Research Article

Attachment Patterns of Mothers with Daughters Affected by Anorexia Nervosa: Exploring Psychosocial Dimensions and Intervention Perspectives

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Abstract

Introduction: Research in clinical developmental psychology has offered a relational reading of early-onset eating disorders, highlighting the important role played by the attachment bond in the genesis of EDs. The present study aims to investigate attachment styles in adulthood in a sample of mothers of daughters with Anorexia Nervosa (AN), the quality of family functioning, the possible presence of positive/negative affectivity, and the perception of self-efficacy.

Method: Eleven mothers (mean age=49.09; SD=4.65) of adolescents with AN voluntarily participated in the study. The following standardized tests were selected and administered: 12-item General Functioning Scale of the Family Assessment Device (GF-FAD); Relationship Questionnaire (RQ), to assess attachment style; Parental Self-Efficacy Scale (PSES); Positive and Negative Affect Schedule (PANAS).

Results: 36.4% of the sample showed relational dysfunction in the household (GF-FAD>2.00). 45.5% of the mothers presented a dismissing attachment style. All responding mothers fell within the clinical range of the PN-PANAS scale with a medium level of PSES (M=25.09; SD=5.89).

Conclusion: It is important to strategically target treatment pathways also for preventive purposes in order to better manage personal and family resources, with the aim that the family should be a protective factor and not a maintenance factor of the disorder.

Keywords: Attachment style; Anorexia nervosa; Family relationships; Self-efficacy; Interventions

Introduction

Eating Disorders (EDs) are debilitating psychiatric disorders, characterized by a pathological relationship between food and one's body, potentially life-threatening, and impairing the physical health and social functioning of the individual [1]. According to a systematic review and meta-analysis of 32 studies 22% out of a sample of 63,181 children and adolescents from 16 different countries showed EDs [2]. A review study of the medical literature indicates average prevalence rates of 0.7 percent in adolescent girls for anorexia and 1-2 percent for bulimia among women aged 16-35 years [3]. Studies seem to show a decreasing trend in bulimia and instead an increase in anorexia. At the heart of EDs, which manifests itself as a complex disease resulting from the interaction of multiple biological, genetic, environmental, social, psychological, and psychiatric factors, there is, however, on the part of the patient an obsessive overestimation of the importance of his or her own fitness, weight and body and a need to establish control over it [4].

Among the reasons that lead to the development of anorexic and bulimic behavior are, in addition to a familial component (transgenerational and twin studies have shown that eating disorders are more likely to occur among the relatives of a person who is already ill, especially if it is the mother) the negative influence of other family and social members, the feeling of being over-pressurized and over-expected, or on the contrary, of being severely neglected by one's parents, the feeling of being mocked for one's physical fitness or of not being able to achieve the desired results because of weight and appearance problems. Research in clinical developmental psychology in recent years offers a relational reading of early-onset eating disorders, highlighting the important role played by the attachment bond in the genesis of eating disorders in childhood [5].

Specifically, the quality of interactions with attachment figures has a significant impact on future normal and pathological development and certainly, among the various mother-child exchanges, feeding represents an essential moment [6]. Bowlby defines the attachment bond as the child's innate predisposition, on a biological basis and evolutionarily determined, to develop a relationship with a caregiver. The main function of this innate behavioral system is to obtain care and protection from a significant figure in times of stress, danger, and fear. He further argues that in parallel to the attachment system, the parent develops another behavioral system, complementary to it, whose specific goal is to provide protection to the child: Caregiving [7-9].

According to motivational systems theory caregiving is reciprocal to attachment. It leads to the offer of care towards a

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conspecific, facilitating the possibilities of sustenance of other individuals within one's own group [10,11]. The system is activated by signals of request for comfort and protection emitted by another individual, in turn motivated by the attachment system, or by perceptions of his or her fragility/condition of difficulty. Emotions arising from obstacles to achieving the system's goal are solicitude anxiety, compassion, protective tenderness, or guilt for not being cared for. When the system is deactivated, emotions of relief, protective tenderness, and happiness are experienced.

Research on the relationship between attachment and EDs shows a prevalence of insecure styles and disorganized (or, in adulthood, unresolved) styles in both patients and their parents, underlining the importance of the intergenerational transmission of attachment with respect to understanding these pathologies and maladaptive family strategies [12]. Intergenerational transmission of attachment is that phenomenon whereby individuals, in their relationships with their children, use an interaction style like that of their attachment figure. This does not represent mere imitation behaviour, but rather the effect of the action exerted by internal operating models that allow the parent to grasp the real meaning of signals coming from the other. A subject who has received emotional support and thus acquired a certain emotional competence will become able, as an adult, to recognize their child's signals and implement appropriate responses. This is why adults' Internal Working Models (IWMs) make sense within the bond with their children.

In line with these assumptions, Ward et al., proposed that the prevalence of insecure attachment patterns in the anorexia nervosa population can be explained by the attachment patterns of mothers (intergenerational transmission of attachment) [13]. In particular, it has been found that the Avoidant attachment pattern (Distancing/Devaluating in adults) is prevalent in individuals with restrictive behavior typical of AN [14]. In contrast, bulimic behavior has been proposed to represent the expression of the affective dysregulation characteristic of the Ambivalent or, in adults, the Worried/Involved pattern [15]. An interesting study by Kronner, interpreted disturbed eating behavior, rather than as a direct expression of the attachment pattern, as a re-enactment of proximity-seeking behavior, described by Bowlby in 1969, in terms of one of the main attachment behaviors in young children [16]. Tasca et al., understand attachment style as a determining factor in the learning of affective regulation strategies, which in turn, influence feeding behavior [17].

Ringer and Crittenden instead identify the family system as a factor mediating the relationship between attachment style and eating disorders suggesting that unresolved conflicts or histories of trauma in parents may contribute to the development of insecure attachment styles and Eds [18]. In Italy, Attili conducted a study aimed at identifying attachment mental organizations in eating disorders, finding that EDs are rarely associated with secure attachment mental models [19]. In general, scholars who have compared attachment styles between groups of patients with EDs and healthy subjects have found a prevalence of insecure attachment styles in subjects with EDs and largely secure styles in the control group [20]. On these premises, the aim of the present study is to investigate attachment styles in adulthood in a sample of mothers of daughters with AN, the quality of family functioning, the possible presence of positive/negative affectivity, and the perception of self-efficacy.

Materials and Methods

Procedure

Mothers of adolescents suffering from AN were recruited during the first acquaintance meeting of the psycho-education program organized by a clinic specialized in EDs located in the Campania region (Southern Italy). The mothers were asked to join the research protocol and leave their contact details. Within 48 hours they were contacted to fix an appointment, during which both the informed consent with the research purposes and the quantitative section concerning the screening tests were submitted. Each meeting lasted on average between 40 and 50 minutes and took place between November 2021 and March 2022.

Materials

The following standardized tests were administered to the mothers who participated in the study:

The 12-item General Functioning Scale (GF-FAD) of the Family Assessment Device (FAD) is designed to measure the overall health and functioning of a family unit [21]. It provides insights into how well a family is functioning in terms of communication, problem-solving, roles, affective responsiveness, affective involvement, and behavior control. The scale comprises 12 items that cover different aspects of family life and functioning. Respondents, often family members, rate each item based on their perception of the family's functioning. The scoring system varies but typically includes a Likert scale ranging from "Strongly Agree" to "Strongly Disagree." Higher scores on the GF-FAD generally indicate healthier family functioning, while lower scores may suggest areas of concern or dysfunction.

The Relationship Questionnaire-RQ aims to assess adult attachment styles, building upon the attachment theory framework developed by John Bowlby and Mary Ainsworth [22]. Bartholomew and Horowitz proposed a model that identifies four attachment styles: 1) Secure: Comfortable with intimacy, trust, and autonomy. 2) Preoccupied (Anxious): Desire closeness but worry about rejection. 3) Dismissive (Avoidant): Value independence and avoid intimacy. 4) Fearful-Avoidant (Disorganized): Fear both abandonment and closeness. Participants respond to each item, related to feelings and behaviors in romantic relationships, indicating the extent to which it reflects their feelings or behaviors. The scoring helps determine their predominant attachment style.

The Parenting Self-Efficacy Scale-PSES is a tool designed to assess a parent's self-perceived competence and confidence in various aspects of parenting [23]. Developed within the framework of Albert Bandura's social cognitive theory, self-efficacy refers to one's belief in their ability to perform specific tasks or handle particular situations effectively [24]. The scale consists of 12 items related to different parenting tasks, challenges, or situations. Respondents rate their level of confidence or competence on each item using a Likert scale, where they may indicate their agreement or disagreement with statements about their parenting

abilities. Higher scores on the PSES indicate greater perceived parenting self-efficacy, suggesting a higher level of confidence in one's ability to meet the demands of parenting.

Positive and Negative Affect Schedule-PANAS is a psychological questionnaire that assesses an individual's positive and negative affectivity [25]. It typically consists of two separate scales measuring positive (PA) and negative (PN) emotions, each containing several mood-related adjectives. Respondents rate the extent to which they currently experience each emotion. Higher levels of PA are associated with pleasurable engagement with the environment; in contrast, higher levels of NA reflect a dimension of general distress summarizing a variety of negative states such as anger, guilt, or anxiety.

Results

The scores of the scales described above were analyzed using IBM-SPSS v.23 software (SPSS Inc., Chicago, IL, USA) to provide an overview of how the parents assessed their current situation.

Characteristics of the mother's group

Eleven mothers (mean age=49.09; SD=4.65; min.-max. 42-55) voluntarily participated in this study. All the mothers came from the province of Naples (southern Italy), which is under the territorial jurisdiction of the Local Health Unit where the clinic is located. The number of household members varied from min 2 to max 5. Nine mothers were married or cohabiting, and two were separated or divorced. For education level, four had a high school license, three had a bachelor's degree, three had finished middle school and one a primary school. As to employment, two were freelancers, three were permanent employees, three were housewives, two were unemployed, and one was temporary employees. For caregiving, 63.6% had been taking care of their daughters for one to two years, 27.3% for less than a year, and 9.1% had been involved for more than two years. When asked who within the household was mainly responsible for the care of their daughter, 72.7% answered predominantly the mother and 27.3% chose both equally. For all descriptive characteristics see Table 1.

Table 1: Characteristics of the mother's group (n°11)

Variables		%
Partnership status	Married/cohabiting	81.8
	Separated/divorced	18.2
Scholarship	Bachelor's degree	27.3
	High school license	36.4
	Middle school license	27.3
	Primary school license	9.1
Job position	Freelancer	18.2
	Housewife	27.3
	Permanent employees	27.3
	Temporary employees	9.1
	Unemployed	18.2
Caring daughter	Both equally (mothers and fathers)	27.3
	Predominantly mother	72.7
Time for caring	1 to 2 years	63.6
	Less than a year	27.3
	More 2 years	9.1

Characteristics of the daughters

All patients are diagnosed with AN based on DSM-5 criteria (American Psychiatric Association, 2013) and the Eating Disorders Inventory-EDI-3 [26]. Daughters had a mean age of 15.82 (SD=1.4; min.-max.13-17), an average BMI of 17.19 (SD=1.53; min.-max. 14-19) at the time of assessment, and a Global Psychological Maladjustment (GPM) mean of 133.64 (SD=41.33), which considerably exceeds the clinical cut-off of >70.

Family functioning

A total of 36.4% of the sample exceeded the clinical cut-off of the GF-FAD scale (>2.00). Negative family functioning can influence the development of AN in different ways. For example, a family environment characterized by dysfunctional dynamics, conflict, high pressure for excellence, or low family cohesion may contribute to the development of eating disorders [27]. The presence of excessive criticism, unrealistic expectations, or emotional abuse within the family can negatively influence the subject's self-esteem and body perception, contributing to the onset of anorexic behavior as a distorted way of gaining control and acceptance.

Attachment style

Of our sample, 45.5% presented a Fearful-Avoidant (Disorganized) attachment style, 18.2% (n°2) a Secure attachment style, 18.2% (n°2) were Preoccupied (Anxious), and 18.2% (n°2) were Dismissive (Avoidant). People with a disorganized attachment style may have difficulty developing secure and reliable relationships. This instability in relationships may contribute to the development of a distorted self-image and increased vulnerability to eating disorders, including AN. In addition, a dismissing attachment may affect the ability to handle emotional stress in a healthy way, leading to dysfunctional strategies such as excessive control of food as a way of coping with difficult emotions. It is important to emphasize that AN is a complex and multifactorial disorder, so the role of dismissing attachment is only one of several factors that may contribute to its onset.

Parental self-efficacy

Mothers' mean score on the PSE scale was 25.09 (SD=5.89), determining a medium level of perceived self-efficacy. Low levels of self-efficacy may indicate that mothers may feel powerless or ineffective in understanding or managing their daughter's situation, especially considering the complexity and challenging nature of AN. Family involvement is often a crucial element in the treatment of EDs, and working on mothers' perceptions of self-efficacy may be an integral part of the psychological support offered, in understanding the underlying causes of the disorder, providing appropriate support or managing family dynamics that may contribute to the development or maintenance of AN.

Mothers' positive and negative affectivity

With regard to the positive and negative emotions expressed by the sample, it emerges that all of the responding mothers (n=11) fall within the clinical range of the PN scale, as the mean of the scores detected are below the reference cut-off (Mean=14.80, SD=5.49); and that 18.2% of the mothers fall within the clinical range with regard to positive emotions (PA) as the scores are below the reference cut-off of 26.48 (SD=8.1).

These data in Table 2 are in line with previous studies in which it was shown how caring for patients with AN can negatively affect the caregiver's quality of life and contribute to the onset of anxiety-depressive symptoms [28,29]. (Table 2)

Table 2: Psychological asset and functioning of the mother's group (n°11)

Variables		%	Mean	SD
Family functioning (GF-FAD)	Nonclinical	63.6		
	Clinical	36.4		
Attachment Style (RQ)	Secure	18.2		
	Preoccupied (Anxious)	18.2		
	Dismissive (Avoidant)	18.2		
	Fearful-Avoidant (Disorganized)	45.5		
Parental Self-Efficacy (PSES)			25.09	5.89
Positive and negative affectivity (PANAS)	PA			
	Nonclinical	81.8		
	Clinical	18.2		
	NA			
	Clinical	100		

Discussion

To date, the scientific community agrees in affirming the multifactorial nature of the aetiopathogenesis of the disorder. The pathogenetic core of EDs is in fact the outcome of a complex interaction between individual, family, and socio-cultural factors that, in varying degrees, play predisposing, precipitating, and maintaining functions in EDs. Interventions for people with eating disorders should go beyond the medical and mechanistic model aimed exclusively at nutritional rehabilitation, since as they are complex disorders that involve not only the person as an individual but also the family system in which they live, they require a multidisciplinary intervention involving various professionals (psychologist, nutritional doctor, sometimes also psychiatrist). The family can be both a resource and a limit; it can be both a protective factor for the child and a factor in the genesis and maintenance of certain psychological disorders, including the anorexic symptoms [30]. Since people suffering from anorexia impose themselves on the hunger stimulus in order to experience control, strength, and autonomy and the control of their own body can be experienced as a way to regain space and escape the control of others combined, however, with strong feelings of inadequacy, the work should be focused on the acquisition of greater autonomy, a solid identity, and greater emotional stability.

Examination of the recent literature concerning the role of family members in EDs provides further experimental confirmation that the caregiving experience for family members of patients with EDs is problematic. These data seem to support the hypothesis that dysfunctional relationships within the family constitute a significant maintenance factor for the disorder itself. Less clear, on the other hand, appears to be the possible causal role that family relationships and habits relating to eating may or may not play in the development of the disorder. From the studies currently available, in fact, no clear pattern of family dysfunction emerges that can be associated with an increased risk of developing EDs. It, therefore, seems more probable that family relationships may rather play a concausal role, the characteristics of which should, however, be studied in greater detail, including by means of cross-cultural studies (exploring family relationships, which are so different in different countries of the world) and also revealing with greater clarity the relevant positive aspects of relationships within families with EDs (as a possible element of therapeutic reinforcement).

In recent years, moreover, a great deal of empirical evidence has accumulated in support of different psychotherapeutic approaches that place the family members of patients with EDs at the center of the therapeutic project, and of the evolution and continuous updating of family therapy models. It is not surprising, therefore, that some prestigious national and international scientific bodies (such as the National Institute for Clinical Excellence and the Academy for Eating Disorders) have officially recognized the validity of such approaches, especially for adolescent EDs. These confirmations, on the whole, further underline the centrality of the role of family members in the therapeutic pathways. Already Dare et al., had implemented, with good results, support for caregivers in the outpatient management of eating disorders in adolescents [31]. Macdonalds et al., created a competency-based training program that incorporated five psycho-educational DVDs, a manual, and telephone coaching to caregivers [32]. The transfer of specialized skills was highly valued in reducing caregiver stress and caregiving difficulties and, in some cases, appeared to have a positive effect on both the caregiver and the patient themselves.

Whitney et al., created daytime workshops for families and individual caregivers as a supplement to hospital care for patients with AN, in which three levels of activity were provided: 1) Individual family work, 2) Daytime workshops for families in small groups, 3) Therapist training and discussion groups on the caregivers being cared for. Toubøl et al., created a "competence-based training" inspired by the Maudsley Method i.e. an 8-meeting course that aimed to implement caregivers' communication skills to facilitate conflict management and foster externalization and motivation [33-36]. At the end of the training, the researchers observed a reduction in negative emotions, anxiety, guilt, and distress in the caregivers. In 2020, our research team designed an innovative psycho-educational support pathway exploiting the potential of Telemedicine, in which individual counseling activities were carried out by the caregiver and/or the parental couple [37].

Conclusion

Specifically, the psycho-education pathway was implemented through No. 7 face-to-face meetings held fortnightly by a specialized psychologist and structured as follows: A presentation and cognitive meeting, n°5 meetings based on issues related to information and management of EDs, and a follow-up meeting. Furthermore, in parallel, an app was created to provide continuous psychological counseling to caregivers, with suggestions and guidelines online and the possibility of requesting counselling, in a very short time, through chat and/or video-call support, in the event of crises and/or problems of patients.

However, in the future, it is desirable for family-based therapeutic approaches to be more closely integrated with other approaches that also have a large evidence base to support their effectiveness (e.g., aiming to explore the cognitive and behavioral mechanisms of the family that occur during the clinical management of EDs). We believe that the impact of psycho-educational programs aimed at family members of patients with EDs could turn out to be much greater than hitherto evident: in fact, in this group of disorders, given the high burden of disease and the considerable involvement of family members in the genesis and maintenance of the disorder, it seems clear that a psycho-educational intervention could both improve family functioning in the immediate term and ensure that the affected individuals have a lower risk of relapse in the long term.

It should be noted that this study has certain limitations. Firstly, the limited size and the non-randomly selected sample do not allow us to generalize the results too little. Finally, further studies are needed to investigate the role of respondents' psychosocial conditions in moderating or mediating the stressful impact of complex patient caregiving. Further studies comparing this with

other preventive and therapeutic approaches will have to confirm the potential that these interventions currently seem to open up, also with a view to achieving effective preventive action in at-risk adolescents, as already advocated by recent initiatives.

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