A variety of social, emotional and physical factors have been suggested as contributing to or causing the development of eating disorders. Cultural pressures, family dysfunction, sexual abuse, genetics and chemical imbalance have all been offered as possibilities. There is one comprehensive theory, which has been given little attention in the literature of eating disorders, which seems to me to provide a useful framework for illuminating how each of these factors contributes to these painful and potentially dangerous disorders. Each of these factors can be understood as a form or effect of attachment disruption or disturbance. In my own experience of sixteen years treating eating disorders, this perspective has greatly enhanced my ability to take an effective therapeutic stance with these challenging patients.

Attachment theory is the name given to the body of work which describes the process of bonding between mother and infant, and the consequences, primarily to the infant, of the disruption of that bond. It describes the patterns of human behavior "that serve to assure those physical and psychological intermeshings of individuals that enhance survival." (Stern, 1985,
p. 137) The work of John Bowlby is the cornerstone of attachment theory. Attachment theory as described by Bowlby (1977) is a means of:

  conceptualizing the propensity of human beings to make strong affectional bonds to particular others, and of explaining the emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise (p. 127).

Bowlby characterized certain infant behaviors, such as sucking, clinging, following, smiling and crying as catalysts for attachment. He posited that the mother’s presence for, and correct reading and response to the infant’s cues established a secure attachment, which in turn allowed the baby, child and adult to experience herself in the world in a primarily positive, trusting way. If this process was interrupted by extended separation or loss, Bowlby theorized, the impact on the baby/child/adult could be permanently damaging to her sense of safety in intimate human relationships.

Bowlby’s work (and the work of other early attachment researchers, including Renee Spitz, who studied the devastating effects of extended hospitalization on infants, and Mary Ainsworth, developer of the Strange Situation test which assessed the level of security in infant attachment to their mothers) was greatly influenced by the research of ethnologist Harry Harlow. Harlow separated infant rhesus monkeys from their mothers to explore the effects on their individual and social behavior. Separation was found to have a profoundly negative effect on the infant monkeys’ psychological well-being. Later studies by other researchers demonstrated that these effects lasted well beyond the time when they were returned to social relationships. It was also demonstrated that the experience of isolation could negatively affect the way in which these monkeys would relate to their future offspring, if they mated at all.
In recent years neuroscientists have been expanding their understanding of the evolution of brain structure and function in the developing infant and child. Much of this work has been done without reference to attachment research or psychological theory. These generally separate fields of study have begun to converge, thanks in large part to the work of Dr. Allan Schore. Schore has gathered massive neurological research and correlated it with infant observation studies as well as with psychoanalytic theory, to develop a theory that bridges the previous gap in communication and understanding among the three arenas. His theory explains how attachment processes like the ones described by Bowlby affect the development of the structures and chemistry of the brain which affect the processing of emotions.

Schore (1994) describes how communication and bonding occur through mutual gaze interaction and facial expressiveness between mother and infant:

Studies of the infant brain demonstrate that its development occurs in stages over critical periods and that its maturation is influenced by the environment and is experience dependent. Concurrent developmental psychological research dramatically emphasizes that the infant’s emerging socioaffective functions are fundamentally influenced by the dyadic transactions the child has with the primary caregiver. In these fast-acting ‘hidden’ communications, the mother senses and modulates the nonverbal and affective expressions of her infant’s psychobiological states. In other words, the experiences that fine-tune brain circuitries in critical periods of infancy are embedded in socioemotional interchanges between an adult brain and a developing brain (pp. xxix–xxx).
Schore discusses how direct unconscious communication from the right hemisphere of the maternal or caregiver’s brain to the right hemisphere of the infant’s brain (transmitted through mutual gaze and facial expression) facilitate the infant’s ability to regulate and process her own internal emotional state. This process also regulates the release of neurohormones in the infant’s brain which affect not only her responses to stressful stimuli, but also the developing structure of her brain. As Schore (1994) states, this post-natal socio-environmental interaction also affects genetic expression, since “the human cerebral cortex adds about 70% of its final DNA content after birth, and the amount of protein in the postnatally expanding brain are directly influenced by early environmental enrichment and social isolation experiences” (p. 97). Thus there is evidence to suggest that the caregiver’s ability to correctly identify the infant’s emotional and physical state of being, and respond appropriately through facial expression will directly affect infant’s ability to regulate her own emotional states. This visual social interaction profoundly influences whether the infant becomes a child and adult overwhelmed by internal and external stimuli, psychologically vulnerable, or one who moves more easily through life with a basic sense of trust and security in relationships.

In describing the development of secure attachments, Schore (1994) says, “Psychobiological attunement has been proposed to be the mechanism that drives the attachment process” (p. 97). And it is “now accepted that the baby becomes attached to the modulating caregiver who maximizes and expands opportunities for positive affect and minimizes the experience of negative affect… It is also now well established that the combination of joy and interest motivates attachments and that pleasure and interest are the major indicators of affect attunement” (p. 97).
Over the years that I have been treating eating disorder patients I have been keeping an informal catalog of their infant experiences. These are not the subjective memories of the patients, but events or relationships which have been confirmed by family histories or by the direct reporting of the patients’ mothers. It is a list of severe and sometimes multiple attachment disruptions, during critical early developmental periods. The commonality and prominence of these kinds of events in the infancies of my patients, suggests to me the likelihood that these experiences had a profoundly damaging effect on the psyches of these women, which later evolved into an eating disordered pathology.

Here are just a few examples:

- A bulimic woman who was adopted at 2 months after spending those months with a foster mother.
- A bulimic woman whose mother was in a skiing accident when she was 8 months pregnant, and who was subsequently born with hip dysplasia and spent several months in a full body cast; mother by her own admission was “freaked out” by her baby’s needs (This baby also had a fall off a changing table.)
- An obese woman, born to a psychotically depressed mother, was removed from her mother’s care and placed in two different foster care situations, then later returned to her mother at age four. (This woman’s sister and brother, two years younger and two years older, also went through similar separations. Her sister was anorexic and took out her own eye while in inpatient treatment, and her brother committed suicide.)
- An obese woman, born prematurely as a twin to an alcoholic mother who had previously had another set of twins, one of which had died. (There was also an older child in this family. The father was alcoholic and manic-depressive.)
An anorexic woman, born to a mother going through a divorce at the time, who left her baby in the care of a nanny throughout her infancy while she went to work. (The nanny was subsequently discovered to have had her own children removed from her due to neglect.)

A bulimic teenager whose mother was divorced during her pregnancy and was by her own statement extremely depressed when her baby was born.

An obese diabetic woman born to teenage parents who by their own statements treated the baby as a kind of doll to dress up and to play with.

A severely obese woman, adopted after spending her first 16 months in an orphanage. (Quit therapy suddenly after 16 months of work. Same pattern with previous therapist.)

A bulimic/anorexic teenager, born after a previous baby’s death, severe colic for first six months.

A bulimic woman - fifth of five children in seven years, born to anxious, brittle mother, separated permanently from beloved nanny at 18 months.

A compulsive overeater who suffered from an extremely severe, months long case of chicken pox at approximately 18 months, which required extended period of completely covered eyes and bandaged hands to keep from worsening the effects of the illness.

These cases are among the most obvious developmental traumas of the number I have worked with over the years. It has also been my experience that when mothers are available to be questioned about the experience of their daughters’ infancies that they often report on their own anxieties about mothering or lack of support from absent fathers (both in the literal and figurative sense). Colic is often reported. Some have spoken about traumatic separations from
their own mothers in early childhood, and some of severe social and emotional isolation during the time when they were raising their infants.

The obvious traumatic separations I have described above would appear to parallel the experimental separations set up by the primate researchers, as well as the orphan or hospital experiences studied by early attachment researchers. The other less obvious, but nevertheless profoundly affecting experiences, of anxious or depressed mothering or lack of paternal support, combined with certain innate sensitivities in infants, can also be understood as traumatic separations. Maternal misattunement to the infant’s cues, or inability to attend due to external or internal emotional circumstances, are likely to be experienced by the infant as overwhelming disconnection, later to be described by patients with words such as dread, annihilation, unbearable frustration, shame and rage.

**Attachment Disruptions and Emotional Misattunement**

“I feel like a nothing sandwiched between failures. The first bite is sudden death.”

- Quote from a compulsive overeater

If, as is posited by attachment researchers, the maternal-infant relationship is the psychobiological regulator for the development of the infant’s brain and for the evolution of the nature of its emotional self, then what occurs when that relationship is disrupted by separation and loss, or by the mother’s inability to respond to her infant’s cues? Bowlby outlined the stages of response of the older infant or child separated from its mother or primary attachment figure. These responses have since been visually documented in infant observation films, and measured through Mary Ainsworth’s Strange Situation Test, or Ed Tronick’s Still-Face test. Bowlby (1973) described the sequence for response to literal separations: (1) vocal or verbal protest, crying to gain the mother’s return (separation anxiety); (2) despair and preoccupation with the
possibility of her return (grief and mourning); (3) loss of interest in the mother or detachment (defence) (p.26). Some of the examples I listed above were physical attachment disruptions, but many were disruptions triggered by emotional illness or vulnerability in the mother. Bowlby also felt that physical presence did not assure emotional well-being. Indeed, he felt that the same damage as was done by literal separation from the mother could also be done by the emotional absence of a physically present mother. Emotional absence, in this context, does not have to come from a mother’s indifference; it often arises from a disconnection due to the mother’s depression or other overwhelming preoccupations.

Psychiatrist and researcher, Dr. Bruce Perry, who has done extensive research on the effects of trauma on infants and children has stated (1998):

The classic adult response to impending threat is fight or flight. (Cannon, 1914). Clearly infants are incapable of effectively fighting or fleeing. Therefore, for the same internal state of anxiety and sense of impending doom, an infant will have a different behavior set, they will cry and thrash as infants, and if this is unsuccessful, they will typically utilize a very primitive adaptive response, comparable to the defeat reaction (Miczek, Thompson, and Tornatzky, 1990; Henry, Stephens, and Ely. 1986). Infants and young children when they are feeling extremely anxious typically freeze and may dissociate as opposed to fighting or fleeing (p.10).

As Schore, Perry and other neuropsychiatric researchers have pointed out, these dissociative processes, which selectively direct the infant’s own attention away from the
traumatic experience, become along with the traumatic experience itself, biochemically imprinted in the brain. As Perry says (1995) “states become traits” (p. 1). This process is not limited to traumas such as separation through adoption, premature birth, or physical trauma. It also occurs through the more subtle, but also traumatic experience of misattuned mothering. An intrusively anxious mother, a depressed mother, a mother who was inadequately mothered herself, all can create an experience in the infant of dysregulation of affect, psycho-somatic states of disintegration from which the infant must dissociate. Dissociation and disintegration can be observed in such behaviors as inconsolable crying, lack of eye contact, arching away from rather than toward the potential comforter, or withdrawal, as in failure to thrive infants.

When the infant is chronically and frustratingly unable to find an attuned emotional connection with the primary caregiver she may attempt to comfort and permanently dissociate herself from intolerable levels of anxiety through thumb or pacifier sucking or demands for food. These self-regulatory mechanisms may become entrenched and imprinted as the primary means of comfort and self care, replacing human attachment and mutual caring (Barnet, 1998). This is the process I believe can lead, in later life, to the development of an eating disorder. Psychobiological imprinting of early attachment disruptions also explains why eating disorders are so often triggered by experiences of separation and loss or feared loss—puberty, leaving for college, breaking up with a boyfriend, or death of a loved one. The felt sense of difference and therefore of emotional separation from parents, or the immediate or larger cultural peer group, can also trigger conscious or unconscious memories of unbearably frustrated desire for connection. Families and the culture at large offer “legitimized” ways to channel such frustration and anxiety by excessive emphases on weight, appearance, nutrition or conversely on comfort through food. “I feel fat or gross,” has become a way of expressing a multitude of other difficult unacceptable or unknowable feelings.
Clinical Material

“My relationship with my mother is an eyesore”

- Quote from a bulimic patient

There are two psychological arenas in which apparent effects of early attachment disruptions are most easily observed: in the therapeutic relationship and in the content of patients’ dreams. Eating disorder patients are widely known to be extremely difficult to treat. In my experience, the reason for this is their intense fear of forming attachments, including therapeutic attachments. Anorexic patients in particular cling stubbornly (in parents’ and sometimes therapists’ eyes) to their symptoms. But the patients’ own internal vision may see this clinging to symptoms as “clinging for dear life”. Their obsession seems to protect them from falling into unending realms of terror and annihilation, realms which stem from early infant trauma. Margaret Little, author of Psychotic Anxieties and Containment (1990), citing pediatrician and psychoanalyst, D.W. Winnicott, described the anxiety originating in infant traumas as “annihilation, being totally destroyed (like a pricked balloon); falling endlessly; having no means of communication and so being totally isolated; being unconnected to one’s body; or lost in space” (p. 87). The intense focus of these patients on eating or not eating, or on how much or how little they weigh, becomes the replacement structure for inadequate or interrupted regulatory functions of early attachment relationships.

The goal of therapy, as I see it, is not simply the absence of symptoms, but an accompanying opening to the joys and frustrations of intimate human relationships. Many eating disordered patients are in therapy at the urging of their families, rather than as a result of their own desire and initiative. But even those who express concern about their symptoms and a desire to be well (usually older patients) will unconsciously resist relating to the therapist. In some extreme cases, these patients may literally rather die than allow themselves to open up to
attached human relationships. Patients often act as if they are relating by being falsely compliant and pleasing, mirroring the therapist. It is essential to see this behavior as an unconscious defense against the possibility of early imprinted traumas being reawakened. It creates an illusion of relating and attachment without the dangers of the real thing.

Separations, real or perceived, present the greatest challenges in the therapy, and interactions around these psychic events highlight the connection to early misattunements and losses. Therapists (and parents) find themselves intensely frustrated, feeling at a loss, or irrelevant, in their attempts to connect emotionally with the patient. Therapists are often left at the drop of a hat, left holding the bag of feelings, so to speak. In such moments, the therapist may experience everything that the patient feared feeling if the relationship were allowed to continue—shocked, annihilated, frustrated, enraged, disappointed and even heartbroken. Such occasions often occur before or after vacation breaks, or after experiances in therapy where the patient began to feel the ghost of lost feelings of overwhelming frustration or disappointment.

One such occasion occurred for me when a patient who had recently moved farther away from my office began to request telephone sessions. I told her I thought we should have some phone sessions and some face to face. This worked for a short time, but when I asked to be informed ahead of time whether she would call or come to the office on a given day, she abruptly quit her therapy. It was the only request I had ever made of her, other than the initial setting of my fee. I was left with a feeling of intense shame, that I had done something horribly wrong, by inserting my own need to know whether I would have face to face contact. I imagine this now as the infant’s need for face to face contact with an enlivened mother, but can’t say for sure which infant I’m talking about.

Occasions like these, can shatter an illusory connectedness, open the door to desire and all its terrifying affective associations. Feelings and sensations which had been previously
selected out of consciousness, by the patient’s focus on food, eating or weight, threaten to
emerge. Addressing the topic of an absence before or after a vacation, one can be met with
disdain, or at the least, surprise that it would be considered in any way important. Therapists
may find that their presence or absences have absolutely no visible significance to the patient;
"out of sight, out of mind". Contents of a session, or interpretations by the therapist are
frequently forgotten by the patient from one session to the next. Absence, for these patients, has
not made the heart grow fonder.

“What the eye does not see, the heart cannot grieve” says an old proverb. The patient
quoted at the beginning of this section was associating to a dream about her mother. (Her mother
was extremely depressed, due in part to the death of the patient’s eight year old cerebral palsied
older sister. The mother had given over the care of the baby/patient to her own mother, and then
asked to have her back when the baby/patient was four years old.) In her dream the patients felt
that her left eye was swollen and disfigured, and that she could not quite focus. The dream’s
reference to the left eye can be interpreted literally in that it is the left eye which connects to the
right hemisphere of the brain, the hemisphere which processes early visual/socio-affective
interactions between mother and infant. The left eye can also be interpreted as a pun, in the
sense of the “I that was left” which has trouble seeing relationships clearly.

An extremely obese patient, also diabetic, raised by teenage parents, had the following
dream—she was sitting in a room with a therapist like Dr. Joyce Brothers. ‘I didn’t say much,
didn’t feel like I got much out of it, but my eye kept bothering me. I had to go look at my
contact lens, took out the lens to wash it. It was big, and a rigatoni noodle, cut in half, was in it.
No wonder there was discomfort!” This patient’s eyelid would often twitch throughout sessions.
The contact lens is impaired by the presence of food. The food is something which resembles an
umbilical cord, and it is cut in half. This patient left therapy abruptly when her insurance
coverage was cut in half. The loss of this coverage which would have required her to pay for one of her two sessions per week, was a loss, or an investment which she could not bear to face.

A patient had a dream of babies with their heads on backwards. Another patient, a bulimic woman “weaning” herself from her addiction to laxatives, dreamed “I was having a baby. It didn’t hurt. I went to the hospital and stayed just two hours. I went home two hours later, 50 pounds lighter and relieved. I never saw the baby.” The next scheduled session was cancelled by this patient and she did not return to therapy.

Treatment Considerations

“For a baby she throws a powerful spell”

Toni Morrison, Beloved (1987)

I have found that one of the most difficult and frustrating things about treating eating disordered patients has been dealing with the needs of medical teams involved or with parents who are unable to resist the desire to focus on the symptoms of purging or weight gain or loss, thereby reinforcing the patients substitution of symptom for relatedness. It is essential to attempt educate parents, if still involved, or medical professionals to enlarge their capacity for experiencing anxiety, increase their patience, so as not to act out or attempt to control the patient’s feelings or symptoms as a way of containing their own anxiety. This can often prove harder than sitting with the patient. But when it is possible can contribute tremendously to the success of treatment by not recreating a misattuned pattern of caretaking.

I have had one case where I only saw the parents. A son away in college had anorexia and refused therapy. By treating the parents and working with them to contain and digest their own anxiety and their anxiety about their son, we were able to change their way of relating to him, and the son was able to give up his anorexia and began to lead a fuller life. Both parents
had experienced severe early infant attachment disruptions. The mother’s mother had been raised
in an orphanage.

The last thing these patients want is to remember or reconnect to is the experience of that
terrified, frustrated, lost baby. (The same may often be said of the parents, doctors and
therapists.) As in the Toni Morrison novel, Beloved, (1987) the baby has been killed rather than
be returned to the horrors of an attachment that was experienced as completely disregarding her
true human needs (slavery, in Morrison’s book). But as Beloved makes clear, this experience
cannot be escaped. It will haunt those who try to forget. Therapy with eating disordered patients
must be a gradual, patient and carefully timed remembering of the misattuned, disconnected
baby, illuminating how she attempts to make her experience known, how she sees, or does not
see, or distorts the possibilities of relatedness. Training which includes an understanding of the
impact of early developmental traumas is only half the picture. One must be prepared to live
through the fearful, but enlivening experience of making contact with one’s own “beloved”, and
ter the very tricky process of sorting out who is the baby and who is the mommy in the blink
of an eye. The artist Paul Klee (Diaries, 1957) best describes the focus needed — “one eye sees,
the other feels” (Columbia Dictionary of Quotations, 1993, p. 961).
NOTES


2. The Still-Face test measures infant stress physiology when "the parent is asked to stop interacting with the infant and to assume a depressed facial expression. In response to this experience many of the infants became upset, showing increases in negative emotion, gaze avoidance, and heart rate. Tronick also found that infants varied in their responses. Some infants tried to reengage the parent by eyebrow raising, laughing, and coughing. Eventually these infants looked away too and became upset. Following this emotional challenge, parents were instructed to reengage with the infant. Infants responded to this reunion with a partial pattern of recovery (i.e., increase in gaze directed toward the parent, a decrease in heart rate, but a carry-over of a negative affect). Summarized from Haley, D.W and Stansbury, K., Infant Stress and Parent Resposiveness: Regulation of Physiology and Behavior During Still-Face and Reunion, Child Development, Vol.74, Issue 5. 2003.

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