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Caregiver Skills in ED in Catalonia

Validation of the Caregiver Skills (CASK) scale in Catalonia:

Concordance between Caregivers in Attitudes and Behaviors

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Conflict of interest

None

Abstract

Objective: The aim of this study was to validate a Spanish version of The Caregiver Skills Scale (CASK) in a sample of eating disorder (ED) caregivers. A further aim was to examine the concordance/discrepancy between them (namely, between the mothers and fathers of ED patients).

Method: 265 ED caregivers were recruited from ED centers in Catalonia, Spain. Confirmatory factor analyses (CFA) was used to test the factorial structure of the CASK scale. Cronbach's alpha was used to measure internal consistency of the CASK scales. A comparison of the CASK measures between respondents (mothers and fathers) was conducted using Generalized Estimating Equations (GEE).

Results: Confirmatory Factor Analysis of the Spanish version of the CASK corroborated the strong factorial validity of the six factors of the original CASK questionnaire. Mothers and fathers did not differ significantly on CASK overall and subscale scores. There was however less concordance between parents on the bigger picture ($ICC=0.28$) and biting your tongue ($ICC=0.08$) subscales.

Conclusions: The CASK is a valid tool to assess ED-related attitudes in Spanish-speaking caregivers. Furthermore, caregivers and patients alike could stand to benefit from interventions focused on improving areas such as ED beliefs, effective communication, quality of life and emotional distancing.

Highlights:

1) Caregiver distress is understood to complicate response to treatment in patients with eating disorders.

2) 265 caregivers were recruited to validate the Spanish version of The Caregiver Skills Scale (CASK).

3) The factor validity of the CASK was confirmed and differences in concordance between caregivers were found.

Keywords: Eating disorders, caregiver; confirmatory factor analysis; family; validation

1. Introduction

Eating disorders (ED) frequently affect adolescents and young adults (Smink, van Hoeken, & Hoek, 2012). The onset of EDs usually coincides with adolescence and early adulthood although they can also appear both in earlier and later stages of life (Bueno et al., 2014). Due to the complexity of these diseases and the age range in which they appear, there are profound family and social disturbances (Striegel Weissman & Rosselli, 2017). These have an intense effect on family members (Martin et al., 2015; Rhind et al., 2016) many of whom develop anxiety and depression (Schwarte et al., 2017; Sepúlveda et al., 2012). This negative impact is not limited to adolescence but persists into adulthood (Ametller, Castro, Serrano, Martínez, & Toro, 2005; Munsch et al., 2017; Soler et al., 2013). The following factors contribute to stress in the caregiving role: lack of knowledge about the illness, carers' fear and guilt and difficulties in managing emotions, and the discrepancy between the families member in terms of motivation to change and seek treatment (Munsch et al., 2017; Treasure & Schmidt, 2013).

In order to address these unmet needs, interventions have been developed to develop skills that facilitate the management of the disorder. One meta-analysis showed that skill training

interventions and psychoeducation can significantly reduce the burden and distress of caregivers (Hibbs, Magill, et al., 2015; Quiles Marcos, Quiles Sebastián, Pamies Aubalat, Botella Ausina, & Treasure, 2013) and also increase patient satisfaction and adherence to treatment (Gisladottir, Treasure, & Svavarsdottir, 2017; Magill et al., 2016; Salerno et al., 2016).

The notable lack of systematized studies in this field, as well as the heterogeneity of the methodologies used, accentuate the need to have psychometric tools, validated in local languages, that allow clinicians and researchers to be informed regarding the opinions and needs of family members. A variety of instruments have been used to examine different features of ED caregivers. The caregiver assessment tools applied specifically in patients with EDs include: the Eating Disorders Symptom Impact Scale (EDSIS) (Sepulveda, Whitney, Hankins, & Treasure, 2008), which assesses the impact of ED symptoms on family members in relation to four factors (nutrition, guilt, dysregulated behavior and social isolation); the Accommodation and Enabling Scale for Eating Disorders (AESED) (Sepulveda, Kyriacou, & Treasure, 2009), which measures family accommodation in the context of having a relative with an ED, covering five different factors (avoidance and modifying routine, reassurance seeking, meal ritual, control of family and turning a blind eye); and the Motivational Interview Scenarios Tool for Eating Disorders (MIST-ED) (Sepulveda, Wise, Zabala, Todd, & Treasure, 2013), which evaluates the motivational interviewing skills of caregivers.

1.1. Aims

The aim of the present study was to validate the Caregivers Ability Skills Questionnaire (CASK) in a Spanish-speaking sample of family members of patients with EDs in Catalonia, Spain. Confirmatory factor analysis was used to test the factorial structure of the Spanish CASK in comparison to the original English version and Cronbach's alpha measured internal consistency of

the CASK subscales. We also sought to examine ED-related attitudes in caregivers and to test the concordance/discrepancy between them (namely, mothers and fathers).

2. Methods

2.1. Sample

Our study sample comprised caregivers of 265 ED patients recruited from thirteen different centers within the Generalitat de Catalonia's *Taula de Diàleg per la prevenció dels Trastorns de la conducta alimentària* (Catalan Eating Disorder Prevention Taskforce), representative of the public and private sectors of the ED community in Catalonia. Participants were involved in ED support groups and were asked by therapists from each center if they would voluntarily be willing to complete the study questionnaires.

Information was obtained from the caregivers of a total of $n=204$ ED patients (193 women and 11 men). The mean age of the ED patients was 19.1 years-old ($SD=5.6$). The distribution of the ED subtype (according to DSM-5 criteria; APA, 2013) was: 112 cases met criteria for anorexia nervosa, 18 for bulimia nervosa, 8 for binge eating disorder and 66 were diagnosed with an Other Specified Feeding or Eating Disorder (OSFED). The mean age of ED onset was 15.6 years-old ($SD=4.4$) and the mean duration of the ED was 3.5 years ($SD=3.7$).

The total number of caregivers that completed the CASK was $n=265$. The number of mothers in the study sample was $n=168$ (63.4%), with a mean age of 50.1 years-old ($SD=5.4$) and the distribution of the civil status as follows: 139 (82.7%) married or with a partner, 25 (14.9%) divorced or separated, 3 (1.8%) widowed and 1 (0.6%) single. The total number of fathers reporting data in the study was $n=97$. The mean age for the fathers was 52.7 years-old ($SD=6.0$). Most fathers were married or living with a partner ($n=84$, 86.6%), while only 12 (12.4%) indicated being separated or divorced and 1 was widowed (1%).

2.2. Measures

2.2.1. *The Caregiver Skills scale (CASK)* (Hibbs, et al., 2015)

This scale measures caregiver skills that can be useful to help patients with EDs. The factorial analyses performed for the original scale produced a good fit for a solution based on six-first-order subscales: bigger picture (include 7 items related to concerns about the capacity to be positive with potential changes), self-care (4 items valuing the capacity to take time for oneself and other family members), biting-your-tongue (3 items asking about the ability to control the urge to enquire/avoid troublesome conversations), insight and acceptance (3 items about the faculty to manage negative emotions), emotional intelligence (5 items related to the capacity to manage feelings) and frustration tolerance (5 items associated to the competence to be firm and calm with the individual with an ED).

Each item in the CASK questionnaire is scored on a visual analog scale, anchored from 0 to 100. The raw scores for each of the six CASK first-order factors were obtained as the mean score of the items included in each subscale.

The CASK was translated into Spanish in accordance with the International Test Commission Guidelines for Translating and Adapting Tests (ITC, 2010). Two bilingual clinical psychologists with extensive experience in the field translated the original English version into Spanish. This translated Spanish version of the CASK was then back-translated and any differences between the original and back-translated versions were discussed and resolved by consensus. The Spanish CASK was reviewed by two other Spanish-speaking clinical psychologists, who had not been involved in the back-translation procedure. Spanish and Catalan versions of the CASK are available in the Supplementary Information.

2.2.2. *Additional information*

Socio-demographic/clinical information, including age, affiliation to the patient with an ED, and marital status, was obtained along with the CASK questionnaire.

2.3. Procedure

The collection of the questionnaires used in this study was approved by the research ethics committee (Ref. HUB-PR176/17). The study procedures were carried out in accordance with the Declaration of Helsinki. All subjects were informed about the study and all provided informed consent.

2.4. Statistical analyses

Confirmatory Factor Analysis (CFA) was performed with Mplus8 for Windows to assess the robustness of the six-factor model obtained in the original development and validation study of the CASK (Hibbs, Rhind, et al., 2015). Maximum Likelihood (ML) estimator was used for the CFA, and the overall goodness-of-fit was evaluated using standard statistical measures (Barrett, 2007): the root mean square error of approximation (RMSEA), Bentler's Comparative Fit Index (CFI), the Tucker-Lewis Index (TLI), and the standardized root mean square residual (SRMR). Adequate model fit was based on the following parameters: $RMSEA < 0.10$, $TLI > 0.9$, $CFI > 0.9$ and $SRMR < 0.1$. Chi-square tests (χ^2) were also obtained for the CFA, although this test should be interpreted with caution due to its sensitivity to sample size (Barrett, 2007). The internal consistency between items within each defined factor was determined by Cronbach's alpha coefficient. The concordance between informants/caregivers for the six sub-domains of the CASK scale was estimated through intraclass correlations.

Other statistical procedures were carried out using Stata15 for Windows. The agreement between respondents was estimated with intraclass correlation coefficient (*ICC*), and the following

concordance levels were used: low $/ICC/ < 0.40$, moderate-fair $0.40 < /ICC/ < 0.60$, high-good $0.60 < /ICC/ < 0.75$ and excellent $/ICC/ > 0.75$ (McGraw & Wong, 1996).

Comparison for the CASK measures between respondents (father and mother) was based on Generalized Estimating Equations (GEE). The selection of these procedures is based on the data structure in the study. Since this research refers to nested structure data (for each ED patient, different caregivers responded to the questionnaires), and because a low level of hierarchy was obtained (for $n=36$ ED cases only a father's report was available, for $n=107$ ED cases only a mother's report was obtained, and for $n=61$ ED cases both father's and mother's responses were obtained; the mean number of caregivers per family was 1.30), multi-level models were not adequate because they did not allow for satisfactory adjustment (Hox, 2002). To account for data dependency at the lower data level, the random factor "caregiver" was included in multiple mixed models through Generalized Estimating Equations (GEE). The consideration of the "caregiver" as a random intra-factor prevent estimation bias allows for generalization of the results to all the caregivers of the larger population of ED caregivers. The GEE models were run defining the Normal distribution and the Identity link-function.

3. Results

3.1. Confirmatory Factor Analysis for the Spanish adaptation of the CASK

Good fitting was obtained in the CFA run for the Spanish CASK, confirming the structure in six first-order factors: RMSEA=0.068 (95%CI: 0.060 to 0.073), CFI=0.936, TLI=0.914, SRMR=0.067 and $\chi^2 = 667.3$ ($df=309$, $p=0.001$). Internal consistency ranged was in the moderate range (between $\alpha=0.703$ for the factor F4 *insight and acceptance* to $\alpha=0.759$ for the factor F6 *frustration-tolerance*). Table S1 (supplementary material) contains the complete results for the CFA (all

standardized coefficients obtained significance and were higher than 0.30), the frequency distribution of the raw scores for each item and for the dimension scores in the sample and the correlation matrix between the factor scores.

3.2. Comparison and concordance of the CASK dimension scores between fathers and mothers

Table 1 includes the distribution of the CASK scores for the fathers and mothers in the sample, as well as the results obtained in the GEE adjusted for the ED patients' sex and age. No differences between respondents emerged, suggesting that caregiver's skills are similar.

-Insert Table 1 here-

Regarding the concordance between the fathers and the mothers measures: a) low agreement was obtained for the dimensions *bigger picture* ($ICC=0.28$) and *biting your tongue* ($ICC=0.08$); b) fair-moderate concordance for the dimensions *insight-acceptance* ($ICC=0.42$), *emotional intelligence* ($ICC=0.55$), and *frustration* ($ICC=0.47$); and c) high-good concordance was achieved for the dimension *self-care* ($ICC=0.60$).

4. Discussion

In this study, we aimed to assess ED-related attitudes in caregivers and to examine the concordance or discrepancy between them. Moreover, we sought to validate the Spanish version of the Caregivers Ability Skills Questionnaire (CASK) in a sample of ED patient caregivers.

While the original validation the sample consisted of family members of patients diagnosed with AN (Hibbs, Rhind, et al., 2015), in the present study, we included the parents of patients with any type of ED (i.e., AN, BN, BED and OSFED). However, it should be noted that more than half of our study sample corresponded to parents of patients with AN. Also, as in the sample in Hibbs et al.

(2015), the percentage of mothers who were the primary caregiver was notably higher than that of fathers. Previous studies on caregivers and ED patients have reported a larger number of mothers take on this role compared to fathers (Coomber & King, 2012; Graap et al., 2008; Jauregui-Lobera, Ruiz-Prieto, Bolanos-Rios, & Garrido-Casals, 2013; Macdonald et al., 2014; Martín et al., 2013). These results are in line with the current literature highlighting the predominance of female caregivers across mental disorders (Graap et al., 2008; Roick, Heider, Toumi, & Angermeyer, 2006; Souza et al., 2017; Stadnick, Chlebowski, & Brookman-Frazee, 2017).

CFA of the Spanish version of the CASK confirmed the strong factorial validity of the six factors of the original CASK questionnaire: *Bigger Picture*, *Self-Care*, *Biting-Your-Tongue*, *Insight and Acceptance*, *Emotional Intelligence*, and *Frustration Tolerance*. Additionally, the internal consistency of the six factors ranged from moderate to excellent.

In the present study, high levels of these six analyzed factors have been obtained. Likewise, compared to the original validation (Hibbs, Rhind, et al., 2015), the levels in all of these sub-scales are higher. These differences in skills in the management of the disorder could be due, among other factors, to the fact that the relatives included in the present study were involved in ED support groups. Being involved in a specific therapeutic intervention could lead to, therefore, an improvement in the strategies used for dealing with the disorder. Both, a group setting and the facilitation of professional support and a better understanding of the peculiarities of the disorder can contribute to a greater ED coping.

Interestingly, in general terms no significant differences were found when comparing CASK mean scores between parents in the study sample. Nevertheless, our results regarding the subsample comprised of both mothers and fathers of the same patient show noteworthy discrepancies in two subscales: *bigger picture* and *biting your tongue*. These findings suggest that mothers and fathers

often differ in their outlook on being able to keep a life span perspective rather a focus on detail or their proneness to “nag” about irritations. We may hypothesize that mothers, being more involved in the illness and therapy process, might tend to be overly emotionally involved. This fact may affect their capacity to remain objective and emotionally more distant in order to not become overwhelmed by the repercussions of the ED. Sharing duties between parents and training caregivers to adopt a more balanced emotional attitude towards the pathology may aid caregivers and patients with EDs alike (Perez Algorta et al., 2017). On the other hand, one other explanation may be related to differing personality traits between parents (Amianto, Daga, Bertorello, & Fassino, 2013; Amianto, Ercole, Abbate Daga, & Fassino, 2016; Amianto, Ercole, Marzola, Abbate Daga, & Fassino, 2015). Martín et al. (2013) reported that female relatives were more likely to endorse higher levels of anxiety, depression and burden of caring. Likewise, Whitney et al. (2005) observed greater distress in the mothers of AN patients compared to other caregivers. Furthermore, Lang, Treasure, & Tchanturia (2016) found mothers of AN patients possessed a more inflexible thinking style and lower levels of global processing compared to unaffected mothers.

Our findings indicate that caregivers, especially the parents of patients with EDs, could stand to benefit from interventions targeting unmet areas such as effective communication. Indeed, other studies of ED caregivers have shown problems in communication with the patient to be frequent in the case of BN and AN (Graap et al., 2008). Although few studies on ED caregiver interventions are available in the literature, some research has demonstrated the utility of using sessions for caregivers to equip parents with skills and guidance to be a supportive influence in the treatment process (Gisladdottir et al., 2017). Such interventions have the potential to improve areas such as ED beliefs, quality of life and emotional distancing.

4.1. Limitations and future research

The present study is not without its limitations. First, this is a self-report measure and data could be subject to social desirability bias. Future studies related with caregivers should attempt to include a semi-structured interview in order to obtain better reliability and specificity. Second, the sample was made up of caregivers of patients who were already in treatment, which could have biased the results. Future studies should compare CASK results in caregivers of patients in treatment and in those who have not received treatment yet. Third, our study group is mostly constituted of caregivers of patients in outpatient treatment, and this population may not be representative of all individuals with ED. Fourth, the convergent validity of the CASK has not been explored in our study. Finally, further longitudinal studies might explore whether score changes on the CASK are associated with changes in patient accommodation and symptomatology.

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Table 1. Comparison of the CASK dimension scores between caregivers

	Father		Mother		GEE adjusted for			
	(n=97)		(n=168)		ED patients' sex and age			
	Mean	SD	Mean	SD	MD	SE	p	d
F1. Bigger picture	75.54	13.54	73.14	13.01	2.40	1.630	.141	0.18
F2. Self-care	60.58	16.64	59.15	17.24	1.43	1.882	.447	0.08
F3. Biting-your-tongue	65.01	19.56	65.01	17.55	0.01	2.363	.998	0.00
F4. Insight-acceptance	66.40	17.27	65.44	17.01	0.96	1.976	.627	0.06
F5. Emotional intelligence	68.93	16.57	69.60	16.27	-0.66	1.882	.724	0.04
F6. Frustration-tolerance	70.27	16.55	69.58	13.65	0.69	1.769	.695	0.05

Note. SD: standard deviation. MD: mean difference. SE: standard error.

*Bold: significant comparison (.05 level). †Bold: effect size into the moderate ($|d|>0.50$) to high range ($|d|>0.80$).

The Caregiver Skills (The CASK)

Estem interessats en conèixer la seva opinió sobre alguns aspectes referits a la cura d'altres persones.

Les afirmacions següents descriuen situacions que de manera habitual, succeeixen en els trastorns alimentaris. Si us plau, puntuï amb quin grau de seguretat respondria a cadascuna de les situacions que es descriuen més avall.

Valori el grau de seguretat, de 0 a 100, emprant l'escala següent:

0	10	20	30	40	50	60	70	80	90	100
<i>Quasi mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

Per exemple, una valoració de 100 significa que vostè està totalment segur, al 100% , que podria actuar tal i com es descriu. Per a cada situació faci un cercle en el número que millor reflecteixi el seu grau de seguretat. Pot escollir qualsevol puntuació entre 0 i 100 (10, 20, 30, etc.).

Si us plau, faci totes les valoracions pensant en el que faria AQUESTA SETMANA, essent la persona que és ARA, i no la que solia ser o la que li agradaria ser. Això és molt important.

Els espais en blanc es refereixen a la persona amb trastorn alimentari de qui vostè té cura. No és necessari emplenar els espais en blanc.

Gràcies per destinar un temps a emplenar aquest qüestionari.

Fins a quin punt està segur que pot ...

1. Seguir fent les coses amb les que vostè gaudeix mentre té cura de _____ ?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

2. ... Dialogar i explicar, obertament, els seus propis sentiments sobre el trastorn alimentari amb _____ ?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

3. ... Dialogar, obertament, sobre el trastorn alimentari amb els familiars propers implicats?

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Amb el suport de la Generalitat de Catalunya i el Centro de Investigación Biomédica en Red de la Fisiopatología de la Obesidad y Nutrición (CIBEROBN)

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

4. Ser comprensiu/va amb _____, fins i tot quan està enutjat, enfadat, frustrat amb ell?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

5. ... Evitar discussions sobre els trastorn alimentari amb _____ ?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

6. ... Estar tranquil/tranquil·la quan ha de gestionar els comportaments difícils associats al trastorn alimentari?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

7. ... Prendre's un temps per a vostè quan necessiti un descans?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

8. ... Parlar i escoltar a _____ quan expressa les complexes emocions que està sentint?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

9. ... Sentir-se confiat/da, fins i tot davant els mínims signes de millora ?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

10. ... Mantenir l'esperança que _____ es recuperarà?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

11. ... Mantenir-se al marge i confiar que _____ afrontarà, per si mateix, els reptes del dia a dia?

0   10   20   30   40   50   60   70   80   90   100
Gairebé mai   Ocasionalment   Freqüentment   Quasi sempre

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Amb el suport de la Generalitat de Catalunya i el Centro de Investigación Biomédica en Red de la Fisiopatología de la Obesidad y Nutrición (CIBEROBN)

12. ... Acordar límits, plans o regles a casa en col·laboració amb _____ ?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

13. ... Mantenir els límits/regles amb fermesa, en un entorn comprensiu, fins i tot quan _____ està discutint amb vostè?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

14. ... Controlar l'impuls de discutir sobre les conductes del trastorn alimentari, malgrat que vostè consideri que el seu argument és lògic?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

15. .... Tenir converses agradables amb _____, no relacionades amb el trastorn alimentari?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

16. .... Controlar la necessitat de seguir indagant o comprovant el comportament de _____, fins i tot quan vostè està molt preocupat/da?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

17. ... Valorar el canvi o intents de canvi de _____, malgrat que els resultats siguin menors als que esperava?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

18. ... Resistir-se a recordar/preguntar constantment sobre la finalitat del comportament acordat?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

19. ... Evitar converses repetitives amb _____ sobre els àpats i els aliments?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

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Amb el suport de la Generalitat de Catalunya i el Centro de Investigación Biomédica en Red de la Fisiopatología de la Obesidad y Nutrición (CIBEROBN)

20. ... Controlar a _____ en el seu progrés general/global?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

21. ... Resistir-se a confiar únicament en el pes, com indicador del que ell/ella està fent?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

22. ... Diferenciar entre _____, com a persona i la seva malaltia?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

23. ... Comprendre l'impacte de la seva pròpia conducta en _____ ?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

24. ... Acceptar que el seu trastorn alimentari no és culpa de vostè?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

25. ... Acceptar que la causa desencadenant del trastorn alimentari pot no ser la solució per a la seva recuperació?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

26. ... Trobar temps per estar amb la resta de membres de la família?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

27. ... Gestionar el seu grau d'ansietat per no sentir-se sobrepassat/da?

0	10	20	30	40	50	60	70	80	90	100
<i>Gairebé mai</i>			<i>Ocasionalment</i>			<i>Freqüentment</i>			<i>Quasi sempre</i>	

Gràcies per completar aquest qüestionari

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The Caregiver Skills (The CASK)

Estamos interesados en conocer cómo piensa sobre algunos aspectos referidos al cuidado de otras personas. Por favor intente contestar con el mayor grado de sinceridad y honestidad posible.

Las siguientes afirmaciones describen situaciones que, habitualmente, se dan en los trastornos alimentarios. Por favor, puntúe con qué grado de seguridad respondería a cada una de las situaciones descritas más abajo.

Valore el grado de seguridad, de 0 a 100, usando la escala siguiente:

0	10	20	30	40	50	60	70	80	90	100
Casi nunca		Ocasionalmente				Frecuentemente			Casi siempre	

Por ejemplo, una valoración de 100 significa que usted está absolutamente seguro, al 100%, de que podría actuar tal como se describe. Para cada situación haga un círculo en el número que mejor refleje su grado de seguridad. Puede elegir cualquier puntuación entre 0 y 100 (10, 20, 30, etc.)

Por favor, haga todas sus valoraciones pensando en lo que haría ESTA SEMANA, siendo la persona que es AHORA y no la que solía ser o la que le gustaría ser. Esto es muy importante.

Si usted considera que algunas de las preguntas no son aplicables a usted, trate de hacer la valoración como si esa situación se diera.

Los espacios en blanco (____) se refieren a la persona con trastorno alimentario que cuida. No es necesario rellenar los espacios en blanco.

Gracias por tomarse el tiempo para completar este cuestionario.

¿Hasta qué punto está seguro de que puede ....

1. ... Seguir haciendo las cosas con las que usted disfruta mientras cuida a _____?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>				<i>Frecuentemente</i>			<i>Casi siempre</i>

2. ... Dialogar y explicar abiertamente sus propios sentimientos sobre el trastorno alimentario con _____?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>				<i>Frecuentemente</i>			<i>Casi siempre</i>

3. ... Dialogar abiertamente del trastorno alimentario con *todos* los familiares cercanos implicados?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>				<i>Frecuentemente</i>			<i>Casi siempre</i>

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4. ... Ser comprensivo/a con _____, incluso cuando está enojado, enfadado, frustrado con él/ella?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

5. ... Evitar entrar en discusiones sobre el trastorno alimentario con _____?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

6. ... Estar tranquilo/a en el manejo de las situaciones difíciles asociadas al trastorno alimentario?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

7. ... Tomarse un tiempo para usted cuando necesite un descanso?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

8. ... Hablar y escuchar a _____ sobre las complejas emociones que está sintiendo?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

9. ... Sentirse confiado/a incluso, ante los más mínimos signos de mejora?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

10. ... Mantener la esperanza de que _____ se recuperará?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

11. ... Mantenerse al margen y confiar en que _____ afrontará, por sí mismo/a, los retos del día a día?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

12. ... Acordar límites, planes o reglas de casa en colaboración con _____?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

13. ... Mantener los límites / reglas, de forma consistente, en un tono comprensivo, incluso cuando _____ esté discutiendo con usted?

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0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

14. ... Controlar el impulso de discutir sobre las conductas del trastorno alimentario, a pesar de que usted considere que su argumento es lógico?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

15. ... Tener conversaciones agradables con _____, no relacionadas con el trastorno alimentario?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

16. ... Controlar la necesidad de seguir indagando o comprobando el comportamiento de _____, incluso, cuando usted esté muy preocupado/a?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

17. ... Valorar positivamente el cambio o intentos de cambio de _____, aunque los resultados sean menores a los que esperaba?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

18.... Resistirse a recordar y preguntar constantemente sobre los objetivos de comportamiento acordados?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

19.... Evitar entrar en conversaciones repetitivas con _____ sobre las comidas y los alimentos?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

20.... Controlar a _____ en su progreso general/global?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

21.... Resistirse a confiar únicamente en el peso, como indicador de lo que él/ella está haciendo?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

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22.... Diferenciar entre _____ , como persona y su enfermedad?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

23.... Comprender el impacto de su propia conducta en _____?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

24.... Aceptar que el trastorno alimentario de él/ella no es culpa de usted?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

25.... Aceptar que la causa o desencadenante del trastorno alimentario puede no ser la solución para su recuperación?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

26.... Encontrar tiempo para estar con otros miembros de la familia?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

27.... Manejar su grado de ansiedad para no sentirse desbordado/a?

0	10	20	30	40	50	60	70	80	90	100
<i>Casi nunca</i>			<i>Ocasionalmente</i>			<i>Frecuentemente</i>			<i>Casi siempre</i>	

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Validation of the Caregiver Skills (CASK) scale in Catalonia: Concordance between Caregivers in Attitudes and Behaviors

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Conflict of interest

None

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