Attachment theory is an established theory of human relationships and among the most influential theories in psychology (Finkel & Simpson, 2015). It was proposed by Bowlby as a theory of human behavior and relationships across the lifespan. According to this, infants develop representations of the self and others in response to their repeated experiences of the availability and responsiveness of their caregivers, which were called “internal working models” of attachment (Bowlby, 1969/82). Internal working models become the bases for consistent ways in which children and adults interact with the world, experience themselves and others, and regulate affect.

Based on her observations of separation and reunion events between children and mothers in laboratory and naturalistic settings, Ainsworth, Blehar, Waters and Wall, (1978) identified and described securely and insecurely attached children, with attachment insecurity being further divided into dismissing (i.e. avoidant) and preoccupied (i.e. anxious). Another category of disorganized attachment related to loss or trauma was later identified by Main and Hesse (1990).

Some years later, Main, Kaplan and Cassidy (1985) described attachment styles in adulthood. Adults rated as secure tend to value attachment relationships, recall favorable attachment-related ex-
periences, lack idealization of parents or of past experiences and openly share and express their feelings; those considered as insecure-avoidant adults usually dismiss attachment relationships as being of little concern, value or influence. They refer to have few memories of the past and these may include idealization, rejection or indifference. Insecure-ambivalent adults often appear as worried with dependency on their own parents and still actively struggle to please them. They express fear of being abandoned and have little autonomy. Their memories of the past often include some kind of rejection or interference from his parents, and usually reflect resentment in relation to past experiences and attachment figures. Finally, those with a disorganized attachment are characterized by being unable to maintain a coherent attachment strategy.

Consistent with attachment theory, the patterns of attachment are relatively stable across time in samples from the general population (as opposed to at-risk samples) (Main & Cassidy, 1988; Waters, 1978). This has been demonstrated both in longitudinal studies of infants assessed with the Strange Situation and followed up in adolescence or young adulthood with the AAI (Hamilton, 2000; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000) and with other measures of attachment in adults (Hazan & Zeifman, 1994).

Furthermore, there is rather robust empirical evidence linking the quality of attachment to mental health problems (Dozier, Stovall-McClough, & Albus, 2008). Clinical groups are characterized by a greater prevalence of insecure attachment patterns than non-clinical samples. Specifically, attachment insecurities (of both the anxious and avoidant varieties) are associated with clinically significant anxiety (Bosmans, Braet, & Van Vlierbergh, 2010), obsessive-compulsive disorder (Doron, Moulding, Kyrios, Nedeljkovic, & Mikulincer, 2009), post-traumatic stress disorder (Ein-Dor, Doron, Solomon, Mikulincer, & Shaver, 2010), suicidal tendencies (Gormley & McNiel, 2010), and eating disorders (Tasca & Balfour, 2014).

In the case of the borderline personality disorder (BPD) insecure attachment has been identified empirically as one such correlate in cross-sectional, retrospective, and prospective studies (Carlson, Egeland, & Sroufe, 2009; Levy, 2005), with the insecure, preoccupied and unresolved attachment status being predominant among adults with BPD (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Levy, 2005). Studies also report that individuals with eating disorders show higher levels of attachment insecurity compared to normal controls (Caglar-Nazali et al., 2014; Kuipers & Bekker, 2012), although a recent review concluded that attachment insecurity may be more related to severity of eating disorder symptoms than to a specific eating disorder diagnosis (Tasca & Balfour, 2014).

Different aspects of attachment theory and of adult relationships have led to development of a variety of assessment methods. The measures are all developed using ideas from attachment theory, and are self-report or interview measures (Levy, 2005). The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) is closely linked with the Bowlby’s tradition in attachment theory, it is the best validated attachment measure for adolescents and adults (Hesse, 2008) and it is considered the “gold standard” attachment measure (Stein, Jacobs, Ferguson, Allen, & Fonagy, 1998). The AAI is a semi-structured interview in which adults are asked to retrieve attachment-related autobiographical memories from early childhood and to evaluate them from their current perspective (Main, Goldwyn, & Hesse, 1998). The coding of the transcripts is not based primarily on reported events in childhood but rather on the thoughtfulness and the coherency with which the adult is able to describe and evaluate these childhood experiences and their effects (Main & Hesse, 1990). The AAI yields three categories that are similar to infant attachment categories: (a) secure/autonomous, (b) avoidant/dismissing, and (c) anxious/preoccupied (the adult version of ambivalent/resistant), and a fourth “unclassifiable” category (George et al., 1985). However, the AAI has some disadvantages, as it has proved to be a complex instrument whose reliable use and rating requires a rigorous extensive training (Hesse, 1999; Van Ijzendoorn, 1995). Furthermore, some authors warn about the subjectivity that may exist in the transcription and coding processes of the AAI, which could imply errors in the attachment categorization of the subjects (Carnelley & Brennan, 2002).

An alternative approach to assessment has been the use of self-report measures of adult attachment styles. Unlike the AAI and some other attachment interviews, all these self-report instruments rely on conscious self-evaluation, are extremely varied, and examine a diversity of contents such as early attachment experience, current representations of attachment, romantic relationships, representations of caregiving etc. (Molina, Casonato, Sala & Testa, 2018). Among the most known and widely used are the forced-choice Adult Attachment Styles self-report (Hazen & Shaver, 1987), the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991), the Relationship Scales Questionnaire (RSQ; Griffin y Bartholomew, 1994) the Experiences in Close Relationships (ECR; Brennan, Clark & Shaver, 1998), the ECR-R (Fraley, Waller, & Brennan, 2000) and the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987). However, some of them show several shortcomings. Scharfe (2016) stated that concerns range from limitations of the original paragraph measure in the forced-choice Adult Attach-
The CaMiR is a self-report questionnaire aimed at measuring attachment cognitions. It is representative of Bowlby's (1969/82) conception of attachment, as its original version was built to evaluate internal working models of attachment, and implies the existence of one's model of self and a model of others in interpersonal relationships (Garrido, Santelices, Pierrehumbert, & Armijo, 2009). It investigates participants' evaluations of past and present experiences (respectively with family of origin and with current attachment figures), their personal interpretations of parents' attitudes during childhood and the impact these had, and their conceptions of family functioning. It was originally created by Pierrehumbert et al. (1996) and consisted of 72 items printed on cards. Its administration takes place in two stages and has a duration of approximately 30 minutes. In the first one, following a Likert scale, participants must sort them into three and then five piles ranging from most characteristic to least characteristic. Subsequently, the Q short procedure is used, in which participants should proceed to a “forced distribution” of their response.

The advantage of the CaMiR over other self-report attachment measures is that it can be administered to participants regardless the structure of their family. For instance, people who grew up with only one parent or in different foster homes are likely to pass the CaMiR (Mijlkovitch, Pierrehumbert, Karmaniola, Bader, & Halfon, 2005) or Camir-R (internal consistency and construct, content, and face validity) in a Spanish sample and other clinical samples, as the authors of that study suggest, running validation processes with adult participants should be advisable. Third, although in the original study a clinical and a maltreated sample of adolescents were included, the diagnosis of those in the clinical sample was not reported, and in any case, it is advisable to replicate the results with other clinical samples, especially with those characterized by having insecure attachment. Finally, some of the factors showed low internal consistency values, which could jeopardize the reliability of the instrument.

To overcome these issues, the present study aimed to:

- a) Analyze the psychometric properties of the CaMiR-R (internal consistency and construct, concurrent and discriminant validity) in a Spanish sample of young adults. It was hypothesized that the seven-factor theoretical model (comprising 5 attachment factors and 2 family functioning factors) would fit to the data. Furthermore, secure attachment style would negatively correlate with the insecure ones, and with both eating disorders and borderline symptoms. Moreover, the insecure attachment styles would positively correlate with both eating disorders and borderline personality symptoms.

- b) Evaluate differences among a healthy female sample, a healthy male sample and an anorexic female sample. Healthy male and female were expected to score higher in the security subscale and lower in the others (insecurity subscales) than anorexic women.

**METHOD**

**Participants and procedures**

The normative sample was composed of 435 university students, 110 (25.29%) men and 322 (74.71%) women with a mean age of 20.33 (SD=2.31) and 19.9 (SD=1.94) respectively. All participants were Caucasian and from middle-class backgrounds. 97.3% had Spanish nationality. Of the participants, 85.2% came from two-parent families, 10.2% had divorced parents, 4.6% came from a family in which one of the parents had died. With regard to parental educational level, 61.6% of the
participants’ fathers and 57.9% of the mothers received education beyond a high school diploma (of which 38.4% and 38.1%, respectively, had obtained a university degree), 21.1% of the participants’ fathers and 25.2% of the mothers had a high school diploma, and 17.3% and 17%, respectively, did not obtain a high school diploma.

The clinical sample comprised 38 female ED inpatients aged 13 to 30 years. The mean age was 21.9 (SD=5.30). All them were receiving psychological treatment in the Basque Public Health System and in different national treatment associations and met the criteria for a full-blown DSM-IV (American Psychiatric Association, 2000) diagnosis of anorexia (AN- restrictive or purgative). All participants were from middle-class backgrounds. 97.7% had Spanish nationality. With regard to family composition; 86.8% came from two-parent families, 10.5% had divorced parents and 2.7% came from a family in which one of the parents had died. Parental educational level was very similar to those of the participants in the normative sample.

Study procedures were approved by the Research Ethics Board of the University of Deusto (Ref: EKT-8/13-14). Participants in the control sample completed the packet of questionnaires during regular classes. The study was presented as a study on health and emotions. The information was neutral and did not disclose anything about the aims of the study. Students were told that they could withdraw from the study at any point during the assessment, and that participation was completely voluntary. They all gave their consent except two participants who refused to do it and consequently did not take part in it.

All participants in the ED sample and their parents in the case of minors under age 18, gave their written informed consent to participate in the study. The study protocol was presented to the Scientific Ethical Committees and the Supervising Boards of the centers in which they were having treatment, neither of whom had further remarks on the subject.

**Instruments**

**Attachment**

The CaMiR-R is a questionnaire aimed at measuring attachment cognitions. It includes 32 items that are evaluated taking into account a Likert scale of 5 points from 1 (strongly disagree) to 5 (strongly agree). As explained before, this distribution is used to calculate 7 dimensions of attachment and family functioning.

(a) Security (7 items) refers to the perception of being and having felt loved by attachment figures, to be able to trust them and to know that they are available when needed (e.g., “As a child, I always knew I could find support from people who were close to me”) (b) Preoccupation (6 items) involves an intense separation anxiety from the loved ones and an excessive preoccupation for attachment figures (e.g. “I’m always afraid of hurting those who are close to me when I leave them”); (c) Parental Interference (4 items) refers to the memory of being over-protected in childhood, to having been a fearful child, and to having been concerned about being abandoned (e.g., “My parents couldn’t help themselves from controlling everything: my appearance, my performance at school or even my friends”); (d) Value of parental authority (3 items) refers to positive assessment of family values of authority and hierarchy (e.g. “In a family, it’s very important for parents to be respected”); (e) Parental Permissiveness (3 items) alludes to memories of lack of limits and parental guidance in childhood (e.g. “As a child, I could do whatever I wanted”); (f) Self-Sufficiency and resentment towards the parents (4 items) involves rejection of feelings of dependence and reciprocity, and anger towards loved ones (e.g., “I only count on myself to solve the problems I have”); and (g) Childhood Trauma (5 items) includes memories of having experienced unavailability, violence, and threats from attachment figures during childhood (e.g., “When I was a child, there were unbearable fights at home”), taking into account past and present attachment experiences and family functioning.

Dimensions 2, 4 and 6 refer to the present, 3, 5 and 7 to the past, and dimension 1 includes items referring to the past and to the present. On the other hand, dimension 1 is associated to secure attachment, 2 and 3 to preoccupied attachment, dimension 6 to avoidant attachment and dimension 7 to disorganized attachment. The other two dimensions (4 and 5) are referred to family structure.

Participants were asked to rate on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) to what extent they agreed with each item. The questionnaire has acceptable psychometric properties (Balluerka et al., 2011). In the original CaMiR, alpha values ranged from .54 to .85.

**Eating disorder symptoms**

Eating disorder symptoms were assessed with the Eating Attitudes Test–26 (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982), a 26-item measure which evaluates attitudes and behaviors associated with anorexia and bulimia nervosa.

The items assess three types of ED symptoms: Dieting, (e.g., “I am terrified about being overweight”), Bulimia and food preoccupation (e.g., “I have gone on eating binges where I feel I may not be able to stop”, and Oral control (e.g., “I avoid eating when I am hungry”). Items are scored on a 6-point Likert-type scale from 1 (never) to 6 (always), higher scores indicating greater eating pathology. The EAT-26 has been found to exhibit strong psychometric properties and correlates highly with eating disorder status and other widely used eating disorder measures (Miller, Schmidt, Vaillancourt, McDougall, &
The Spanish version of the EAT-26 showed good psychometric properties (Castro, Toro, Salmero, & Guimarães, 1993). In the present sample, Cronbach’s alpha for the total score was .84.

**Borderline symptoms**

BPD symptoms were assessed using the “C” scale of the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, 1994). This questionnaire is a 175-item true/false self-report measure that was developed to assess Axis I and II psychopathology as defined in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV; American Psychiatric Association, 2000). The MCMI-III contains 10 clinical scales, 11 basic personality scales, and 3 personality disorder scales. The “C” scale consists of 16 items referring to unstable moods and behaviors, self-destructive behaviors, interpersonal difficulties, feelings of emptiness, and fears of abandonment (e.g., “My moods change a lot from one day to the next” or “I’ve tried to kill myself”). The scale showed excellent psychometric properties, with Cronbach’s alpha of .82 and .93 test-retest reliability in a sample of 964 adults (Millon, 1994). Scores on the “C” sub-scale of the MCMI-III can vary between 0 and 16. Psychometric characteristics of the Spanish version of the MCMI-III are similar to those of the original (Cardenal, Sánchez, & Ortiz-Tallo, 2007). In the present study alpha value was .76.

**Data Analyses**

Data analyses comprised three steps. In the first one, the psychometric properties of the Camir-R were analyzed. More specifically, first, two CFAs were conducted, one on the whole sample (including both the normative and the clinical samples) and another one on the normative sample. In order to verify the stability of the results, the Diagonal Weighted Least Squared (DWLS) method for the estimation of parameters was used, as it is considered the most robust one when ordinal (Likert) items are analyzed. For these analyses, the Lisrel 8.80 software was used. The results of the CFAs were assessed through six goodness of fit indexes: chi square to df ratio, which should be lower than 2 in order to consider a good fit (Brooke, Russell, & Price, 1988). As absolute fit indexes, it was used both the Root Mean Square Error of Approximation (RMSEA) and the Standardized Root Mean Square of Residual (SRMR), which should be lower than .08 (Browne & Cudeck, 1992), and Goodness of Fit Index (GFI), with values above .95 indicating good fit (Hu & Bentler, 1999). Finally, as incremental fit indexes both the Non-Normed Fit Index (NNFI) and the Comparative Fit Index (CFI) were used, with values above .95 indicating a good fit (Hu & Bentler, 1999). Once the structure of the Camir-R was confirmed, the internal consistency (Cronbach’s α), the construct reliability (CR) and the average variance extracted (AVE) of the factors was calculated. Moreover, descriptive statistics of both items and factors were calculated (mean, standard deviation, skewness, factor loading, and item-total correlations).

In the second step, relationships of attachment styles with borderline personality and eating disorder symptoms were analyzed through Pearson’s r. Taking these results into account, two hierarchical regression models were built in order to analyze the multivariate relationship between attachment styles and both borderline personality and eating disorders symptoms. Due to the moderately strong relationship between two of the predictors (Security and Childhood Trauma), this last was introduced in the first step of both regression models, and the other predictors were introduced in the second step.

Finally, in a third step, differences among anorexic women, healthy women and healthy men in the Camir-R factors were analyzed through one-way MANCOVA, introducing age as a covariant. The results were assessed observing the significance and the effect size. This last was interpreted following Cohen’s criteria, according to which values between .01 and .04 are small, between .05 and .14 are medium, and above .14 are large (Cohen, 1988). In the case of significant differences in the MANCOVA test, the Bonferroni Post Hoc test was conducted.

**RESULTS**

First, a CFA with the seven factors was conducted with the whole sample. The results suggested an excellent fit of the model to the data according to all of the goodness of fit indexes: \( \chi^2 / df = 1.59, \ RMSEA = .037 \) (90% C.I.: .032 – .042); \( \text{SRMR} = .071; \ GFI = .96; \ NFI = .98; \ CFI = .98 \). However, whereas six out of the seven factors contained items loading above .37, the three items of the Parental Permissiveness factor loaded close to 0 (\( q < .01 \)). Then, a second CFA was conducted after eliminating this factor. The results showed also an excellent fit to the data, \( \chi^2 / df = 1.62, \ RMSEA = .038 \) (90% C.I.: .033 – .044); \( \text{SRMR} = .072; \ GFI = .96; \ NFI = .98; \ CFI = .98 \). Afterwards, the model was replied only with the normative sub-sample, in order to verify its stability. The results confirmed the stability of the model, \( \chi^2 / df = 1.57, \ RMSEA = .038 \) (90% C.I.: .032 – .044); \( \text{SRMR} = .071; \ GFI = .96; \ NFI = .98; \ CFI = .98 \). Then, the Cronbach’s α, the CR, the AVE, and descriptive statistics of all items and factors were calculated for the whole sample. These results are detailed in Table 1. As it can be observed, all the factors showed good values for internal consistency; these values were particularly better in the case of CR, which represents a more acute parameter than the traditional Cronbach’s α, as it does not depend on the number of items of a subscale (Fornell & Larcker, 1981).

Regarding the items, factor loadings ranged bet-
ween .37 (item 18) and .97 (item 27), suggesting that each item had a significant contribution to the validity of its factor. Furthermore, correlation item-total ranged between .23 (item 27) and .73 (item 3), suggesting that every item contributed significantly to the internal consistency of its factor. On the other hand, both Security and Value of parental authority factors showed a negative skewness, which suggests that the majority of the participants scored high on them. Preoccupation and Self Sufficiency and resentment towards the parents had skewness values close to 0, while Parental Interference and Childhood Trauma had a positive skewness, showing that most of the people had low scores on them.

Second, relationships among the Camir-R’s factors, borderline traits and eating disorder symptoms were assessed. The results are showed in Table 2. Almost all the correlations were significant except for the Value of parental authority subscale, which was relatively independent from the other variables. As expected, Secure attachment negatively correlated with the other measures (insecure attachment styles, eating disorder and borderline symptoms), while the other variables were positively related to each other. In general terms, attachment insecurity subscales were related to eating disorders symptoms and even more significantly to borderline traits.

In the next step, the multivariate relationship of the attachment subscales with both eating disorder symptoms and borderline personality traits was analysed. The Value of parental authority subscale was not introduced in the models, as it did not correlate significantly with any of the two variables. The results of the multiple regressions for both models are represented in Table 3. As it can be observed, the attachment styles predicted more strongly borderline personality traits than eating disorder symptoms, although in both cases all the attachment subscales predicted significantly to borderline traits.

Finally, differences among anorexic women, healthy women and healthy men were assessed through a MANCOVA, controlling for the effect of age. In this case, a multivariate, significant and medium effect size was observed, F(14, 826) = 7.61, p < .001, η² = .11. Age showed also a significant effect, with a medium effect size, F(7, 412) = 3.60, p = .001, η² = .06. Then, univariate differences in each factor were analysed. The results are showed in Table 4. As it can be observed, there were significant differences among all the subscales except for the Value of parental authority, and effect sizes ranging from small (Value of parental authority, Preoccupation and Childhood Trauma) to medium (Security, Parental Interference and Self-sufficiency and resentment towards the others). In all the cases the tendency was the same: anorexic women scored in a significantly different way than healthy women and healthy men. In the case of Security, anorexic women scored lower than the other groups, while in the rest of the variables this group scored higher.

**DISCUSSION**

The aim of this study was to provide evidence confirming the validity and factor structure of the CaMir-R in a Spanish adult population. Furthermore, differences among healthy women, healthy men and anorexic women were analysed.

The CFA provided evidence for a 6-factor model including five dimensions of attachment (Security, Preoccupation, Parental Interference, Self-Sufficiency and resentment towards the parents and Traumatism) and one dimension of family functioning (Value of parental authority). The Parental Permisiveness subscale was discarded, as the factor loadings of its three items were extremely low. Weak psychometric properties of this subscale have also been reported in other studies. In fact, low alpha coefficients of the Parental Permisiveness subscale were found both in the CaMir-R original validation (Balluerka et al., 2011) and in the Chilean (Garrido, Santelices, Pierrehumbert, & Armijo, 2009) and the Italian (Molina, Casonato, Sala, & Testa, 2018) validations of the long versions of the questionnaire, even if the number of items was larger than in the reduced one.

As mentioned in other studies (Balluerka et al., 2011), the first five dimensions are related to the core features of general attachment styles (secure, preoccupied and avoidant). Except for Self-Sufficiency, all the subscales showed an acceptable internal consistency, as measured through both Cronbach’s alpha and construct reliability. The construct reliability index of Self-Sufficiency was also slightly below the critical cutoff of .70. However, this subscale was maintained in terms of its theoretical relevance, especially due to the fact that it is the only one that specifically defines items theoretically connected to the avoidant attachment style. In fact, the avoidant attachment style was identified by Ainsworth et al. (1978) as one of the main ones, including 21% of the population and it remains as an important pattern in most of the existing attachment measures (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010; Stein et al., 1998). Nevertheless, research should be conducted to determine if the number of items should be increased or modified in order to better represent this attachment style.

The final result showed that 29 items out of the 32 in the validation study of Balluerka et al. (2011), to our knowledge the only that has provided evidence about these psychometric characteristics, reached the minimal acceptable threshold for factor loading, and the model fit was excellent.

Moreover, all the Camir-R’s attachment factors
were related in the expected direction to eating disorder symptoms and borderline traits, which supports the concurrent validity of the questionnaire. Specifically, the Security subscale correlated negatively with both them, and all the other insecurity subscales (Preoccupation, Parental Interference, Self-Sufficiency and resentment towards the parents and Childhood Trauma) did it positively. Correlations were stronger for borderline symptoms. These results are consistent with the existing robust empirical evidence that connects insecure attachment with eating disorders (Caglar-Nazali et al., 2014; Kuipers & Bekker, 2012) and particularly with BPD in all the types of studies runned over the last decades (Carlson et al., 2009; Fonagy et al., 1996; Levy, 2005). Past studies using the CaMIR-R have also reported consistent evidence for a correlation between its’ subscales and psychological symptomatology both in adolescents (Balluerka et al., 2011) and adults (Garrido et al., 2009; Lacasa, 2008).

The case of Value of parental authority should be carefully taken into consideration. In our study, low alpha coefficients were found for this subscale; furthermore, and unlike in the case of all the attachment factors, correlations with eating disorder symptoms and borderline traits were not encountered. The low internal consistency of this subscale has also been reported in other validation studies (Garrido et al., 2009; Molina et al., 2018). The relative independence between this subscale and the evaluated symptoms could be explained due to the fact that although being part of the original CaMIR-R, Value of parental authority does not assess attachment ‘per se’, but refers to family structure and/or functioning. Some authors have stated that despite attachment and family functioning may be related to each other, they are not exactly the same constructs (Crowell & Treboux, 1995; Martínez & Santelices, 2005; Stein et al., 1998). The lack of clear evidence about the relationship between family functioning and these symptoms has been previously reported. For example, in a recent review, Holtom-Viesel and Allan (2014) found mixed evidence regarding family functioning and eating disorders, and although ED families perceived themselves to be more dysfunctional than control families, the areas of dysfunction varied from one study to the other (in some of them no differences were found), and there was not a consistent pattern of family dysfunction for ED families as a whole, or for different types of eating disorder. Therefore, and unlike in the case of attachment, there does not seem to be such a broad consensus about the relationship between family structure and functioning and psychopathology. Consequently, the use of this subscale should be done cautiously and according to research objectives.

Furthermore, in our validation study, two regression models were used to isolate the predictors which have significant influence on eating disorder and borderline personality symptoms. Results showed that all the attachment subscales (except for Childhood Trauma) remained as significant predictors of the dependent variables and accounted for a moderate amount of the total variance. This supports the discriminant validity of the factors except for Childhood Trauma, as all of them remained as significant predictors of both eating disorders and more importantly for borderline symptoms. This loss of significance for Childhood Trauma may be explained because disorganized attachment has proved to be not that frequent in anorexic and BPD patients as the other insecure attachment patterns are. In fact, a well-known review that investigated the links between attachment theory and BPD including interview measures, rating scales, case studies and self-report instruments, revealed that most of the studies generally found that BPD traits were significantly associated with fearful avoidant and preoccupied attachment (Levy, 2005) but not to disorganized. In line with this, prevalence rates among the general population in the US show that only the 4.5% of people are included as “unclassified”, a category that collects all the cases not classified in the other types of attachment (secure, avoidant and anxious), and that is frequently matched with the disorganized one (Mickelson, Kessler, & Shaver, 1997). Furthermore, this loss of significance may also be due to a problem of multicollinearity, given the strong relationship existing between secure attachment and disorganized attachment.

As far as differences among groups are concerned, analysis reported that anorexic women scored significantly different than the other two groups in all of the variables, with low to medium effect sizes, and controlling the effect of the age. As expected, and according to other studies (Kuipers & Bekker, 2012) their scores were lower in secure attachment and higher in the other attachment styles. All this reinforces the assumption that attachment issues are implicated in eating disorders and the relevance of evaluating the particular attachment styles in these patients.

Having detailed the strengths of the methodology of this study, some limitations of relevance must now be noted. First, the proportion of women in our test population was much higher than that of men, raising the possibility of gender bias. Furthermore, the clinical sub-sample (anorexic women) was small, so the conclusions regarding this profile should be verified in future studies. However, this sample size was large enough to attain significant effects in the comparison among the three sub-samples. Moreover, the normative sample has a high level of educational attainment, which is not representative of Spanish reality. Future studies should include a more varied strata of the population and other clinical groups.

Second, this is a self-report measure of attach-
ment. These measures probe conscious attitudes towards relationships; therefore, they cannot detect when defenses distort responses. Using them combined with interviews or projective test should be advisable, in order to reduce response bias and to increase attachment activation (Ravitz et al., 2010).

Despite these limitations, this study confirms that the CaMIR-R test, in its revised, adult version, is a valid and reliable measure that permits a relatively short and inexpensive way of administration in large samples of adults.

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| Item / Factor                                                                 | M    | SD   | Sk    | F.L. | E.E. | C.I.T. |
|------------------------------------------------------------------------------|------|------|-------|------|------|--------|
| Seguridad \( (\alpha = .87, \text{CR} = .91, \text{AVE} = .60) \)           | 30.72| 4.45 | -1.96 | -    | -    | -      |
| 1. Cuando yo era niño(a), mis seres queridos me hacían sentir que les gustaba compartir su tiempo conmigo | 4.65 | 0.74 | -2.82 | .65  | .57  | .52    |
| 2. Cuando yo era niño(a) sabía que siempre encontraría el consuelo de mis seres queridos | 4.41 | 0.88 | -1.72 | .83  | .31  | .72    |
| 3. En caso de necesidad, estoy seguro(a) de que puedo contar con mis seres queridos para encontrar consuelo | 4.49 | 0.79 | -1.97 | .87  | .24  | .73    |
| 4. Cuando yo era niño(a) encontré suficiente cariño en mis seres queridos como para no buscarlo en otra parte | 4.38 | 0.87 | -1.78 | .82  | .34  | .70    |
| 5. Mis seres queridos siempre me han dado lo mejor de sí mismos | 4.20 | 0.92 | -1.32 | .72  | .48  | .63    |
| 6. Las relaciones con mis seres queridos durante mi niñez me parecieron, en general, positivas | 4.37 | 0.80 | -1.55 | .74  | .45  | .61    |
| 7. Siento confianza en mis seres queridos | 4.23 | 0.86 | -1.47 | .77  | .41  | .63    |
| Preocupación familiar \( (\alpha = .73, \text{CR} = .76, \text{AVE} = .35) \) | 18.44| 4.47 | -0.13 | -    | -    | -      |
| 8. No puedo concentrarme sobre otra cosa sabiendo que alguno de mis seres queridos tiene problemas | 3.80 | 0.98 | -0.70 | .48  | .77  | .39    |
| 9. Siempre estoy preocupado(a) por la pena que puedo dejar en mis seres queridos al dejarlos ir | 3.01 | 1.13 | 0.06  | .62  | .62  | .46    |
| 10. A menudo me siento preocupado(a), sin razón por la salud de mis seres queridos | 3.23 | 1.20 | -0.17 | .52  | .73  | .43    |
| 11. Tengo la sensación de que nunca superaría la muerte de uno de mis seres queridos | 2.48 | 1.00 | 0.45  | .60  | .64  | .46    |
| 12. La idea de una separación momentánea de uno de mis seres queridos me deja una sensación de inquietud | 2.99 | 1.26 | -0.05 | .53  | .72  | .45    |
| 13. Cuando me alejo de mis seres queridos no me siento bien conmigo mismo(a) | 2.92 | 1.26 | 0.01  | .77  | .40  | .58    |
| Interferencia de los padres \( (\alpha = .67, \text{CR} = .72, \text{AVE} = .42) \) | 9.18 | 3.19 | 1.34  | -    | -    | -      |
| 14. Cuando yo era niño(a) se preocuparon tanto por mi salud y mi seguridad que me sentía apri sionado(a) | 2.84 | 1.07 | 0.10  | .41  | .84  | .32    |
| 15. Mis padres no podían evitar controlarlo todo: mi apariencia, mis resultados escolares e incluso mis amigos | 2.32 | 1.14 | 0.71  | .79  | .38  | .53    |
| 16. Mis padres no se han dado cuenta de que un niño(a) cuando crece tiene necesidad de tener vida propia | 1.97 | 1.38 | 0.89  | .62  | .62  | .47    |
| 17. Desearía que mis hijos fuesen más autónomos de lo que yo he sido | 2.04 | 1.05 | 1.02  | .71  | .49  | .51    |
| Autosuficiencia y rencor contra los padres \( (\alpha = .56, \text{CR} = .61, \text{AVE} = .29) \) | 10.95| 2.84 | 0.42  | -    | -    | -      |
| 18. Detesto el sentimiento de depender de los demás | 3.71 | 0.99 | -0.51 | .37  | .86  | .29    |
| 19. De adolescente nadie de mi entorno entendía del todo mis preocupaciones | 2.34 | 1.04 | 0.54  | .47  | .78  | .36    |
| 20. Sólo cuento conmigo mismo(a) para resolver mis problemas | 2.76 | 1.13 | 0.38  | .72  | .49  | .41    |
| 21. A partir de mi experiencia de niño(a), he comprendido que nunca somos suficientemente buenos para los padres | 2.17 | 1.18 | 0.82  | .53  | .72  | .32    |
| Traumatismo infantil \( (\alpha = .80, \text{CR} = .87, \text{AVE} = .58) \) | 9.07 | 3.94 | 1.52  | -    | -    | -      |
| 22. Las amenazas de separación, de traslado a otro lugar, o de ruptura de lazos familiares son parte de mis recuerdos infantiles | 1.70 | 1.21 | 1.58  | .68  | .54  | .52    |
| 23. Cuando era niño(a) había peleas insoportables en casa | 2.05 | 1.00 | 0.94  | .76  | .42  | .59    |
| 24. Cuando yo era niño(a) tuve que enfrentarme a la violencia de uno de mis seres queridos | 2.08 | 0.93 | 0.90  | .72  | .49  | .50    |
| 25. Cuando yo era niño(a) a menudo mis seres queridos se mostraban impacientes e irritables | 1.37 | 0.95 | 2.65  | .84  | .30  | .59    |
| 26. Cuando yo era niño(a) teníamos mucha dificultad para tomar decisiones en familia | 1.85 | 1.18 | 1.33  | .80  | .36  | .71    |
| Valor de la Autoridad de los Padres \( (\alpha = .54, \text{CR} = .67, \text{AVE} = .44) \) | 12.74| 1.55 | -0.61 | -    | -    | -      |
| 27. En la vida de familia, el respeto de los padres es muy importante | 4.60 | 0.62 | -1.90 | .97  | .07  | .23    |
| 28. Los niños deben sentir que existe una autoridad respetada dentro de la familia | 4.14 | 0.78 | -0.86 | .42  | .82  | .40    |
| 29. Es importante que el niño aprenda a obedecer | 4.02 | 0.74 | -0.42 | .47  | .78  | .44    |

*M: Mean; SD: Standard Deviation; Sk: Skewness; F.L.: Factor Loading; E.E.: Error of Estimation; C.I.T.: Correlation Item-Total.*
|       | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. Security | -     |       |       |       |       |       |       |       |       |       |
| 2. Preoccupation | .14*  | -     |       |       |       |       |       |       |       |       |
| 3. Parental Interf. | -.32** | .21** | -     |       |       |       |       |       |       |       |
| 4. Self-Sufficiency | -.50** | .08   | .41** | -     |       |       |       |       |       |       |
| 5. Childhood Tr. | -.67** | .03   | .36** | .46** | -     |       |       |       |       |       |
| 6. Value of par. auth. | .24** | .07   | -.07  | -.07  | -.13* | -     |       |       |       |       |
| 7. Dieting | -.26** | .15** | .28** | .26** | .22** | .06   | -     |       |       |       |
| 8. Bulimia | -.23** | .15** | .27** | .25** | .23** | .03   | .75** | -     |       |       |
| 9. Oral Control | -.16** | .21** | .22** | .18** | .13*  | .12*  | .59** | .55** | -     |       |
| 10. EAT Total | -.24** | .18** | .29** | .25** | .22** | .08   | .94** | .84** | .76** | -     |
| 11. BPD | -.33** | .35** | .41** | .42** | .33** | -.04  | .51** | .49** | .37** | .54** |

Note: BPD: Borderline symptoms
*p < .05, **p < .001.
Table 3. Regression models predicting eating disorder symptoms and borderline personality traits (n = 473)

| Predictor               | Eating Disorders (R² = .14) | Borderline (R² = .35) |
|-------------------------|-----------------------------|-----------------------|
|                         | B   | SEB  | b   | DR² | B    | SEB  | b   | DR² |
| Step 1                  |     |      |     |     |      |      |     |     |
| Childhood Tr.           | 0.59| 0.13 | .21**|     | 0.25| 0.04 | .31***|     |
| Step 2                  |     |      |     | .14***|      |      |     | .35***|
| Childhood Tr.           | -0.04| 0.18| -.01| 0.01| 0.04| 0.01|     |     |
| Security                | -0.42| 0.16| -.16*| 0.13| 0.04| -0.19**|      |     |
| Preoccupation           | 0.45| 0.12| .18***| 0.24| 0.03| .34***|      |     |
| Par. Interf.            | 0.54| 0.18| .16**| 0.16| 0.04| .16***|      |     |
| Self-Sufficiency        | 0.43| 0.22| .11*| 0.25| 0.05| .23***|      |     |

Note. Par. Interf.: Parental Interference; Self-Sufficiency: Self Sufficiency and resentment toward the others; Childhood Tr.: Childhood Trauma. *p < .05, ** p < .01, ***p < .001.

Table 4. Univariate differences by gender / clinical group in each way of the attachment styles

| Group               | Anorexic Women (n = 38) | Healthy Women (n = 323) | Healthy Men (n = 112) | F   | h²   |
|---------------------|-------------------------|-------------------------|-----------------------|-----|-----|
|                     | M  | SD | M  | SD | M  | SD | M  | SD |     |     |
| 1.Security           | 3.76bc | 0.97 | 4.43a | 0.56 | 4.44a | 0.59 | 21.86** | .09 |
| 2.Preoccupation      | 3.40bc | 0.80 | 3.08a | 0.73 | 2.94a | 0.74 | 5.55* | .02 |
| 3.Parental Interf.   | 2.97bc | 0.88 | 2.21a | 0.77 | 2.33a | 0.76 | 16.55** | .07 |
| 4.Self-Sufficiency    | 3.36bc | 0.68 | 2.64a | 0.69 | 2.78a | 0.65 | 19.52** | .08 |
| 5.Childhood Trauma   | 1.85bc | 0.80 | 1.41a | 0.57 | 1.38a | 0.53 | 10.33** | .04 |
| 6.Value of parental authority | 13.06 | 1.50 | 12.68 | 1.48 | 12.91 | 1.75 | 2.48  | .01 |

Note. Differences by gender / clinical group, being Anorexic Women (a), Healthy Women (b), and Healthy Men (c), according to the Bonferroni Post Hoc test. Self-Sufficiency: Self Sufficiency and resentment toward the others; Par. Interf.: Parental Interference. *p < .01, **p < .001.