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Attachment And The Development Of Eating Disorders

As Measured By The "APDQ"

A Thesis Presented to the Faculty of the

Department of Psychology

Marshall University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

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Running Head: Attachment and Eating Disorders

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as meeting the research requirement for the master of arts degree in clinical psychology.

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Abstract

The impact of family of origin dynamics on the development and maintenance of eating disorders is well documented in the literature. This study sought to investigate the attachment relationships and personality characteristics of eating disordered subjects by administering the Attachment and Personality Dynamics Questionnaire (APDQ). It was hypothesized that the eating disordered subjects would show a pattern of insecure attachments to primary caregivers and significant others in comparison to controls. A total of 23 eating disordered females and 297 female control subjects completed the APDQ. The t tests for the 29 scales of the APDQ revealed lower means for the eating disordered subjects on scales measuring secure attachment to mother, father, partner, and peers. A discriminant function analysis determined that the family suppression of feelings, shame, sexual intimacy, denial, and abuser scales best distinguished between the eating disordered subjects and the controls. Further, standard deviations across all scales were higher for the eating disordered group. Dominant attachment styles were computed for each subject, revealing that the majority of eating disordered subjects had avoidant attachment styles to mother, father, and partner, and the majority of control subjects had secure attachment styles to all three figures. Thus, the APDQ may prove to be a helpful device for clinicians who want to assess attachment and personality variables in this population.

Attachment and the Development of Eating Disorders as Measured by the "APDQ"

Family relationships have typically been construed as significant factors in comprehensive models of the etiology and maintenance of eating disorders (Bruch, 1973; Heesacker & Neimar, 1990; Kenny & Hart, 1992; Minuchin, Rosman, & Baker, 1978; Patton, 1992; Sherman & Thompson, 1990). Theories of attachment provide a framework for understanding the underlying familial mechanisms that contribute to the development of these harmful behaviors. Attachment is defined as a relatively enduring emotional bond to a specific person. Originally formulated by Bowlby, (1969/1982, 1973, 1983, as cited in West & Sheldon-Keller, 1994), attachment theory proposed that infants enter this world biologically prepared to form close relationships with their primary caregiver which are necessary for the infant's survival. The primary caregiver, in return, is said to provide a safe base from which infants can explore their environments without fear of harm, thereby supporting the development of autonomy. If the caregiver provides affection and support and offers assistance as needed without interfering or limiting the independent strivingings of the child, a secure attachment is formed. Characteristics of a secure attachment are considered important to the development of self-esteem, social and psychological competence, and psychological well-being including resilience to stress (West &

Sheldon-Keller, 1994). Insecure attachments, on the other hand, are said to result from parental relationships in which feelings of trust, responsiveness and caring are low or inconsistent (Kenny & Hart, 1992).

These early attachments appear to remain consistent over time, allowing the child to form what Bowlby (1988, as cited in West & Sheldon-Keller, 1994) terms "working models" or internalized attitudes and beliefs about the self and others that will govern the formation of future relationships and have a pervasive effect on everyday thinking and behavior (Cohen, 1974, as cited in Rice, 1990). These working models are initially compiled based on experience with the primary attachment figures and the degree of success the individual has in having their needs met (West & Sheldon-Keller, 1994). They are then modified through ongoing personal relationships and increased self-understanding (Bowlby, 1988, as cited in Kenny, Moilanen, Lomax, & Brabeck, 1993). These formative relationships are incorporated into the individual's sense of self as good, lovable, competent, valuable, worthy of care, and effective in eliciting care. Consistent failure to achieve a sense of security and affection from attachment figures forms the basis for a representation of attachment as unproductive or insecure, and a negative view of the self as ineffective and incompetent (West & Sheldon-Keller, 1994).

Ainsworth (1989) wrote of the normative shifts in the nature of a child's

attachment to parent figures beyond infancy and early childhood. Ainsworth (1989) noted that a major shift in attachment, brought on by hormonal changes, takes place in adolescence. At this time the adolescent begins to search for a relationship with a peer of his or her own age, usually a mate of the opposite sex. In addition, the quest for autonomy becomes particularly pronounced. However, even though the individual is likely to have found a new principal attachment figure when a sexual pair bond is eventually established, this does not mean that attachment to parents has disappeared, but rather that the attachment relationship has been altered (Ainsworth, 1989). Kobak, Cole, Ferenz-Gillis, Fleming, and Gamble (1993, as cited in Kenny, et al., 1993) also suggest that early adolescence is a time of likely change in attachment relationships "as adolescents equipped with more sophisticated cognitive skills reflect on and reevaluate models of self and parent and strive to renegotiate an adaptive balance between connection and autonomy (p. 410)." If adolescents have not achieved a secure attachment with parents, it is thought that they may lack the confidence to form other attachment relationships outside the family (Kenny et al., 1993). Parents can facilitate the adolescent's search for a sense of self identity (as separate from that of the family) by allowing them to develop their independence and form relationships with peers, while continuing to provide guidance and a secure base at home. Close relationships with parents can help buffer the negative effects of early

adolescent stress and provide a source of comfort and security in the changing adolescent world. When that source of comfort and support is lacking, risk for psychological dysfunction increases (Kenny et al., 1993).

This paper focuses on the impact of attachment relationships on the development of eating disorders. This addictive behavior begins primarily during the critical period of adolescence. Like alcohol or drugs, food is the narcotic used to "medicate" away the anxiety and pain that may accompany the difficult transitions of adolescence. However, unlike typical substance abusers, those individuals suffering from eating disorders can not avoid food, their drug of choice. The following section contains a brief description of the prevalence rates, personality factors, and family dynamics that have been associated with the two types of eating disordered patients.

The American Anorexia and Bulimia Association stated in 1985 (as cited in Brumberg, 1989) that anorexia and bulimia strike a million Americans every year, and that one-hundred and fifty-thousand die annually. The incidence rates have risen over the past decade to eight million women suffering from anorexia or bulimia nervosa (Pipher, 1994). The Diagnostic and Statistical Manual of Mental Disorders-fourth edition (DSM-IV (1994) divides anorexia nervosa into two categories, restricting type and binge-eating/purging type, and states that anorexia nervosa typically begins in early adolescence. Prevalence studies

indicate that between .05 and 1.0% of adolescent and early-adult females meet the full criteria for anorexia, though individuals who are subthreshold for the disorder (for example, with Eating Disorder Not Otherwise Specified) are more commonly encountered. This disorder is found most often in Caucasian females from middle to upper-middle class families (Pipher, 1994). Anorexia nervosa has the highest mortality rate (over 10%) of all the psychiatric illnesses (Brumberg, 1989; DSM-IV, 1994; Pipher, 1994) and is one of the most difficult disorders to treat (Brumberg, 1989; Pipher, 1994).

Researchers have found a number of personality traits common to patients with anorexia nervosa. These young women seem to have feelings of ineffectiveness (DSM-IV, 1994; Bruck, 1973, as cited in Vitousek & Manke, 1994) for which the ritualistic control of food and weight provides a substitute sense of purpose and accomplishment (Goodsitt, 1985, as cited in Vitousek & Manke, 1994). The DSM-IV (1994) lists several descriptive features for anorexic females, such as a strong need to control one's environment, inflexible thinking, limited social spontaneity, and overly restrained initiative and emotional expression (see also Casper, Hedeker, & McClough, 1992). In their investigation of personality variables in anorexia and bulimia nervosa, Vitousek and Manke (1994) explored a number of problems that complicate the interpretation of personality data in these populations, including: young age at onset, the influence

of depression and starvation sequelae, denial and distortion in self-report, the instability of subtype diagnosis and the persistence of residual problems following symptom control. These researchers reported that the most consistent profile emerged in regard to restricting anorexia nervosa. Most of these patients were reticent, constricted, conforming children who, under the strains that adolescence imposed on their limited adaptive repertoires, developed psychopathology fully consonant with their temperamental style. These results are in full concert with Minuchin et al. (1978, as cited in Calam, Waller, Slade, and Newton, 1990) in their description of the anorectic family as having a characteristic style of interaction, including rigidity, enmeshment (diffuse boundaries), poor resolution of conflicts and overprotectiveness. Viewed from the attachment perspective, children growing up in such a family might form working models of themselves as ineffective problem-solvers whose inflexible coping skills and forced dependence on parents cannot withstand the pressures of adolescence, thus contributing to the development of pathology. Since the family does not encourage autonomy or provide appropriate modeling of flexible conflict resolution these young women are ill-prepared to meet the challenges of becoming more mature independent individuals.

Prevalence rates for bulimia typically range from 1-3% of young adult females (DSM-IV, 1994; Fairburn & Beglin, 1990; Pipher, 1994). While the

onset of anorexia is early adolescence, bulimia usually develops in late adolescence and has been called the "college girl's disease" because so many young women develop it in sororities and dorms (Pipher, 1994; Thelen, Mann, Pruitt, & Smith, 1987, as cited in Thelen, Farmer, Mann, & Pruitt, 1990). Estimates of bulimia nervosa range as high as 20% of all college women (DSM-IV, 1994; Pipher, 1994). The later onset of bulimia may reflect another major developmental change as the adolescent female leaves home for perhaps the first time, and is exposed to the stressful demands of college life. Indeed, as Armstrong and Roth (1989) note, the connection between leaving home and the onset and recurrence of eating-disorder symptomology is well documented in the literature. Bulimics who seek treatment report having engaged in these behaviors for approximately four years prior to seeking treatment (Pyle, Mitchell, & Ekert, 1981, as cited in Thelen, et al., 1990).

The DSM-IV (1994) divides bulimia nervosa into two categories: Purging type, which includes 80-90% of all bulimics patients, and nonpurging type. Characteristics of the bulimic patient commonly include feeling powerless and not in control of her life or her feelings, low self-esteem, lack of impulse-control, low tolerance for frustration or anxiety, and a need for approval (Casper et al., 1992; Sherman & Thompson, 1990; Vitousek & Manke, 1994). Root, Fallon, and Friedrich (1986, as cited in Sherman & Thompson, 1990) were able to describe

three common family types for bulimic individuals: the "perfect family," the "overprotective family," and the "chaotic family (p. 41)."

The perfect family is achievement and appearance oriented, with clear and rigid ideas about how family members are supposed to act. These families avoid problematic feelings and situations by expecting members to keep a happy exterior. The bulimic adolescent typically appears to be the perfect "good girl," and pressure is placed on her to live up to unrealistic expectations. The overprotective family lacks a fundamental trust in the ability of other family members, especially the bulimic individual, to take care of themselves. These families make separation difficult for the bulimic because they teach that no one outside the family can take care of her or can be trusted. Thus, this type of family does not encourage children to be autonomous or independent, which interferes with the development of a sense of self-competence. The chaotic family is unstructured and unstable. The parents are rarely available for guidance or support and for the most part the children raise themselves. If rules exist, they tend to be inconsistent and children never know what to expect. The chaotic family differs from other bulimic families in that emotions, especially anger, are expressed more often. Unfortunately, that expression is usually excessive and inappropriate, sometimes to the point of being destructive or violent.

Other descriptive studies of the family environments in which eating-

disordered behavior appears have reported similar characteristics common to these families. Such characteristics include: denying conflict, or handling conflicts inappropriately; little or no emphasis on open expression of feelings; and enmeshment in which generational boundaries are lacking and efforts towards separation, independence and self-assertion are undermined (Lundholm & Waters, 1991). Shapiro Jr., Blinder, Hagman, and Pituck (1993) propose that control and self-control may be among the most critical variables in the development and maintenance of eating disorders. The importance of a secure attachment in the adolescent to the primary caregiver is providing the right mixture of support and independence. Enmeshed families are over involved and controlling of their daughters lives, which does not allow for the development of a separate identity. Chaotic or disengaged families do not provide the support needed to engender self-confidence in forming an identity. Both types of families foster insecure attachments and a need for control in their daughters. The eating disordered individual attempts to cope by limiting her anxieties and quest for control to one aspect of her life: eating.

Several theoretical perspectives, including family systems (Minuchin, Rosman, & Baker, 1978, as cited in Kenny & Hart, 1992) and psychoanalytic theories (Bruch, 1978; Humphrey & Stern, 1988, as cited in Kenny & Hart, 1992) claim that parental separation-individuation problems are a causal factor in the

onset of psychopathology. Youniss and Ketterlinus (1987) cite Grotevant and Cooper's (1986), and Youniss and Smollar's (1985), interpretation of the concept of individuation in adolescent development as, "moving away from the definition of self that was valid during childhood and going on to construct a self that fits with one's own experience rather than parental desires (p. 267)." This concept also involves remaining connected to parents so that one can solicit and receive their validation for the individual that one has constructed. Adolescents seek their parents' approval while they also strive to be seen as new individuals rather than as children. Friedlander and Siegal (1990) used Edward, Ruskin, and Turrini's (1981) definition of separation-individuation as, "the normal developmental sequence of achieving a sense of separate individual entity (p. 74)," in their investigation of the etiology of eating disorders. Friedlander and Siegal (1990) found strong empirical relations between the failure to achieve and a sense of psychological separateness and the development and maintenance of eating disorders in a group of college women. Similarly, Armstrong and Roth (1989) found that eating-disordered inpatients evidenced significantly more severe separation and anxious attachment difficulties than normal adolescent and adult controls.

Considering that instances of adolescent eating disorders are on the rise, and that these behaviors are associated with adverse social, emotional and

physical consequences as well as mortality arising from medical complications, it is apparent that effective assessment devices for the early detection of risk factors for these disorders are desperately needed. One of the problems in the literature is finding an appropriate device to measure attachment issues and the development of eating disorders. Bradley (1994) and Nessel (1995) developed the Attachment and Personality Dynamics Questionnaire - (APDQ) to address some of the limitations of previous attachment measures. Rather than looking only at a person's attachment to their primary caregiver or partner and inferring that she will have the same type of relationship with other significant individuals in her life, the APDQ measures attachment to mother, father, partner, and peers. In addition, the APDQ also measures issues of social functioning, intrapersonal insecurity, family relations, abuse, and family dynamics. The APDQ currently consists of 264 questions, 29 scales, and six factors. The six factors include: Codependency, Insecure Mother Relations and Defenses, Conflicted Partner Relations, Withdrawal and Suppression of Feelings with Friends and Family, Poor Father Relations, and Sexual Drives and Religion. The questionnaire's scales and factors have a coefficient alpha level of .82. However, the independent scales are not completely reducible to the factors (Nessel, 1995). This survey takes approximately 90 minutes to complete.

The purpose of the present investigation was to explore the family-of-

origin dynamics of individuals with eating disorders by administering the APDQ to this population. It was hypothesized that the eating disordered clinical group would show a pattern of insecure attachments to primary caregivers and significant others in comparison to non-clinical controls. It was expected that extreme scores with larger differences between high and low scores will differentiate these individuals from the control group. It was believed that these individuals would not only have insecure attachments to their primary caregivers, but through the formation of working models form insecure attachments to themselves. In other words, they may lack confidence, have low self-esteem, and a low tolerance for anxiety. In order to fill this metaphorical "hole in the soul" they find something in the external environment to focus upon, such as food. More specifically it was expected that the clinical group would show patterns of personality variables consistent with those reported in the literature.

METHOD

Subjects

The Eating Disordered subjects were 23 females. Twelve subjects were recruited from a private practice, three came from a community mental health center, six from a Christian counseling center, and two volunteered from a

support group for people with eating disorders. All the subjects in therapy were diagnosed with anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified. The 297 controls were taken from females matched in age and socioeconomic status. They came from a larger study and consisted of Department of Health workers, high school teachers, members of churches, office workers, and college students. Socioeconomic status was defined in terms of parents' education and family income while growing up. The college students were given extra credit in their psychology classes for their participation. Subjects indicated their ages by responding according to the following categories: (a) 17-21, (b) 22 - 35, (c) 36 - 49, and (d) 50 - 65. Mid-mean category ages were then used for each subject. The mean mid-category age was 40 for the Eating Disordered group, and 43 for the control group. To keep as many subjects as possible in the study the demographics were not matched with exact percentages.

Measures and Procedure

Subjects were required to complete 264 questions on the APDQ. The subjects rated the extent to which each statement described their feelings on a 4-point response scale ranging from (A) "never" to (D) "always". See Figure 1 for representative questions of each scale. Of the 29 scales which comprised the APDQ, nine scales attempted to measure the three main classifications of attachment according to Bowlby and Ainsworth - secure, avoidant, and

ambivalent, across relationships with mother, father, and partner. Three scales measured another form of insecure attachment, codependence-enmeshed, to all three figures. Partner was defined as the respondent's spouse, fiance, steady date, or significant romantic interest. If they were not currently involved in such a relationship, they were instructed to think of their most significant past partner and refer to that relationship when answering questions referring to partners. If they had never had a meaningful romantic relationship, respondents were instructed to leave the questions referring to partners blank. The answers from the questionnaires were placed on scan-tron sheets and computer scored, where A = 1 and D = 4.

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Insert Figure 1 About Here

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RESULTS

Because a primary purpose of this study was to describe what differences might exist between Eating Disordered subjects and their Controls in relationship functioning, preliminary t tests were performed for each of the scales. These data, along with the means and standard deviations for both populations can be seen in Figure 2.

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Insert Figure 2 About Here.

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The second analysis performed was designed to see which of the scales best discriminated between the Eating Disordered and control subjects. Stepwise Discriminate function analysis were performed. These analyses determine whether the pattern of characteristics that the subjects endorsed suggest that the populations were clearly distinct from one another. The coefficients can be interpreted like regression coefficients. Larger coefficients suggest that the characteristic had a strong influence on the function. The function's squared canonical correlation was .26, with tests of significance yielding F (5, 283) = 19.67, p<.001. The pooled within-class standardized canonical coefficients were as follows: Family Suppression of Feelings = .72, Shame = .47, Sexual Intimacy = -.53, Denial = .18, and Abuser = .05. The Class Means on the Canonical Variable were Eating Disordered = 2.15, and Control = -.16.

The third set of analyses addressed the question, "If the Eating Disordered patients were all somewhat different with respect to the scales, (for example, some being high on avoidance, some high on codependency), the standard deviations across the 29 scale scores for the Eating Disordered group would be expected to be significantly higher than the controls. That is, if one were to

conceptualize plotting a line from each scale score to the next, would the lines for the Eating Disordered group be more variable than the lines for control subjects?" This analysis was performed by first combining the populations and assigning standard scores for each scale and standard deviations from those for each subject. The standard deviations were then analyzed by using a Wilcoxon nonparametric test which revealed significant differences between the groups' standard deviations with a Kruskal-Wallis Test Chi square approximation $\chi^2 = 13.87$, $p<.01$. The Eating Disordered group's mean standard deviation between the 29 scales was 2.23, while the control's was 1.75.

Given the above results, it was possible that the discriminant analyses did not adequately test the attachment theory of Eating Disorders. That is, Eating Disordered subjects could all be insecurely attached, but show different patterns of insecurity. Therefore, dominant attachment style scores were computed for each subject. For example, if a subject's score of secure attachment for father was higher than avoidant, ambivalent, or codependent father scores, then that person was scored as "Secure Father". If the subject's avoidant father score was higher than the other three scores, then that person was scored as "Avoidant Father". Similar dominant attachment scores were computed for mother and partner for each of the attachment types. A final overall measure of security was computed and is listed as "Global Security" in Figure 3. If the subject scored higher on

security for mother, father, and partner than all the other attachment scores, then that person was scored as "Global Secure." These data were analyzed by 2 (Eating Disorders versus controls) by 2 (Dominant versus Other Attachment Styles) Chi Square tests. They were performed for dominant secure, dominant avoidant, dominant ambivalent, and dominant codependent styles for mother, father, and partner. These results can be seen in Figure 3. The final entry labeled "Global Security" was defined as whether one listed secure attachments higher than insecure attachments to all three figures.

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Insert Figure 3 About Here

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DISCUSSION

Because one of the primary purposes of the present study was descriptive in nature, the scales showing significant differences between Eating Disordered and control populations will be discussed first. As shown in Figure 2., t scores between the two groups reached at least $p \leq .05$ significance on 19 of the 29 scales, with nine scales having a significance level of $p \leq .001$. It was hypothesized that the Eating Disordered clinical group would demonstrate higher means on the scales measuring insecure attachment styles. The results were consistent with this hypothesis. The largest differences seemed to occur with regard to the Avoidant

Attachment scales for mother and partner, with the Eating Disordered group having means significantly higher on these avoidant scales than the controls, substantiating the predictions of Armstrong and Roth (1989), and Casper, Hedeker, and Mc Clough (1992). The Ambivalent Mother and Ambivalent Partner scales were also higher for the Eating Disordered group.

It was interesting that the scales measuring relations to the father were not generally as powerful in describing the differences between the two groups. The Avoidant Father scale was the only scale measuring insecure attachment to father that reached significance. Perhaps insecure attachments to one's father do not play as crucial a role in the development and maintenance of eating disorders in the female subjects as the insecure attachments to mother and partner.

Codependency with any of the three figures did not seem to distinguish the two groups, (with the exception of the Codependent Father scale reaching $p \leq .001$ significance on the Chi Square test, as shown in Figure 3.). This finding was inconsistent with clinical studies reporting eating disordered family environments as enmeshed (such as in Minuchin, et al., 1978, as cited in Calam, Waller, Slade, & Newton, 1990; and Lundholm & Watters, 1991). However, given the difficulty with treatment and compliance issues, perhaps the notion of avoidance rather than codependence makes more sense clinically.

The Eating Disordered group had significantly lower means on the scales

measuring Secure Attachment to Mother, Father, and Partner. These results support the predictions of the current study that individuals with eating disorders do not have secure attachments to mother and /or father, and lack the ability to form secure relationships outside of the family. This notion is also supported by lower means and higher standard deviations for the Eating Disordered group on the Peer Relations scale. This indicates that the Eating Disordered group's attachments to friends may be less secure as well.

It was expected that scales measuring Trust, Control, Denial, Anxiety, Shame, Anger, and Obsessive Compulsive tendencies would distiguish the means of the Eating Disordered group from the control group. As discussed earlier, secure attachments to primary caregivers have been found to be important to the development of self esteem, sensitivity to one's own feelings, and psychological well-being, including resilience to stress. If the Eating Disordered subjects had insecure attachments to their parents, it could be that they formed working models of themselves as ineffective in eliciting loving feelings from others and coping with stress on their own. Therefore, the eating disordered women in this study may have lower self esteem and reported greater anxiety than control subjects. Higher feelings of shame may be related to lower self esteem and feelings of ineffectualness. As reported in the literature, the families of eating disordered patients are described as rigid and discouraging independence, or at

the other extreme, offering too little guidance and inconsistent rules. In both types of families control becomes an issue, so obsessive compulsive tendencies and a high need for personal control become highly characteristic of these individuals. This supports Shapiro Jr., Blinder, Hagman, and Pituck's (1993) claim that control and self control may be among the most critical variables in the development and maintenance of eating disorders. The Diagnostic and Statistical Manual of Mental Disorders-fourth edition (1994) also supports these hypotheses, stating that "obsessive compulsive features, both related and unrelated to food, are often prominent (p.541)" in patients with anorexia nervosa, as well as "feelings of ineffectiveness, a strong need to control one's environment, and inflexible thinking (p.541)." Similarly, individuals with bulimia nervosa are described as having a sense of lack of control and low self esteem (DSM-IV, 1994). In summary, the above mentioned predictions from the literature that Eating Disordered subjects would show higher levels of mistrust, shame, anger, denial, anxiety, and obsessive compulsive tendencies were strongly supported by the present results.

Root, Fallon, and Friederich's (1986, as cited in Sherman & Thompson, 1990) description of the bulimic "perfect family" includes avoidance of problematic feelings and situations, denial of negative feelings, and pressure to meet unrealistic standards. It is interesting to note that although the Perfectionism

scale was not significant, this description and others similar to it (such as in the DSM-IV, 1994) support the reasoning behind the elevated means for the Family Suppression of Feelings and Denial scales. Indeed, Lundholm and Watters (1991) described eating disordered patient's families as denying conflict with little or no emphasis on open expression of feelings. The Eating Disordered subjects did have higher means on the Anger scale than controls, but this is not inconsistent with suppression of feelings. As noted in Figure 1., one of the representative questions for the Anger scale was, "When I get angry, I explode." It is reasonable to assume that this statement is compatible with suppression of feelings, because anger is suppressed until the individual can no longer contain it and "explodes".

Regarding sexual functioning, the Eating Disordered subjects did not have significantly lower means than control subjects on the Sexual Arousal scale. However, the two groups were significantly different on the Sexual Relationship scale. This difference is easily explained if one refers back to representative questions (Figure 1.) for the scales. The Eating Disordered subjects may report feeling just as sexually aroused in certain situations as the control group, but considering that these individuals have greater difficulty trusting people than the control subjects, and they have the tendency to supress their feelings, perhaps they do not discuss sex as openly with their partners as control subjects. After all, it is unlikely that sex was discussed openly in their family of origin. In addition

to this, many clinicians have reported higher incidence rates of premorbid sexual abuse in eating disordered patients than in the normal population. This might also account for difficulties with sexual intimacy, and aid in explaining the observed differences on the Sexual Relationship scale. This, of course, needs to be addressed by further research.

After comparing means and standard deviations between the Eating Disordered subjects and the control subjects, a discriminant function analysis determined that the following scales best distinguished the two groups: Family Supression of Feelings, Shame, Sexual Intimacy, Denial, and Abuser. The Abuser scale was not expected to delineate between Eating Disordered subjects and controls. Perhaps, this finding can be explained in terms of the descriptive reports of eating disordered patients that mention low frustration tolerance and lack of impulse control (seen mostly in bulimics). This might influence their tendency to lash out at others. It is important to note that this scale assesses the **desire** to hit people, and the **thought** that certain people "deserve to be put in their place," it does not necessarily mean that the subjects physically act on their thoughts or desires.

The third set of analyses performed on the data revealed that standard deviations between scaled scores were significantly higher for the Eating Disordered group than the controls. So, if the scores were plotted in a profile for

each subject, those subjects with eating disorders would have profiles with a great deal of variation between the scales. This result supports the initial hypothesis that individuals with eating disorders are out of balance. The data obtained during this study supports the literature on the role of insecure attachments with the family of origin in the development and maintenance of eating disorders, and identifiable personality characteristics of eating disordered individuals. Clinically, however, it would be a mistake to make blanket statements about the profiles of such individuals. One can expect to observe more extreme means, but analysis of the variable standard deviations demonstrates that it would be more beneficial to look at individual profiles for each subject.

The final set of analyses attempted to discover dominant attachment styles. The majority of the control subjects reported secure attachments to mother, father and partner, with 32% being labled as "Global Secure". The majority of the Eating Disordered subjects were insecurely attached (96%) to the three figures, with only 4% receiving the label "Global Secure". The largest percentage of Eating Disordered subjects had avoidant attachments to mother, father and partner. This finding is logical considering that the Family Suppression of Feelings Scale best discriminated the eating disordered subjects from the controls. If those individuals with eating disorders were encouraged by family members to suppress their feelings, avoidance and rejection of the person

they were upset with would have been the easiest way to hide their feelings. Higher scores on avoidance might also be associated with lower levels of compliance to therapy.

Summary and Conclusions

One of the major goals of this study was to investigate the role of attachment style and personality variables that have been reported in the literature as characteristic of those individuals with eating disorders. The results of this study generally supported observations that women with eating disorders were more likely to have insecure attachments to their parents, partners, and peers, than control subjects. Most of the features associated with this population were also found to be significant, such as anxiety, control, obsessive compulsive tendencies, difficulty trusting others, and withdrawal. The factors that best discriminated these women from controls were: family supression of feelings , shame, sexual intimacy, denial, and abusive characteristics. Perfectionism and codependency did not seem to differentiate between the eating disordered subjects and controls as they were expected to from reports in the literature. It was also found that as a group, the eating disordered subjects had larger standard deviations on their average scores for the 29 scales. That is, their profiles were more "sawtooth" in nature.

For future study it would be interesting to survey anorexic and bulimic

clients separately, to see if different attachment styles and personality characteristics emerge. Males with eating disorders are rare, but incidence rates are reportedly on the rise; therefore, including males in a similar study may prove beneficial. Examining the individual profiles of subjects with eating disorders might help discern whether eating disordered subjects maintain the same attachment patterns to partners and peers that they had with their parents while growing up. Finally, the subjects in this study were not matched exactly on demographics, nor were concommitant diagnoses accounted for, so an investigation which obtained a larger sample of eating disordered subjects and controlled for these variables would be valuable.

The Attachment and Personality Dynamics Questionnaire may serve as a useful tool for identifying insecure attachment styles and personality variables that may contribute to the development of an eating disorder in females. It may also be helpful to clinicians to administer the APDQ at the beginning of therapy to assist in identifying individual treatment goals and objectives for their clients.

Figure 1. Scales of the APDQ and Representative Questions

ABUSER SCALE (ABR)

I feel like hitting those people who are close to me.

Some people deserve to be put in their place.

AMBIVALENT ATTACHMENT - FATHER (AMF)

My feelings for my father were confusing.

Arguments with my father were a love-hate kind of thing.

AMBIVALENT ATTACHMENT - MOTHER (AMM)

My feelings for my mother were confusing.

Arguments with my mother were a love-hate kind of thing.

AMBIVALENT ATTACHMENT - PARTNER (AMP)

My feelings for my partner are confusing.

Arguments with my partner are a love-hate kind of thing.

ANGER (ANG)

I feel resentful because I can not pursue my own interests.

When I get angry, I explode.

ANXIETY (ANX)

I feel that something bad is about to happen.

I use a lot of energy worrying about my problems.

AVOIDANT ATTACHMENT - FATHER (AVF)

After an argument with my father, I tried to avoid him.

When I got really mad at my father, I felt cold and rejecting towards him.

AVOIDANT ATTACHMENT - MOTHER (AVM)

After an argument with my mother, I tried to avoid her.

When I got really mad at my mother, I felt cold and rejecting towards her.

AVOIDANT ATTACHMENT - PARTNER (AVP)

After an argument with my partner, I try to avoid him/her.

When I get really mad at my partner, I feel cold and rejecting towards him/her.

CODEPENDENCE-ENMESHED MOTHER (CODM)

I changed my feelings to make my mother happy.

When my mother felt sad for days, I did too.

CODEPENDENCE-ENMESHED FATHER (CODF)

I changed my feelings to make my father happy.

When my father felt sad for days, I did too.

CODEPENDENCE-ENMESHED PARTNER (CODP)

I change my feelings to make my partner happy.

When my partner feels sad for days, I do too.

CONTROL (CTRL)

I avoid situations that I can not control.

If people would just change a little bit then most of my problems would go

away.

DENIAL (DEN)

It is good to keep a stiff upper lip even when I hurt inside.

I say I am happy when I really am not.

FAMILY RIGIDITY VS CHAOS (FRVC)

My family believed that family rules should not change.

Family rules were clear.

FAMILY SUPPRESSION OF FEELINGS (FSUP)

People in my family had firm expectations for how we were supposed to feel.

It was good to keep your feelings to yourself in our family.

JEALOUSY (JEAL)

I worry that my partner will find somebody else.

I get angry when others flirt with my partner.

OBSESSIVE-COMPULSIVE (OBCO)

Once I start thinking about a problem, I think about it over and over again.

I am distracted in conversations with others because I am thinking about something else that is important.

PEER RELATIONS (PEER)

My friends will always be there when I need them.

My friends know how I feel.

PERFECTIONISM (PERF)

I like to be the best at things.

I like to do things right or not do them at all.

RELIGION (RELG)

I attend a place of worship/church.

A higher power/God is important to me.

SECURE FATHER (SECF)

My father was there when I needed to talk about a problem.

When I was upset, my father helped me deal with it.

SECURE MOTHER (SECM)

My mother was there when I needed to talk about a problem.

When I was upset, my mother helped me deal with it.

SECURE PARTNER (SECP)

My partner is there when I need to talk about a problem.

When I am upset, my partner helps me deal with it.

SEXUAL AROUSAL (SAR)

I am turned on if I see a pornographic movie.

I am easily turned on sexually.

SEXUAL RELATIONSHIP (SX)

I talk about what turns me on sexually with my partner.

Sex is best when it is accompanied by warm feelings.

SHAME (SHA)

I feel ashamed when I feel sad, rejected, fearful, lonely, dependent or hurt

I do not amount to much as a person.

MISTRUST (MTR)

It is good to be suspicious about the motives of others.

If I do not trust other people then I will not be disappointed.

WITHDRAWAL / ENGAGEMENT (WIEN)

I like to withdraw from people when I am stressed.

I do not want others to know what is going on in my life.

VALIDITY (VLD)

Opposite questions of four of the above.

Figure 2. Comparisons of the eating disordered group with the controls on the 29 APDQ scales.

	Eating-Disordered Group		Control Group		
Scale	Mean	Standard Deviation	Mean	Standard Deviation	T Score
Abuser	1.89	0.53	1.76	0.45	-1.08
Ambivalent Father	2.13	0.69	1.89	0.69	-1.51
Ambivalent Mother	2.45	0.74	1.88	0.61	-3.22**
Ambivalent Partner	2.45	0.72	1.92	0.60	-3.51**
Anger	2.39	0.50	2.09	0.45	-2.92**
Anxiety	2.54	0.48	2.11	0.51	-3.91***
Avoidant Father	2.54	0.71	2.13	0.73	-2.42*
Avoidant Mother	2.77	0.69	2.12	0.65	-4.46***
Avoidant Partner	2.50	0.62	1.96	0.50	-3.85***
Codependent Mother	2.46	0.51	2.31	0.44	-1.48
Codependent Father	2.19	0.62	2.01	0.46	-1.27
Codependent Partner	2.45	0.53	2.58	0.48	1.16
Control	2.39	0.53	2.05	0.38	-2.81**

Denial	2.66	0.63	2.38	0.56	-2.27*
Family Rigidity vs Chaos	2.76	0.78	2.46	0.55	-1.78
Family Suppression of Feelings	3.06	0.66	2.10	0.59	-7.27***
Jealousy	2.43	0.73	2.40	0.63	-0.18
Obsessive-Compulsive	2.69	0.51	2.45	0.50	-2.21*
Peer Relations	2.41	0.75	2.99	0.64	4.07***
Perfection	3.07	0.38	2.95	0.43	-1.25
Religion	2.95	0.84	2.92	0.70	-0.13
Sexual Arousal	2.11	0.40	2.17	0.42	0.60
Secure Father	2.08	0.74	2.59	0.92	2.42*
Secure Mother	2.14	0.74	2.97	0.83	4.46***
Secure Partner	2.27	0.83	2.96	0.71	4.25***
Shame	2.29	0.58	1.68	0.43	-4.80***
Sexual Relationship	2.43	0.68	3.21	0.62	5.34***
Trust	2.52	0.68	2.21	0.52	-2.14*
Withdrawal vs. Engagement	2.65	0.54	2.31	0.40	-2.88**

$p<.05$ = *

$p<.01$ = **

$p<.001$ = ***

Figure 3. Chi Square tests and percent of those getting highest secure, avoidant, ambivalent, and codependent scores to mother, father, partner, and all three, with $p<.05$ = *, $p<.01$ = **, $p<.001$ = ***.

Attachment Figure	Control	ED	N	Chi Square
Secure Mother	68%	26%	321	16.94***
Secure Father	58%	17%	321	14.53***
Secure Partner	61%	26%	321	10.77***
Avoidant Mother	18%	48%	321	11.28***
Avoidant Father	23%	48%	321	7.20**
Avoidant Partner	5%	30%	321	20.17***
Ambivalent Mother	7%	13%	321	1.11
Ambivalent Father	11%	4%	321	1.10
Ambivalent Partner	6%	21%	321	7.91**
Codependent Mother	2%	4%	321	0.55
Codependent Father	3%	13%	321	6.92**
Codependent Partner	19%	13%	321	0.60
Global Secure	32%	4%	321	7.86**

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