The integration of attachment interventions into the transdiagnostic cognitive-behavioral treatment in two eating disorder cases

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“Attachment-based mental representations can mediate between early experiences and adult psychopathologies” (Unoka, 2007)

Attachment can be insecure in all EDs (Ward et al., 2010)

Attachment security and symptom severity (Broberg et al., 2001)

Symptoms influence the proximity of patients and objects → hidden attachment dynamics? (Orzolek-Kronner, 2002)

Vs. Mainstream models emphasize biological, cultural, or cognitive-behavioral aspects, without attachment concepts (Tasca & Balfour, 2014)
Interpersonal difficulties in the transdiagnostic theory of the maintenance of eating disorders (Fairburn et al., 2003, p. 516)
Hybrid therapies?
An unexplored gap of treatment

- Other factors interact with the maintaining mechanisms and outcomes (Fairburn et al., 2003)
- Patients with PDs, emotion-processing deficits and attachment disturbances respond worse to symptom-focused therapies (Myers et al., 2006)

Integrating attachment interventions into evidence-based CBT treatments?
Can we cognitively operationalize attachment functioning?
(Barholomew & Horowitz, 1991; Elliot & Reis, 2003; Mikulincer et al., 2003; Tasca & Balfour, 2014)
Aims and Hypotheses

- **Aim:** to test the hypothesized two-level treatment model in two relevant ED cases
- **Hypothesis 1:** attachment and CBT interventions could be integrated to personalized case models and treatments
- **Hypothesis 2:** improvements in attachment functioning would be associated with positive outcomes
20-year-old female engineering student (BMI = 20.5)
High demands her studies and sport career
Symptoms: after moving to a dormitory, during daytimes she felt unable to eat, in her room she was lonely and stressed
Weekly 2-3 binges, no compensation → mild BED (APA, 2013) + critical body checking
No comorbid physical or psychiatric conditions
High perfectionism, avoidant attachment
Agreement: 1 initial + 10 treatment sessions + a one-month follow-up
Aim: improve her coping with negative moods and interpersonal difficulties to reduce her symptoms
Case 2

- 32-year-old female bookkeeper (BMI = 20.3)
- Symptoms: after her husband’s cheat and a fitness competition
- Weekly 4-5 binges + vomiting → moderately severe BN (APA, 2013)
- No somatic complications or psychiatric anamnesis
- Extremely critical attitude to body with lacking insight and alexithymia
- Insecure, strongly ambivalent, dependent attachment
- Agreement: 1 initial, 12 treatment sessions + a one-month follow-up
- Aim: improve emotion regulation, interpersonal functioning and control over the symptoms
- She complained about her husband’s unresponsiveness + BN episodes were precipitated by interpersonal situations with impaired reflections
Transdiagnostic treatment frame: four phases for all (BMI > 17.5) ED outpatients with regular 1st, 2nd and closing stage

- Initial session, intervention period, a one-month follow-up

- Each 60-minute session had three stages:
  1. Food diary, mood and symptom changes;
  2. Weekly experiences and topics based on the case model;
  3. Summarizing the session and setting homework
CBT interventions
(Fairburn, 1993, 2005, 2008)

- Self-help recovery guidelines (Cooper, 1995; Túry, 2005)
- Food diary
- Normalization of daily meals
- Reducing dietary restraint
- Reducing over-evaluation of eating, shape and weight control
- Avoidance of body checking
- Modifying maladaptive thoughts related to eating
1. phase: rapport, patient education, initial case formulation

2. phase: discussion of the first model was, excessive control, perfectionism and factors influencing emotion regulation, self-esteem and interpersonal behavior

Breaks of primary bonds and poor attachment functioning among precipitating and maintaining factors

Extended case conceptualizations integrated attachment
The interaction of attachment functioning with the four cognitive-behavioral factors
3rd phase of treatment
Assessment of attachment functioning and attachment interventions

* Insight on non-reflective knowledge on concepts of self and others
* Identifying maladaptive chain-reactions → graph about the symptoms
* Modifying attachment-related automatic thoughts → other explanations
* Improving mentalization and interpersonal reflective skills → social diary
* Supporting self-esteem → sources of self-acceptance, differentiating personal value from achievements and self-appraisal from others’ attitudes
* Improving mood regulation → cues of distress and comforting activities
* Counteracting de/hyper-activated distress-reducing strategies
Closing phase: personal risk and protective factors to prevent relapses and ensure progress
Discussion
Similarities of the cases

* Symptoms after breaks of primary bonds
* Negative self-concept, low self-esteem
* Need for external reinforcement
* Low distress tolerance
* Interpersonal sensitivity
* Impaired reflective functioning
* Low awareness of attachment-related behaviors
Differences of the cases

**Case 1**
- Moderate BED, less impulsive, better personality organization, more reflective
- Perfectionism decreased, self-esteem and mood regulation improved
- Decreased tendency for avoidance, but active social life and good insight into her interpersonal behavior
- Counteracted her tendencies to respond to distress with avoidance
- Symptoms ceased with one-month follow-up

**Case 2**
- Moderately severe BN, worse personality organization, emotion regulation and reflective capability
- She gained insight into the consequences of her behavior, her mood regulation improved
- Little improvement in interpersonal reflective functions
- Not able entirely to overcome her dependency and hyper-activation
- More secure, less ambivalent attachment, better body image, but relapses about once a month
Attachment interventions in eating disorders

- Improvement in attachment-functioning, reflective skills and reduction in attachment anxiety → positive outcomes (Maxwell et al., 2014; Tasca et al., 2011, 2013)
- Categorical diagnosis + dimensional description of personality and attachment functioning (Illing et al., 2010; Tasca et al., 2009)
- Attention to attachment anxiety, preoccupation or avoidance of relationships, need for approval, mood regulation and reflective functions (Roberts et al., 1996; Tasca & Balfour, 2014)
Four key attachment interventions applied in the cases

(Roberts et al., 1996; Illing et al., 2010; Tasca et al., 2011, 2013; Tasca & Balfour, 2014)
Limitations

* A theoretical model was tested with only two patients
* No anorexia or EDNOS patients were involved
* Case studies cannot fully assure the methodological grounding
* Treatments were relatively short
* Improvements in interpersonal reflections, self-appraisal, mood regulation and counteracting attachment functioning can be rather suspected, then the corrections of the IWM
* Generalizability of the findings and the test of the efficacy of the model is limited
Conclusions

* No previous research integrated attachment interventions into a mainly cognitive-behavioral ED treatment
* When attachment disturbances contribute to precipitating or maintaining symptoms, multilevel treatment shall be offered targeting both the key aspects of attachment functioning and the cognitive-behavioral maintaining factors
* Randomized controlled intervention-baesd studies are required to establish the efficacy and determine indications
References


Thank you for your kind attention!

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