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Review of attachment interventions in eating disorders: Implications for psychotherapy

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Background: Attachment theory has been used in personalized treatments since decades. It is a major framework for understanding images of the self, affect regulation, reflective functions and interpersonal relationships. The improvement of attachment functioning is associated with positive treatment outcomes in eating disorders. However, attachment interventions have not been summarized in their psychotherapy. *Aims:* The aim was to review the relevance of attachment features in the psychotherapy of eating disorders. *Methods:* A literature review was carried out for empirical review and case studies, using the terms "eating disorder" and "attachment" from 1987 until 2017. From the 320 matches, 50 relevant studies were integrated into this review. *Results:* The relationship between dysfunctional attachment and eating disorders could be conceptualized in seven ways, including transgenerational transmissions and mediator personality traits. Attachment can mediate between early experiences and adult symptoms, between intra- and interpersonal experiences, or may moderate the relationship between the risk factors and maladaptive eating. Attachment features also display a direct relationship with eating disorders, or may underlie their maintaining mechanisms. Nine psychotherapeutically relevant mediator factors could be identified, namely the patient's self-concept and emotion-regulation, the conflation of self-esteem and body satisfaction, a sensitive interpersonal style, levels of perfectionism, depression, alexithymia, mentalization and reflective functions. *Conclusions:* The assessment of attachment dysfunctions in the individual symptomatology may facilitate personalized case models. For patients with severe attachment dysfunctions, multimodal psychotherapies targeting the described focal points could be recommended. Randomized, controlled studies are required to test the efficacy of the interventions summarized, and to determine indications.

Keywords: attachment, eating disorder, intervention, psychotherapy, review

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1. Introduction

1.1. Attachment Theory and Mental Health

Early attachment is the primary bond of affection between the infant and its primary caretaker (Ainsworth, 1985) that "characterizes human beings from the cradle to the grave" (Bowlby, 1977, p. 129). Attachment theory is rooted in Bowlby's (1977, 1988) theoretical framework, which conceptualizes attachment as an evolutionarily grounded, motivational behavioral system that serves the infant's physical and psychological safety. Neuroimaging techniques have also reinforced the neural basis of attachment systems (Lenzi, Trentini, Tambelli, & Pantano, 2015), which contain elementary representations of the self and the significant other (Bowlby, 1977).

Adult attachment can be conceptualized as a result of the entire attachment history (Fraley, 2002). According to its revisionist perspective, attachment traits can be modified by later life events and experiences with significant others (Fraley, 2002). According to its prototype perspective, early attachment patterns can influence perceptions, emotions, cognitions, and behavior in interpersonal contexts, serving as a relatively stable prototype for relationship dynamics throughout the lifespan (Mikulincer & Shaver, 2007; Pinquart, Feußner, & Ahnert, 2013). The maturation of the self is also interwoven with the attachment functioning (Amianto, Ercole, Abbate Daga, & Fassino, 2015; Amianto, Northoff, Abbate Daga, Fassino, & Tasca, 2016). Attachment traits can substantially influence the personality development (Hrubý, Hašto, & Minárik, 2011).

While attachment security is a crucial protective factor of mental health and stable self-structure, attachment dysfunctions can contribute to self-disturbances (Amianto et al., 2015, 2016). Through interactions with developmental transitions, environmental and temperamental factors, dysfunctional attachment can increase the risk of pathological personality development and various psychiatric disorders (Lenkiewicz, Srebnicki, & Bryńska, 2016; Mikulincer & Shaver, 2012). Among them, attachment disturbances were linked with maladaptive eating behaviors and eating disorders (Dakanalis et al., 2014; Faber & Dubé, 2015; Gander, Sevecke, & Buchheim, 2015).

1.2. Parental Bonding Features in Eating Disorders

Dysfunctional family structure, communication and the traits of enmeshment, overprotection, triangulation, suppression of conflicts and rigidity are well-distinguished, therapeutically relevant features of families living with

and eating disorder (Minuchin, Rosman, & Baker, 2009). Eating disorder patients generally perceive lower levels of cohesion, parental care and emotional support as well as less autonomy-fostering parenting in their families; therefore, both family functioning and attachment quality can be important discriminating factors in eating disorders (Latzer, Hochdorf, Bachar, & Canetti, 2002). Eating disorder patients generally report severe, separation anxiety provoking experiences in their childhood (Kuipers, van Loenhout, van der Ark, & Bekker, 2016; Troisi, Massaroni, & Cuzzolaro, 2005). Perhaps as a result, maternal attachment can be more insecure in cases of anorexia nervosa and more ambivalent in bulimia nervosa than in the normal population (Tereno, Soares, Martins, Celani, & Sampaio, 2008).

Although the role of paternal bonding is less investigated, its dysfunctions may hold the same relevance, as both neglectful and overprotective paternal bonding traits are associated with higher risk of mood disorders, lower body satisfaction and worse eating habits, including more severe restrictive eating than in careful, benevolent paternal attachment (Horesh, Sommerfeld, Wolf, Zubery, & Zalsman, 2015). Worse parenting quality can lead to more dysfunctional eating attitudes, it may predict the quantity of high-caloric food intake; thus the quality of parental bonding may moderate the risk of EDs (Faber & Dubé, 2015; Milan & Acker, 2014). Childhood experiences such as traumas and the accompanying anxiety can result in insecure, dysfunctional adult attachment of eating disorder patients (Tasca, Ritchie, & Balfour, 2011; Troisi et al., 2005).

1.3. Adult Attachment Characteristics in Eating Disorders

Attachment-functioning in adolescent in eating disorder patients is generally still dysfunctional (Gander et al., 2015). While more than 80% of all eating disorder patients have insecure adult attachment (Münch, Hunger, & Schweitzer, 2016; O'Shaughnessy, & Dallos, 2009). Ward Ramsay and Treasure (2000) argued that attachment abnormalities can be found in each eating disorder type; especially in patients who suffer from personality disorders and emotion-processing deficits (Gander et al., 2015; Myers et al., 2006). Furthermore, the degree of attachment insecurity can discriminate eating disorder patients from sine morbo individuals (Friedberg & Lyddon, 1996). Attachment quality can be central across all eating disorders (Orzolek-Kronner, 2002), as attachment insecurity is strongly related to bulimic symptoms and lower body satisfaction (Elgin & Pritchard 2006; Ringer & Crittenden, 2007). Both anorexic and bulimic patients are characterized with high attachment anxiety; however, they may differ in

the extent of attachment ambivalence and avoidance (Ringer & Crittenden, 2007). Relationships of bulimic patients are often characterized by strong distrust, need for approval and anxiety about losing the primary object (Becker, Bell, & Billington, 1987). In line with this, in bulimia, preoccupied attachment pattern can be predominant, but in restrictive anorexia, predominantly dismissive attachment is found (Elgin & Pritchard, 2006; Ringer & Crittenden, 2007; Zachrisson & Skårderud, 2010). However, the specific relationship between attachment features and the type of eating disorders is contradictory (Gander et al., 2015).

This can be explained as follows: In fact, related findings highly depend on the diagnostic subtypes of the assessed sample (Illing, Tasca, Balfour, & Bissada, 2010). Some studies suggested that the type of symptoms is related to the attachment quality rather than the diagnosis itself (Illing et al., 2010; Pace, Guiducci, & Cavanna, 2017; Tasca et al., 2006). Furthermore, the severity of eating symptomatology can be strongly linked with the extent of attachment insecurity (Broberg, Hjalmers, & Nevonen, 2001; O'Shaughnessy & Dallos, 2009). Attachment features can influence the individual's personality traits, personality organization, so they may contribute to personality disorders, which are often found in the background of eating disorder symptoms (Cassin & von Ranson, 2005; Steele & Siever, 2010). In restrictive anorexia, compulsive, perfectionist personality traits and avoidant personality disorder can be observed. While in purge type anorexia and bulimia can result from high neuroticism, strong impulsivity and borderline personality organization (Díaz-Marsá, Luis, & Sáiz, 2000). This means that dysfunctional attachment can be conceptualized as a central developmental factor of personality dysfunctions, which can serve as a major, however non-specific maintaining factor of eating disorder symptoms (Gander & mtsai, 2015).

Orzolek-Kronner (2002) emphasized the central role of attachment concerns in eating symptomatology, as the symptoms raise the family's attention and increase the proximity between parents and patients, who report higher proximity and stronger needs of care after the onset of symptoms (Orzolek-Kronner, 2002). Eating and body concerns can distract patients' attention from their attachment conflicts, suggesting hidden attachment dynamics as a crucial background of the whole symptomatology (Latzer et al., 2002). Certainly, one of the major biases of eating disorder studies is placing one factor in their focus without mentioning others, but studies should not isolate the correlates of symptoms (Polivy & Herman, 2002). Eating disorders have a highly multicausal etiology; and symptoms develop through complex circular interactions of predisposing, precipitating, and maintaining factors (Jansen, 2001). Several potential

background variables must be addressed, such as genetic, biologic and cultural influences, age, gender, personality and family traits, cognitive-behavioral factors as well as effects of starvation itself (Fairburn Cooper, & Shafran, 2003; Stice, Marti, & Durant, 2011; Tholin, Rasmussen, Tynelius, & Karlsson, 2005). The role of attachment and each putative factor should also be presented in a comprehensive framework (Polivy & Herman, 2002). Therefore, it can be therapeutically highly relevant to be aware of the mechanisms through which attachment dysfunctions lead to an increased risk of eating disorder symptoms.

1.4. Aims

The primary aim was to review the relevance of attachment features in the psychotherapy of eating disorders. Secondary aims were:

a) to conceptualize the possible relationships of dysfunctional attachment and eating disorders;

b) to detail therapeutically relevant factors, that may mediate between attachment features and eating disorder symptoms;

c) to summarize attachment issues in emotional eating;

d) to discuss the relevance of attachment in personalized case models for appropriate choice of treatment;

e) to describe the relevance of attachment features in the relationship with patients;

f) to summarize attachment-related psychotherapeutic focal points, which has been used in previous intervention-based studies in eating disorders.

2. Methods

A literature review was carried out for empirical, review and case studies, using the terms "eating disorder" and "attachment" in PubMed and Google Scholar search engines from 1987 until 2017. The search resulted in 320 studies, of which 50 treatment-relevant matches were integrated into this review.

3. Results of the Literature Review

3.1. Concepts about the Relationship between Dysfunctional Attachment and Eating Disorders

Several studies showed that worse parental bonding and dysfunctional adult attachment can contribute to a poorer self-esteem, identity conflicts, more sensitive interpersonal functioning, stronger distress and stress-reactivity, higher levels of anxiety and depression, problems with emotion-regulation, lower coherence of mental processes, worse reflective skills or even to an impaired recognition of hunger and satiety (Gander et al., 2015; Lee & Hankin, 2009; Maunder & Hunter, 2008; Tasca et al., 2009b, 2011). These factors display various direct and indirect paths between attachment dysfunctions and eating symptomatology (Tasca et al., 2009b). These may be expressed as follows:

1. The first path may be a *transgenerational transmission* of attachment-related mental states between eating disorder patients and their mothers (Ward et al., 2001). Most mothers of anorexic patients also revealed unresolved losses, traumas and avoidant attachment style just as their daughter. The disorganized mental states, high idealization, low reflective functions may be learned from mother to daughter that may contribute to the risk of the daughters' anorexic symptoms (Tasca & Balfour, 2014; Ward et al., 2001).

2. Secondly, early negative experiences, traumas can pose their effect on the increased risk of later eating disorder symptoms – at least partly – through the *mediation of dysfunctional adolescent or adult attachment patterns in course of the individual life* (Tasca et al., 2011, 2013; Tasca & Balfour, 2014). Childhood abuse and traumatization is of high prevalence across most eating disorders (Smolak & Murnen, 2000); and these negative experiences can be both directly and indirectly associated with core eating pathology, where both attachment anxiety and avoidance can have a mediator role (Tasca et al., 2013; Tasca & Balfour, 2014).

3. Since personality and family dysfunctions are among the central risk factors of eating pathology (Minuchin et al., 2009; Stice et al., 2011), and attachment pattern contribute to both the ego functioning and object relations (Dozier, Stovall-McClough, & Albus, 2008), patients' disturbed attachment patterns may function as an *impaired mediating system between intra- and interpersonal experiences that contributes to maladaptive information processing*; thus it may serve the maintenance of symptoms (Szalai, 2016).

4. Many studies proved that insecure attachment – or dimensions of both attachment anxiety and avoidance – can be directly associated with higher level of eating disorder symptoms (Orzolek-Kronner, 2002; Szalai & Czeglédi, 2015; Tasca & Balfour, 2014). The decrease of attachment anxiety was associated with lower symptom severity and better treatment outcomes (Tasca et al., 2011; Tasca & Balfour, 2014), suggesting that *insecure, anxious attachment can be a general risk factor of eating disorders* just as in the case of most psychiatric disorders (Orzolek-Kronner, 2002).

5. Attachment-related dysfunctions such as mentalization and emotion regulation difficulties contribute to the development of borderline personality organization (Bateman & Fonagy, 2005). This personality pathology can contribute to impulsive symptoms such as binges and purges in purge type anorexia and bulimia, and it is especially important in case of multi-impulsive eating disorders (Díaz-Marsá et al., 2000; Lacey & Evans, 1986). So, dysfunctional attachment can be regarded as a *contributory developmental factor of the underlying personality organization* behind various forms of eating disorders. Among them, borderline personality can play a special role in impulsive symptoms (Pace et al., 2017). Thus, interventions targeting attachment dysfunctions may be particularly important for those patients who suffer from both eating disorders and personality disorders (Myers et al., 2006).

6. According to longitudinal study designs, *attachment quality may have a moderator role in eating symptomatology*, as it can moderate the association between distinct risk factors of eating disorders and disordered eating attitudes and behaviors in the later life (Milan & Acker, 2014).

7. Lastly, many studies (Dakanalis et al., 2014; Illing et al., 2010; Keating Tasca, & Hill, 2013; Koskina & Giovizolias, 2010; Tasca et al., 2009b, 2013) which applied structural equation modeling highlighted further therapeutically relevant psychological mediator factors *between* attachment dysfunctions and eating disorder symptoms.

3.2. Therapeutically Relevant Mediators between Attachment and Eating Disorder Symptoms

In the following the paper reviews the most important factors that can potentially mediate the relationship between attachment dysfunctions and eating disorder symptoms; as they may mean therapeutically relevant paths depending on the individual psychopathology (*Figure 1*).

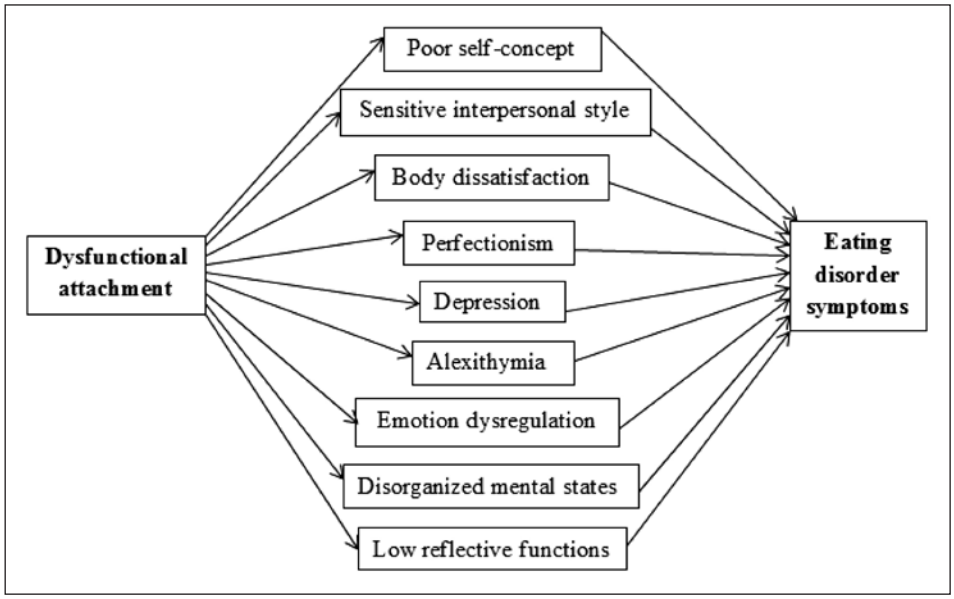

Figure 1. Potential mediator factors between dysfunctional attachment and eating disorder symptoms.

The relationship between dysfunctional attachment and eating disorders can be mediated by the patent's *self-concept* (Amianto et al., 2016; Illing et al., 2010), *self-worth and self-acceptance* (Gander et al., 2015). Core negative self-esteem is the central maintaining factor of eating disorders (Fairburn et al., 2003), and both preoccupied and fearful attachment are featured by negative images of the self (Sable, 2008). From the aspect of self-psychology, most psychiatric disorders can be at least partly explained by dysfunctions of the self (Karterud & Monsen, 1999). On the basis of a substantial conflation of psychological self-esteem and body-esteem (Stein & Corte, 2003), anorexia nervosa can be also conceptualized as a disorder of the self (Amianto et al., 2016). On account of developmental deficiencies, the definition of the self is incomplete, so the deficient self-concept can be compensated through overemphasizing body-image, serving as a proxy mechanism (Amianto et al., 2016). Similar mechanisms can be suspected in the background of binge eating symptoms, which attempt to consolidate the patients' interpersonal and self-image problems (Steiger, Gauvin, Jabalpurwala, Se´guin, & Stotland, 1999).

Insecure attachment negatively influences *body satisfaction* with adjustment for age and weight both in ones with and without eating

disorders from preadolescent age onwards (Gander et al., 2015; Keating et al., 2013; Szalai Czeglédi, Vargha, & Grezsa, 2017). This can be explained either through the conflation of the deficient psychological and the perceived bodily self (Amianto et al., 2016; Stein & Corte, 2003), or through lower moods that may mediate between dysfunctional attachment and body dissatisfaction (Szalai et al., 2017). As body dissatisfaction is a major maintaining factor of eating pathology (Fairburn et al., 2003), it can mediate the relationship between attachment features and eating disorder symptoms (Koskina & Giovizolias, 2010).

Maladaptive clinical *perfectionism* can also mediate the relationship between insecure attachment patterns and eating disorder symptoms (Dakanalis et al., 2014; Tasca & Balfour, 2014). According to Dakanalis and colleagues (2004), both attachment anxiety and avoidance can sensitize patients to higher levels of perfectionism. Besides the over-evaluation of weight and shape control, clinical perfectionism is the second compensatory mechanism for low self-esteem in eating disorder. It is also central in the maintenance of eating disorder symptoms (Fairburn et al., 2003).

Higher levels of *depression* can also mediate the relationship of attachment and eating disorders (Tasca et al., 2009b). Through lower self-esteem and dysfunctional attitudes, insecure attachment contributes to negative moods and higher levels of depression (Roberts, Gotlib, & Kassel, 1996). Depressive thinking can impair self-acceptance (Olivardia, Pope, Borowiecki, & Cohane, 2004), body satisfaction (McCabe, Ricciardelli, & Banfield, 2001; McCabe & Ricciardelli, 2004); therefore, it poses an almost three-fold increased risk to the development of eating disorders (Stice et al., 2011).

It seems that one of the major paths between dysfunctional attachment and eating disorder symptoms are *emotion-dysregulation and difficulties with handling states of negative moods* (Ty & Francis, 2013; Van Durme, Braet, & Goossens, 2015). Eating can regulate emotions and emotions can influence eating through various ways, including emotionally-driven food choice, emotional suppression of food intake, dysfunctions of eating control, eating as a maladaptive emotion-regulation strategy, or emotion-congruent modulation of eating behavior (Macht, 2008). Suppression of emotions is a well-known trait of anorexia nervosa, and emotional instability is an apparent feature in bulimia nervosa and binge eating disorder (Münch et al., 2016). Most eating disorder patients are unable to cope effectively with negative mood, and they engage in dysfunctional mood modulatory behaviors, including the symptoms (Overton, Selway, Strongman, & Houston, 2005). Fairburn and colleagues (2003) conceptualized eating disorder patients' disability of handling negative moods, as 'mood intolerance'.

This means that most patients tend to either under- or overcontrol their negative emotions, which contributes to the maintenance of symptoms.

While attachment security is linked with better psychophysiological responses to stress and interpersonal challenges, attachment insecurity is related to higher autonomous reactivity (Dias, Soares, Klein, Cunha, & Roisman, 2011). Different attachment types may result in diverse attachment-related distress-reducing strategies (Mikulincer, Shaver, & Pereg, 2003). In line with Fairburn and colleagues' (2003) concept, patients with dismissive (avoidant) attachment are more prone to deactivate their emotions, while those with preoccupied (anxious-ambivalent) attachment usually respond with an excessive activation of emotions in interpersonal conflicts (Mikulincer et al., 2003). Therefore, attachment-driven emotional hyper-activation or deactivation of emotions can substantially contribute to eating disorder patients' emotion-dysregulation, highlighting a therapeutically essential path between attachment and eating disorders (Ty & Francis, 2013; Van Durme et al., 2015). The negative effect of depression on eating disorders also can be at least partly explained by the patients' deficient mood regulation (Tasca et al., 2009b).

Another therapeutically relevant chain between attachment and eating disorders is the *sensitive interpersonal style* (Tasca et al., 2011). Insecure attachment patterns can result in different, often maladaptive interpretations of interpersonal situations (Mikulincer et al., 2003). Most eating disorder patients reveal separation-individuation problems with their primary objects (Latzer et al., 2002; Orzolek-Kronner, 2002). Interpersonal sensitivities can be rooted in conflicts with autonomy or separation (Ringer & Crittenden, 2007; Tasca et al., 2011). The individual history of problematic relationships can result in higher sensitivity to similar situations. In line with this, patients refer to interpersonal conflicts that are parallel with their attachment styles (Illing et al., 2010; Tasca et al., 2011). Situations in which there is a conflict between autonomy and dependence can trigger negative emotions, self-criticism or binges (Speranza et al., 2005; Szalai, 2016; Tasca et al., 2011). Thus, the interpersonal sensitivity can contribute to development and maintenance of an eating disorder in many points (Tasca et al., 2011).

The relationship of dysfunctional attachment and eating disorders can be also mediated by *alexithymia*, which refers to the difficulties of identifying, labelling, describing, processing and regulating bodily senses, emotions and affections (Keating et al., 2013; Speranza et al., 2005; Tasca & Balfour, 2014). Alexithymia can lead to maladaptive emotion regulation strategies and several psychological or somatic disorders (Taylor, 2000). Patients with anorexia and bulimia often exhibit strong alexithymia, and their difficulties in identifying emotions are associated with higher self-criticism (Speranza et al., 2005). Attachment avoidance can be also related to lower body satisfaction through higher levels of alexithymia in eating disorder patients (Keating et al., 2013). Alexithymia can contribute to an increased frustration

in interpersonal conflicts that leads to a higher probability of maladaptive emotion-regulation strategies, including the symptoms themselves (Szalai, 2016).

The *coherence of the patients' mental states and the efficacy of reflective functions* can play a central role in the maintenance of symptoms, and they can serve as major target points of psychotherapies (Tasca et al., 2011; Tasca & Balfour, 2014). Adverse childhood experiences can have negative effects on the coherence of mental states that is associated with more severe psychopathology in general (Bakermans-Kranenburg & Ijzendoorn, 2009). In line with this, several studies, including reviews (Barone & Guiducci, 2009; O'Saughnessy & Dallos, 2009; Ringer & Crittenden, 2007) found less organized mental states in anorexia, bulimia and binge eating disorder. This can result in the patient's lower ability of constructing a coherent narrative about her psychological development, as well as difficulties in detecting the symptoms' role in her personal life (Tasca et al., 2011).

Lastly, attachment dysfunctions can be linked with eating disorders through impaired *mentalization skills and reflective functions* (Kupiers, van Loenhout, van der Ark, & Bekker, 2016; Tasca et al., 2011; Tasca & Balfour, 2014). Attachment insecurity can be associated with lower reflective capability, especially in cases of anorexia (Kuipers et al., 2016). Early attachment traumas and parental bonding difficulties may disrupt the individual's ability to depict thoughts and emotions in her/him and in others (Bateman & Fonagy, 2005). In line with this, Russell, Schmidt, Doherty, Young and Tchanturia (2009) found impaired social cognition and worse affective theory of mind in anorexia nervosa. The impaired mentalization capability leads to difficulties of social adjustment and affect regulation that limits the patients' ability to engage in well-organized, intimate relationships both in personal and psychotherapeutic settings (Tasca et al., 2011).

3.3. Attachment and Emotional Eating

A barely discovered area of related studies is the relationship of attachment dysfunctions and emotional eating, which is defined as eating in response to negative emotions like anger, loneliness, emptiness or depression (Masheb & Grilo, 2006). However, Hernandez-Hons and Wooley (2011) found attachment concerns among the most important themes related to emotional eating, including (a) relationship history; (b) degree of acceptance; (c) addiction as a coping mechanism for insecure attachment; and (d) emotional eating as reminiscent of ambivalent attachment, suggesting that at least in part maladaptive coping circles with insecure

attachment can be suspected in the background of emotional eating (Hernandez-Hons & Wooley, 2011). This supports the idea of taking attachment concerns such as ambivalence, anxiety, avoidance, and dependence into account when investigating precipitating or maintaining factors of emotionally induced eating (Szalai & Czeglédi, 2017).

The introduction of new, attachment-based, relationship-focused interventions against emotional eating can be a highly relevant field for further investigation, as interventions targeting emotional eating may also hold potentials in the prevention of clinically significant eating disorders like binge eating (Masheb & Grilo, 2006). Attachment-based interventions in emotional eating may include fostering the availability of attachment objects, enhancing the degree of parental care, highlighting attachment-driven irrational thoughts, counteracting attachment preoccupation and emotional hyper-activation, reducing distrustfulness, seeking for more adaptive means of coping with distress as well as improving images of both the self and significant others (Kenny & Hart, 1992; Szalai, 2016; Szalai & Czeglédi, 2017).

4. Discussion

4.1. Attachment Concerns in Case Conceptualizations

In summary, attachment dysfunctions can be associated with the patient's eating disorder symptoms through the following potential mechanisms: 1. Attachment-related mental states can be transmitted between parents and patients (Ward et al., 2001). 2. Attachment patterns can mediate between early traumas and the adolescent or adult eating pathology (Tasca et al., 2013; Tasca & Balfour, 2014). 3. Attachment dysfunctions contribute to the development of personality disorders, which often underlies impulsive symptoms in eating disorders (Bateman & Fonagy, 2005; Lacey & Evans, 1986). 4. Attachment quality can moderate the relationship between risk factors of eating disorders and disordered eating behaviors (Milan & Acker, 2014). 5. Dysfunctional attachments contribute to misinterpretations of interpersonal situations, thus to less adaptive interpersonal responses (Mikulincer et al., 2003; Szalai, 2016). 6. Both attachment anxiety and avoidance can pose a direct risk on eating disorder symptoms (Orzolek-Kronner, 2002). 7. Probably in most of the cases, the relationship between attachment dysfunctions and eating disorders can be mediated by several therapeutically relevant factors (Dakanalis et al., 2014; Illing et al., 2010; Keating et al., 2013; Koskina & Giovizolias, 2010; Tasca et al., 2009b, 2013).

These mechanisms can allow the use of attachment concerns both in case conceptualizations and personally tailored treatments with high pragmatic

relevance (Markin & Marmarosh, 2010). In spite of this, mainstream models emphasize cognitive-behavioral, biological or cultural aspects of eating disorders, without taking attachment concerns into account (Tasca & Balfour, 2014). Tasca and colleagues (2009a) directly suggested that the diagnostics of eating disorders shall not exclusively focus on the DSM (APA, 2013) categories, but it shall also include a dimensional description about the patient's personality and attachment functioning. Therapists shall be aware of the mechanisms above outlined, and the *individual case conceptualizations* shall address them in order to determine the appropriate form of treatment, as well as to introduce personalized interventions besides the proven international therapeutic recommendations (Hay et al., 2014).

4.2. Attachment Features and Therapeutic Relationships with Eating Disorder Patients

Furthermore, the patient's attachment style can be highly relevant in the therapeutic alliance (Tasca et al., 2006; Tasca & Balfour, 2014). The patients' attachment style − including dimensions of anxiety, avoidance or ambivalence − is also closely associated with the therapeutic alliance (Tasca, Balfour, Ritchie, & Bissada, 2007). Higher levels of attachment avoidance featured by devaluing the need for relationships can predict drop-outs from treatment, especially in binge-purge anorexia nervosa patients, but not among restrictive ones (Tasca, Balfour, Ritchie, & Bissada, 2004; Tasca et al., 2006). Provision of choice for patients and fostering self-determination in an early stage of the treatment can balance these high drop-out rates (Vandereycken & Vansteenkiste, 2009). In contrast, anxious attachment pattern is featured by preoccupation with interpersonal issues, and intimate relationships can predict completing treatment (Tasca et al., 2014). This may also suggest that different therapeutic interventions can be used effectively in patients with anxious or avoidant attachment (Tasca et al., 2011). On the basis of these, attachment-sensitive treatments can be highly beneficial for a certain part of eating disorder patients.

4.3. The Efficacy of Attachment-Interventions in the Treatment of Eating Disorders

Attachment theory has been used in case conceptualizations and personalized treatments since decades (Markin & Marmarosh, 2010). As a meta-theory, it integrates various treatment-relevant psychological

constructs (Cassidy & Shaver, 1999). Among them, it serves as a major conceptual framework for understanding images of the self and the other, stress-sensitivity, affect regulation, mentalization skills and human relationships (Bateman & Fonagy, 2005; Maunder & Hunter, 2008; Mikulincer & Shaver, 2007, 2012).

The above-written attachment-relevant factors are central concerns in eating disorder patients (Fairburn et al., 2003). The mental representations about the cognitive and affective dimensions of attachment are accessible from adolescence onwards (Buist, Dekovic, Meeus, & van Aken, 2002), which allows the therapeutic work with attachment-related thoughts, emotions and behaviors in the treatment of adolescent and adult eating disorder patients. The coherence of the patient's narrative about memories reflect how refined the emotional and cognitive representations of interpersonal experiences are and how secure the attachment style is (Waters & Waters, 2006).

The internal working model is relatively stable throughout the lifespan (Bowlby, 1988; Pinquart et al., 2013). However, attachment characteristics can be modified through dramatic interpersonal changes and long-term, encouraging relationships (Waters & Waters, 2006). The therapist is also an attachment figure, who supports the patient's safety and autonomy, and encourages the examination of the patient's self and object representations. Therefore, the complementary interaction of the therapist and the patient may contribute to the personality development as well as to the refinement of the internal working model that serves more adaptive attachment-related thoughts, emotions and distress-reducing strategies. These aspects can allow the therapeutic utilization of attachment concerns in eating disorders.

Several psychotherapeutic method involves the above written attachment-related factors, such as the emotion-focused family therapy (Robinson Dolhanty, & Greeberg, 2015), and dialectical behavior therapy (Rizvi, Steffel, & Carson-Wong, 2013). Although psychodynamic approaches also contain various attachment-related aspects of psychotherapies such as paternal relationships, transference or emotion-regulation (Tasca, 2016; Thompson-Brenner, 2014), the efficacy of interventions focusing exclusively on patients' attachment-functioning were only recently tested (Illing et al., 2010; Maxwell, Tasca, Ritchie, Balfour, & Bissada, 2014; Tasca et al., 2006). Related efficacy studies showed that the more the patient's attachment functioning improved during the course of the treatment, the better outcomes could be observed (Illing et al., 2010; Maxwell et al., 2014; Tasca et al., 2011, 2013; Tasca & Balfour, 2014). The patient's level of attachment anxiety or avoidance may moderate the long-term individual outcomes (Tasca et al., 2006). The reduction of attachment anxiety can be associated with positive treatment outcomes and a reduction

of eating disorder symptoms even at one-year follow-up (Tasca et al., 2013). Integrating interventions that target attachment preoccupation, ambivalence, fearfulness or avoidance to evidence-based treatment methods of eating disorders can be especially important in patients who complain about relationship stressors besides the maladaptive eating behaviors (Szalai, 2016; Szalai & Czeglédi, 2017). Furthermore, the improvement of attachment functioning and attachment anxiety is associated with decreased depression in eating disorder patients. Therefore, attachment anxiety can be an important focal point of psychodynamic and interpersonal therapies of eating disorders (Tasca et al., 2007).

5. Conclusions

5.1. The Summary of Therapeutically Relevant Attachment-related Factors

The present review identified nine therapeutically relevant factors, which can mediate between attachment dysfunctions and eating disorder symptoms. Depending on the individual case, the following mediator factors can be emphasized:

1. the patient's self-concept, self-esteem and self-acceptance (Amianto et al., 2016; Gander et al., 2015; Illing et al., 2010);
2. the sensitive interpersonal style coupled with separation-individuation difficulties (Latzer et al., 2002; Orzolek-Kronner, 2002; Tasca et al., 2011);
3. the higher probability of disorganized mental states (Tasca & Balfour, 2014);
4. the impairment of mentalization skills and reflective functions (Kupiers et al., 2016; Tasca & Balfour, 2014);
5. the dysregulation of emotions and difficulties with handling negative moods (Ty & Francis, 2013; Van Durme et al., 2015);
6. as well as higher levels of depression (Tasca et al., 2009b);
7. alexithymia (Keating et al., 2013; Speranza et al., 2005);
8. body dissatisfaction (Gander et al., 2015; Koskina & Giovizolias, 2010; Szalai et al., 2017);
9. and maladaptive perfectionism (Dakanalis et al., 2014; Tasca & Balfour, 2014).

These factors can be partly shared in various mental health problems such as personality disorders and other psychiatric disorders, while other factors can be more specific in eating disorders (Bateman & Fonagy, 2005; Fairburn et al., 2003; Tasca & Balfour, 2014). These suggest that several

aspects of insecure attachment can be considered as non-specific risk factors of psychopathologies (Ennis, 2002; Orzolek-Kronner, 2002). According to the principle of multi-causality, similar risk factors can interact with others, and may lead to different disorders through diverse paths (Ciccheti & Doyle, 2016). However, when these attachment-related factors contribute to the maintenance of eating disorder symptoms, they can serve as *intervention points* in the course of personalized treatments. This implies the usefulness of longer, relationship-focused psychotherapies in eating disorders (Tasca, 2016).

5.2. The Summary of Attachment-related Interventions in the Psychotherapy of Eating Disorders

As some of these factors represent similar psychological phenomena, we may provide clusters of attachment interventions in eating disorders. On the basis of these and according to studies that implemented attachment interventions into the treatment of eating disorders, four focal points can be highlighted, which may unite a variety of attachment interventions that therapists can apply in the psychological treatment of eating disorders (Amianto et al., 2016; Faber & Dubé, 2015; Keating et al., 2013; Kuipers et al., 2016; Maxwell et al., 2014; Tasca et al., 2009a, b, 2011, 2013; Tasca & Balfour, 2014).

Firstly, the *self-concept* shall be targeted, according to a refined assessment how attachment experiences influenced the self-representation. Related interventions can include: a) fostering self-acceptance; b) distinguishing personal value from the distorted body image and excessive achievement expectations; c) discriminating self-appraisal from others' judgements; d) seeking positive self-domains; e) decreasing self-criticism; f) counteracting clinical perfectionism, h) reducing the conflation of self-esteem and body-esteem (Amianto et al., 2016; Dakanalis et al., 2014; Fairburn et al., 2003; Speranza et al., 2005; Stein & Corte, 2003; Tasca et al., 2011).

Secondly, the *sensitive interpersonal style and maladaptive attachment tendencies* shall be modified. Related interventions may include: a) highlighting the concept of social others; b) raising the awareness about the effects of interpersonal sensitivity; c) psychoeducation about the patients' separation-individuation problems; d) conceptualizing the role of attachment experiences in the development and maintenance of symptoms; e) modifying attachment-related, automatic thoughts (e.g. with social diary); f) improving trust and autonomy; g) describing maladaptive emotional and behavioral chain-reactions that are parallel with the patient's attachment style (e.g., with a graph about the escalation of their symptoms);

h) improving social conflict solution skills in order to decrease impulsive tendencies; i) fostering emotional responsivity from others; j) in case of avoidant attachment, emotional connection shall be increased, while in case of preoccupied attachment, separation anxiety shall be reduced (Fossati et al., 2005; Illing et al., 2010; Mikulincer et al., 2003; Ringer & Crittenden, 2007; Tasca et al., 2011; Szalai, 2016).

Thirdly, patients can benefit from *increasing the coherence of mental states and improving reflective functions*. Interventions that target this area can include: a) the construction of a coherent narrative of the patient's emotional, interpersonal and psychological development, with special attention on those experiences, which could predispose for the symptoms; b) the identification of the place and role of symptoms' in the patients' life; c) improving the ability to depict thoughts and emotions in oneself and in others (e.g., by diary techniques, mentalization tasks, or analyzing interpersonal experiences); d) enhancing reflections on themselves and significant others, especially in severe distress; e) in avoidant attachment, a more coherent, emotionally involving narrative of attachment-related experiences shall be developed, while in anxious attachment, a more refined assessment of others' emotional states can be required; f) in avoidant attachment the coherence of mental states can be further supported by a less idealized or dismissive view of the patient's primary objects, while in preoccupied attachment the disruption of anger, anxiety and self-hatred shall be decreased (Bateman & Fonagy, 2005; Kupiers et al., 2016; Russell et al., 2009; Tasca et al., 2011; Tasca & Balfour, 2014).

Lastly, a major focal point is *identifying, tolerating and regulating negative moods and emotions*. Related interventions can foster many areas, among them the following ones: a) The therapist shall recognize each case of comorbid depression, and help the patient in successfully coping with depressive moods. b) Patients can receive psychoeducation on how emotions and eating can mutually influence each other. c) Patients may require help distinguishing physical and psychological satiety or hunger. d) The therapist shall help them in counteracting emotion-congruent modulation of eating such as emotionally-driven food choice, or eating as a maladaptive emotion-regulation strategy. e) Decreasing features of alexithymia is a central intervention point in improving emotion-regulation. Related techniques can involve enhancing emotional awareness, labeling emotional explanations of somatic distress, and integrating symbolic elements of emotion schemas. f) Patients may require help in distinguishing irrational proximity seeking, flustered, dependent interpersonal behavior in preoccupied attachment, or distrustful interpersonal isolation in avoidant attachment. This can be essential for the patient in order to understand his/her own emotional and behavioral responses. g) Thus, a major aim is to identify attachment-driven

emotional answers, and change maladaptive distress-reducing strategies. This can be supported by decreasing downregulation of emotions in anxious attachment, and by counteracting upregulation of emotions and reducing psychological defenses in avoidant attachment. h) The therapist can facilitate the process of emotion-regulation by describing the patient's emotions, empathically attuning to them, then confronting the defenses against emotions, and interpreting the interpersonal response pattern. i) Besides these, enhancing frustration tolerance can be necessary. j) Furthermore, patients shall acquire more effective personalized mood regulation strategies. This may be supported by consciously selecting and modifying situations, including those that trigger the symptoms; deployment of attention; change of attachment-related cognitions; and modulation of the regular responses (Macht, 2008; Mikulincer et al., 2003; Overton et al., 2005; Speranza, et al., 2005; Szalai, 2016; Tasca et al., 2009b, 2011; Taylor, 2000; Ty & Francis, 2013; Van Durme et al., 2015).

5.3. Limitations and Outlook

These therapeutic implications shall, however, be read in the light of certain limitations. Attachment domains have been integrated into a multilevel treatment of eating disorders only in case studies (Szalai, 2016); this approach should therefore be considered experimental. This review is not systematic. Results of case studies, cross-sectional and longitudinal designs, intervention-based trials, systematic reviews and meta-analyses were incorporated to this paper, without the assessment of the strength of evidences. Longitudinal, intervention-based, randomized, controlled studies are required to test the efficacy of attachment-based treatment procedures in eating disorders, and to determine the exact indications of the described attachment-interventions in distinct symptomatic subtypes and subgroups of patients.

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Conflict of Interest Statement

The author declares no known conflict of interest.

Az evészavarokban alkalmazható kötődéssel kapcsolatos intervenciók áttekintése – Pszichoterápiás ajánlások

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Elméleti háttér: A kötődéselméletet évtizedek óta alkalmazzák személyre szabott terápiákban. Egyben az én kép, az érzelemszabályozás, a reflektív készségek és személyközi kapcsolatok megértésének fő elméleti kerete. A kötődési funkciók fejlődése pozitív terápiás kimenettel áll kapcsolatban evészavarok esetén. Ennek ellenére azok pszichoterápiájában alkalmazható kötődési intervenciókat nem összegezték. *Cél:* A cél a kötődési jellemzők evészavarok pszichoterápiájában betöltött szerepének áttekintése volt. *Módszerek:* Szakirodalmi áttekintés empirikus vizsgálatokra, áttekintő és esettanulmányokra az „eating disorder" és "attachment" kereső szavakkal 1987 és 2017 közt. A 320 találatból 50 releváns vizsgálat került be az áttekintésbe. *Eredmények:* A diszfunkcionális kötődés és evészavarok kapcsolata hétféleképpen írható le, köztük transzgenerációs transzmissziók és közvetítő személyiségvonások révén. A kötődés közvetíthet a korai élmények és felnőttkori tünetek, illetve az intrapszichés és interperszonális élmények közt. Moderálhatja a rizikófaktorok és maladaptív evés kapcsolatát, megalapozhatja a tünetfenntartó mechanizmusokat, valamint közvetlen kapcsolatban is állhat az evészavarokkal. Kilenc pszichoterápiás jelentőségű tényezőtényező került azonosításra, így a beteg én-koncepciója és érzelemszabályozása, az önértékelés és testtel való elégedettség összemosódása, a szenzitív személyközi stílus, a perfekcionizmus, a depresszió, az alexithymia szintje, a mentalizációs és reflektív készségek. *Következtetések:* A kötődési jellemzők és a tünetek kapcsolatának

feltárása támogathatja a személyre szabott esetmodelleket. A kötődési diszfunkciókkal küzdő betegeknek multimodális pszichoterápiák lehetnek javasoltak, amelyek a leírt fókuszpontokat is célozzák. Randomizált, kontrollált vizsgálatok szükségesek ezen intervenciók hatékonyságának ellenőrzésére, és a pontos indikációk meghatározása érdekében.

Kulcsszavak: kötődés, evészavar, intervenció, pszichoterápia, áttekintés