

Attachment to God/Higher Power and Bulimic Symptoms Among College Women

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The authors examined the relationship between avoidant and anxious attachment to God/Higher Power and bulimia symptoms among 599 female college student participants. After controlling for body mass index, the authors found a positive association between both attachment variables and bulimia. When entered together in a regression, anxious attachment to God/Higher Power had a stronger relationship with bulimia than did avoidant attachment to God/Higher Power. The authors discuss implications for college counseling.

Keywords: attachment to God, spirituality, bulimia

Researchers have noted that college counselors engage in treatment efforts with clients who struggle with eating disorder symptomatology (Hoyt & Ross, 2003). In particular, college counselors are likely to work with female clients who struggle with bulimic symptoms, given the high number of female college students who report such symptoms (e.g., binge-eating and purging behaviors; Kelly-Weeder, 2010; Vohs, Heatherton, & Herrin, 2001). Among female college students, rates of bulimic symptoms are alarming; for example, 14.9% of college student participants ($n = 342$) reported habitual binge-eating behavior (Vohs et al., 2001). Kelly-Weeder (2010) found that 26.6% of female college students ($n = 139$) reported engaging in self-induced vomiting to lose weight. These rates of bulimic symptoms are distressing in light of the damage associated with bulimic symptoms. Researchers have noted negative physical and psychosocial factors linked with bulimic symptoms, such as esophageal damage, electrolyte imbalance, anxiety, depression, and difficulty fulfilling role obligations in areas such as one's home life or social life (Mehler, Crews, & Weiner, 2004; Mond et al., 2009).

College counselors also work with clients who have spiritual beliefs relevant to counseling concerns (Kellems, Hill, Crook-Lyon, & Freitas, 2010). For example, Kellems et al. (2010) reported findings from a survey of college counseling center therapists. In this study, therapists reported a range of ways in which they addressed spirituality or religion in sessions with clients: Clients drew on faith as a way to cope, identified and examined their beliefs, and discussed difficulties in separating from family belief systems.

In a subset of the literature on eating disorders, researchers have discussed the relationship between spiritual beliefs and bulimic symptoms (Boyatzis & Quinlan, 2008). Individuals with certain spiritual beliefs may be more prone to engage in bulimic behaviors, whereas individuals with other spiritual beliefs may have

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reduced rates of bulimic symptoms (Buser & Bernard, 2013). This literature on spiritual beliefs and bulimic symptoms is still in its early stages, and more research is needed to better understand the ways in which different types of spiritual beliefs are associated with bulimic behaviors and attitudes (Boyatzis & Quinlan, 2008).

Bulimia

College women who struggle with symptoms of bulimia may evince either clinical or subclinical levels of symptomatology. Clinical levels of bulimic behavior and attitudes refer to symptoms that meet diagnostic criteria for bulimia nervosa. The lifetime prevalence rate for bulimia nervosa among female adults was reported to be 1.5% (Hudson, Hiripi, Pope, & Kessler, 2007). The symptom pattern necessary for a clinical diagnosis of bulimia nervosa, as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013), includes engagement in binge eating (i.e., eating a large amount of calories in a certain time frame), compensatory actions (i.e., vomiting, overexercising, laxative use, and diuretic use), and valuing body shape and size as measures of self-worth (American Psychiatric Association, 2013). A clinical bulimia nervosa diagnosis also requires that binge eating and compensatory actions occur at least once per week for the past 3 months (American Psychiatric Association, 2013).

Female college students may also struggle with subclinical bulimic symptoms (Vohs et al., 2001). Tylka and Subich (1999) reported that subclinical bulimia likely falls on a continuum of disordered eating behavior, differing only in severity and frequency from clinical bulimia nervosa, as opposed to representing an entirely different symptom pattern. As underscored previously, subclinical bulimic symptoms are quite high among college students (Kelly-Weeder, 2010; Vohs et al., 2001).

Attachment Theory and Bulimia

Attachment theory describes an individual's relationship with a main early caregiver and his or her development of internal working models, which are posited to guide an individual's view of self and the nature of relationships with others (Bowlby, 1969, 1973, 1980). Attachment can be thought of as being either secure or insecure. Securely attached individuals have trust in the dependability of relationships, whereas insecurely attached individuals lack surety and trust in relationships (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1973, 1980). Researchers have studied patterns of infant-caregiver attachment (Ainsworth et al., 1978) and patterns of adult romantic attachment (Hazan & Shaver, 1987).

In combining the findings on childhood attachment and adult attachment, researchers have identified two main facets of insecure attachment bonds and behavior: anxious attachment and avoidant attachment (Brennan, Clark, & Shaver, 1998). An anxiously attached individual fears being abandoned and may cling to relationships; an avoidantly attached individual evades relying on others and distances him- or herself from relationships (Brennan et al., 1998; Hazan & Shaver, 1987). A securely attached individual, on the other hand, is not consumed with qualms

about abandonment and is able to experience closeness in relationships and rely on others (Brennan et al., 1998; Hazan & Shaver, 1987). Researchers have found a link between attachment style and clinical and subclinical bulimia (for a review, see Zachrisson & Skårderud, 2010). For example, Bamford and Halliwell (2009) found a link between insecure attachment and augmented bulimic symptoms among female college student participants ($N = 213$).

Attachment to God/Higher Power

The construct of attachment to God/Higher Power has received minimal attention in the literature on bulimia and spirituality, particularly among participants in nonclinical settings (e.g., college students). Homan and Boyatzis (2010) surveyed college students and found that an anxious attachment to God was related to several bulimia risk variables (i.e., pressure to be thin, thin-ideal internalization, body dissatisfaction, and dieting) and that an avoidant attachment to God was associated with one bulimia risk factor (i.e., body dissatisfaction). The potential link between attachment to God/Higher Power and symptoms of bulimia among college students in a nonclinical setting deserves increased empirical study.

Researchers have discussed attachment theory in reference to an individual's relationship with God (e.g., Kirkpatrick, 1999; Kirkpatrick & Shaver, 1990). Beck and McDonald (2004) discussed two types of insecure attachment to God: anxious and avoidant. In both cases, the stability of an individual's relationship with God is questioned. Anxious attachment signifies an apprehension about being deserted by God, emotions of irritation and anger regarding God's failure to provide care, a fixation on this divine bond, envy about the divine love others receive, and "anxiety over one's lovability in God's eyes" (Beck & McDonald, 2004, p. 94). Avoidant attachment "involves themes such as a need for self-reliance, a difficulty with depending upon God, and unwillingness to be emotionally intimate with God" (Beck & McDonald, 2004, p. 94).

As noted previously, there is a dearth of research regarding the link between attachment to God/Higher Power and symptoms of bulimia. Researchers have, however, studied the association between bulimia and conceptually similar constructs. Anxiously attached individuals feel nervous and uncertain about God's/Higher Power's care and stability and worry about being deserted by God/Higher Power (Beck & McDonald, 2004). Researchers have found increased rates of bulimic symptomatology among individuals who feel that God/Higher Power has abandoned them in times of stress (Buser & Bernard, 2013). Avoidantly attached individuals also lack surety in their relationship with God/Higher Power; this avoidant tendency may be exhibited by distancing oneself from God/Higher Power and refusing to rely on God/Higher Power (Beck & McDonald, 2004). Researchers have found a link between the use of a spiritual coping style that emphasizes reliance on God/Higher Power in times of stress—so that an individual feels a partnership with God/Higher Power—and reduced bulimic symptoms (Buser & Bernard, 2013).

The Current Study

Women who report an anxious or avoidant attachment to God/Higher Power may report increased levels of bulimic symptoms. Previous research on general attachment styles and bulimia (Bamford & Halliwell, 2009), spiritual coping and bulimia (Buser & Bernard, 2013), and attachment to God and bulimia risk factors (Homan & Boyatzis, 2010) provided direction for the study hypotheses.

We examined three research hypotheses. In particular, we posited the following:

Hypothesis 1: a significant, positive association between anxious attachment to God/Higher Power and symptoms of bulimia, such that increased anxious attachment would be related to increased bulimia.

Hypothesis 2: a significant, positive association between avoidant attachment to God/Higher Power and symptoms of bulimia, such that increased avoidant attachment would be related to increased bulimia.

Hypothesis 3: a stronger relationship between anxious attachment to God/Higher Power and bulimia, in comparison with the relationship between avoidant attachment to God/Higher Power and bulimia.

Method

Participants

All participants ($N = 599$) self-identified as female and reported a mean age of 20 years (range = 18–38), although only five respondents were age 30 or older, and five respondents were above age 23. Three participants declined to answer the age item or provided an inaccurate number. The racial composition of the sample included Caucasian/European American ($n = 451$, 75.3%), Asian American/Pacific Islander ($n = 61$, 10.2%), Hispanic/Latina ($n = 36$, 6.0%), African American ($n = 22$, 3.7%), multiethnic/multiracial ($n = 17$, 2.8%), and other ($n = 12$, 2.0%). Participants were fairly evenly distributed across academic status: 27.0% freshmen ($n = 162$), 23.9% sophomores ($n = 143$), 24.0% juniors ($n = 144$), and 25.0% seniors ($n = 150$). (Some percentages do not total 100 because of rounding.) Participants identified as noninternational students ($n = 592$, 98.8%) and international students ($n = 4$, 0.7%); three (0.5%) chose not to answer. A majority of participants identified as middle class ($n = 327$, 54.6%); participants also identified as lower class ($n = 14$, 2.3%), working class ($n = 83$, 13.9%), upper middle class ($n = 170$, 28.4%), and upper class ($n = 5$, 0.8%). Participants identified as heterosexual ($n = 573$, 95.7%), lesbian ($n = 1$, 0.2%), gay ($n = 1$, 0.2%), and bisexual ($n = 20$, 3.3%); four participants (0.7%) chose not to answer. Participants reported religious affiliation as follows: Catholic ($n = 310$, 51.8%), Protestant ($n = 93$, 15.5%), Jewish ($n = 19$, 3.2%), Muslim ($n = 15$, 2.5%), Hindu ($n = 11$, 1.8%), Buddhist ($n = 4$, 0.7%), Unitarian ($n = 4$, 0.7%), Universalist ($n = 1$, 0.2%), agnostic ($n = 24$, 4.0%), other faith/religious tradition ($n = 67$, 11.2%), and no religious affiliation ($n = 51$, 8.5%). Based on the Centers

for Disease Control and Prevention (2015) parameters, participants' body mass indexes (BMIs) were categorized as underweight (under 18.5; $n = 36$, 6.0%), normal weight (18.5 to 24.9; $n = 450$, 75.1%), overweight (25.0 to 29.9; $n = 79$, 13.2%), or obese (30.0 and higher; $n = 30$, 5.0%). Participants reported a mean BMI of 22.82, which is within the normal range (Centers for Disease Control and Prevention, 2015). Four participants (0.7%) provided improbable or incomplete height and weight information, and we thus could not calculate BMIs for these participants. Researchers have noted that some female participants may inaccurately self-report height and weight information (Craig & Adams, 2009), which would lead to an incorrect BMI calculation. We chose to assess BMI because of the precedent set by other researchers in the eating disorder field (e.g., Vohs et al., 2001). In addition, despite the potential for inaccurate self-reports, Craig and Adams (2009) concluded that there was "moderate agreement" (p. 494) between female participants' actual and self-reported height and weight.

Procedure

We gained approval from the institutional review boards of our respective institutions. We worked with the assessment and research office of a public college in the mideastern United States and used Qualtrics survey software to send a link to the informed consent and survey electronically through the campus e-mail system. A total of 3,589 students were potential participants in this study. This number represented all female students age 18 or older enrolled in the college ($N = 3,583$) and six students age 18 or older who did not provide gender information to the institution. We sent two reminder e-mails to nonrespondents 1 week and 2 weeks after the original administration. We offered an optional lottery for two \$100 Visa gift cards as an incentive for survey participation.

We included only participants who indicated having spiritual beliefs via a dichotomous yes/no question (Would you say that you have religious/spiritual beliefs?), which resulted in a total of 599 participants (16.7% response rate). Prior to the removal of participants who identified as atheist or reported no spiritual/religious beliefs, our sample consisted of 838 participants (23.3% response rate).

Measures

In addition to gathering participant demographic data, we measured attachment to God/Higher Power and bulimic symptomatology for this research. All instruments were self-report, and, on the basis of previous research, all instruments evidenced sufficient reliability and validity.

Attachment to God/Higher Power. We measured attachment to God/Higher Power with the Attachment to God Inventory (AGI; Beck & McDonald, 2004), which is a 28-item instrument that assesses an individual's perceived relationship with God over time. Two types of attachment to God are measured by the AGI. The Anxiety subscale (14 items) measures an individual's unease about God's love and care, and the Avoidance subscale (14 items) measures an individual's desire to

distance him- or herself from God (Beck & McDonald, 2004). The AGI is based on Brennan et al.'s (1998) conceptualization of attachment, which focuses on anxious and avoidant attachment as "two continuous dimensions [which] underlay most attachment classification models" (Beck & McDonald, 2004, p. 93).

On the AGI, participants rate their relationship with God on a 7-point Likert scale ranging from 1 (*disagree strongly*) to 7 (*agree strongly*). Higher scores indicate increased levels of insecure (anxious or avoidant) attachment, and lower scores suggest increased levels of secure attachment (Dumont, Jenkins, Hinson, & Sibcy, 2012). Beck and McDonald (2004) reported sufficient reliability and construct validity for the AGI subscales. In this study, we modified the AGI to use the term *God/Higher Power* (rather than only *God*) to increase inclusivity of additional religious and spiritual beliefs. The Anxiety subscale ($\alpha = .86$) and the Avoidance subscale ($\alpha = .82$) were reliable among our study participants. Both AGI subscales also had acceptable skewness and kurtosis values (Miles & Shevlin, 2001).

To categorize participants as having either secure or insecure attachment via the AGI subscales, Dumont et al. (2012) determined that scores greater than or equal to 49 on either subscale indicated insecure attachment, whereas scores less than or equal to 48 on both subscales indicated secure attachment. On the basis of the Dumont et al. parameters, current participants self-reported secure ($n = 378$) or insecure ($n = 221$) attachment to God/Higher Power.

Bulimia. We measured bulimia symptoms with the Bulimia Test–Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991). The BULIT-R contains 36 items (28 items compose the total score), and participants rate their bulimic behaviors and attitudes on a 5-item Likert-type scale ranging from 1 (*absence of disturbance*) to 5 (*severe disturbance*). Thelen et al. (1991) reported reliability and validity data for the BULIT-R. In our study, the BULIT-R was also reliable ($\alpha = .94$). We assessed the normality of the BULIT-R through a histogram of the standardized residuals and by examining the skewness and kurtosis values (Miles & Shevlin, 2001). Because the BULIT-R was mildly positively skewed and had a potentially problematic kurtosis value (Miles & Shevlin, 2001), we transformed this variable using a logarithm transformation (Tabachnick & Fidell, 2007), which improved the skewness and kurtosis of the BULIT-R. We used the transformed BULIT-R variable in the correlation analyses and in the hierarchical regression analysis.

Results

To examine Hypotheses 1 and 2, we conducted correlation analyses (see Table 1). We carried out a hierarchical multiple regression analysis to test Hypothesis 3. We found significant bivariate correlations between anxious attachment to God/Higher Power and bulimia ($r = .21, p < .001$) and avoidant attachment to God/Higher Power and bulimia ($r = .10, p < .05$), indicating that higher levels of avoidant or anxious attachment to God/Higher Power were related to increased bulimic symptoms. These findings supported Hypotheses 1 and 2.

Prior to the hierarchical regression analysis, we examined relationships between age, religious affiliation, economic background, BMI, international

TABLE 1

**Means, Standard Deviations, Observed and Possible Ranges,
and Correlations for Attachment to God/Higher Power
and Bulimia Variables**

Variable	<i>M</i>	<i>SD</i>	Observed Range	Possible Range	1	2	3
1. AGI-Anxiety	38.13	13.03	14–82	14–98	—		
2. AGI-Avoidance	56.91	16.42	17–97	14–98	-.23**	—	
3. BULIT-R	50.80	18.34	29–129	28–140	.21**	.10*	—

Note. *N* = 599. The mean, standard deviation, and range values are reported using the non-transformed Bulimia Test–Revised (BULIT-R) variable; the correlations are reported using the transformed BULIT-R variable. AGI-Anxiety = Attachment to God Inventory–Anxiety subscale; AGI-Avoidance = Attachment to God Inventory–Avoidance subscale.

* $p < .05$. ** $p < .001$.

student status, sexual identity, and academic status. We conducted an eta correlation ratio to test the strength of associations between the dependent variable (bulimia) and the nominal-level demographic variables (i.e., race/ethnicity, sexual identity, international student status, academic status, religious affiliation, and economic background), with only sexual identity showing a significant correlation. For this analysis, we compared participants who identified as lesbian, gay, or bisexual with participants who identified as heterosexual and found that participants who self-identified as lesbian, gay, or bisexual had lower rates of bulimia than did those who self-identified as heterosexual ($\eta = .10$, $p < .05$). This finding of statistical significance may not be practically meaningful, however, because few participants identified as lesbian, gay, or bisexual. We conducted Pearson product–moment correlation analyses to examine the relationship between the continuous demographic variables (i.e., age and BMI) and bulimia. We found no significant association between age and bulimia but found a significant positive correlation between BMI and bulimia ($r = .27$, $p < .001$).

Therefore, in a hierarchical regression, we controlled for BMI by entering this variable in Step 1 (see Table 2). We did not control for sexual identity, because the majority of participants identified as heterosexual. A total of 595 participants were included in the regression, because four participants did not have complete BMI data. In Step 2, we entered the attachment to God/Higher Power (anxiety and avoidance) variables. The results of Step 1 indicated that the variance accounted for (R^2) by BMI equaled .07 (adjusted R^2), which was significant ($\beta = .27$, $p < .001$), $\Delta F(45.00)$, $p < .001$. The effect size of this relationship was $f^2 = 0.07$ (Soper, 2012), which was a small effect (Cohen, 1992). In Step 2, the two subscales of attachment to God/Higher Power (Anxiety and Avoidance) were entered into the regression equation. The change in variance accounted for (ΔR^2) was equal to .06, which was significant, $\Delta F(19.60)$, $p < .001$. According to Cohen (1992), the effect size of $f^2 = 0.06$ (Soper, 2012) was small. The unstandardized regression coefficients (B) and intercept, the standardized regression coefficients (β), and t values for the full model are reported in Table

TABLE 2
Unstandardized Regression Coefficients and Intercept,
Standardized Regression Coefficients, and *t* Values
for Variables as Predictors of Bulimia

Step and Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>
Step 1				
Constant	1.46	.03		44.20
Body mass index	0.01	.00	.27	6.71
Step 2				
Constant	1.31	.04		31.76
Body mass index	0.01	.00	.25	6.50
AGI-Anxiety	0.00	.00	.23	5.74
AGI-Avoidance	0.00	.00	.15	3.76

Note. *N* = 595. For all variables, *p* = .000. AGI-Anxiety = Attachment to God Inventory–Anxiety subscale; AGI-Avoidance = Attachment to God Inventory–Avoidance subscale.

2. Both anxious attachment to God/Higher Power and avoidant attachment to God/Higher Power contributed significantly to the explanation of bulimic symptoms. After inspecting the beta values of both subscales, we found support for Hypothesis 3; anxious attachment to God/Higher Power ($\beta = .23, p < .001$) had a stronger association with bulimia compared with avoidant attachment to God/Higher Power ($\beta = .15, p < .001$).

Discussion

In this study, we found support for all three hypotheses. We found significant links between anxious and avoidant attachments to God/Higher Power and bulimic symptoms. Moreover, anxious attachment evinced a stronger relationship with bulimic symptoms than did avoidant attachment. In light of these findings, we discuss theory development and college counseling implications.

In our investigation, we reported a significant relationship between anxious attachment to God/Higher Power and bulimic symptoms. Our results support and extend previous research on the link between anxious attachment to God/Higher Power and risk factors for bulimia (Homan & Boyatzis, 2010). However, on the basis of our results, the mechanisms by which anxious attachment to God/Higher Power and bulimia are related are unknown. Potentially, our findings could offer support for the mechanisms studied by Homan and Boyatzis (2010); their research suggested that, for participants who reported an anxious attachment to God/Higher Power, factors associated with sociocultural theory and the dual pathway model of bulimia (Stice, 2001) may be relevant concerns. In particular, Homan and Boyatzis found that anxious attachment to God had a significant association with four risk factors for bulimic symptoms: pressure to be thin, thin-ideal internalization, body dissatisfaction, and dieting. On the basis of sociocultural theory and the dual pathway model of bulimia, these risk factors are hypothesized to interact in the following manner: An individual experiences pressure to be thin, which leads to an internalization of

a thin body ideal, which leads to body dissatisfaction, which leads to dieting behavior in an effort to change one's body size and shape, which ultimately leads to bulimic symptoms (Stice, 2001). To test the salience of the dual pathway model of bulimia for individuals with anxious attachment to God/Higher Power, future researchers could examine a multivariate model (e.g., Bamford & Halliwell, 2009), wherein the direct and indirect links between anxious attachment to God/Higher Power, sociocultural risk factors for bulimia, and bulimic symptoms are examined. It may be that an individual who fears being abandoned by God/Higher Power and questions God's/Higher Power's love is more vulnerable to accepting sociocultural messages and pressures about body image (Homan & Boyatzis, 2010). Alternatively, an etiological model divergent from the dual pathway model may be more salient for participants; future researchers can examine additional potential models to explain the link between anxious attachment to God/Higher Power and bulimia.

Although Homan and Boyatzis (2010) did not find support for the link between avoidant attachment to God and several sociocultural risk variables consistent with the dual pathway model for bulimia, we found a relationship between bulimic symptoms and avoidant attachment to God/Higher Power. Thus, individuals with an avoidant attachment to God/Higher Power may engage in bulimic symptoms for reasons other than sociocultural pressures. In line with this theory, Bamford and Halliwell (2009) found a direct link between adult avoidant attachment and eating disorder symptoms but did not find an indirect link between avoidant attachment, sociocultural variables, and eating disorder symptoms. Bamford and Halliwell hypothesized that a different etiology may be at work for avoidantly attached individuals who engage in disordered eating, such as a goal of social avoidance. Because our study revealed a link between avoidant attachment to God/Higher Power and bulimia, future researchers can examine mediating variables to explain the association between these constructs. An individual with an avoidant general attachment style may place minimal value on personal connection (Bamford & Halliwell, 2009); by extension, an individual with an avoidant attachment to God/Higher Power may place little value on having a relationship with God/Higher Power. Because researchers have noted that Judeo-Christian traditions stress the value of a personal relationship with God (Beck & McDonald, 2004), such an individual may thus feel upset about this lack of emphasis on a personal spiritual connection. Experiencing unpleasant emotions may then lead to using bulimic behaviors to alleviate negative emotions (Tachi, Murakami, Murotsu, & Washizuka, 2001).

In addition, we found that, when anxious attachment to God/Higher Power and avoidant attachment to God/Higher Power were entered together in a regression, anxious attachment had a stronger relationship with bulimic symptoms. This finding supports those of previous researchers. Buser and Bernard (2013) found that the association between bulimic symptoms and thoughts about being abandoned by God/Higher Power during times of stress was stronger than the link between bulimic symptoms and another spiritual coping style. As discussed previously, anxious attachment to God/Higher Power

involves concerns about the instability of God's/Higher Power's love and fears about being deserted (Beck & McDonald, 2004). Thus, a belief in an unstable God/Higher Power who is prone to neglect and forsake an individual appears to be an especially damaging belief in relation to bulimic symptoms.

Implications for College Counseling

The findings of this study may be relevant for college counselors. As noted previously, researchers have found evidence that some clients explore spiritual and religious beliefs in counseling sessions (Kellems et al., 2010). Thus, female clients who endorse spiritual beliefs and report problems with bulimic symptoms may want to discuss their relationship with God/Higher Power in counseling. Treatment interventions can be designed that address attachment to God/Higher Power and the potential link to bulimic symptoms.

Initially, after determining the salience of a client's spiritual beliefs (Hodge, 2005c), college counselors may want to assess an individual's attachment to God/Higher Power. Creative, free-form assessments may yield meaningful information (Hodge, 2005a). In describing a group treatment model on attachment to God for clients who identified a religious issue as a primary concern, Thomas, Moriarty, Davis, and Anderson (2011) used art-based assessment tools drawn from Moriarty (2006). Such assessment tools included having clients draw "a picture of you and God" (Moriarty, 2006, p. 26). Understanding a client's visual representation of and way of relating to God/Higher Power may illuminate the anxious or avoidant stance with which a client often approaches this connection.

After gaining client permission, college counselors may want to use the spiritual ecogram assessment and intervention tool as a part of therapy (Hodge, 2005b). A spiritual ecogram blends a spiritual genogram (Hodge, 2001) and a spiritual ecomap (Hodge, 2000) into one visual depiction; the top section of an ecogram represents a client's generational history of spiritual beliefs, and the bottom section represents current patterns of spiritual beliefs (Hodge, 2005b). Although Hodge (2005b) provided guidelines for what can be included in a spiritual ecogram, he also noted the importance of "letting the client's experience shape the construction of the ecogram" (p. 290). For example, counselors will want to attend to issues such as using the client's language for spiritual and religious beliefs (Hodge, 2005c). In the spiritual genogram section, a client and counselor can discuss generational themes of spiritual beliefs, important spiritual relationships, critical past spiritual experiences (e.g., crises, times of growth), and areas of generational strength and discord (Hodge, 2001, 2005b). In the spiritual ecomap portion, a client and counselor can discuss the client's present relationship with salient spiritual practices, themes, and/or organizations, such as spiritual communities, prayer, or a client's connection to God/Higher Power (Hodge, 2000, 2005b). Finally, the client and counselor can spend time analyzing the links between the generational history depicted in the spiritual genogram and the client's current spiritual beliefs portrayed in the spiritual ecogram (Hodge, 2005b).

In using the spiritual ecogram, clients and counselors may gain a deeper understanding of the client's spiritual beliefs and the ways in which generational patterns influence current beliefs (Hodge, 2001, 2005b). The spiritual ecogram is a strengths-based tool, because counselors are working to help clients identify resources (Hodge, 2005b). Such an intervention may be particularly relevant to clients who struggle with symptoms of bulimia and who evince avoidant or anxious attachment to God/Higher Power. For example, a client with anxious spiritual attachment likely fears abandonment by God/Higher Power. In creating and discussing the spiritual genogram portion of the ecogram, a client may realize that he or she overlooked the spiritual strengths and surety of a certain family member and may decide to seek out further discussions with that family member about his or her view of God/Higher Power (Hodge 2001). Speaking with a trusted family member who feels stable and grounded in a relationship with God/Higher Power may assist a client in alleviating a fear of spiritual abandonment. In analyzing the client's present relationship (i.e., the spiritual ecomap portion) to various spiritual practices and issues, the client may be able to identify areas of strength, such as a dedicated prayer life or a supportive church community (Hodge, 2005b). As suggested previously, it is possible that clients who feel anxiously attached to God/Higher Power are susceptible to sociocultural pressures to fit a certain female body image (Homan & Boyatzis, 2010). On the basis of the dual pathway of bulimia, an ascription to social standards of thinness may lead to bulimic symptoms (Stice, 2001). Gaining cognizance of his or her current spiritual resources may facilitate a client's movement away from an emphasis on societal standards of attractiveness to a focus on alternative modes of self-identity. For example, a client who identifies a supportive spiritual community through the spiritual ecogram intervention may benefit from a counseling discussion of the ways in which this spiritual community is valuable to the client. The counselor can explore issues such as the client's role in the community and the client's relationships in this community. Hodge (2005b) discussed how this awareness of spiritual strengths may assist clients in shifting their narrative from a negative narrative of self-doubt to a positive narrative of competency and confidence.

In working with clients who struggle with spiritual questions, college counselors will also want to develop relationships with spiritual and religious representatives on campus and in the community; clients may want to meet with such individuals (Richards et al., 1998). However, Richards et al. (1998) cautioned that "not all religious leaders are helpful or therapeutic" (p. 138) and noted the importance of counselors meeting with spiritual and religious representatives to ascertain their views about eating disorders and harmful opinions they may hold. Counselors should also be cognizant of the client's openness to such meetings; clients may have had negative past experiences with spiritual or religious representatives and may be resistant to such interactions (Richards et al., 1998).

Strengths and Limitations

We explored a minimally examined relationship among college students and reported results from participants attending a secular university. Many studies

on spirituality and eating disorders reported findings from participants from religious institutions (e.g., Buser & Bernard, 2013; Homan & Boyatzis, 2010). Our research was also limited in certain ways. Our participants lacked diversity in race/ethnicity, sexual orientation, and religious affiliation, which restricted the study's generalizability. Moreover, the instrument used to assess attachment to God/Higher Power was formed on the basis of Judeo-Christian beliefs (Beck & McDonald, 2004). We broadened items to include "Higher Power," but results cannot extend to participants of different faith traditions. Although our response rate was similar to the response rates of other research with college students using e-mailed survey links (e.g., Murray, Wester, & Paladino, 2008), it may be a limitation; participants may not be representative of the university community. In addition, because we did not assess general attachment style in this study, the variance explained by attachment to God/Higher Power beyond general attachment is unknown.

This study represents an initial step in the scholarship on attachment to God/Higher Power and bulimic symptomatology. Future researchers can examine the connection between these constructs with a more diverse sample, in addition to assessing the ability for attachment of God/Higher Power to predict bulimia after controlling for general attachment style. Moreover, longitudinal designs and multivariate models may shed light on the mechanisms by which anxious and avoidant attachment to God/Higher Power are associated with bulimia.

Conclusion

Clients with spiritual beliefs may view their relationship with God/Higher Power in various ways. Some clients may see God/Higher Power as a stable and dependable source of support and love, others may view God/Higher Power as unfair and prone to abandonment, and others may perceive distance in their relationship with God/Higher Power (Beck & McDonald, 2004; Kirkpatrick, 1999). Given the findings we reported and discussed in this study, clients who endorse spiritual beliefs that suggest an anxious or avoidant attachment to God/Higher Power may be at increased risk for engaging in bulimic behaviors and attitudes. College counseling assessment and intervention methods that allow the client to explore beliefs about God/Higher Power may be beneficial inclusions in therapy.

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