

Eating Disorders and their Affect on Interpersonal Difficulties

A Senior Honors Thesis

Presented in partial fulfillment of the requirement
for graduation in the college Honors Program

By

Katheryn LaPorta

Psychology Major

The College at Brockport

May 2012

Thesis Director: Dr. Lori-Ann Forzano, Associate Professor, Psychology

Abstract

With an estimated eight million Americans suffering from an eating disorder, understanding these disorders is of significant importance to help them. One aspect of eating disorders that needs to be more understood is how eating disorders affect a diagnosed person's interpersonal relationships. To examine this relationship, research on eating disorders and interpersonal difficulties was gathered and analyzed. Two important models that were found and are examined are the four factor maintenance model for Anorexia Nervosa and the "vicious cycle" for Bulimia Nervosa. Based on research gathered, the more eating disorder behaviors or traits a person has the more interpersonal difficulties there are. Based on these findings it can be shown that the use of interpersonal psychotherapy in rehabilitation of eating disorders can decrease bingeing behavior in those diagnosed with Bulimia Nervosa and decrease relapses in those diagnosed with Anorexia Nervosa.

An estimated eight million Americans suffer from an eating disorder, and of those eight million 95% of them are between the ages of 12-25 (South Carolina Department of Mental Health, 2006). With such a large number of people suffering from eating disorders it is of significant importance to understand all aspects of eating disorders and how they affect a person's life. Not only is the number of those diagnosed with an Eating Disorder frighteningly large, but Eating Disorders also have the highest mortality rate than any other mental illness (South Carolina Department of Mental Health, 2006). For example, in the case of those diagnosed with Anorexia Nervosa 5-10% will die within ten years and 18-20% will die within twenty years of having the disease either from complications, suicide, or starvation (South Carolina Department of Mental Health, 2006). By understanding how an eating disorder can affect a person's life we can use that knowledge to develop ways to help a person understand and recover from their disorder.

The impact of Eating Disorders on our society have a much larger impact than most are aware of or willing to see. The fact that 95% of those with Eating Disorders are between the ages of 12-25 is something most do not know, or that Anorexia Nervosa is the 3rd most chronic illness among adolescents (South Carolina Department of Mental Health, 2006). These are serious and compelling statistics that should prove in themselves that the need for continuing to research the effects of Eating Disorders is something that should be of vital concern to those with the resources. The impact Eating Disorders have on interpersonal difficulties should be something that is given more thought and research as well, especially since 95% of those with Eating Disorders are within the adolescence age range. In adolescence the impact of interpersonal relationships is huge as anyone who went through High School could agree. Adolescence being a time of self-discovery and finding an identity being able to develop healthy

relationships with others is something that is crucial. The fact that so many adolescent age people have an Eating Disorder, which has the potential to negatively impact their ability to develop meaningful and healthy relationships with others, is something that can seriously impact their lives, and chances for recovery from the disorder. This is a significant reason why the research into the impact of Eating Disorders on interpersonal difficulties is something that should be looked at as of value and critically important to the field of knowledge of Eating Disorders and their effects of those diagnosed with them.

One factor that has been found to be associated with eating disorders is interpersonal problems. Understanding the interpersonal difficulties that people diagnosed with either Anorexia Nervosa or Bulimia Nervosa struggle with is crucial to understanding the disorder and to developing effective treatment plans. By looking critically and clinically at the interpersonal problems that a person diagnosed with Anorexia Nervosa or Bulimia Nervosa struggles with, we can evaluate how these problems may trigger the disorder or are caused by the disorder.

In order to explore the importance of interpersonal problems for those diagnosed with eating disorders, the research of many is brought together to be analyzed. First the paper explains the diagnostic criteria of both disorders, and then explores common characteristics and traits that people diagnosed with Anorexia Nervosa and Bulimia Nervosa share using information from research as well as the Diagnostic Statistic Manual TR-IV (APA, 2000). The paper then explains what is meant by the interpersonal difficulties, as well as explains attachment styles, and how they have an impact on the type of relationships a person has and how they can affect how a person views relationships. Following that is a discussion of how the disorder affects the relationships for those diagnosed and then how treatment can assist in helping better relationships. The paper ends with a discussion of how treatment that includes interpersonal

psychotherapy can reduce symptoms of the eating disorders, as well as how they can decrease the chances for relapses after treatment.

Eating Disorders

Diagnostic Criteria

There are two major types of eating disorders, Anorexia Nervosa and Bulimia Nervosa. According to the DSM TR–IV, the diagnostic criteria for Anorexia Nervosa are the “refusal to maintain body weight at or above a minimally normal weight for age and height” (APA, 1994, p. 251). Other criteria are “intense fear of gaining weight or becoming fat, even though underweight.”, “body weight of less than 85% of that expected” (APA, 1994, p. 251). In addition, criteria include: a disturbance in the perception of one’s body weight and shape, as well as a denial of the gravity of low body weight and for postmenarcheal women the lack of at least three consecutive menstrual cycles (APA, 1994, p. 251). After meeting these criteria someone can be diagnosed with Anorexia Nervosa.

Within the diagnosis of Anorexia Nervosa, there are two subtypes: Restricting, and Binge Eating/Purging type. Clients diagnosed with the restricting subtype will not engage in binge eating or purging methods during an anorexic episode, instead they will continue to severely constrict their caloric intake or starve themselves, as well as exercise excessively. Clients diagnosed with the binge eating/purging subtype will regularly engage in binge eating, which is the consumption of an amount of food that is larger than a normal person would eat within a certain period of time, such as two hours. This binge eating is then accompanied with a purging method which could be self-induced vomiting or abuse of medications such as laxatives or diuretics (APA, 1994). The binge eating/purging type of anorexia nervosa is different from Bulimia Nervosa because the binge eating/purging subtype will need to meet the criteria for

Anorexia Nervosa. The binge and purging anorexic will refuse to maintain a normal body weight, and will have an intense fear of becoming fat which are two things that differ from a diagnosis of Bulimia Nervosa.

Bulimia Nervosa, a second kind of eating disorder, is different in its criteria from Anorexia. The first listed criterion is “Recurrent episodes of binge-eating” (APA, 1994, p. 252). An episode of binge eating is when a person consumes, within a two hour period, an amount of food that is clearly larger than what a normal person would in the same amount of time. Also during this binging period the person experiences a lack of control over their eating, they feel as if they just cannot stop eating (APA, 1994). The second listed criterion is “Recurrent inappropriate compensatory behavior in order to prevent weigh gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications fasting or excessive exercise” (APA, 1994, p. 252). Other criteria include “The binge eating and inappropriate compensatory behaviors both occur, on average at least twice a week for 3 months.” “Self-evaluation is unduly influenced by body shape and weight,” and “The disturbance does not occur exclusively during episodes of Anorexia Nervosa.” (APA, 1994, p. 252).

Within the diagnosis of Bulimia Nervosa there are also two subtypes: purging and non-purging types. Clients diagnosed with the purging subtype will regularly engage in compensatory behaviors such as the self-induced vomiting and misuse of medications mentioned earlier as a means to prevent weight gain after a binging episode. Clients diagnosed with the non-purging subtype will not use those methods but will instead fast, or exercise excessively as a way to prevent weight gain during a bulimic episode (APA, 1994).

Traits and Characteristics

People diagnosed with Anorexia Nervosa commonly share a number of traits and behaviors. Along with traits such as perfectionism, and obsessive compulsive disorders can often occur comorbidly with an Anorexia Nervosa diagnosis. Obsessive compulsive behaviors can consist of things such as constant hand washing, obsession with foods, and as discussed in the criteria, a denial of their disorder (APA, 2004). Obsessive Compulsive disorder includes both obsessions and compulsion factors. Obsessions refer to the recurrent thoughts, that is, often unwanted ideas that people have difficulties dismissing. The compulsion factor refers to the repetitive behaviors used to lower anxiety from the obsessions. These behaviors can be physical, such as, touching a door knob so many times, or mental, such as praying or counting (APA, 2004). These traits and behaviors all complement the eating disorder well, in that the perfectionism and obsessive compulsive behaviors allow the person diagnosed with anorexia to perpetuate the disorder. Perfectionism in people diagnosed with Anorexia Nervosa causes them to strive to be the thinnest of the thin. Obsession with food is something that seems counterintuitive, since the word “anorexia” literally means lack of appetite. However, it is quite the opposite. People diagnosed with Anorexia Nervosa control what and if they eat very well, that is, restricting themselves carefully. But they are known to make elaborate and detailed meals for others, (APA, 2004). Another obsession that people with Anorexia Nervosa have is the constant checking of their weight.

The behavior of denying the seriousness of the disorder can disrupt people diagnosed with Anorexia Nervosa’s relationships with others because they have convinced themselves the disorder is good for them. They will use their irrational logic to get around others who try to get them to eat. This typically results in a fight in which the non-disordered person will not understand the person diagnosed with Anorexia Nervosa’s logic and usually give up fighting.

Thus allowing the diagnosed person to feel a victory, which encourages the continuation of the disorder (Schmidt & Treasure, 2006). This type of situation will be further discussed later in this paper, when more in depth coverage is provided on how these different traits can and do affect the anorexics ability to relate, or form relationships and maintain them with others.

People diagnosed with Bulimia Nervosa also share common traits that are quite the opposite of Anorexia Nervosa traits. With Bulimia Nervosa, a person is quite aware of their disorder and is quite shamed by it. Part of the criteria of Bulimia Nervosa is binge eating and a feeling of a loss of control over eating. After a person diagnosed with Bulimia Nervosa engages in a binge eating episode they can be filled with feelings of despair, guilt, and shame (APA, 2004). Self-induced vomiting, as a way of compensating for the binge, can lessen these feelings of guilt for having a lack of control. However the person diagnosed with Bulimia Nervosa still recognizes that they have abnormal eating. This recognition in Bulimia Nervosa is quite the opposite of the diagnostic criteria of Anorexia Nervosa, in which there is a denial of the severity of the disorder (APA, 2004). People diagnosed with Bulimia Nervosa also appear to have a submissive way about them; they can be very focused on pleasing others to maintain relationships (Schembri, Evans, 2008). Bulimics also tend to hide their disorder because of the shame that they feel about it.

Interpersonal Difficulties and Attachment Styles

This paper examines interpersonal difficulties, or problems those diagnosed with Anorexia Nervosa and Bulimia Nervosa have in how they “relate” with others. The term *relate*, refers to the forming (or ability to form) social or sympathetic relationships with other people. This is an extremely important factor of the paper because examining how one forms meaningful relationships is what is meant by interpersonal difficulties. Interpersonal difficulties are things

that will challenge the effectiveness of a person to form relationships with others and maintain them. More specifically, as Hartmann, Zeeck, and Barrett (2010) states, interpersonal problems are “a wide range of issues related to the person’s social interaction and engagement with others” (p. 619). The maintenance of healthy or unhealthy relationships will depend in part on the attachment style of the person with Anorexia Nervosa or Bulimia Nervosa.

Attachment styles are learned in infancy (Berk, 2008). Attachment styles refer to the manner in which an infant learns to depend on a caregiver (Berk, 2008). The technique, called the Strange Situation, is used to determine an infant’s (between ages one and two) attachment to their caregiver (Berk, 2008). The way this procedure begins is with a researcher introducing the infant and caregiver to a playroom then the researcher leaves, the caregiver and infant stay in the playroom alone for about three minutes. The next step is for the infant to use the caregiver as a secure base to explore the room and play, while the caregiver stays seated. Step three is that a stranger will walk in the room and sit down and talk to the caregiver. Step four has the caregiver leave the room, leaving the infant with the stranger. This results in separation anxiety for the infant, or a distressing reaction of sorts. The stranger will try to soothe the infant during this step. Step five is the return of the caregiver who greets and soothes the infant, if necessary, and the stranger leaves the room. Step six the caregiver leaves the room, and the infant is alone, again separation anxiety sets in. Step seven the stranger returns and tries to comfort the infant. Step eight the caregiver returns, comforts infant, and tries to re-interest them in the toys (Berk, 2008). Each of the steps, from two on, only last 30 seconds and are cut short if the infant becomes too upset (Berk, 2008).

Based on how the infant reacts is how the attachment style is determined. Four attachment styles have been identified. For secure attachment, an infant may or may not cry

when the caregiver leaves the room. If they do cry, it is because they prefer the caregiver to the stranger. When the caregiver returns to the room, the infant actively seeks contact with the caregiver, and the crying is reduced immediately (Berk, 2008). Avoidant attachment is when the infant has a lack of response to the caregiver's presence, and does not become unsettled when the caregiver leaves the room. Similarly the infant has little reaction to the stranger, and when the caregiver returns the infant is slow to greet them (Berk, 2008). Resistant attachment is seen in infants that try to be close to the caregiver and do not explore the room before the caregiver leaves, when the caregiver does leave the infant becomes very distressed. When the caregiver comes back the infant has a combined reaction of clinging with angry behaviors such as pushing or hitting the caregiver and will not be calmed easily (Berk, 2008). Last with the disorganized/disoriented attachment style, the infant shows the greatest insecurity. This is when the infant has mixed behaviors when reunited with the caregiver. The behaviors range from looking away when the caregiver is holding them, crying out after calming down as well as looking confused, and having odd frozen postures (Berk, 2008).

Attachment styles in adults are described as "the expectations people have about their relationship partners" (Sanderson, 2010, p. 436). These expectations are usually formed from early experiences with a caregiver (Sanderson, 2010). There are three attachment styles, secure, avoidant, and anxious. Avoidant and anxious styles are considered insecure attachment styles. Secure attachment is the healthiest of these, which means that a person is confident about being close with others and can handle being depended on and depending on others for things (Sanderson, 2010). Avoidant attachment is an insecure style in which a person does not feel totally comfortable depending on others and has issues trusting others completely. Anxious attachment is different from avoidant because those who have anxious attachment are not

distancing like the avoidant style can be. However the anxious style is full of worry and concern regarding their relationships with others. People who have an anxious style need reassurance that they are wanted and loved by others, and worries that others do not actually want to be close to them as they may want to be close with others (Sanderson, 2010). Knowing the different styles of attachment we will be able to distinguish which can harbor healthy or unhealthy relationships and we will also be able to examine possible differences in attachment styles between anorexics and bulimics.

Eating Disorders and Interpersonal Difficulties

Anorexia Nervosa

Schmidt and Treasure (2006) developed a maintenance model with regards to people diagnosed with Anorexia Nervosa and how they form relationships with others and how they are maintained or affected by their eating disorder. This maintenance model consists of four factors, including: perfectionism, experiential avoidance, pro-anorexic beliefs, and the response of close others. Each of these factors is viewed as a means for a person with Anorexia Nervosa to continue or maintain their eating disorder. People with Anorexia Nervosa have a higher rate of childhood perfectionism or some sort of obsessive compulsive behavior; they can use this perfectionism as a means to control their food intake. They will continue to lower their ideal weight as a way of reaching perfection (Schmidt & Treasure, 2006). We can see this behavior in a sample of an Anorexia Nervosa supporting website homepage which states, "I am the thinnest. The thinnest. This is how my day was yesterday. I am 5'4 and 51 pounds. Clinically dying; and if that's what gets me the thinnest, thinner than every other anorexic, then so be it." (Lyons, Mehl, & Pennebaker, 2006, p. 254). The control of appetite and restriction of food intake makes

the person diagnosed with Anorexia Nervosa feel in control because these actions gratify their perfectionism and with a feeling of control it encourages them to continue the behaviors (Schmidt & Treasure, 2006).

From this description, one could infer that the presence of perfectionist traits could put a strain on relationships with others because of the need for control that perfectionism requires. A person seeking perfection constantly strives for unattainable goals; this could cause anxiety and depression when the goals cannot be reached. In the case of people diagnosed with Anorexia Nervosa these types of goals can be weight related. In the diagnosed persons efforts to get to their ideal weight they could damage relationships with those in their lives who discourage them from losing weight. It can be assumed that to a person diagnosed with Anorexia Nervosa who is striving for perfection that a person who discourages them from losing weight is trying to control them, or to push them towards failure. The reaction to being controlled or being pushed toward failure could be to lash out at whoever is discouraging them from losing weight, causing issues in the relationship.

The second factor of the maintenance model is experiential avoidance which is the tendency of people diagnosed with Anorexia Nervosa to be self-silencing or to suppress their negative emotions in an effort to maintain close relationships (Schmidt & Treasure, 2006). By keeping their own needs at a minimum and not expressing negative emotion they believe they can continue a relationship better. This suppression of negative emotion is a big part of the avoidance factor, starvation leads people to be less interested in relationships, but it is thought that those diagnosed with Anorexia Nervosa acknowledge and welcome this as a way to escape facing their negative emotions and to continue feeling “in control” (Schmidt, Treasure, 2006).

From this explanation one can conclude that avoidance would cause interpersonal problems because if a person refuses to express negative emotion a close relationship cannot be attained. Most relationships are built off of disclosure, being able to explain positive and negative emotions to another person builds trust with that person. Without that ability, developing new relationships with depth would appear a difficult task. To a person diagnosed with Anorexia Nervosa who may already have close relationships who starts refusing to express negative emotions as a way to suppress them could end up pushing those close to them away because those close could feel helpless because the diagnosed person will not talk to them about their problems.

The third factor in the maintenance model is pro-anorexic beliefs. Pro-anorexic beliefs consist of ideas that the Anorexia Nervosa is not a disorder, but a life style choice (Lyons, Mehl, & Pennebaker, 2006). These beliefs help a person diagnosed with Anorexia Nervosa maintain their disorder because they will defend their disorder. They believe their disorder gives them control and they enjoy that. These pro-anorexic beliefs feed into the last factor of the maintenance model which is: response of close others.

Ways that one could perceive the pro-anorexic beliefs to contribute to interpersonal issues is that these beliefs are so illogical to a non-disordered person that it could lead to arguments. Both parties could try to argue the logic of their view on the disorder and if a person diagnosed with Anorexia Nervosa has these beliefs that it is not a disorder but a healthy life style choice then they will not respond to ideas that do not correspond with theirs. In this manner the person diagnosed with Anorexia Nervosa could again push people from being close to them.

Response of close others is how those closest to the person with Anorexia Nervosa, typically family members, respond to their disorder. The family dynamic is an important one and also one that the person diagnosed with Anorexia Nervosa can claim control of easily. Mothers of daughters diagnosed with Anorexia Nervosa tend to go out of their way to give attention to the disordered child and they are known to take great care and time making special meals in an effort to get the child diagnosed with Anorexia Nervosa to eat (Schmidt & Treasure, 2006). The attention given in this case will cause siblings to feel neglected and for husbands to fall to the wayside creating resentment and hostile emotions towards the child diagnosed with Anorexia Nervosa. This family dynamic helps the person diagnosed with Anorexia Nervosa to hold up their avoidant walls and ignore these negative emotions because if other members of the family feel resentment toward the person with Anorexia Nervosa there is already a wall in the relationship (Schmidt & Treasure, 2006). If there is a wall in a relationship then communication can be expected to be strained thus allowing the person diagnosed with Anorexia Nervosa to ignore negative emotions because the relationship is being forced into a standstill.

A case that takes into account the dynamic of those close to people diagnosed with Anorexia Nervosa along with the other three factors is the attempt to engage the person to eat (Schmidt & Treasure, 2006). This interaction could be viewed as an attack on the person diagnosed with Anorexia Nervosa's goal for reaching their perfect weight. This could then turn into a battle in which the person diagnosed with Anorexia Nervosa can use their pro-anorexic beliefs to reject the logic of the non-disordered and "defeat" them. This defeat will be from the non-disordered person losing emotional control, or giving up. This "victory" will affirm the person diagnosed with Anorexia Nervosa's beliefs in their disorder because they get to feel that their logic is superior. Hence this reinforces their pro-anorexic beliefs. The non-disordered person giving up

allows the person diagnosed with Anorexia Nervosa to avoid the communication of negative emotions, and they remain in control (Schmidt & Treasure, 2006).

Bulimia Nervosa

With regard to those diagnosed with Bulimia Nervosa, there is a cognitive-behavioral model which examines how the “vicious circle” perpetuates in a Bulimic episode. By examining the parts of this model we can assess how these factors would affect relationships for those with Bulimia Nervosa. According to Cooper, Wells and Todd, the cognitive model has four parts to it, “thoughts reflecting cognitive and emotional avoidance (positive beliefs about eating), negative beliefs about weight and shape, permissive thoughts, and thoughts of no control.” (Cooper, Wells & Todd, 2004, p. 5).

Binge eating is characteristic of the diagnosis of Bulimia Nervosa, therefore what creates a circumstance for binge eating to occur needs to be examined. Many things can trigger a binge episode but anxiety and tension are leading triggers (Tasca, Ritchie, & Balfour, 2011). The anxiety and tension can come from many things. For example, an argument or a mention from someone else about their eating behaviors can result in the person feeling criticized and the anxiety of it can trigger a binge. The binge eating calms the distress a person is feeling because it distracts them from the negative thoughts and feelings for a time (Cooper et al., 2004). This distracting effect can lead a person to develop positive feelings towards eating because to them the eating is what is calming the distress.

Many things begin to happen during a binge, when the binge begins a person is distracted from their negative emotions by eating. This develops into a positive feeling towards eating because eating becomes linked with anxiety relief. During a binge a person starts to have

permissive thoughts/thoughts belief that a person cannot control their eating. This way of thinking removes the responsibility from the person for eating so much because they simply cannot seem to control themselves. These feelings and thoughts of a lack of control play into the negative feelings a person has of eating. That is, they do not like eating because they cannot control themselves (Cooper et al., 2004). A person is thus conflicted because they have their positive beliefs about eating because it lowers their distress levels. When a binge is ending or over the core negative self-beliefs a person has creep in. These negative self-beliefs would develop negative feelings about eating because they begin to fear for their weight and shape (Cooper et al., 2004). With all of these thoughts settling in the person diagnosed with Bulimia Nervosa the need for a compensatory behavior arrives to again relieve the anxiety and distress they are now experiencing. After a purge, either of self-induced vomiting or another inappropriate compensatory behavior is experienced, the anxiety will decrease once again.

Both the bingeing and purging can be viewed as negative reinforcement to the individual. It begins with a person diagnosed with Bulimia Nervosa having feelings of anxiety or stress, when they begin to consume food it removes the feelings of anxiety because they are no longer thinking about what was making them anxious but they are thinking about food. From this removal of the negative emotions comes the positive view of food. After a binge episode a person diagnosed with Bulimia Nervosa begins again to have negative emotions such as anxiety but because of all of the food they ate during their binge episode, so now food has given them anxiety which creates negative feelings towards food so there is a switch back and forth between positive and negative feelings toward food. The person diagnosed with Bulimia Nervosa will participate in an inappropriate compensatory behavior such as self induced vomiting. This behavior again removes their anxiety which increases the likelihood of future inappropriate

compensatory behaviors. It is clear that with this “vicious cycle” a person diagnosed with Bulimia Nervosa could be triggered into a binge episode by something very simple such as a disagreement or a piece of criticism by someone they know (Cooper et al., 2004). With this cyclic state of being this could easily cause strain on relationships with others who know about the disorder because those close would be cautious to not upset them.

In several studies women diagnosed with or having bulimic symptoms were found to have either anxious and avoidant attachment to others. The anxious attachment shows a fear of abandonment and rejection the person holds. Avoidant attachment shows a discomfort of being close with others (Evans & Wertheim, 2005). This is interesting because it is thought that a developmental factor for Bulimia Nervosa could be trauma (Cooper et al., 2004). For example it could be a type of abuse or the loss of a parent or caregiver, which would induce these feelings of fear in a person. One could argue that it makes sense if a person has an anxious attachment that they long for closeness but fear abandonment so the rejection of one’s own negative feelings to maintain a relationship in a happy status makes sense. This way of ignoring negative feelings or emotions one has in a relationship is called self-silencing. Self-silencing are behaviors which are submissive and include not expressing negative emotions or thoughts in an attempt to avoid damaging a relationship (Schembri & Evans, 2008). But because a person does not have the chance to express their negative emotions and work through them the vicious circle can continue because the negative emotions can be continuously triggered. All of this anxiety and self-consciousness means that when it comes to treatment a person diagnosed with Bulimia Nervosa will more willingly go because they find their disorder very distressing and they often wish to get rid of the main behaviors of their disorder (APA, 2004).

Treatment

Anorexia Nervosa Treatment

When a person with Anorexia Nervosa does get treatment, and wants to get better, relationships have more meaning. In treatment when therapy is done to work on interpersonal difficulties, this can lower chances of relapses in those with Anorexia Nervosa (Hartmann, Zeeck, & Barrett, 2010). Those recovering from Anorexia Nervosa are noted to be the most difficult to work with, which may be an affect of the avoidant behaviors from their disorder (Hartmann, et al. 2010). However, those who do choose to go to treatment and begin to recover will start to view their relationships with others, themselves, and their disorder as more important. It has been seen that in patients under eighteen or those who have had Anorexia Nervosa for less than three years respond very well when family therapy is included in treatment (APA, 2004). The affect siblings can have for example, can be both positive and negative. Sometimes the support or normalcy of a sibling can be very positive for a girl recovering from Anorexia Nervosa and encourage her to keep fighting. But siblings can also trigger incidents from a lack of knowledge or being too focused on the disorder (Honey, Clarke, Halse, Kohn, Madden, 2006). It is noteworthy that people with Anorexia Nervosa will ignore negative emotions in order for them to maintain relationships with others, so with therapy to work on issues like that relationships with siblings could be more and more of a positive influence on them. Also with the positive influence and work done on the interpersonal difficulties that those diagnosed with Anorexia Nervosa have the chances of relapses does go down (Hartmann, et al. 2010).

Bulimia Nervosa Treatment

People diagnosed with Bulimia Nervosa are generally much more compliant when it comes to treatment because their disorder is distressing to them and they will accept treatment goals which typically include developing a regulated diet, and abstaining from bingeing and purging (APA, 2004). People with Bulimia Nervosa believe themselves to have poor social competence (Hartmann, et al. 2010) and score high on self-blame and self-hate when tested with the Structural Analysis of Social Behavior (SASB) (Bjorck, Clinton, Sohlberg, Hallstrom, Norrig, 2003). With interpersonal psychotherapy those diagnosed with Bulimia Nervosa showed a significant decrease in the severity of binges (Hartmann et al., 2010). Some believe that understanding the type of attachment those with eating disorders have could dramatically improve treatment and thus reduce relapses (Bjorck et al., 2003). The idea is that by understanding if a person with Bulimia Nervosa has either anxious or avoidant attachment treatment and therapy can be used to work on the insecure attachment (Bjorck et al., 2003). Working on the type of attachment would be helpful because this can change how a person acts around others and could improve their self-image.

Conclusion

For both Anorexia Nervosa and Bulimia Nervosa, after examining the research on early attachment styles and attachment styles, it is clear that there is a connection to interpersonal relationships and the depth of eating disorder behaviors a person has. This can be concluded because there is a fair amount of research that shows that those diagnosed with either Anorexia Nervosa or Bulimia Nervosa portray insecure attachment styles and it appears that there are facets of the eating disorders that help them to handle or ignore their issues in maintaining relationships. It is also apparent that for those diagnosed with Anorexia Nervosa interpersonal psychotherapy as a part of treatment could be crucial in teaching them how to attend to negative

emotions instead of blocking them out. For those diagnosed with Bulimia Nervosa it is clear that the interpersonal psychotherapy can assist them in developing confidence in themselves so they may learn to work through anxiety instead of turning to food to relieve their anxiety.

I feel that with the information provided in this paper it is clear that more research should be done in incorporating interpersonal therapy into eating disorder treatments. I would insist this because of the results that have shown the decrease in binge eating in cases of Bulimia Nervosa as well as a decrease in relapses for those diagnosed with Anorexia Nervosa. It is also clear that there is a severe lack of research on interpersonal relations for those diagnosed with Bulimia Nervosa when compared to the amount of research done on those diagnosed with Anorexia Nervosa.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision). Washington, DC: American Psychiatric Association.

- Björck, C., Clinton, D., Sohlberg, S., Hällström, T., & Norring, C. (2003). Interpersonal profiles in eating disorders: Ratings of SASB self-image. *Psychology & Psychotherapy: Theory, Research & Practice*, 76(4), 337-349. Retrieved from EBSCOhost.
- Berk, L. E. (2008). *Infants, children, and adolescents*. (sixth ed.). Boston: Pearson Education Inc.
- Cooper, M. J., Wells, A., & Todd, G. (2004). A cognitive model of bulimia nervosa. *British Journal of Clinical Psychology*, 43(1), 1-16. Retrieved from EBSCOhost.
- Evans, L., Wertheim, E.H., (2005). Attachment styles in adult intimate relationships: comparing women with bulimia nervosa symptoms, women with depression and women with no clinical symptoms. *European Eating Disorders Review*, 13(4), 285-293.
doi:10.1002/erv.621
- Hartmann, A, Zeeck, A, & Barret, M.S. (2010). Interpersonal problems in eating disorders. *International Journal of Eating Disorders*, 43(7), 619-627.
- Honey, A, Clarke, S, Halse, C, Kohn, M, & Madden, S. (2006.) The influence of siblings on the experience of anorexia nervosa for adolescent girls. *European Eating Disorders Review*, 14(5), 315-322. doi:10.1002/erv.713
- Lyons, E. J., Mehl, M. R., Pennebaker, J.W. (2006) Pro-anorexics and recovering anorexics differ in their linguistic Internet self-presentation. *Journal of Psychosomatic Research*, 60(3), 253-256. doi:10.1016/j.jpsychores.2005.07.017
- Sanderson, S. A., (2010) *Social Psychology*. Hoboken: John Wiley & Sons, Inc.

- Schembri, C., & Evans, L. (2008). Adverse relationship processes: the attempts of women with Bulimia Nervosa symptoms to fit the perceived ideal of intimate partners. *European Eating Disorders Review*, 16(1), 59-66. doi:10.1002/erv.797
- Schmidt, U, & Treasure, J. (2006). Anorexia nervosa: valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical* , 45(3), 343-366. doi:10.1348/014466505X53902
- South Carolina Department of Mental Health. (2006). *Eating disorder statistics*. Retrieved from <http://www.state.sc.us/dmh/anorexia/statistics.htm>
- Tasca, G. A., Ritchie, K., & Balfour, L. (2011, May 23). Implications of Attachment Theory and Research for the Assessment and Treatment of Eating Disorders. *Psychotherapy: Theory, Research, Practice, Training*. Advance online publication. doi:10.1037/a0022423