The role of adult attachment styles in fibromyalgia

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Resumo

Introdução e objectivos: A fibromialgia é uma doença debilitante caracterizada por dor crónica sem causa orgânica subjacente conhecida, frequentemente associada a outros sintomas debilitantes, causando grande sofrimento aos doentes. Este estudo pretende aprofundar o conhecimento acerca do papel do estilo de vinculação do adulto na fibromialgia, caracterizando e comparando o estilo de vinculação de mulheres com fibromialgia e suas irmãs saudáveis e apreciando a sua relação com o impacto, idade de aparecimento da doença, e morosidade no diagnóstico desta.

Metodologia: Díades familiares compostas por uma doente com fibromialgia e sua irmã saudável foram recrutadas para uma entrevista onde completaram os questionários "Experiência em Relações Próximas" e "Fibromyalgia Impact Questionnaire – versão portuguesa", enquanto parte do projecto conjunto ScanFM. Os dados de cada família foram recolhidos num tempo único.

Resultados: Observou-se uma tendência, mas sem diferenças significativas, nas dimensões da vinculação entre doentes e irmãs. Não se verificaram correlações estatisticamente significativas entre estilos de vinculação do adulto e o impacto da doença, idade de aparecimento desta, ou intervalos no processo diagnóstico.

Conclusões: Foram consideradas e discutidas implicações teóricas do estilo de vinculação do adulto na fibromialgia, mas não se encontraram efeitos significativos. As limitações do estudo não permitem, sobretudo pela reduzida dimensão, que se retirem conclusões definitivas, pelo que são recomendados estudos subsequentes neste tema.

Palavras chave: *Demora diagnóstica, Dimensões da vinculação, Estilos de vinculação, Fibromialgia, Vinculação no adulto*

Abstract

<u>*Introduction and objectives:*</u> Fibromyalgia is a debilitating disease characterized by generalized chronic pain without organic explanation, frequently associated with other disruptive symptoms, causing great suffering to those afflicted. This study aims to gather insight into the role of adult attachment orientations in fibromyalgia by characterizing and exploring how the attachment profile of patients relates to the impact, age of onset, and delays in diagnosing the disease.

<u>*Methods*</u>: Family dyads composed of a fibromyalgia patient and an healthy sister were recruited for an interview where they completed the Portuguese versions of the Fibromyalgia Impact Questionnaire and Experience in Close Relationships Scale questionnaires, as a part of the joint ScanFM project. Data for each family was collected on a single occasion.

<u>*Results*</u>: A tendency was observed, but no significant differences were found in attachment dimensions between fibromyalgia patients and healthy sisters. No statistically significant correlations were found between adult attachment orientations and impact of the disease, age of onset, or delays in the diagnostic process.

<u>*Conclusions:*</u> Theoretical implications of adult attachment style in fibromyalgia were discussed and considered, but no significant effects were found. The limitations of the study, namely the reduced sample, do not allow for definitive conclusions to be attained, therefore further research on the matter is recommended.

<u>Keywords</u>: *Adult attachment, Attachment dimensions, Attachment styles, Diagnostic delay, Fibromyalgia*

Introduction

Fibromyalgia (FM) is a condition characterized by the presence of generalized chronic pain with tenderness on pressure in at least 11 of 18 defined points, according to the 1990 American College of Rheumatology[1]. The pain is devoid of organic explanation, and is frequently associated with a variety of other symptoms, such as fatigue, sleep disturbances, depression[2-4], cognitive disfunction, irritable bowel syndrome, among many others[2]. All this usually causes severe impairment in work and daily activities, thus resulting in profound suffering and remarkable deterioration of quality of life for those afflicted[2, 5-6] and close family[7].

FM is quite frequent, with an estimated prevalence of 2% - 3% in the general population[8-9]. In Portugal, the prevalence has been postulated to be around 3.6%[10]. Taken together, these facts demonstrate that FM constitutes a relevant health problem, deserving further in-depth investigation in order to improve existing preventive, diagnostic and treatment strategies.

The pathogenesis of fibromyalgia is very complex and still largely unknown. Research suggests involvement of genetic[11], hormonal[12], neurological[13-15], psychiatric and psychological[5, 16] factors, amongst many others[4].

Among the psychological domains invoked in the understanding of FM, aspects of stress, coping strategies and interpersonal relationships have gathered considerable attention, with attachment theory being considered relevant[5-6, 17-18]. According to Bowlby's attachment theory[19-20], human relationships are crucially affected by each person's attachment style: working models one creates will modulate how one regards and what one expects from himself or from others. A person with a positive cognitive representation of both self and others tends to be secure, therefore, likely to be well adjusted and able to cope appropriately

with stressful situations. Having a negative model of others means that the person will not expect much of others, and is unlikely to rely on others or establish trust easily. A negative model of self reflects the same kind of insecurity, but about oneself instead of other people. These positive or negative orientations will affect the strategies one uses to deal with situations, reflecting what they expect or fail to expect from themselves, others, or both, and may often result in poor management of those situations, leading to conflict and stress. Attachment styles may therefore be a predisposing factor to FM. They may also, among those already suffering from FM, lead to more or less adaptive coping strategies, consequently resulting in lesser or greater suffering from the disease, and impact the effectiveness of treatment[5, 17-18, 21-22].

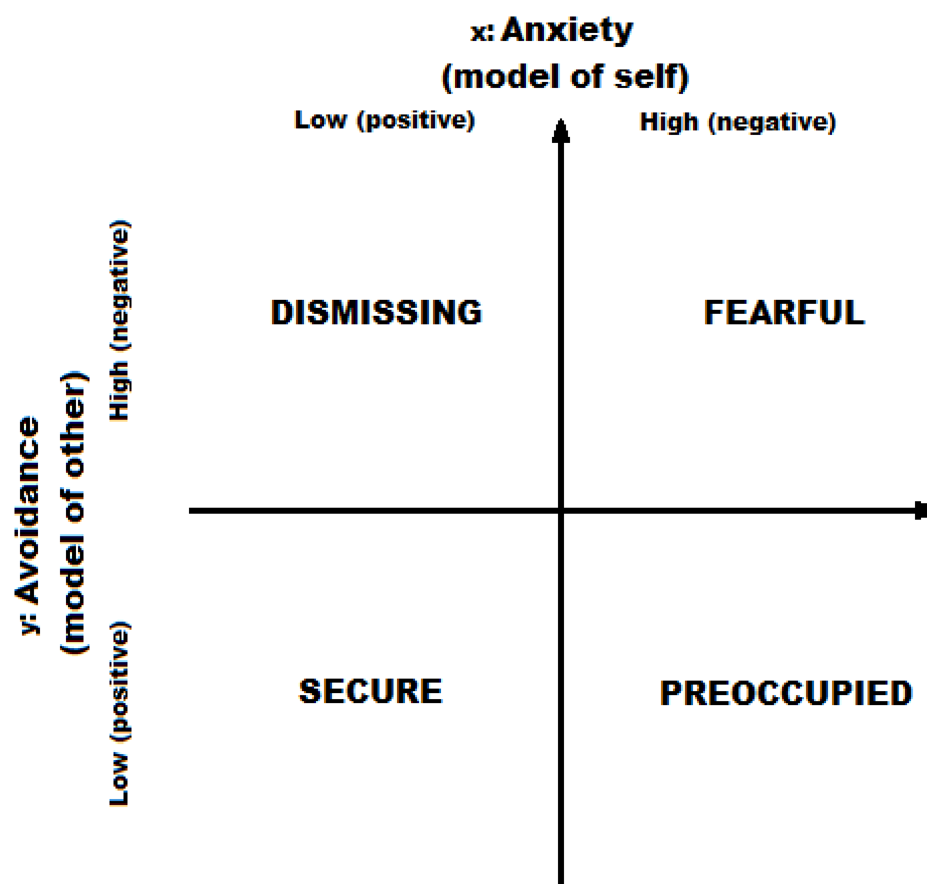

Figure 1: Scheme of the dimensions and categories of attachment styles. *(adapted from* Griffin, D. and Bartholomew, K., *Metaphysics of measurement:The case of adult attachment).*

Tools for measuring adult attachment orientations have evolved into two main approaches currently in use: In the **prototypical approach** attachment style is defined according to how adequately one fits each of four categories – secure, preoccupied, fearful and dismissing. The **dimensional approach** adopts two dimensions – anxiety, which reflects the model of self, and avoidance, which reflects the model of others[17, 23]. Although not totally equivalent[23], these two methods of representing adult attachment styles are regarded as very interchangeable. They can be schematized as double axis system with anxiety and avoidance as the axes and the four categories represented by the quadrants thus defined, as shown in Figure 1[23].

Some studies have explored the interplay between attachment styles and fibromyalgia[5, 19, 21]. Most have found that insecure attachment styles are related to maladaptive coping strategies which worsen the experience of chronic pain.

In this paper we aim to go beyond these observations and explore whether attachment styles significantly differ between patients with FM and their non-affected sisters as well as how attachment dimensions influence certain aspects of the disease, such as i) impact of the disease in the patient; ii) age of onset of the disease; iii) interval from the beginning of symptoms to the search of medical attention and from there to making a definitive diagnosis.

Methods

In order to maximize the efficiency of the whole investigation, this study was conducted in partnership with other colleagues, as part of a project called ScanFM. Each of the investigators involved had dedicated outcomes of study, assuming responsibility for the choice of measuring instruments and for the analysis and interpretation of corresponding data.

Data for all the studies was cooperatively gathered from the same population on a single occasion for each family.

Population

Due to the overall design of the studies being conducted, we decided to study female patients with fibromyalgia paired with their mother and an unaffected sister. Participants were drawn from a list of 712 patients with an established diagnosis of FM from a single site (all diagnosed and followed by Prof. J.A.P. da Silva). The following screening criteria were used for selection: Female gender, age between 18 and 55 years, absence of any other chronic pain condition, residence within an radius of 100 Km from the study centre.

Selected patients were contacted by phone and asked to participate if i) they had at least one unaffected sister willing to participate, ii) the mother of both was the same person, still alive and capable of participating and providing reliable information, and iii) all these family members were willing to travel to the research site and participate in the study, which involved signing an informed consent, responding to questionnaires, providing a blood sample and undergoing physical examination. Participants were reimbursed for transportation costs but no other fees were offered. The study was approved by Ethical Committee of the Faculty of Medicine of the Universidade de Coimbra.

All research proceedings were performed in the morning. After receiving an explanation of the study procedures and having an opportunity to present any questions and discuss all issues, participants signed an informed consent form. This was followed by a fasting blood sample collection. Breakfast was offered to participants before following with the questionnaires and examinations.

Psychometric instruments

Besides a custom demographic questionnaire, this paper made use of the validated Portuguese translations of the Fibromyalgia Impact Questionnaire (FIQ)[24], and of the Experience in Close Relationships Scale (ERP)[25]. The FIQ is a self-report questionnaire developed to measure the impact of FM in patients, and consists of 20 questions grouped in 10 items answered as either *Likert-type* or analogic visual scales, resulting in a score ranging from 0 to 100, with 100 standing for the maximum impact of the condition. The Cronbach's α for the translated FIQ is of 0.81[26]. The ERP is a self-report questionnaire used to measure attachment style according to the dimensional approach, with 36 *Likert-type* items making up two scales for the dimensions of attachment style. The scales range from 1 to 7, higher scores reflecting higher anxiety or avoidance. The Cronbach's α is 0.93 for the avoidance scale and 0.87 for the anxiety scale[27].

Statistical analysis

Results were analyzed using PASW Statistics 18. Exploratory data analysis (Kolmogorov-Smirnov test for normality, box-plotting for outliers) showed that the requirements for parametric testing were not met, thus the hypothesis of a difference in attachment styles between patients with FM and unaffected sisters was tested with a Wilcoxon signed-rank test. The remaining hypothesised correlations were calculated with the Spearman rank correlation coefficient.

Results

Population

The screening criteria used reduced the potential population to 317 individuals, which were contacted by phone. Of these, 278 were excluded for the following reasons: 121 did not have an unaffected sister, 27 had their sister living too far away to attend, 73 were already orphans or their mother was not capable or participating, 57 were not reachable through the phone. Of the remaining 39 families satisfying inclusion criteria, 11 refused to participate and 6 never made themselves available to attend the research centre.

Altogether, 22 family triads, composed of a fibromyalgia patient, one unaffected sister and the mother of both were included in the study. In one of these families our evaluation revealed that the sister satisfied classification criteria for FM, thus leaving only 21 matched FM – healthy pairs for comparison. Non-paired correlations using only the FM group, however, take all 22 patients into account. The demographic characteristics of the 22 families are presented in Table I.

		FM patients	**Sisters**
Age (years)	Mean (SD)	40.7 (10.7)	40.2 (10.0)
	Range	18.7 - 55.0	19.5 - 52.5
Age at first symptoms (years)	Mean (SD)	32.3 (13.4)	-
	Range	12.7 - 49.4	-
Age at diagnosis (years)	Mean (SD)	39.5 (10.7)	-
	Range	18.0 - 54.5	-
Formal education (years)	Mean (SD)	12.8 (4.2)	12.3 (5.3)
	Range	5 - 21	4 - 24
Marital status	Single	4 (18.2%)	7 (31.8%)
	Married	18 (81.8%)	13 (59.1%)
	Divorced	0	2 (9.1%)
Professional activity	Employed	14(63.6%)	14 (63.6%)
	Self-employed	5 (22.7%)	2 (9.1%)
	Unemployed	2 (9.1%)	2 (9.1%)
	Student	1 (4.5%)	3 (13.6%)
	Unknown	0	1 (4.5%)

Table I: Demographic characteristics of the study population.

Statistical analysis

Figure 2 shows a scatterplot of the data collected from the ERP questionnaire.

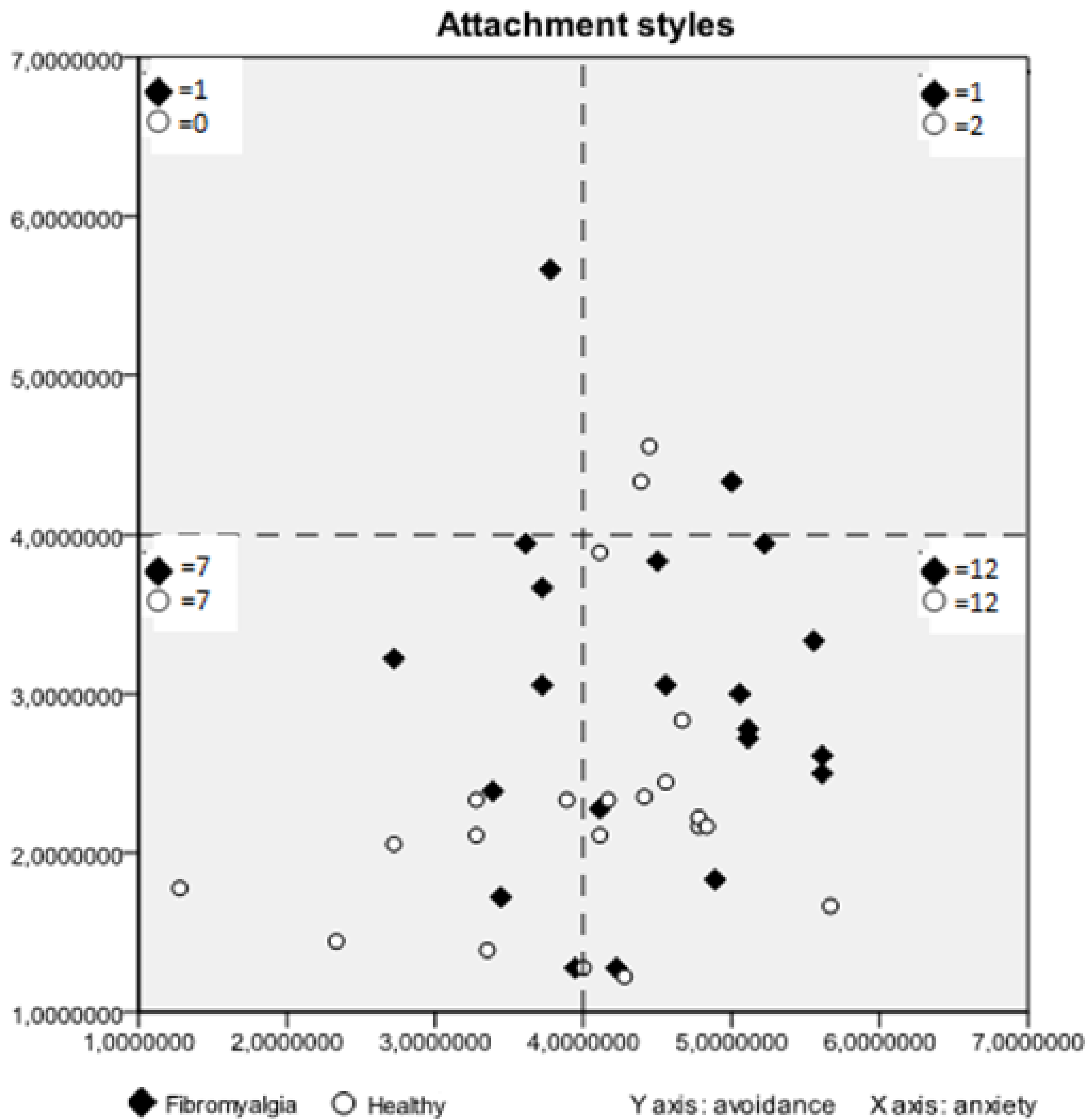

Figure 2: Attachment styles scatterplot.

Dashed lines mark the boundaries between different attachment styles as shown in Figure 1. The number of individuals in each category is noted in a corner of the respective quadrant.

Overall, the distribution of attachment styles seen as categories is very similar in FM patients and healthy sisters, the vast majority corresponding to secure and preoccupied

individuals with exactly the same number in each category. The differences observed in the dismissing and fearful styles are negligible. Further analysis of the scatterplot suggests that none of these subjects can be considered a remarkable example of the category they fit in, as they stand close to the axes, making them borderline. Even disregarding this observation, the distribution of FM and controls is very similar, the chi-square test showing no significance for the difference, with $p = 0.721$.

Considering the attachment dimensions, the mean values for anxiety and avoidance in FM patients were 4.42 and 2.97, with standard deviations (SD) of 0.84 and 1.06 respectively. In the healthy sisters the means for anxiety and avoidance are 3.97 and 2.33 with SD of 0.98 and 0.91, respectively. The matched-pair comparison of values between the two groups showed a tendency for higher values in both dimensions for the FM patients, however at a $p = 0.054$ for avoidance and $p = 0.073$ for anxiety.

The means, range, and SD of all variables tested in the 22 FM patients are presented in Table II. Results for the Spearman rank correlation between these psychological dimensions and disease features are shown in Table III. Anxiety and avoidance scores had no significant correlation with either the FIQ results or diagnosis time intervals.

	Mean	SD	Range
Anxiety	4.44	0.82	2.72 – 5.61
Avoidance	2.90	1.09	1.28 – 5.67
FIQ	50.2	13.2	25.4 – 68.0
Age at diagnosis	39.5	10.7	18.0 – 54.5
Time from first symptoms to search for medical care	2.3	4.5	0.0 – 19.2
Time from search for medical care to diagnosis	4.7	5.5	0.0 – 23.0
Time from first symptoms to diagnosis	7.1	6.5	0.4 – 23.0

Table II: Mean, SD and range of the studied variables in FM patients.
Times are in years.

	Anxiety	Avoidance
FIQ	0.245 (0.272)	0.153 (0.496)
Age at diagnosis	-0.79 (0.726)	0.198 (0.376)
Time from symptoms to medical care	-0.77 (0.747)	-0.234 (0.320)
Time from medical care to diagnosis	-0.428 (0.053)	-0.212 (0.357)
Time from symptoms to diagnosis	-0.270 (0.236)	-0.341 (0.131)

Table III: Pearson correlation results.
Unbracketed, r_s *correlation coefficient; bracketed,* p *value.*

Discussion

This study compared attachment orientations in people with or without fibromyalgia, and examined interrelationships between adult attachment styles and disease characteristics on those afflicted: severity, age of onset, and time intervals relative to the search for medical help and establishment of the diagnosis.

As expected, overall results obtained for attachment scores in our study population are within comparable terms with previous studies[17, 27-28], supporting the assumption that the sample adequately represents general population. The sample size, however, is small, with most variables not following normal distribution and outliers being present in some. This caused great restraints on statistical processing and greatly reduced its power.

Previous studies have found that insecure attachment styles can worsen the pain experience[28], and may act as facilitators to the development of the disease, as the inability to deal and cope with pain in an appropriate fashion could lead to the worsening and chronicity of the problem[17]. While no such tendency was observed in our study with a broad categorical distinction, considering the scores in each attachment dimension was more informative since the values are continuous, and account for how strongly each individual fits the model as well as for within-category differences. This exposed the expected tendency as being present in the studied sample, as both anxiety and avoidance tend to be higher in the FM group, with a *p*

value much stronger than the simple comparison of categories. The differences did not reach statistical significance but they certainly suggest a strong trend.

As for the impact of attachment styles on the course and severity of the disease, the same perspective is valid: insecure attachment tendencies in FM patients would be expected to lead to greater impact, as worse coping strategies are believed to exist for a relatively equivalent pain degree when compared to securely attached FM patients. These inadequate strategies might be especially relevant in the context of personal relationships or work environments, and could offer a framework for understanding the high prevalence of comorbidities such as depression[4] . No results were obtained at significant levels, though, and as a result no support can be offered to these considerations.

The long time intervals observed for diagnosing fibromyalgia have been subject of studies[29-30], but no thorough attempts were made to explain the underlying causes. This investigation searched for a correlation between those intervals and the dimensions of attachment. We hope that working models could be derived to help understand if a greater delay from first symptoms to search of medical care or from there to a definitive diagnosis could be related to behaviours conditioned by attachment styles. Such is a plausible case, since a dismissing patient would be less likely to rely on medical help or trust a physician, therefore delaying search for medical care or impairing description of symptoms – which seems to be a frequent difficulty in FM[29]. A preoccupied patient, on the other hand, would be expected to seek medical care sooner and with greater success. However such patients might, upon an unsatisfactory first consultation – also a seemingly frequent scenario[3] – eventually engage in sabotaging of treatment[21]. Amongst other factors, these considerations are all likely to have some degree of influence over the delays until the actual establishment of a diagnosis and subsequent improvement in quality of life[29, 31], and as such, understanding how attachment relates to those delays could have shed light on subjacent mechanisms.

However, none of the correlations tested reached the significance threshold and only the relationship between anxiety and time from medical care to diagnosis was close to significance (p = 0.053) suggesting that individuals with higher degrees of anxiety may be diagnosed earlier once a physician is consulted.

This study had limitations with obvious consequences, the reduced sample size subsequent to the criteria used for recruitment being one: matching each patient with an healthy sister greatly minimized the influence of confounding factors such as differences in upbringing, socio-economical status or cultural influences, but the size and characteristics of the resulting sample led to constraints with statistical processing as previously mentioned. Other potential limitations should be taken into account. The ERP, despite being a validated and accepted translation of the Experiences in Close Relationships questionnaire[27], seems to have been derived from a slightly modified version of the original[25] which focuses more on romantic relationships instead of overall close relationships. This may have introduced a bias in the interpretation of questions and results in comparison to overall adult attachment as addressed in the original questionnaire. However, we believe that it is globally adequate to the paper's objectives. Also, despite having matched each patient with an healthy sister, it was verified that not all siblings reported seeing the same person as their maternal figure until the age of 7, different relatives being indicated as having that role in 4 sibling pairs, other 4 answering ambiguously. Since the attachment developed during early childhood may strongly influence adult attachment orientations, these differences in maternal figure are probably relevant in the psycho-social domains we address but cannot be gauged with the instruments we used. There may be another source of eventual bias in that, as the ScanFM project was a compound research for several investigators, many questionnaires were administered during a single interview with the subjects. Fatigue could thus influence patients' responses. To minimize this problem, all participants answered the questionnaires in the same order.

Conclusions

The absence of statistically significant correlations in this study suggests that, contrary to what was theoretically expected, adult attachment orientations are not directly related to the impact, age of onset, or delays in diagnosing the disease. The null hypothesis was not proved nor excluded, and the limitations discussed may have been responsible for the absence of significance, despite the advantages of the strong control group constituted by the sibling pairs.

This paper also discussed some considerations that make sense from a theoretical point of view and could benefit from further exploration; the large delays from the first symptoms to a diagnosis of FM are a relevant matter since this period concentrates an important portion of the patient's suffering, and results in significant costs to healthcare, as repeated appointments are frequent and unnecessary exams ordered as diagnosis is sought after. Knowing how to expect patients to manifest their complaints in regard to this matter would help adjusting suspicion towards the disease, possibly reducing costs and offering more well-adjusted care to the needs of patients and family. Knowing how the patients' image of others or self influences their disease would also help further understanding the psychological fundamentals behind fibromyalgia and possibly prove useful in improving the effectiveness of the relation established with the patient and of the psychological or psychotherapy approaches.

All these considerations remain relevant; further investigation with a larger patient basis might be fruitful, and is certainly pertinent.

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Appendix 1: Portuguese version of the Fibromyalgia Impact Questionnaire

FIBROMYALGIA IMPACT QUESTIONNAIRE
(VERSÃO PORTUGUESA) – FIQ-P

INSTRUÇÕES: Nas perguntas 1 a 11 por favor faça um círculo no número que, em relação à **última semana**, melhor descreve a maneira como, **em geral**, foi capaz de executar as tarefas indicadas. Se habitualmente não faz uma dessas tarefas risque essa pergunta.

Foi capaz de:	**Sempre**	**Quase Sempre**	**Quase nunca**	**Nunca**
1. Ir às compras?	0	1	2	3
2. Tratar da roupa na máquina de lavar / secar?	0	1	2	3
3. Cozinhar?	0	1	2	3
4. Lavar louça à mão?	0	1	2	3
5. Aspirar a casa?	0	1	2	3
6. Fazer as camas?	0	1	2	3
7. Andar vários quarteirões (200 a 500 metros)?	0	1	2	3
8. Visitar a família ou os amigos?	0	1	2	3
9. Tratar das plantas ou praticar o seu passatempo?	0	1	2	3
10. Se deslocar, no seu próprio carro ou em transportes públicos?	0	1	2	3
11. Subir as escadas?	0	1	2	3

12. Na última semana, em quantos dias se sentiu bem?

0 1 2 3 4 5 6 7

13. Na última semana, quantos dias faltou ao trabalho e/ou não realizou as tarefas domésticas, devido à fibromialgia?

0 1 2 3 4 5 6 7

INSTRUÇÕES: Nas perguntas que se seguem, assinale um ponto na linha que melhor indica o modo como, **em geral**, se sentiu na **última semana**.

14. Nos dias que trabalhou, quanto é que a sua doença – Fibromialgia - interferiu no seu trabalho?

Trabalhei sem problemas •__|__|__|__|__|__|__|__|__|__• Tive grande dificuldade no trabalho

15. Que intensidade teve a sua dor?

Não tive dor •__|__|__|__|__|__|__|__|__|__• Tive dor muito intensa

16. Que cansaço sentiu?

Não senti cansaço •__|__|__|__|__|__|__|__|__|__• Senti um cansaço enorme

17. Como se sentiu quando se levantava de manhã?

Acordei bem repousada •__|__|__|__|__|__|__|__|__|__• Acordei muito cansada

18. Que rigidez sentiu?

Não tive rigidez •__|__|__|__|__|__|__|__|__|__• Senti muita rigidez

19. Sentiu-se nervosa ou ansiosa?

Não tive ansiedade •__|__|__|__|__|__|__|__|__|__• Senti-me muito ansiosa

20. Sentiu-se triste ou deprimida?

Não me senti deprimida •__|__|__|__|__|__|__|__|__|__• Senti-me muito deprimida

Appendix 2: Portuguese version of the Experience in Close Relationships Scale

Experiências Com Relações Próximas

Instruções: Por favor, leia cada uma das seguintes afirmações e avalie o grau em que cada uma delas descreve os seus sentimentos acerca das relações com os seus parceiros (p. ex., marido, namorado, companheiro, etc). Pense em todas as suas relações, passadas e presentes, e responda em termos de como geralmente se sente nessas relações. Responda a cada afirmação indicando o quanto concorda ou discorda. Assinale com um círculo o número correspondente à sua resposta, utilizando a seguinte escala:

Discordo fortemente			Neutro/ misto			Concordo fortemente
1	2	3	4	5	6	7

1. Prefiro não mostrar ao meu parceiro como me sinto lá no fundo.	1	2	3	4	5	6	7
2. Preocupa-me o ser abandonada.	1	2	3	4	5	6	7
3. Sinto-me muito confortável em estar próxima dos meus parceiros.	1	2	3	4	5	6	7
4. Preocupo-me muito com as minhas relações afectivas.	1	2	3	4	5	6	7
5. Quando o meu parceiro começa a aproximar-se emocionalmente de mim, tendo a afastar-me.	1	2	3	4	5	6	7
6. Preocupa-me que os meus parceiros não se preocupem tanto comigo como eu com eles.	1	2	3	4	5	6	7
7. Sinto-me desconfortável quando um parceiro quer ser muito próximo.	1	2	3	4	5	6	7
8. Preocupo-me bastante com a possibilidade de perder o meu parceiro.	1	2	3	4	5	6	7
9. Não me sinto confortável ao "abrir-me" com os meus parceiros.	1	2	3	4	5	6	7
10. Desejo muitas vezes que os sentimentos do meu parceiro por mim sejam tão fortes como os meus por ele.	1	2	3	4	5	6	7
11. Quero tornar-me próxima do meu parceiro mas estou sempre a afastar-me.	1	2	3	4	5	6	7
12. Quero muitas vezes unir-me completamente aos meus parceiros e isso, por vezes, afasta-os.	1	2	3	4	5	6	7
13. Fico nervosa quando os meus parceiros se tornam demasiado próximos.	1	2	3	4	5	6	7
14. Preocupa-me o estar sozinha.	1	2	3	4	5	6	7
15. Sinto-me confortável ao partilhar os meus pensamentos e sentimentos íntimos com o meu parceiro	1	2	3	4	5	6	7
16. O meu desejo de me tornar muito próxima por vezes, assusta as pessoas.	1	2	3	4	5	6	7
17. Tento evitar tornar-me demasiado próxima do meu parceiro.	1	2	3	4	5	6	7

Discordo fortemente			Neutro/ misto			Concordo fortemente
1	2	3	4	5	6	7

18. Preciso de muitas manifestações de amor para me sentir amada pelo meu parceiro.	1	2	3	4	5	6	7
19. Sinto que é relativamente fácil tornar-me próxima do meu parceiro.	1	2	3	4	5	6	7
20. Às vezes sinto que pressiono os meus parceiros para mostrarem mais sentimento e mais empenho.	1	2	3	4	5	6	7
21. Sinto dificuldade em permitir a mim mesma apoiar-me nos meus parceiros.	1	2	3	4	5	6	7
22. Não me preocupo muitas vezes com o ser abandonada.	1	2	3	4	5	6	7
23. Prefiro não ser muito próxima dos meus parceiros.	1	2	3	4	5	6	7
24. Se não consigo que o meu parceiro mostre interesse por mim, fico perturbada ou zangada.	1	2	3	4	5	6	7
25. Conto praticamente tudo ao meu parceiro.	1	2	3	4	5	6	7
26. Penso que o meu parceiro não se quer tornar tão próximo como eu gostaria.	1	2	3	4	5	6	7
27. Costumo discutir os meus problemas e preocupações com o meu parceiro.	1	2	3	4	5	6	7
28. Quando não estou envolvida numa relação, sinto-me um pouco ansiosa e insegura.	1	2	3	4	5	6	7
29. Sinto-me confortável ao apoiar-me nos meus parceiros.	1	2	3	4	5	6	7
30. Fico frustrada quando o meu parceiro não está comigo tanto tempo como eu gostaria.	1	2	3	4	5	6	7
31. Não me importo de pedir aos meus parceiros conforto, conselhos ou ajuda.	1	2	3	4	5	6	7
32. Fico frustrada se os meus parceiros não estão disponíveis quando eu preciso deles.	1	2	3	4	5	6	7
33. Ajuda-me poder contar com o meu parceiro nas situações de necessidade.	1	2	3	4	5	6	7
34. Quando os meus parceiros me desaprovam, sinto-me muito mal comigo mesma.	1	2	3	4	5	6	7
35. Recorro ao meu parceiro para muitas coisas, incluindo conforto e segurança.	1	2	3	4	5	6	7
36. Fico ressentida quando o meu parceiro passa tempo longe de mim.	1	2	3	4	5	6	7

Appendix 3: Original version of the Experience in Close Relationships Scale

Experience in Close Relationships Scale (ECR)

The following statements concern how you generally feel in close relationships (e.g., with romantic partners, close friends, or family members). Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

1	2	3	4	5	6	7
Disagree Strongly	*Disagree*	*Disagree Slightly*	*Neutral/ Mixed*	*Agree Slightly*	*Agree*	*Agree Strongly*

____ 1. I prefer not to show others how I feel deep down.
____ 2. I worry about being rejected or abandoned.
____ 3. I am very comfortable being close to other people.
____ 4. I worry a lot about my relationships.
____ 5. Just when someone starts to get close to me I find myself pulling away.
____ 6. I worry that others won't care about me as much as I care about them.
____ 7. I get uncomfortable when someone wants to be very close to me.
____ 8. I worry a fair amount about losing my close relationship partners.
____ 9. I don't feel comfortable opening up to others.
____ 10. I often wish that close relationship partners' feelings for me were as strong as my feelings for them.
____ 11. I want to get close to others, but I keep pulling back.
____ 12. I want to get very close to others, and this sometimes scares them away.
____ 13. I am nervous when another person gets too close to me.
____ 14. I worry about being alone.
____ 15. I feel comfortable sharing my private thoughts and feelings with others.
____ 16. My desire to be very close sometimes scares people away.
____ 17. I try to avoid getting too close to others.
____ 18. I need a lot of reassurance that close relationship partners really care about me.
____ 19. I find it relatively easy to get close to others.
____ 20. Sometimes I feel that I try to force others to show more feeling, more commitment to our relationship than they otherwise would.
____ 21. I find it difficult to allow myself to depend on close relationship partners.
____ 22. I do not often worry about being abandoned.
____ 23. I prefer not to be too close to others.
____ 24. If I can't get a relationship partner to show interest in me, I get upset or angry.
____ 25. I tell my close relationship partners just about everything.
____ 26. I find that my partners don't want to get as close as I would like.
____ 27. I usually discuss my problems and concerns with close others.
____ 28. When I don't have close others around, I feel somewhat anxious and insecure.
____ 29. I feel comfortable depending on others.
____ 30. I get frustrated when my close relationship partners are not around as much as I would like.
____ 31. I don't mind asking close others for comfort, advice, or help.
____ 32. I get frustrated if relationship partners are not available when I need them.
____ 33. It helps to turn to close others in times of need.
____ 34. When other people disapprove of me, I feel really bad about myself.
____ 35. I turn to close relationship partners for many things, including comfort and reassurance.
____ 36. I resent it when my relationship partners spend time away from me.