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Research article

# Validation of the Greek version of the Accommodation and Enabling Scale for Eating Disorders (AESED)

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**ABSTRACT**

Eating disorders-related research has shown that families, to alleviate family conflict and stress, accommodate the symptoms of individuals with eating disorders. It has been argued that by tolerating or alleviating symptoms, the latter may gradually be reinforced or even fully accepted, as the family becomes increasingly "trapped" in specific eating patterns, weight control behaviors, and body shape worries. The Accommodation and Enabling Scale for Eating Disorders was created in 2009, aiming to assess the family adaptability of individuals with eating disorders. The purpose of the present research was to test the psychometric properties of the Greek version of the scale in a sample of parents of individuals with eating disorders. The translation procedure was carried out based on the forward-backward method, while the study was conducted at the Eating Disorders Clinic of the First Psychiatric Clinic of Aiginiteion Hospital. Convenience sampling methods were used for the sample's recruitment. Respondents reported on their basic demographic characteristics and completed the General Health Questionnaire-28, and the Accommodation and Enabling Scale for Eating Disorders. The final study's sample consisted of 125 parents of individuals with eating disorders (69.6% women), with a mean age of 55.2 years. Factor analysis revealed a five-factor model, similar to that of the original version of the scale, with the model explaining 63.3% of the total variance. Internal consistency was judged to be high, with Cronbach's coefficient being 0.93 for the scale's total score, while Cronbach's α for the five subscales ranged from 0.78 to 0.90. Convergent validity was tested with Spearman's coefficient rho, which revealed a statistically significant correlation of the weighted scale with the General Health Questionnaire (rho=0.33, $p<0.5$). The results showed that the Greek version of the Accommodation and Enabling Scale for Eating Disorders is a valid and reliable tool for assessing the adaptability of families of people suffering from eating disorders. Application of the tool to larger samples will validate its psychometric properties on a larger scale.

**KEYWORDS:** Eating disorders, validation, reliability, caregivers, Accommodation and Enabling Scale for Eating Disorders.

## Introduction

The onset of an eating disorder (ED) in a young person's life has an impact on both the individual and the family. The burden of the disorder on the family is multifactorial,[1] as parents often need to cope with not only the patient's refusal to get treatment, and various medical complications caused by malnutrition, but also social stigmatization as well as the sufferer's gradual marginalization.[2] In addition, several studies has shown that caregivers' mental state is negatively affected.[3]

Lately, the number of published studies on family distress and the negative experience of relatives caring for ED patients has risen.[4–7] According to these studies car-

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egivers of ED patients demonstrate poor quality of life, depression, anxiety, loss of behavioral or emotional control, and low psychological well-being.[8–11] Furthermore, family members suffer from significant emotional strain and often demonstrate intense and distressing patterns of interpersonal interaction.[12–15]

To alleviate familial stress and conflict, family members may accommodate ED symptomatology, such as food restriction, and weight and shape control, by organizing domestic life around the disorder.[6,13,14] For example, caregivers may modify leisure activities regarding the time and place of meals to meet the patient's needs. In the long run, these decisions have been shown to adversely affect both caregivers and ED patients,[7,16,17] as they can result in intense emotional responses ranging from guilt and self-blame to anger and disgust.[6] Consequently, the high levels of negatively expressed emotion intensify conflict within the family thus obstructing treatment progress.[18]

It is known from previous research that ED patients tend to demonstrate obsessive-compulsive behaviors, such as rituals regarding food intake, perfectionism, and rigidity.[19] It has been suggested that the caregiver's coping strategies concerning those obsessive-compulsive behaviors can play an integral part in ED treatment.[6,20] Based on this hypothesis, Sepulveda, Kyriacou, and Treasure developed in 2009 the Accommodation and Enabling Scale for Eating Disorders (AESED). The scale was based on the Family Accommodation Scale which was developed to measure the behaviors of families with patients suffering from obsessive compulsive disorder. The original scale involved measuring obsession, reassuring, participating in rituals, avoiding referring to obsession triggers, and modifying familial routines to fulfill the patient's needs.[21] AESED was also translated and validated in the Spanish language.[22] The study aimed to determine the reliability and validity of the Greek version of AESED in a sample of ED patients' parents.

## Material and Method

### Translation procedure

The research team obtained permission from the AESED developers to validate the Greek version of the scale. The instrument was translated into the Greek language according to the backward-forward translation method, as suggested by the World Health Organization.[23] Originally the scale was translated independently from English to Greek by two professional translators. The two Greek versions were checked by a panel of mental health experts in ED research and treatment to achieve a consensus on the Greek version of AESED. No major cultural adjustment was deemed necessary. Consequently, a third translator performed a backward translation into the English language. The two versions were compared by the same panel of experts to resolve any discrepancies. The final Greek version of the scale was used in an unpublished pilot study of 10 family-members who participated in a psychoeducation group on ED. No further adjustments of the Greek version to AESED were necessary, as the participants found the scale comprehensive and easy to complete.

### Participants and procedures

The study's participants were recruited from the Eating Disorders Unit of the First Psychiatric Department of the National and Kapodistrian University of Athens using the convenience sampling technique. For participants to be eligible for inclusion, they had to be parents of female ED patients between 17 and 30 years of age. They had to be able to read and write in Greek, and should not demonstrate a decline in cognitive functions due to a general medical condition, psychotropic medication, or alcohol addiction. All measurements were administered during the first session of a family intervention psychoeducational program run by the Eating Disorder Unit.

## Measures

### Sociodemographic characteristics

Participants completed a questionnaire on demographic data, which included age, gender, educational level, employment status, marital status, number of children, and medical history.

### Accommodation and Enabling Scale for Eating Disorders (AESED)[24]

The scale measures accommodating and enabling behaviors of families or caregivers of ED patients. It includes 33 items and five dimensions, that investigate the frequency that the respondent demonstrates specific behaviors. The five dimensions are (a) Avoidance and modifying Routine, (b) Reassurance seeking, (c) Meal ritual, (d) Control of family, and (e) Turning a blind eye. Responses are given on a 5-point Likert-type scale (0=never, 4=nearly always). The total score ranges from 0 to 132, with the highest scores indicating higher accommodation of ED symptoms. The AESED has shown high internal reliability, with Cronbach's coefficient ranging from 0.77 to 0.92.[24,25]

### General Health Questionnaire (GHQ-28)[26]

The scale is used to detect signs of psychopathology. It includes 28 items investigating 4 different dimensions of

health; somatic symptoms, anxiety/insomnia, social dysfunction, and severe depression. The validation of this questionnaire in the Greek population has satisfactory internal consistency, with a Cronbach's α value of 0.93.[26]

### Statistical analysis

Descriptive analyses were used to calculate frequencies (%), means, and standard deviations (SD). The Kaiser-Meyer-Olkin (KMO) statistic and Barlett's Sphericity Test were used to examine the sample's adequacy. Exploratory Factor Analysis was performed with Principal Component Analysis (PCA) to identify items' factors. PCA was performed using the Varimax rotation. The Kaiser-Meyer-Olkin statistic and Barlett's Sphericity Test were used to investigate the sample's adequacy. The cut-off point for factor loadings was 0.40, while the appropriate number of factors was determined by eigenvalues greater than 1. Internal consistency was determined by the calculation of Cronbach's coefficient a. Values equal to or greater than 0.70 were considered acceptable. The correlation of the AESED and GHQ-28 scales was explored with Spearman's coefficient rho. Differences between married and separated participants in their AESED scores were explored via the Mann-Whitney test. All reported p-values were two-tailed. Statistical significance was set at $p<0.05$ and analyses were conducted using the SPSS statistical software (version 24.0).

### Ethical considerations

The study design was reviewed and approved by the Research and Ethics Committee of the Eginition Hospital (398/ 05-07-2021). Eligible candidates could participate only after providing their signed consent, maintaining the right to withdraw their participation at any time, with no consequences on the provided psychiatric care. Participants did not receive any type of remuneration. The collected data were anonymous and their safety was secured according to the current legislation.

## Results

### Participant characteristics

The sample consisted of 125 participants (69.6% women) with a mean age of 53.1 years (SD=6.0 years). The basic sociodemographic characteristics of the sample are presented in table 1. The mean total GHQ-28 score was 55.2 (SD=13.9), while for each subscale the mean scores and standard deviation were 14.3±4.5 for somatic symptoms, 16.1±4.7 for anxiety and insomnia, 14.9±3.7 for social dysfunction, and 10.1±4.3 for severe depression.

**Table 1.** Sample's basic sociodemographic characteristics.

| Variable | N (%) |
|---|---|
| Gender | |
| Men | 38 (30.4) |
| Women | 87 (69.6) |
| Family status | |
| Married | 103 (82.4) |
| Divorced | 22 (17.6) |
| Health problem | 53 (42.4) |
| Under medication | 52 (42.3) |
| | Mean (SD) |
| Age | 53.1 (6.0) |
| Years of education | 15.2 (2.9) |

### Correlation between demographic characteristics and AESED

The Mann-Whitney U test was used to check for the relation between the demographic characteristic categories and the total score of the AESED, as well as its subscales. The results found no significant relationship between any of the variables except marital status. Analysis showed that married parents scored higher in the "Meal ritual" and "Turning a blind eye" subscales with a p-value of 0.037 and 0.002 respectively.

### Exploratory Factor Analysis (EFA)

KMO coefficient and Barlett's Sphericity Test ($x^2$) were calculated for the examination of the adequacy and suitability of the collected data. KMO value was 0.93, while $x^2=2093.2$ was statistically significant ($p<.001$). All loadings were above 0.4 and the factors explained 63% of the total variance. All items demonstrated loadings above 0.4, thus no item needed to be excluded. Similar to the initial version of the scale, AESED items were grouped into five factors. The results of EFA are presented in table 2. According to the structure of the English version of the instrument, items "the exercise routine of the relative with an ED?" and "your relative's checking their body shape or weight?" were included in the "Reassurance Seeking" factor, while for the present study, these were included in the "Meal Context Ritual" factor.

### Internal consistency

The Cronbach's α value was 0.93. Table 3 presents the descriptive statistics of each item, and the α value if items of the scale were deleted.

**Table 2.** Factor analysis results after Varimax rotation.

| Item | Subscale | | | | |
|---|---|---|---|---|---|
| | Meal Context Ritual | Avoidance & Modifying Routine | Reassure Seeking | Control of Family | Blind Eye |
| 1. Control choice of food that you buy | | | | .78 | |
| 2. Control what family members do and for how long in the kitchen | | | | .63 | |
| 3. Control cooking practice and ingredients used | | | | .79 | |
| 4. Control what other family members eat | | | | .70 | |
| 5. Repeated questioning about whether she will get fat? | | | .84 | | |
| 6. Repeated questioning whether it is safe or acceptable to eat certain foods? | | | .76 | | |
| 7. Repeated seeking of reassurance about whether she looks fat in certain clothes? | | | .87 | | |
| 8. Repeated conversations about ingredients and amounts in food prepare | | | .58 | | |
| 9. Repeated conversations about negative thoughts and feelings? | | | .69 | | |
| 10. Repeated conversations about self-harm? | | | .68 | | |
| 11. Accommodating to what crockery is used? | .66 | | | | |
| 12. Accommodating to how the crockery is cleaned? | .78 | | | | |
| 13. Accommodating to what time food is eaten? | .62 | | | | |
| 14. Accommodating to what place food is eaten in? | .77 | | | | |
| 15. Accommodating to how the kitchen is cleaned? | .77 | | | | |
| 16. Accommodating to how food is stored? | .74 | | | | |
| 17. Accommodation of the exercise routine of the relative with an eating disorder? | .57 | | | | |
| 18. Accommodation of routines of checking their body shape or weight? | .55 | | | | |
| 19. Accommodating to how the house is cleaned and tidied? | .74 | | | | |
| 20. Ignore food disappearing | | | | | .68 |
| 21. Ignore if money is taken | | | | | .56 |
| 22. Ignore kitchen left in a mess | | | | | .81 |
| 23. Ignore bathroom left in a mess | | | | | .85 |
| 24. To what extent would you say that the relative with an ED control family life and activities? | | .57 | | | |
| 25. How often did you participate in behaviours related to your relative's compulsions? | | .54 | | | |
| 26. How often did you assist your relative in avoiding things that might make him/her anxious? | | .41 | | | |
| 27. Have you avoided doing things, going places or being with people because of your relative's disorder? | | .82 | | | |
| 28. Have you modified your family routine because of your relative's symptoms? | | .84 | | | |
| 29. Have you modified your work schedule because of your relative's needs? | | .81 | | | |
| 30. Have you modified your leisure activities because of your relative's needs? | | .88 | | | |
| 31. Has helping your relative in the previously mentioned ways caused you distress? | | .69 | | | |
| 32. Has your relative become distressed when you have not provided assistance? | | .54 | | | |
| 33. Has your relative become angry/abusive when you have not provided assistance? | | .54 | | | |
| % Variance explained | 16.3 | 15.5 | 11.8 | 1.6 | 8.9 |
| Eigenvalue | 10.9 | 3.3 | 2.5 | 2.2 | 1.8 |
| % Total Variance Explained | | | | | 63.3 |
| Cronbach's α | | | | | 0.93 |

**Table 3.** Descriptive Statistics of the AESED instrument.

| Item | Mean (SD) | Cronbach's Alpha if Item Deleted | Subscale's Cronbach's Alpha |
|---|---|---|---|
| Meal Context Ritual | | | .90 |
| 1. Control choice of food that you buy | 2.5 (1.3) | .89 | |
| 2. Control what family members do and for how long in the kitchen | 1.6 (1.4) | .88 | |
| 3. Control cooking practice and ingredients used | 2.5 (1.3) | .89 | |
| 4. Control what other family members eat | 1.7 (1.5) | .88 | |
| 5. Repeated questioning about whether she will get fat? | 1.8 (1.4) | .88 | |
| 6. Repeated questioning whether it is safe or acceptable to eat certain foods? | 1.7 (1.3) | .88 | |
| 7. Repeated seeking of reassurance about whether she looks fat in certain clothes? | 1.8 (1.4) | .90 | |
| 8. Repeated conversations about ingredients and amounts in food prepare | 2.1 (1.3) | .90 | |
| 9. Repeated conversations about negative thoughts and feelings? | 2.1 (1.2) | .89 | |
| Avoidance & Modifying Routine | | | .90 |
| 10. Repeated conversations about self-harm? | 0.9 (1.2) | .90 | |
| 11. Accommodating to what crockery is used? | 0.9 (1.3) | .89 | |
| 12. Accommodating to how the crockery is cleaned? | 1.0 (1.4) | .90 | |
| 13. Accommodating to what time food is eaten? | 1.5 (1.4) | .89 | |
| 14. Accommodating to what place food is eaten in? | 1.5 (1.4) | .88 | |
| 15. Accommodating to how the kitchen is cleaned? | 1.2 (1.4) | .89 | |
| 16. Accommodating to how food is stored? | 1.3 (1.4) | .88 | |
| 17. Accommodation of the exercise routine of the relative with an eating disorder? | 1.7 (1.4) | .89 | |
| 18. Accommodation of routines of checking their body shape or weight? | 1.8 (1.4) | .90 | |
| 19. Accommodating to how the house is cleaned and tidied? | 1.5 (1.4) | .89 | |
| Blind Eye | | | .78 |
| 20. Ignore food disappearing | 1.2 (1.4) | .75 | |
| 21. Ignore if money is taken | 0.5 (1) | .79 | |
| 22. Ignore kitchen left in a mess | 1.5 (1.4) | .68 | |
| 23. Ignore bathroom left in a mess | 1.4 (1.4) | .65 | |
| Reassure Seeking | | | .88 |
| 24. To what extent would you say that the relative with an ED controls family life and activities? | 6.1 (2.6) | .83 | |
| 25. How often did you participate in behaviours related to your relative's compulsions? | 1.7 (1.4) | .84 | |
| 26. How often did you assist your relative in avoiding things that might make him/her anxious? | 2.3 (1.4) | .85 | |
| 27. Have you avoided doing things, going places or being with people because of your relative's disorder? | 1.5 (1.3) | .87 | |
| 28. Have you modified your family routine because of your relative's symptoms? | 1.8 (1.2) | .86 | |
| 29. Have you modified your work schedule because of your relative's needs? | 1.5 (1.3) | .87 | |
| Control of Family | | | .83 |
| 30. Have you modified your leisure activities because of your relative's needs? | 1.9 (1.4) | .78 | |
| 31. Has helping your relative in the previously mentioned ways caused you distress? | 1.8 (1.3) | .81 | |
| 32. Has your relative become distressed when you have not provided assistance? | 1.9 (1.3) | .77 | |
| 33. Has your relative become angry/abusive when you have not provided assistance? | 1.9 (1.4) | .77 | |

### Correlation with GHQ-28

The correlation of the AESED total score and its subscales with the GHQ-28 total score and its subscales was examined with Spearman's coefficient rho. The correlation between the total scores of the two instruments was statistically significant ($p<0.5$). The correlations between the subscales of the two instruments as well as their total scores are shown in table 4.

## Discussion

The present study aimed to validate the Greek version of AESED. The study verified the validity and reliability of the Greek version of the AESED questionnaire, which can be used to evaluate the accommodating and enabling behaviors of ED patients' parents.

Following the original version of the scale, the analyses of its psychometric properties proposed a final set of 33 items, including five factors. Factor analysis, with a Cronbach's alpha value higher than the acceptable limit of 0.7, revealed that the AESED instrument is adequately reliable. Results were in agreement with the English and Spanish versions of the scale. The analysis of the components revealed that Item 17 ("Accommodation of the exercise routine of the relative with an eating disorder?") and Item 18 ("Accommodation of routines of checking their body shape or weight?") fell under the subscale of "Meal ritual". When compared to other validations, no changes regarding the item-factor classification were reported in the Spanish version. Regarding factor loadings, the present study found that all items demonstrated loadings greater than 0.40. Even though item 10 ("Your relative with an ED involves a family member in repeated conversations about self-harm?") of the Spanish version presented a factorial loading below 0.4, researchers decided to maintain it.

Strong positive correlations were found between the AESED and the GHQ-28 subscales. Although the two scales focus on different aspects of mental health, the general psychopathology of the participants can be used as an indication of how well they deal with their child's ED thus providing an indirect indication of the AESED's convergent validity. More precisely, the factor "Avoidance and modifying routine" had a positive correlation with all the GHQ-28 subscales. These results are in agreement with the relevant literature, which has shown that caregivers' burden is connected to poor mental health.[27] On the contrary, no strong positive correlation was found between the "Turning a blind eye" subscale and GHQ-28 subscales. This could be explained by the fact that this subscale mostly addressed behaviors related to family members suffering from Bulimia Nervosa while most of the families in the study had members suffering from Anorexia Nervosa.

As for correlations between demographics and AESED questionnaire scores, some points are worth mentioning. Firstly, the results showed that married caregivers had a higher score in the "Meal ritual" and "Turning a blind eye" factors than divorced caregivers. This could be explained by the fact that to maintain a family atmosphere without tensions and arguments, married parents tend to accommodate ED symptomatology and choose to ignore behaviors that disrupt family life, thus reinforcing ED in the long run. It can be hypothesized that some married parents choose these accommodating and enabling behaviors because they believe that the rest of the family (children) will not be affected. The results of the study indicate that evaluating a relative's perspective and behaviors regarding ED can play an important part in designing family-based interventions.[16,24]

It is worth mentioning that AESED is the first relevant scale validated in the Greek language, and will facilitate research on family reactions to the manifestation of ED and the effectiveness of family intervention for ED. However, the study has certain limitations. Firstly, the sample was recruited solely from one treatment fa-

**Table 4.** Spearman's rho correlation coefficients between AESED and GHQ-28 total scores and subscales.

| | Somatic Symptoms | Anxiety and Insomnia | Social Dysfunction | Severe Depression | Total GHQ-28 score |
|---|---|---|---|---|---|
| Meal Context Ritual | .20 | .31** | .17 | .03 | .24* |
| Avoidance & Modifying Routine | .34** | .36** | .38** | .24* | .42*** |
| Blind Eye | .05 | .14 | .14 | .12 | .13 |
| Reassure Seeking | .22 | .17 | .19 | .11 | .15 |
| Control of Family | .21 | .30* | .24* | .20 | .23 |
| Total AESED score | .27* | .40** | .30* | .14 | .33* |

*p<.05; **p<.01; ***p<.001

cility using the convenience sampling technique, making it questionable concerning its representativeness. Representativeness could also be characterized as troubling due to the gender distribution given that the vast majority of the participants (almost 70%) were women. In addition, the study used a small sample size, and thereby the results should be treated with caution. Due to the small size of the sample, an exploratory factor analysis was performed. A larger sample size would enable a confirmatory factor analysis. Further research is needed in a larger and more diverse sample of caregivers, to draw more reliable conclusions on the reliability of the scale in Greek populations. Finally, since there is no other scale in Greek measuring the caregivers' behaviors regarding ED symptomatology, convergent validity was tested by comparing AESED with a scale that measures the general health of the participants (GHQ-28). The use of the caregivers' health status as a measurement of convergent validity should be treated with caution.

To conclude, the Greek version of the AESED can prove to be a valuable addition to ED research. Further research with larger sample sizes could test the scale's reliability more extensively. In addition, the AESED could become a useful tool for the assessment of therapeutic interventions. Therefore, longitudinal studies could facilitate the identification of patient-parent factors that may cause changes in symptoms over time.[24]

## Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi: 10.22365/jpsych.2023.019

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Ερευνητική εργασία

# Μελέτη επικύρωσης της Κλίμακας Προσαρμοστικότητας και Διαχείρισης των φροντιστών για τις Διαταραχές Πρόσληψης Τροφής

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**ΠΕΡΙΛΗΨΗ**

Η έρευνα που σχετίζεται με τις διαταραχές πρόσληψης τροφής έχει δείξει ότι συχνά οι οικογένειες, προκειμένου να μετριάσουν τις οικογενειακές συγκρούσεις και το άγχος, «εξυπηρετούν» τα συμπτώματα των ατόμων με διατροφική διαταραχή. Έχει υποστηριχτεί ότι με την ανοχή ή τη διευκόλυνση των συμπτωμάτων, ενδεχομένως σταδιακά να ενισχυθούν ή ακόμη και να γίνουν αποδεκτά, καθώς το οικογενειακό πλαίσιο παγιδεύεται όλο και περισσότερο στις συμπεριφορές διατροφής, ελέγχου βάρους, και σχήματος του σώματος. Η Κλίμακα Προσαρμοστικότητας και Ικανότητας Διαχείρισης για τις Διαταραχές Πρόσληψης Τροφής (Accommodation and Enabling Scale for Eating Disorders) δημιουργήθηκε το 2009 με στόχο την αξιολόγηση της προσαρμοστικότητας της οικογένειας ατόμων με διαταραχές πρόσληψης τροφής. Σκοπός της παρούσας έρευνας ήταν ο έλεγχος των ψυχομετρικών ιδιοτήτων της ελληνικής έκδοσης της εν λόγω κλίμακας σε δείγμα γονέων ατόμων με διατροφικές διαταραχές. Η μετάφραση του εργαλείου πραγματοποιήθηκε βάσει της forward-backward μεθόδου, ενώ η μελέτη διεξήχθη στο Ιατρείο Διατροφικών Διαταραχών της Α΄ Ψυχιατρικής Κλινικής του Αιγινήτειου Νοσοκομείου. Η συγκέντρωση του δείγματος έγινε με τη μέθοδο ευκολίας. Από τους συμμετέχοντες συγκεντρώθηκαν βασικά δημογραφικά δεδομένα, ενώ διαμοιράστηκε προς συμπλήρωση το Ερωτηματολόγιο Γενικής Υγείας (General Health Questionnaire-28) και η Κλίμακα Προσαρμοστικότητας και Ικανότητας διαχείρισης για τις Διαταραχές Πρόσληψης Τροφής (Accommodation and Enabling Scale for Eating Disorders). Στη μελέτη συμμετείχαν 125 γονείς ατόμων με διατροφικές διαταραχές, με το 69.6% να αποτελείται από γυναίκες, και μέση ηλικία δείγματος τα 55.2 έτη. Η παραγοντική ανάλυση ανέδειξε ένα μοντέλο πέντε παραγόντων, όμοιο με αυτό της αρχικής έκδοσης της κλίμακας, με το μοντέλο να εξηγεί το 63.3% της συνολικής διακύμανσης. Η εσωτερική συνοχή κρίθηκε ως υψηλή, με τον συντελεστή α του Cronbach να είναι 0.93 συνολικά για το εργαλείο, και για τις πέντε υποκλίμακες να κυμαίνεται από 0.78 ως 0.90. Ο έλεγχος της συγκλίνουσας εγκυρότητας με τον συντελεστή rho του Spearman ανάδειξε τη στατιστικά σημαντική συσχέτιση της υπό στάθμιση κλίμακας με το Ερωτηματολόγιο Γενικής Υγείας (rho=0.33, p<0.5). Τα αποτελέσματα έδειξαν ότι η ελληνική έκδοση της Κλίμακας Προσαρμοστικότητας και Ικανότητας διαχείρισης για τις Διαταραχές Πρόσληψης Τροφής αποτελεί ένα έγκυρο και αξιόπιστο εργαλείο για την αξιολόγηση της προσαρμοστικότητας της οικογένειας ατόμων που πάσχουν από διαταραχές πρόσληψης τροφής. Εφαρμογή του εργαλείου σε μεγαλύτερα δείγματα θα επικυρώσουν τις ψυχομετρικές τους ιδιότητες σε μεγαλύτερη κλίμακα.

**ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ:** Διαταραχές πρόσληψης τροφής, στάθμιση, αξιοπιστία, φροντιστές, Κλίμακα Προσαρμοστικότητας και Ικανότητας Διαχείρισης για τις Διαταραχές Πρόσληψης Τροφής.

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