UNDERSTANDING ANOREXIA NERVOSA AND BULIMIA NERVOSA FROM AN ATTACHMENT PERSPECTIVE

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ABSTRACT: Using the Attachment History Questionnaire (AHQ), 30 female anorectic and bulimic inpatients were compared to a control group of 31 primarily female social work students to determine the connection between anorexia and bulimia and early childhood attachment relationships. As predicted, the results indicated that the anorectics and bulimics differed significantly from the controls on all four subfactors of the AHQ: secure attachment base (Factor 1), parental discipline (Factor 2), threats of separation (Factor 3), and peer affectional support (Factor 4). Post hoc comparisons between the eating-disordered group and the controls on the fifty-one individual items of the AHQ showed that within Factor 1, the items involving feelings of being unwanted, alone, helpless, and of shame and guilt, clearly and significantly discriminated between groups. Within Factor 3, the item addressing the child feeling responsible for parental happiness produced significance. The results of this study are interpreted in relation to John Bowlby's attachment theory and the clinical implications are discussed.

KEY WORDS: attachment; anorexia nervosa; bulimia nervosa; eating disorders; bonding.

Anorexia nervosa and bulimia nervosa are complex illnesses whose etiology has been understood from divergent theoretical perspectives. Early attempts to understand anorexia nervosa paralleled Freud's drive-conflict model, which understood anorexia as a defense adaptation to oral unconscious fantasies (Freud, 1905, 1954; Waller, Kaufman, &

This research paper has been presented at the 24th Annual Conference for the California Society for Clinical Social Work, 1993 and at the Committee on Psychoanalysis Second National Clinical Social Work Conference, 1994.
Deutsch, 1940). Following Freud's model, ego psychologists focused on disturbances in ego functions and an early disordered mother-child relationship to explain the disorder (Eissler, 1943; Meyer & Weinroth, 1957). Interpersonal theory (Bruch, 1973, 1978) focused on anorectic's ego weaknesses arising from problematic parent-child interactions, while object relations has understood the core dynamic problem of the anorectic as a developmental failure in the processes of separation-individuation (Masterson, 1977; Palazzoli, 1978; Sours, 1974, 1980). Paralleling the object relations theorists are the self-psychologists who have examined the symptoms of anorectic patients as representing both a disruption of the self and defensive adaptive measures against further disruption (Goodsit, 1977, 1985).

Psychoanalytic views of bingeing and purging have been extracted from the theories of anorexia and applied to the understanding of bulimia. In letters to Fliess, Freud (1899) described psychogenic vomiting as an oral impregnation fantasy. Freud delineated the self-punishing aspects of vomiting along with their function as a drive-defense compromise formation. From a Freudian or classical perspective, eating has become erotically appealing and the bulimia nervosa syndrome is interpreted as representing a displacement and regression from genital wishes. From an object relations perspective, bulimia nervosa has been understood as the semi-symbolic equivalent of the oral mother (Sperling, 1949), a concrete expression of the introjection-projection struggles of early infancy (Jesner & Abse, 1960), and traced to a developmental arrest at the earliest stage of transitional object development (Sugarman & Kurash, 1982).

Relevant research has linked anorexia nervosa and bulimia nervosa to disturbances in object relations ego functioning (Aronson, 1986; Becker, Bell, & Billington, 1987), problems with separation-individuation (Friedlander & Siegel, 1990), and disturbed family functioning (Humprey, 1988; Igoin-Apelbaum, 1985; Johnson & Flach, 1985; Strober, 1981). The importance of the father has also been studied in the etiology of anorexia (Engel & Stienen, 1988).

In attempting to understand anorexia and bulimia, most theories have focused on the disorders resulting from a failure to achieve independence via a resolution of the developmental task of separation-individuation from the maternal object, and few attempts have been made to integrate Bowlby's attachment theory with these eating disorders (Chatooor, Schaefer, & Dickson, 1984; Crisp, 1981; Henderson, 1974; Minuchin, Rosman, & Baker, 1978; Sours, 1974). While research connecting eating disorders to attachment is scant, some authors have empirically linked anorexia and bulimia to a disrupted attachment behavioral system (Armstrong & Roth, 1989; Helinski, 1984; Kenny, 1991). Kenny
(1991) found, when comparing levels of bulimic behavior, patients with the highest levels of bulimic behavior viewed their parents as significantly less available as a source of support and perceived the affective quality of parental relationships as significantly more negative than patients with the lowest levels of bulimic behavior. Helinski (1984), in examining attachment issues in anorectics and bulimics, found bulimic women showed less psychological differentiation when compared to non-eating-disordered women. Moreover, the bulimic women reported more dissatisfaction in relation to the maternal figure in terms of the mother's perceived ability to meet affecional needs and the mother’s approval of her daughter, relative to control subjects. Similarly, Armstrong and Roth (1989) found that the eating-disordered sample relative to the normal comparison groups was significantly more anxiously attached.

Using the Attachment History Questionnaire the purpose of this investigation was to examine the connection between anorexia nervosa and bulimia nervosa and early childhood attachment relationships, from the conceptual framework of John Bowlby’s attachment theory to further advance clinical understanding of attachment dysfunction in eating disordered patients.

ATTACHMENT THEORY

In an attempt to reformulate his theory about the origins of children’s ties to their mother, Bowlby (1958) introduced the concept of attachment. Attachment theory, which combines ethology, cognitive psychology and psychoanalytic thought, is defined as “a way to conceptualize the propensity of human beings to make strong affecional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment to which unwilling separation and loss give rise” (Bowlby, 1979, p. 127). Within this framework, attachment is the bond that forms between a mother and child over time and in response to familiarity and caretaking (Bowlby, 1969). The main variable to which Bowlby (1979) draws attention is the extent to which a child’s parents provide him or her with a secure base and encourage him or her to explore from it. If the attachment figure is available and responsive (Bowlby, 1979; McMillen, 1992) and can provide protection, aid, and comfort when it is needed, the child is able to develop the emotional, psychological, and cognitive skills necessary to acquire mastery and a strong and pervasive sense of security. The child, then, has a secure base from which to move out and explore the world and to which he or she can return (Ainsworth & Bell, 1970; Bowlby, 1979). Thus, the capacity of the
individual to make a bond with main attachment figures is fundamental to emotional security and provides the basis for all later attachments (Ainsworth, 1972).

Reformulating the concept of the "good" and the "bad" object, Bowlby postulated the existence of an internal psychological organization. Included are "representational" (Bowlby, 1979, p. 136) or "working models" (Bowlby, 1979, p. 117; Shneider, 1991) of the self and of the attachment figure who is either experienced as accessible and trustworthy, or inaccessible, untrustworthy, unwilling to respond, and hostile. Bowlby noted that whatever working models an individual forms out of the "real-life" (Bowlby, 1979, p. 142) experience of childhood and adolescence "tend to persist relatively unchanged into and throughout adult life" (Bowlby, 1979, p. 141). Deviations or failures in the development of attachment behavior lead to many forms of personality disorders marked by a disturbed capacity for the making of affectional bonds and often by the repeated disruptions of bonds once made (Ainsworth, 1962; Bowlby, 1951). Bowlby (1973) introduced the concept of anxious attachment to describe the feelings and behavior of people who are "apprehensive lest attachment figures be inaccessible or unresponsive" (p. 213). Anxious attachment derives from the individual's repeated experiences of inconsistent caretaking that undermine the sense of a secure base in relationships with others. As a result, these individuals have adopted certain strategies to ensure proximity and may be hampered in exploring the world and also in coping with stressful situations. Compulsive self-reliance, another maladaptive pattern of attachment behavior, is overtly the opposite of anxious attachment (Parkes, 1973). An individual who exhibits this pattern is unable to seek the love and care of others and insists on keeping a "stiff upper lip" and doing everything for him or herself. Under stress, he or she is likely to break down and to present with psychosomatic symptoms. Another pattern of personality development that represents a severe disruption of absence of affectional bonds involves the emotionally detached individual who is incapable of maintaining a stable affectional bond with anyone. The person seems unable to make and maintain genuine relations with others. Attachment behavior is absent, replaced by an aloof, noncommittal attitude (Bowlby, 1973).

It was predicted that anorectic and bulimic patients would manifest a significantly greater degree of attachment difficulties (e.g., anxious attachment and/or avoidant attachment), than the control group on the Attachment History Questionnaire (AHQ). In particular, this study predicted that the groups would differ significantly when compared on the four subscales of the AHQ labeled as: Factor 1, secure attachment base, Factor 2, parental discipline, Factor 3, threats of separation, and Factor 4, peer affectional support.
METHOD

Subjects

A total of 61 subjects participated in this study. Of those, 30 female anorectic and bulimic referrals to inpatient eating disorder units throughout California comprised the research group and met the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (1987) criteria for anorexia nervosa and bulimia nervosa. The comparison group consisted of 31 primarily female second-year graduate students at the University of Southern California School of Social Work with no known history of eating disorders. The controls were significantly older (37 years ± 9.2) than the subjects in the research group (30 years ± 10.6) (t (59) = 2.75, p = .008). There were no significant differences in the gender, marital status (40% of the research subjects and 29% of the control subjects were married), or ethnicity of the two groups. While the marital status of the two groups parents did not differ significantly (approximately half of both groups had parents who were still married), surprisingly both groups had a considerable number of subjects whose parents were deceased (16.7% of the research subjects and 38.7% of the control subjects). Extended maternal separations, which might account for later attachment difficulties, were no more numerous among the research subjects (47%) than among the controls (42%).

Attachment History Questionnaire and Ratings

The Attachment History Questionnaire (AHQ) (Pottharst, 1990) is a structured interview with both demographic questions and 51 self-evaluating Likert-style scale items for each of the four subfactors. The instrument was developed to gather information concerning the experiences and relationships each subject had with the primary care-giver and other attachment figures throughout his or her life. The 7-point Likert-scale for the subject's response uses endpoints labeled "Never" or "Always." Psychometrically, the results of the principal component factor analysis show the AHQ to have construct validity. Specifically, its manner of gathering information regarding attachment status from consciously accessible aspects of a subject's working model of self and others and from his or her memory lends itself to the measurement of central concepts of Bowlby's (1973, 1980, 1982) theory of affectional bonding. The AHQ has been shown to be an internally reliable instrument. First, results of a 51 item analysis showed that each item was positively correlated with the total AHQ index as well as with respective subtotal scores with which it was meaningfully affiliated in the factor analysis. Of the fifty-one inter-item correlations, forty-three were significant (p < .05).
Second, Cronbach’s (1951) alpha reliability coefficients computed for the subfactors secure attachment, parental discipline, and peer systems were .89, .85, and .75 respectively. The computed alpha for the total AHQ index was .91.

Procedure

The AHQ for the eating-disordered subjects was individually administered by a hospital staff member on the eating disorder unit. This researcher held a training session to familiarize the staff with the basic concepts of Bowlby’s attachment theory and to describe the nature of the study and the procedure for administering the questionnaire. The AHQ was administered to the control subjects in a group format, by an expert in Bowlby’s attachment theory who holds a Ph.D. in Social Work.

Data Analysis

Testing of the hypotheses was performed using t-tests. Subfactor scores were not computed for four research subjects due to excessive missing data. Alpha was set at .05. Post hoc t-tests were performed on individual Likert-scaled items within AHQ factors using a stricter alpha of .001 as the criterion for significance.

RESULTS

Table 1 presents the comparison of research and control groups on the four subfactors of the AHQ. As indicated, the research subjects scored significantly lower on Factor 1 (Secure Attachment Base) ($t(55) = 4.21, p < .001$) and on Factor 4 (Peer Affectional Support) ($t(55) = 3.15, p = .003$). Conversely, the research subjects scored significantly higher on Factor 2 (Parental Discipline) ($t(55) = 2.47, p = .017$) and on Factor 3) Threats of Separation ($t(55) = 3.79, p < .001$).

In order to further understand attachment differences found between groups, post hoc comparisons on individual Likert-scaled items within the AHQ subfactors were conducted using an alpha of .001. As children, the anorectics and bulimics felt significantly more unwanted ($t(56) = 3.67, p < .001$) more alone ($t(59) = 4.88, p < .001$) more helpless ($t(56) = 3.59, p < .001$) and experienced significantly more shame and guilt ($t(59) = 4.52, p < .001$) than did those in the control group. Finally, the research group felt significantly more responsible for parents’ happiness than did the control subjects ($t(58) = 3.71, p < .001$). The five items that showed differences between research and control groups at this level of significance are presented in Table 2.
TABLE 1
Comparisons Between Anorectic and Bulimic Subjects and Controls on Four Attachment History Questionnaire Subfactors

<table>
<thead>
<tr>
<th>Subfactors</th>
<th>Anoretics and Bulimics (n = 26)</th>
<th>Controls (n = 31)</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Attachment Base</td>
<td>84.78</td>
<td>115.75</td>
<td>29.98</td>
</tr>
<tr>
<td>Parental Discipline</td>
<td>29.08</td>
<td>23.03</td>
<td>9.40</td>
</tr>
<tr>
<td>Threats of Separation</td>
<td>29.59</td>
<td>20.79</td>
<td>10.48</td>
</tr>
<tr>
<td>Peer Affectional Support</td>
<td>31.88</td>
<td>37.91</td>
<td>7.86</td>
</tr>
</tbody>
</table>

*p < .05  
**p < .01  
***p < .001

DISCUSSION

While the results of this study have suggested strong correlations between the development of eating disorders and the nature and quality of early relationships with significant attachment figures, generalizability of the data from this study with reference to the causes of anorexia nervosa and bulimia nervosa must be tempered by certain limitations and considerations. The limitations inherent in the use of self-report questionnaires to gather information apply to this study. Due to financial considerations and time constraints the AHQ was administered to the experimental and control subjects in different manners, and subjects were not selected using random sampling methods, both of which may have influenced the responses. In future studies, random sampling methods should be employed and the questionnaire should be administered to both groups in the same manner. Next, the eating-disordered subjects were recruited from inpatient eating disorder units and may be different from those anorexies and bulimics who seek outpatient psychotherapy, or do not enter therapy. Additionally, all patients were prediagnosed by the staff of the institutions at which they were treated. A future study should rediagnose the patients prior to their inclusion in a study. Further, as all subjects in the control group were social work students, they are inherently different from a clinical population. This study did not test for differences in patterns of attachment among eating-disordered patients. Future studies need to compare the responses
TABLE 2

Comparisons Between Anorectic and Bulimic Subjects and Controls on Five Likert-Scaled Items of the Attachment History Questionnaire

<table>
<thead>
<tr>
<th>Items</th>
<th>Anoretics and Bulimics (n = 30)</th>
<th>Controls (n = 31)</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1: Child Felt Unwanted</td>
<td>4.24 1.88</td>
<td>2.55 1.62</td>
<td>3.67*</td>
</tr>
<tr>
<td>Factor 1: Child Felt Alone</td>
<td>6.20 1.19</td>
<td>4.26 1.84</td>
<td>4.88*</td>
</tr>
<tr>
<td>Factor 1: Child Felt Helpless</td>
<td>5.86 1.67</td>
<td>4.17 1.90</td>
<td>3.59*</td>
</tr>
<tr>
<td>Factor 1: Child Felt Shame/Guilt</td>
<td>5.90 1.40</td>
<td>4.03 1.80</td>
<td>4.52*</td>
</tr>
<tr>
<td>Factor 3: Responsible for Parents' Happiness</td>
<td>5.93 1.69</td>
<td>4.29 1.74</td>
<td>3.71*</td>
</tr>
</tbody>
</table>

*p < .001

of anorectics and bulimics to further clarify how early patterns of attachment influence the development of anorexia versus bulimia.

As there were no comparison groups manifesting psychological symptomatology (other than the anorectic and bulimic subtypes) this research did not answer the question of whether the early attachment disturbances of eating-disordered patients are significantly different when compared to other diagnostic categories. To determine that attachment difficulties are significant in eating disorders relative to other clinical populations, it will be necessary for future research to include such groups. In future studies, the larger sociocultural environment must be considered (Johnson & Conners, 1987). Swift, Andrews, and Barklage (1986) have suggested a multidimensional model, which considers the interaction of biological, psychological, familial, and sociocultural factors. Finally, it should be noted that parametric statistical analyses were conducted on ordinal data.

The above limits notwithstanding, the results of the present investigation extend the findings of previous research and provide empirical
support for the theoretical relationship between attachment and the onset of anorexia nervosa and bulimia nervosa. The findings add empirical support to the speculation that anorectics and bulimics perceived a more disrupted attachment history in terms of both the nature and the quality of their attachments to primary caretakers than did the controls. These findings would appear to indicate that one of the precursors to anorexia and bulimia may lie within family relationships. All of these issues relate directly to the tenets of attachment theory which state that individuals who develop psychiatric problems invariably display an “impairment of the capacity for affectional bonding. . . .” (Bowlby, 1979, p. 71) “preceded by a high incidence of disrupted affectional bonds during childhood” (Bowlby, 1979, p. 72).

As hypothesized, on Factor 1 of the AHQ (see Table 1), the anorectics and bulimics in this study experienced early attachment figures as significantly less responsive, less available, and less trustworthy than the controls. The subjects’ recall of their mothers’ discouraging the separation-individuation process is supported by Sours (1974) who noted that some anorectic mothers fostered dependency while others failed to foster autonomy through their inability to provide an adequate and secure home base from which to separate. The results on Factor 1 provide empirical support for Bowlby’s (1979) premise that when attachment figures are experienced as untrustworthy, unloving, inconsistent, or rejecting, the child develops some distortions of attachment behavior patterns. Having been deprived of a secure attachment base, anorectics and bulimics move into the teen years, and onward into adulthood, failing to have acquired the necessary skills and sense of resilience (Bowlby, 1979) to deal effectively with the hazards and risks of the world. Consequently, eating-disordered persons develop strategies to ensure proximity. This idea has been supported by Henderson (1974) who placed anorexia nervosa in the category of “care-eliciting” (p. 172) syndromes. Henderson defined “care-eliciting” as a pattern of signals initiated by one individual which causes distress to the individual and others but invariably brings the others closer. By declining food and becoming notably thin, the anorectic evokes anxiety in the parents, thereby eliciting caring and comforting responses from them.

Questions on the AHQ determining the style of parental discipline (see Table 1) focused on the subject’s recall of how frequently his or her parents threatened to hit or spank him or her, how often his or her parents used other forms of discipline such as sending him or her to his or her room, having things taken away, or his or her parents acting hurt when the subject misbehaved. This study has linked aversive forms of parental discipline as a factor in the development of anorexia nervosa and bulimia nervosa, and supports Bowlby’s (1973, 1979, 1980) premise
that children's difficulties arise more frequently out of the ill-effects of premature and excessive punishment, which more than likely places a heavy burden on the developing attachment behavioral system.

The literature is sparse in empirically linking the effect of parental discipline styles on the development of anorexia nervosa and bulimia nervosa. Several authors (Chandara & Malla, 1989; Root & Fallon, 1988) have linked trauma-induced experiences (i.e. physical/sexual abuse) in the development of eating disorders, however only a few have empirically linked the role of physical abuse as a form of punishment in eating-disordered patients (Schmidt, Tiller, & Treasure, 1993). Forms of punishment included hitting, screaming, locking the child in the cellar, and forcing the child to eat dog food after a minor misdemeanor. Empirical studies have suggested that bulimic patients and the restricting anorectics appear to experience different styles of family interaction. This disparity might influence differences in methods of discipline among eating-disordered patients. Strober (1981) found that families of bulimic anorectics were more dissatisfied, conflictual, negative, and less cohesive and organized, than were the families of restrictors. In addition, mothers of bulimics were more hostile and depressed, while fathers were more impulsive and irritable, showed poor frustration tolerance, and were more often alcoholic. Similarly, Humphrey's study (1988) which showed that anorectic restrictors and their parents viewed the parent-child relationships in a more positive way than both bulimic and bulimic-anorectics supported Bruch's (1973) clinical observations that, almost uniformly, parents described the pre-anorectic youngster as having functioned extremely smoothly.

The AHQ threats of separation subfactor (see Table 1) elicited responses pertaining to the amount subjects recalled their parents arguing and/or threatening divorce; how often subjects' parents threatened to call the police, leave, and send him or her away, and how fearful the subjects were of being left by their parents. The finding that a history of threats of separation was consistently a significant predictor in the development of anorexia nervosa and bulimia nervosa supports Bowlby's premise that separation anxiety reflects "anxiety about losing, or becoming separated from, someone loved" (Bowlby, 1982, p. 670). This finding is consistent with clinical theory and research on eating disorders. As Igoi-Apelbaum (1985) has assessed, the occurrence of bulimia may be related to the combination of a history of violent separations (or threats of violent separations). The following remark of one subject is likely to be representative of many from the current study: "My parents always threatened that if I wasn't good, I would be sent to the orphanage. One night my dog, Spotty, chewed my father's slipper. The next day he disappeared. No one told me what happened to him. I always thought he was sent to the orphanage and I was scared I would be next."
The results also indicate that peer relationships (see Table 1) were significantly, and negatively, affected. In childhood, anorectics and bulimics reported having a poorer peer support system, fewer friends, and more difficulty making friends than did the controls. This finding supports the attachment literature (Ainsworth, Bell, & Stayton, 1971; Arend, Gove, & Sroufe, 1979; Pastor, 1981) and Bowlby's (1969, 1977, 1979) contention that an early secure base facilitates the child's capacity to explore the world and to develop satisfactory relationships with peers. A number of authors (Bruch, 1973; Mintz, 1983; Palazzoli, 1978) have noted that life long attachment and dependency conflicts within the family mitigates against the development of healthy interpersonal attachments in anorectic patients. Several studies have indicated that bulimics experience dissatisfaction with social relationships (Pyle, Mitchell, & Eckert, 1981) and tend to be schizoid and avoidant (Tisdale, Pendleton, & Marler, 1990). Moreover, anorectics have been found to be withdrawn, depressed, anxious, and alienated, avoiding close interpersonal relationships (Norman & Herzog, 1983).

Although some authors have connected eating disorders with feeling rejected (Palazzoli, 1978; Stuart, Larraia, Ballenger, & Lydiard, 1990), and unloved (Landry, 1992), strikingly, the current study has empirically linked anorexia nervosa and bulimia nervosa to feeling unwanted (see Table 2). In terms of attachment theory, children feel unwanted when one or both parents are persistently unresponsive to the children's care-eliciting behavior and are actively disparaging and rejecting of them. Bowlby (1973) said, "an unwanted child is likely not only to feel unwanted by his parents but to believe that he is essentially unwanted, namely unwanted by anyone" (p. 204). Repeated disruptions in attachment lead a child to feel unloved, deserted, and rejected (Bowlby, 1977).

Albeit research linking anorexia nervosa and bulimia nervosa to feelings of loneliness is scant (Abraham & Beaumont, 1982b; Carroll & Leon, 1981) this study expands the eating disorder literature relating loneliness to early disturbances in attachment (see Table 2). Bowlby (1969, 1973) wrote that one of the reasons a child cries is out of loneliness for the comfort of the caretaker, and he or she needs the mother to respond with certain caretaking behaviors, such as cuddling and rocking. Bowlby (1973) suggested that "an infant comes to learn that the presence of mother is associated with comfort while absence of mother is associated with distress" (p. 180). A number of mothers mistakenly interpret that all infants' crying is due to hunger, failing to understand that infants need and want cuddling.

This study's finding that the eating-disordered subjects experienced a significant amount of helplessness (see Table 2) relative to controls is consistent with earlier writers who have suggested the relationship of feelings of helplessness to the development of anorexia nervosa. Bruch
(1973) viewed the anorectics extreme negativism, stubborn defiance and rejection of personal contact as a camouflage for an "undifferentiated sense of helplessness, a generalized parallel to the fear of eating one bite lest control be lost completely" (p. 254). Similarly, Palazzoli (1978) found that the anorectic patient's oral needs have been sufficiently frustrated by the caretaking person to the point that eating has become equated with helplessness and the inability to influence people. In support of Seligman's (1975) studies of learned helplessness, Bowlby (1979) viewed prolonged moods of hopelessness and helplessness as evidence that during early infancy and childhood, the child has been subjected repeatedly to "situations in which his attempts to influence his parents to give him more time, affection, and understanding have met with nothing but rebuff and punishment" (p. 158).

The results indicating that the anorectic and bulimic subjects experienced significantly more feelings of shame and guilt than the controls (see Table 2) might be attributed to growing up in a family environment in which it felt unsafe to express openly the normal feelings of hate and hostility. This finding, consistent with the eating disorder literature, extends the ideas of several authors (Barth, 1988; Johnson & Flach, 1985; Levenkron, 1982; Sperling, 1983) who have written on the difficulties bulimics and anorectics experience with an open expression of feelings. A number of theorists (Freud, 1915; Winnicott, 1965) have written about the crucial role in personality development of the child's capacity to tolerate ambivalence—that is, of being able to regulate the contradictory impulses of love and hate. Bowlby (1979) commented that parents who feel that hatred and jealousy are bad express their disapproval of their children either by means of punishment or, more subtly, by exploiting the child's guilt by indicating the moral and physical pain his or her outbursts has caused his or her devoted parents (Bowlby, 1979). In describing the way in which anorectics use food to deal with deep-rooted feelings of hatred toward the mother, Sperling (1983) wrote, "to reduce food intake to a minimum and to renounce the pleasures of eating . . . the patient rebels against, and declares her independence from, mother while expiating her guilt for the hatred and murderous impulses toward mother" (p. 75). Levenkron (1982) found that the anorectic attaches his or her sense of shame, vulnerability, and competition for thinness to food.

This study's finding that, in an attempt to preserve the harmony within the family, the anorectic and bulimic subjects felt significantly more responsible for his or her parents' happiness than the controls (see Table 2) is consistent with, and adds to, the literature on attachment theory and eating disorders. Bowlby (1979) discussed research that links the development of depression or phobias to individuals who are anxious and insecure, having been exposed to a number of patterns of patho-
genic parenting, which include “inducing a child to feel guilty by claiming that his behavior is or will be responsible for the parent’s illness or death” (p. 137). While Bowlby addressed the child’s sense of parental responsibility in illness or death as a possible cause of anxious attachment, he failed to relate this experience to the child’s sense of responsibility for parents’ happiness. A number of authors have addressed impaired patterns of interaction within anorectic families, and the burden of responsibility felt by the anorectic patient in attempting to maintain the family’s harmony, cohesion, and emotional stability (Levenkron, 1982; Minuchin, Rosman, & Baker, 1978). However, while the literature and research on bulimia relates bulimic symptomology to greater levels of family conflict and disharmony (Scalf-McIver & Thompson, 1989) and individual self-sacrifice (Humphrey & Stern, 1988), it has not been established that bulimics share the anorectic’s burden to maintain the family harmony and equilibrium.

CONCLUSION

The results of this study have broad implications for the practice of clinical social work. Because of their separation and attachment difficulties, anorectic and bulimic patients are usually resistant to psychotherapy, which complicates the establishment of a positive therapeutic relationship. The primary transference themes revolve around “whether the patient is capable of being loved and whether the therapist is committed, durable, and able to help her contain and organize her thoughts and behaviors” (Johnson & Conners, 1987). Familiarity with the anorectic’s and bulimic’s deviant patterns of attachment will broaden the clinician’s understanding of client’s difficult transferences so that he or she will be better able to provide an atmosphere in which the eating-disordered patient can experience a secure attachment relationship (Sable, 1992, 1994). Bowlby (1979) emphasized that “a therapist should, so far as he can, meet the patient’s desire for a secure base, whilst recognizing that his best efforts will fall short of what a patient desires and might well benefit from . . .” (p. 155). The transference becomes the playground (Freud, 1914; Sanville, 1991) in which anorectic and bulimic patients can form a new attachment relationship and repair the original caretaking failures “so that they may develop the sense of security and confidence to move along the normal path toward growth and self reliance” (Chassler, 1994).

Knowledge of a more disturbed attachment history may be a useful method in identifying individuals who are at risk for developing anorexia nervosa and bulimia nervosa so that early detection and intervention (Chassler, 1985) can then take place at the earliest stages of the
illness. Attachment concepts will extend the clinician's overall effectiveness in working with anorectic and bulimic patients and is applicable in individual, family, and group treatment. The findings of the current study raise important questions in examining the relationship of attachment to the etiology of anorexia nervosa and bulimia nervosa and clearly indicates the need in clinical social work for further investigation of attachment as a determinant in the development of these conditions.

REFERENCES


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