeled after dad, that batter and perhaps even self-mutilate receptive, experiencing parts of the self who encapsulate all of the distressing, traumatized contingent affects. Therefore, what were once external patterns of relating become internal ones:
“intra-relational” (Lamagna & Gleiser, 2007; Lamagna, in press) patterns of relating, crystallized in a rigid, conflict-ridden identity system (see Figure 1).

Given fragmentation of the self system in many eating disordered clients, a central goal of treatment is healing and integrating dissociated or disowned parts of self (Lamagna & Gleiser, 2007; Schwartz, 1996) to create a more cohesive sense of self. This process proceeds from understanding the original survival function of protective parts of self, such as those that engage in the eating disorder or alternative seemingly self-undermining behaviors, as well as ascertaining the ongoing function of these behaviors (Fosha, 2000; Schwartz, 1996). For example, anorexic parts of self may hold various and contradictory positions (Table II), so that the client can both hate her eating disorder, yet fear giving it up, resulting in an internal “civil war” and a great deal of energy expended in hating oneself for it. Resolution of these internal conflicts is one essential milestone toward integration.

Different parts of self may also have different attachment schemas (Blizard, 2003) and may enact different relational dynamics internally (Lamagna & Gleiser, 2007). Particularly in disorganized attachment the distinctions are clearly perceptible. Anorexic parts can be avoidant in external relationships, isolating when distressed, as well as in internal relationships by devaluing and distancing intra-relationally from needy parts of self; while bulimic parts can be preoccupied with and crave others’ affection in the outside world, while inside, they may amplify distress and emotion to harness the attention of other parts of the self. Creating secure internal attachment (Lamagna & Gleiser, 2007) among parts of self is a vital aspect of self-cohesions and self-regulation, that then gives rise to secure relating with spouse, children, friends
Intrarelational AEDP (Lamagna & Gleiser, 2007) imports the relational, emotion-focused and meta-reflective aspects of AEDP described above into a client’s fragmented inner landscape of selves. From the foundation of an explicitly forged secure relationship between therapist and client (no small feat with chronic trauma survivors!), the dyad can proceed to co-create new internal emotional experiences through internal dialogue, fantasized scenes, re-working traumatic memories with the introduction of new elements (e.g. adult parts of the self and/or therapist “entering” the memory). These new internal experiences are characterized by resolution of chronic conflict and ruptures, self-protection, self-soothing, emotional attunement, internal affect regulation: the stuff of secure attachment. Once again, the external becomes internal, but this time to foster healing, integration and self-flourishing (see Figure 2). In this way, secure attachment and identity clarity and cohesion are inextricable and co-emergent processes: we need other to attune to and mirror and organize self-experience in order to scaffold the development of a resilient and cohesive self-identity, which is then capable of seeking out healthy and secure attachments with others. Intra-relational AEDP seeks to intervene and foster development through the dual pathways of external and internal relationships.

By extending family therapy tenets and techniques – into the internal realm, Richard Schwartz’s Internal Family Systems (IFS; 1995; 2006; 2009) the therapy offers another approach for resolving self-fragmentation an fostering integration. In IFS, therapists first aim to access an inner “Self” characterized by a sense of calmness, curiosity, clarity, compassion, confidence, courage and connectedness, along with Main’s coherence, collaborativeness, and consistency. This is achieved by “unblending” parts of self that have limited roles and capacities, often defensive/self-protective in nature, by asking them to step aside, until the more
spiritual, centered, resourced Self can take a leadership position in the internal system. A Self-led, securely attached individual can turn to Self and to others for self-soothing and intimacy. IFS uses internal dialogue, experiential, fantasized scenes between Self and parts to promote understanding, healing and integration.

**Healing Underlying Trauma in Eating Disordered Clients**

To fully process past traumatic experiences in therapy, the client must, in an environment of safety and support (1) recall the overwhelming events (exposure), (2) re-experience and modulate the dissociated affect, (3) integrate the memory, emotions and cognitions (4) reprocess the core beliefs and destructive behavior engendered by the experience, metacognitively, (5) establish a less maladaptive response, other than eating disorder, or other maladaptive strategies to deal with current distress, (6) make meaning from the overwhelming experience and resulting trauma, and (7) reexamine stuck points and schema resulting from the trauma. The difficulty in most cases is that trauma has been chronic throughout the childhood and adolescent years and as one piece of work is complete, another pops up. The second problem is that traumatic memories are linked and tied to other overwhelming experiences. For example, most clients who were sexually abused within the family find the resolution of the abuse memories are linked to their ambivalent feelings regarding the non-perpetrating parent’s not protecting them. This dilemma is further linked to the original early misattuned attachment. Full resolution of the sexual abuse requires trauma work in each of these areas.

In general, the therapist’s job in this process is to facilitate transformation of the self through an attuned, secure, affect-regulating internal relationship that allows for tolerating, modulating and communicating affect and enables exploration and eventual mastery of feared
experiences and relationships (Fosha, 2000). In addition, the therapist helps the client reintegrate affect with experiences, which strengthens coherent narrative competence. The therapist also facilitates the learning of behavioral skills around: tolerating intense emotion, soothing negative feelings, problem solving, social skills, dating skills, maintaining healthy boundaries, de-catastrophizing, playing, recreational skills, labeling emotions, body mindfulness and many more. Finally, the therapist enables the client to deconstruct the attachment patterns of the past and construct new ones in the present (Wallin, 2007).

One challenging aspect of trauma resolution therapies is accessing the traumatic memories specifically tied to the symptoms of anorexia and bulimia. Typically, the work begins by having the client evoke a mental image of her injured child self and allowing her to express affect and her perceptions of her world. Often the depression, anxiety or compulsive behavior symptoms can be activated in the therapy, and used as “leading-edge feelings” back to associated events. For example, the client might write about her worst eating disorder day in detail and read it out loud. When she expresses the emotions of horror or sadness, she is instructed to follow those feelings back in time to any event that (1) might have contributed to such behavior or feelings or (2) any time in the past she felt similarly.

Another requirement of effective trauma work is that the adult self or executive self is present with the injured or child self and that they form an internal relationship in imagery. The injured self can then express the memories with internal pictures and words that were not fully expressed at the time, with the assistance of the adult self and feel witnessed (Schwartz, R. 1999; Lamagna & Gleiser, 2007). Any overwhelming event needs to be expressed and witnessed by self and other to be fully integrated. Children are ill-equipped to do this without a parent or therapist’s assistance. The injured self also verbalizes beliefs that were engendered by the
trauma, i.e., “I am bad,” “Others will hurt you,” and the schema or core beliefs around power control, esteem, trust, and intimacy and how each contribute to the eating disorder symptom, (i.e. “I need control of what I put into my body”). In this way, unconscious contributory factors are made explicit, can be questioned and revisited and thereby lose their power. The injured self must then talk to the healthy adult self to correct the maladaptive beliefs. The therapist may coach this dialogue, but such wisdom in this strong affective state often leads to one-trial learning or a correction of the core beliefs that fueled the addictive behavior. As part of the witnessing and cognitive reprocessing, a process described by Richard Schwartz (1999) emerges called “unburdening.” Burdens are thoughts, beliefs or feelings that constrain dissociated parts from fulfilling their natural roles. Thus the parts of self involved in restricting might give up that burden and instead help the client play and have fun or build a successful career. The energies bound up in the dysfunctional behavior are freed for life-affirming pursuits.

Horowitz (1993) believes that some catharsis is also necessary in order that the energy generated by the stress response cycle diminishes and there is a “release” of bodily tension. Many body therapies (Ogden, Minton, & Pain 2006) and expressive therapy techniques are useful in facilitating such a process. For example, in AEDP, bodily rooted emotional experiences are deepened and released through experiential dialogue, imagery and sometimes movement, allowing a full processing of “stuck” emotions (Fosha, 2000). Typically, after a full wave of emotional processing clients report feeling lighter, clearer, liberated, at peace, as well as times invigorated energized. It is not uncommon for heaviness, weight, “sludge” (as one my clients describes it) to be replaced by a tingling, vibrating energy. These are somatic markers of emotional transformation and healing.
Continued focus on these contributing aspects “loosens the mortar” of the factors maintaining the eating disorder. The client begins to reexamine metacognitionally how they came to have false beliefs that have controlled their life choices and decisions. Such insight is rarely sufficient for symptom remission because of the developmental and cognitive deficits resulting from the initial symptom development. In other words, the client doesn’t know how to function without pleasing others and is terrified of being in the world without the internal object of the eating disorder and all the pricey comfort, familiarity and control it affords. She then must individuate with the therapist’s secure attachment as a home base. To do so, she needs to build an equally secure attachment with Self in order not to internally reenact the original relationship with her mother.

Wherever there is severe trauma, there is commonly disorganized attachment and dissociation, making the interconnection between the symptom and trauma unrecognized. Dissociation implies that there are shifts in modes of responding or increased fragmentation of personality into compartmentalized ego states. The client can display childlike vulnerability, adolescent like anger, and adult like responsibility in a five minute period. The same client can appear both concerned with others and extremely narcissistic, furious with his or her family - but very affectionate, dependent and needy when in the room with the family – not requiring much attention and care, but be desperate for affection and nurturing; and so on. Eating disorder symptoms such as restricting followed by bingeing seem to reflect these contradictory and polarized states.

The dissociation therefore, requires special interventions in psychotherapy since the eating disorder had become the means through which the vulnerable state obtained attention, the angry state released fury, the sad state grieved, the independent state remained powerful, and so
on. The eating disorder allowed for the balance of internally polarized states. Some therapists (Schaefer & Rutledge, 2004) have referred to the eating disordered state as “ED,” in order to dis-identify with it, but we believe that the eating disorder can be more accurately conceptualized as representing the polarization of many dissociated states. Some integration of these states is essential, requiring trauma resolution and internal communication and negotiation with the polarized states. The client might discover that previously the eating disorder was “necessary” to have people love and care about her. She fears being alone and rejected if she gives it up. Simultaneously, the eating disorder currently has kept her alone and rejected. As these contradictions are brought into consciousness, she then finds that she has potentially greater current control or choice relative to friendships and rejection than in the originating circumstances, and the parts of self that have over-controlled food can accept the new job of facilitating rather than preventing the process.

**Building a Vital and Healthy Life after Trauma and Eating Disorder**

Factors influencing the origin of the eating disorder may be quite different from the factors maintaining and perpetuating the symptom. Once a client becomes over-compliant, isolated, and numb, they continuously reconfirm their self-perceptions by selective feedback and cognitive distortions, and thereby miss life experiences such as having fun at slumber parties, and dating at various ages, which become difficult to “make up.” This becomes an important focus of grieving as clients realize all that they have missed out on; it is vital that therapists acknowledge and facilitate this mourning of the self (Fosha, 2000). It is as if they have slept through adolescent maturation in some cases and their identity has consequently remained undifferentiated. They verbalize, “I don’t know who I am” and they frequently appear chameleon-like, being highly susceptible to external influences as their eating disorder symptoms
go into remission. They feel unable to adequately control the events around them and often exhibit behavior congruent with their worst fears – as if they were choiceless. At this point, the restricting eater is at risk for overeating, the sexual anorexic is at risk for sexual acting out, and so on. Clients often revictimize themselves at this juncture as they grasp for some other form of illusionary control. At this stage of recovery, a secure attachment with therapist is as crucial as ever, as the therapist attunes to and mirrors the clients burgeoning self, noting and deepening glimmers of true self experiences, positive affects and strengths (Russell & Fosha, 2008), all of which contribute to building a confident assured, and genuine self.

Another critical developmental deficit in eating disordered individuals are experiences related to gender and sexual development. In the absence of certain critical abilities in negotiating the outside world which might be described as “structural abilities” (Greenspan, 1996), the client becomes terrified to grow-up. Such structural abilities might include managing social interaction via boundaries, inability to play or experience pleasure, demonstrative gestures such as showing you like the other person by smiling, laughing, and appearing like you are enjoying your time with them; calling them and verbalizing how much you appreciate the conversation and then accurately picking up the other’s reciprocal behavior. Since, in eating disordered individuals, natural manifestations of affect are often blunted or diminished, meals are anxiety provoking, and contact with others are perceived with distrust, anxiety and anticipated rejection, the eating disordered individual may appear miserable, quiet and anxious, which can be misconstrued. People may perceive such individuals as not interested, not engaged, not enjoying themselves, and respond by distancing, thereby creating a self-fulfilling prophesy of rejection.
Similarly, feeling effective in mastering small developmental tasks has often been impaired by the engulfing parent as previously discussed, so simple tasks are accompanied by extreme anxiety. One adult client said, “I can’t take care of myself, work and pay bills.” She certainly could hold a job and write checks since she had finished several years of college, but these tasks were accomplished while binging and purging 10 times a day. Without her addiction, she felt immobilized. Clearly she needed step-by-step assistance in recognizing that she could master difficult situations such as parking in the lot at school, going grocery shopping and applying for jobs and going to interviews, one small, encouraged step at a time.

Finally, close relationships require a tremendous amount of developmental rehearsals and skill acquisition involving the self-functions of being able to say no, self-assertion of needs, expressing interests and desires separate from the partner, and using touch and conversation with appropriate self-disclosure for self-soothing. All these social interactions seem developmentally delayed in eating disordered clients, which becomes painfully clear once their symptoms begin to remit and trauma begins to heal. Unless each of these deficits is assessed (and the client will not easily disclose them because of shame) and a direct intervention is then rehearsed in role play or psychodrama, the client is likely to relapse with eating disorder symptoms.

Without the eating disorder, the client experiences rejection, failure and loneliness, and basic human needs are experienced as excessively unbearable and overwhelming. The eating disorder somehow allows him/her to bypass, override and transcend these. It puts the person in control, binds the anxiety and makes them feel invincible, ironically while they are, in truth, most out of control. So as symptoms remit, new, healthy, positive skills, resources and coping, not to mention relationships, must replace the void left by the disorder.
Emergence of Self-Development and Self-Reliance

To alter the client’s hyper-reactivity to others, extreme neediness and isolation, gullibility and suggestibility, and “otherization,” it is critical to seed the development of the real self, establish a greater awareness of inner states (alexithymia) and finally to teach them to trust their own abilities to operate in the world (agency), protect and care for self (nurture) and to feel pride and esteem about who they are (esteem). These are generally skills that, had environment and internal elements not mitigated against it, would have unfolded during early childhood and then would have been practiced throughout childhood and adolescence.

With their high degree of dissociation, eating disorder clients do not express a sense of accomplishment from their achievements. They feel as if they are imposters, “I didn’t do that; another part of me did and that’s not really me. I am bad for being needy and, therefore, cannot feel good about who I am or what I do.” Clients dismiss their actual successes and accomplishments and attain no satisfaction from mastery. Every action seems accompanied by anticipatory anxiety of the next challenge. Thus, self-cohesion and efficacy are also problematic.

When clients begin to experience sobriety, integration of self reaches a new level. In psychodynamic terms there is a re-owning of the disowned parts of self, (the vulnerable, needy, scared parts), and those parts begin to be cared for by “Self” (Schwartz, 1996). The emptiness inside is filled and the client also gets better at reaching out to others and really assimilating rather than deflecting, their accurate feedback and mirroring. At this stage of treatment, body image distortions and obsessions are more likely to be corrected. One client states, “I looked in the mirror this morning and saw myself accurately for the first time.” The client gets to know the punitive internal voices running the show during their joyless pursuit of perfection, and can
dialogue with them from their healthy self. The internal sense of entitlement slowly changes as they feel more deserving of good life events and less personally devastated by selective attention to bad events or less than “perfect performances.” Living, in actuality, begins to become a possibility rather than merely sequential performances accompanied by debilitating pre and post anxiety.

**The Role of Family in Treatment**

Another important component to healing and fostering secure attachment relationships in eating disordered clients is intervening on the systemic level to guide family members in developing healthier modes of interaction. Family therapy may facilitate conversations about feelings and relationships, particularly dealing with conflict. The primary goal of the therapist is to develop an attuned secure attachment with the client, which allows her to explore, discover, question reflect, feel and consider alternative possibilities. Abstinence from addictive behaviors results in experiencing high degrees of anxiety and being forced to individuate and become more self-reliant. The client relies on the relationship with the therapist as a bridge to forming a deepened and compassionate relationship with self as well as a new “family of choice” over time, consisting of friends, acquaintances and lovers, while renegotiating boundaries with the family of origin. The timing of the process of facilitating inter-psychic intimacy is critical. After the client has established the core of self-compassion and communication with “exiles” in split off - and disowned parts of self, there is a greater access to authentic, albeit confused emotions and beliefs of the developing child. The parent can be facilitated to provide “reflective function” (Fonagy & Target, 1997) and add their adult attributes and chronological history (i.e. “that is the time father and I were considering divorce”). With a non-blaming supportive relationship with the parent, the therapist may be able to facilitate strongly emotional regrets and honest discussion.
of “mistakes” in optimal parenting, and the adult child can contextualize their natural response with less guilt. A similar interchange may include siblings or spouse. This inter-psychic intimacy is a necessary aftermath of intra-psychic intimacy to reality test the tactile beliefs about self beginning to form. This, however, is a delicate process and negative experiences with others can be devastating.
<table>
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<tr>
<th>Study</th>
<th>Attachment Measure Used</th>
<th>Sample</th>
<th>Conclusions</th>
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<tbody>
<tr>
<td>Pole et al. (1988)</td>
<td>PBI-parental bonding instrument</td>
<td>56 bulimics and 30 ‘normal’ controls</td>
<td>Bulimics perceived their childhood experiences with their parents as sig. Lower in care compared to the control group. Also perceived their mothers as sig. less caring and fathers as sig. more overprotective</td>
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<tr>
<td>Calam et. Al (1990)</td>
<td>PBI</td>
<td>98 British Women recruited from clinical practices and self-help groups (31 An, 34 Bul (with hx of An). 33 Bul (no hx of An) compared to 242 non ED women</td>
<td>Ed patients rept both parents exhibited less caring and warm bxs. –father sig. more overprotective –only partially supported hypoth that ED patients would rate their parents higher on overprotection</td>
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<tr>
<td>Kent &amp; Clopton (1992)</td>
<td>PBI and also the Family Environment scale, Bulimia Test, and the EDI</td>
<td>24 bulimic college students, 24 sub-clinical bulimics, 24 ‘symptom free’ students</td>
<td>-did NOT support link btw att and EDs -bulimics in no-clinical setting did not report more family conflict or less parental caring than symptom free subjects</td>
</tr>
<tr>
<td>Palmer et al. (1988)</td>
<td>PBI</td>
<td>35 AN, 37 BN British patients, compared to a previous study’s control group</td>
<td>-did NOT support idea that EDs are associated with childhood parenting due to varied responses on the PBI</td>
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<tr>
<td>Study</td>
<td>PBI also used</td>
<td>Participants</td>
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<td>Rhodes &amp; Kroger (1992)</td>
<td>Separation Individuation Test of Adolescence and EDI</td>
<td>20 Ed women aged 18-22 (4 with AN, 9 with BN, 7 who met both criteria)</td>
<td>ED group scored low on maternal care and high on maternal overprotection</td>
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<td>19 outpatient, 1 inpatient</td>
<td>- Adol. ED women may be struggling with the second separation-individuation process</td>
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<td>20 female undergrad controls</td>
<td>- Study highlights that developmental arrest in the separation-individuation process of infancy has been implicated in EDs of late adol.</td>
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<tr>
<td>Steiger et al. (1989)</td>
<td>PBI</td>
<td>58 inpatient ED women (15 ANR, 9 ANB, 21 normal weight bul, 13 bul with hx of anorexia) compared to 24 norm women</td>
<td>1) Eds exhibited more primitive defenses 2) Primitive defenses assoc. with recollections of parents as low caring and overprotective 3) Patterns of perc. or real empathic parental failures may encourage reliance on prim. defenses and that overprot. by parents can suppress the devel. of mature defenses</td>
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<td></td>
<td>Also used the Bond Defense style questionnaire and EAT</td>
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<tr>
<td>Lavik et. al. (1991)</td>
<td>PBI</td>
<td>1193 Norwegian fem and male 13-18 year olds</td>
<td>For Eds total Eat score correl. with mother overprotection</td>
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<td></td>
<td>Also used EAT and a general health questionnaire</td>
<td></td>
<td>- Restrictive characteristics associated with both parents overprotection and low care from mother</td>
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<td>Study</td>
<td>Measure</td>
<td>Sample Description</td>
<td>Results</td>
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<tr>
<td>Russell, et. al (1992)</td>
<td>PBI</td>
<td>54 AN adolescents in inpatient or outpatient tx, ages from 12-19</td>
<td>-AN patients were more likely to perceive their parents as optimal-more caring and less protective than non-ed clinical pop.</td>
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<td>Armstrong and Roth (1989)</td>
<td>Hansburg Separation Anxiety Test</td>
<td>27 female, inpatient (11 AN, 12 BN, 4 atypical ED) ages 17-43. Compared to previous data-an intimacy sample of 89 fem. college students btw 18-25 and an identity sample of 140 F and M New Zealand college students</td>
<td>-ED patients showed both anxious att. and separation based depression -prevalence of anxious att. was sign. higher among EDs -formed a soc-emotional profile of indiv with EDs: -elevated levels of separation induced anxiety, lowered sense of self-efficacy and self-worth, strong beliefs regarding social-rejection, internally and externally focused anger over separation, and denial that serves to reduce the neg. internal experience associated with sep.</td>
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<tr>
<td>Kenny and Hart (1992)</td>
<td>Parental Attachment Questionnaire, and the EDI</td>
<td>Inpatients sample of 68 women with ED’s (75% BN, 13% AN, 13% both AN &amp; BN) and 162 college females</td>
<td>-ED’s viewed their parents as less emotionally supportive and not fostering a sense of autonomy -data supports that secure attachment is associated with adaptive psych.</td>
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<tr>
<td>Study</td>
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<td>Friedburg and Lyddon (1996)</td>
<td>Used Bartholomew's attachment framework</td>
<td>17 females receiving inpatient or outpatient tx for Eds (10BN, 7AN)</td>
<td>-sign. attachment differences btw ED and non-ED sample-preoccupied and secure. -eating disorder populations have disturbed att. relationships which impact tasks of separation-individuation and internalization of soothing object</td>
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<tr>
<td>Chassler (1997)</td>
<td>Used Bowlby's attachment framework</td>
<td>30 females being impatient treated for An or BN and 31 female undergrad students with no-ed symptoms</td>
<td>-ED Subject scored sign. lower on secure attachment base and peer affectional support and sig. higher on parental discipline and threats of separation -as children the Ed individ. felt significantly more alone, helpless, unwanted, had sign more shame and guilt and felt more responsible for their functioning. -women with Eds who view their parental relationship as lacking warmth, support and interfering with indep. are more likely to experience anxiety and feel that their parents can’t provide them with their needs of comfort and support</td>
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<td>Salzman (1997)</td>
<td>Adolescent Attachment Interview</td>
<td>28 female undergrad students (18-22) (10 secure, 11 ambiv, and 7 avoidant)</td>
<td>-Prevalence of ED in 7 out of 11 ambiv attc group. -Supports observ. of tendency of ambivalently attached children and adoles. To manifest anxiety in the form of bodily preoccupation or symptoms.</td>
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<tr>
<td>Becker, Bell and Billington (1987)</td>
<td>Bell Object Relations Inventory and the Bulimia Inventory</td>
<td>547 women undergraduate students</td>
<td>Bulimic women manifested 2x the percentage of object relations disturbance in the area of insecure attachment</td>
</tr>
<tr>
<td>Heesacker and Neimeyer (1990)</td>
<td>Bell Object Relations and EDI, EAT</td>
<td>183 Undergrad women</td>
<td>-Insecure attachment and social incompetence subscales contributed sign. to prediction of drive for thinness and EAT scores -In addition, more sever eating disorders were associated with oversimplified and rigid social cognitions</td>
</tr>
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</table>
| Cole-Detke and Kobak (1996) | AAI And s demographic measure and Beck Depression Inventory | 61 college females –four subcategories (12 in Ed group, 14 in depression group, 19 in ED and Depression group and 16 in non-symptomatic group) | -Ed and depression were positively correlated
-attachment classifications differed by subgroup as follows:
-62% of asymptomatic group was secure
-76% of symptom groups were dismissing or preoccupied
-67% of Ed group was dismissing
-43% of depression group were preoccupied
-53% of ED/depression group were preoccupied
-data suggests that attachment theory accounts for relations btw ED and deactivating strategies (which evolve when access to the parent is low)
-believe that an ED patient’s focus on appearance serves as a diversionary function by redirecting attention from attachment to the more attainable goal of changing their body or appearance |
| Sharpe et. al (1998) | Attachment style assessed by a self-report measure by Hazan and Shaver (1987) and also a weight concerns scale, perceptions of Body Image assessed by drawing silhouettes, and a self-esteem question- “How happy are you with yourself?” | 305 9-12 year olds | -68% of subjects were securely attached  
-32% insecurely attached  
- these clts showed sign/ higher weight concerns  
-lower levels of self-esteem  
-overall indicated disturbed attachment styles contribute to development of weight concerns and places individuals at higher risk for EDs |
|---|---|---|---|
| O’Kearney (1996) | Lit Review | | -Attachment disturbances were evident in women with EDs  
-data suggests that anxious, insecure attachment, fear of abandonment, and difficulty with autonomy differentiated women with EDs from non-ED women  
-Major limitations of Studies  
1) none used appropriate comparison groups  
2) didn’t try to limit the confound of problem eating among non-ed pops. |
like dietary restraints
*argues for multifactorial and process oriented models of the role of attachment functions in the pathogenesis of EDS

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<th>Author(s)</th>
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</table>
| Ward, Ramsey, & Treasure (2000) | Lit Review | | -studies confirm evidence of disturbed attachment in ED population
- found strong association btw anorexia and ambivalent attachment |
| Shari Noe (2001) | Experiences in Close Relationships Inventory and also Q-EDD | 549 female undergrads (17-21 years old) | -Women with EDs less likely to have secure attachment
-women with EDS more frequently possess disorganized or preoccupied attachment
-Women with AN are more likely to have a positive view of themselves (secure or dismissing attachment) and BNs are more likely to have a neg. impression of themselves (avoidant or disorganized) |
| Chester (1997) | AN and BN compared to a control group (non-ED) | | -those with EDs had a higher incidence of insecure attachment |
| Troisi et al. (2005) | Attachment Style Questionnaire and Anxiety Symptom Inventory | 78 outpatient ED women 64 healthy women with no psychiatric history | -Women with ED’s scored higher on ASQ scales, so strongly associated with insecure attachment
-Both AN and BN more strongly associated with anxious attachment than avoidant attachment
-also EDs associated with more severe separation anxiety in childhood |
| Hochdorf et al. (2005) | Adult Attachment Scale and BDI and Multi-Attitude Suicidal Tendency | 34 AN and 34 BN recruited from ED clinic compared to 37 normal controls | -EDs associated with avoidant attachment
- AN women scored higher for anxious/ambivalent attachment |
Table III. Facilitating “Earned Secure Attachment”

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Facilitating a coherent, cohesive and reflective narrative.</td>
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<tr>
<td>2.</td>
<td>Neutralizing idealization and loyalties to family system.</td>
</tr>
<tr>
<td>3.</td>
<td>Facilitating metacognition.</td>
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<tr>
<td>5.</td>
<td>Utilizing an attuned relationship with therapist as a home base for exploration of developmental</td>
</tr>
<tr>
<td>7.</td>
<td>Re-examine detailed beliefs about self and others.</td>
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<tr>
<td>8.</td>
<td>Relinquishing defense of dissociation and re-associating affect, sensation, and knowledge.</td>
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<td>9.</td>
<td>Not inhibit or minimize internal experiences and learn to tolerate, express attachment and related</td>
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<td>10.</td>
<td>Resolution of internal relational exchanges between parts of self.</td>
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<td>11.</td>
<td>Internalize self-parenting, is forgiving of mistakes, and listens to disowned parts of self.</td>
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<td>12.</td>
<td>Sets and teaches healthy boundaries.</td>
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<tr>
<td>13.</td>
<td>Resolution of significant losses in one’s life.</td>
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<tr>
<td>14.</td>
<td>Deconstruct the attachment patterns of the past and construct new ones.</td>
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<td>15.</td>
<td>Integrate traumatic attachments, losses and re-enactments.</td>
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<tr>
<td>16.</td>
<td>Establishing appropriate entitlements related to having needs, expressing needs, and meeting</td>
</tr>
</tbody>
</table>

(Schwartz, 2009)
Bibliography


