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CONSTRUCTION AND INITIAL VALIDATION OF A SCALE TO EVALUATE SELF-CARE PATTERNS: THE SELF-CARE SCALE

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Abstract

Objective: The main goal of this article is the construction and initial validation of an instrument to evaluate self-care patterns.

Method: An initial questionnaire was designed and analyzed, which led to revisions in the items and the scoring scale. Five new items were added. All 46 items were evaluated again in a sample of 270 psychiatric outpatients.

Results: The final version of the scale includes 31 items. Cronbach's alpha is 0.91. Six factors have been identified: self-destructive behavior, difficulty in asking for and accepting help, resentment about not receiving reciprocity, absence of positive activities, not taking into account one's own needs, and lack of tolerance for shared positive affect.

Conclusions: The Self-Care Scale is presented as a specific instrument to measure self-care patterns with a multidimensional definition. It has shown good reliability and validity in this clinical sample.

Key words: self-care; self-care patterns; evaluation; self-care patterns scale

Declaration of interest: none

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The term Self-care is used with various meanings. From a general health perspective, Orem (2001) defined self-care as the activities that an individual practices, performs or initiates on his own behalf, to maintain life, health and well-being. Self-care is considered essential in coping with chronic illness and in the process of maintaining health (Riegel et al. 2012). The concept has been operationalized through instruments for identifying self-care behaviors, usually external, and specific actions performed for a concrete medical condition (Vaughan et al. 2016) or psychiatric illness (Roldán-Merino et al. 2015). Emotional and cognitive factors interact reciprocally in influencing specific self-care behaviors (Hudson et al. 2016). These behavioral conceptualizations of self-care are directed to the outside world, but the existing scientific literature has not addressed the psychological, internal aspects of self-care, nor external relational issues.

From the mindfulness perspective, Germer (2009) defined a distinct but related concept of self-compassion. Germer proposed that radical acceptance, initially considered as the main goal in mindfulness practices, should be substituted for that of self-compassion. Neff et al. (2007) defined self-compassion as the acceptance of ourselves when we are in pain, as well as compassion and acceptance of self even when one makes mistakes. This self-compassion aspect of self-care has been proposed as a resilience factor when facing traumatic experiences (Tanaka et al. 2011) and is closely related to the concept of self-care as it is addressed by the Self-Care Scale. These aspects of self-care previously described in the literature, reflect self-care as an intrapsychic phenomenon.

A more comprehensive concept of self-care has needed to be developed, one that includes three dimension: external material aspects of self-care, intrapsychic self-care, and the relational aspects of how humans take care of themselves through interactions with others.

The concept of self-care used in this article includes all three of these dimensions and is defined as a pattern of relationship with the self, with the world and with others (Gonzalez and Mosquera 2012, Mosquera 2004). Positive self-care includes three distinct elements: 1) an attitude or state of mind of valuing and loving the totality of who one is, 2) an absence of self-defeating actions and 3) specific actions that provide benefit, growth or value to the one-self.

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We propose that severe, early neglect and traumatization are the origin of unhealthy self-care patterns (Gonzalez and Mosquera 2012, Mosquera 2004). Other authors have also proposed that patients who grow up in a neglectful or abusive environment fail to internalize a healthy self-care pattern (Chu 1998, Ryle and Kerr 2002). Instead, they internalize the same criticism, punishment or neglect of their core needs as they experienced receiving from their caregivers. Often such individuals have developed what the theory of structural dissociation of the personality (Van der Hart et al. 2006) calls substitute actions, i.e. addictions, precocious or excessive caring for others, etc. The goal of the substitute actions is to regulate feelings or protect the self from overwhelming feelings, but they do so in a dysfunctional manner inconsistent with the person's larger life goals. In this way, early neglect and trauma severely disturb the ways in which people care for themselves.

The consequences of active maltreatment are different from those of neglect when essential mirroring, healthy modeling and validation of experience from caregivers are deficient or absent. However, both neglect and abuse influence a person´s self-image and attitude toward self-care. Bowlby (1969) reported that caregivers of young children validate and consolidate the child's experience as they observe and respond to children's experiences with unconditional acceptance and love. These nurturing connections are an essential element in children's learning of self-nurturing skills, basic trust in others and valuing of self. The absence of sufficient nurturing by caretakers disrupts healthy development in several ways. Specifically, in these sad circumstances, the innate attachment seeking behaviors of such children are repeatedly frustrated, leading to insecure or disorganized attachment. In addition, children who are repeatedly neglected do not have sufficient opportunities to become skillful with positive and effective attachment-related behaviors (e.g. conversational skills, empathy with others, methods of resolving interpersonal conflict).

Nurturance affect (the parental caregiving system) has been identified by Panksepp (1998) as a core affective circuit in mammals, and this circuit seems to be activated and developed through the early nurturance of caregivers. We hypothesize that these early experiences of healthy nurturance are internalized as a positive attitude toward the self. Without these early experiences of nurturance, or when children have caregivers who are neglectful or abusive during key developmental stages, the internal model of self-care is disturbed, leading to the internalizing of damaging attitudes towards children's own inner experiences.

This expanded concept of self-care can also be related to the internal working model derived from the organization of the attachment system (Liotti 2006). In disorganized attachment, precocious attempts to care for others are considered by Liotti to be a controlling strategy and may serve as a substitute for the development of a secure attachment. Insecure attachment due to neglect and maltreatment by adults becomes reproduced in chronic intrapsychic patterns of failing to take adequate care of self and excessive efforts to take care of other people, that is, to over-adapting to the perceived needs of others.

The development of a scale measuring this expanded understanding of self-care has two purposes. The first aim is to analyze the construct of self-care and to test its transdiagnostic character. This aim is also aligned with the range of therapeutic procedures explored in this issue. The second aim is to examine the hypothesized relationship between self-care, attachment and early trauma. This second aim may clarify the bridge between early adverse relational experiences and later adult psychopathology.

As defined above, this extended concept of self-care includes three dimensions. The *material* dimension involves the capacity to search for good things, to seek positive experiences, and to try to meet one's own needs. The *internal* dimension involves the intrapsychic capacity of looking at oneself in both a positive way and at the same time, in a realistic way. Finally, the *interpersonal* dimension is related to seeking positive interactions with others to meet one's interpersonal needs for support and care. Some people growing up in adverse environments struggle to find positive interactions with others, and may even have problems in tolerating moments when they are offered shared positive affect and recognition (Leeds 2015). When dealing with difficult life experiences, some people become extremely self-critical and are unable to search for and to accept help from others. Some individuals consistently fail to recognize and protect themselves from danger or from damaging interpersonal relationships or may even actively hurt themselves. A different, but related, maladaptive substitute action is the tendency to excessively take care of other people in ways that are not balanced with self-care. These three dimensions of an expanded concept of self-care form the foundation for the development of the Self-Care Scale.

Method

Sample

The initial version of the scale was evaluated in a pilot sample of 200 outpatients with a variety of mental disorders from rural and urban areas near A Coruña, Spain. Based on an initial assessment, a modified version of the scale was then developed and tested again to evaluate the level of understanding of the new items in another group of psychiatric patients (n=40) ages 18 to 65 years old.

Later, a third scale analysis was carried out in a larger sample of psychiatric outpatients (n=273), from 18 to 65 years old. These patients had received a range of diagnoses such as anxiety (24.2%), depression (17%), adjustment disorders (9.5%), personality disorders (15.2%), dissociative disorders (6.8%), eating disorders (6.1%), obsessive compulsive disorder (OCD; 4.2%), and others. The average age was 37.96 years old (SD=9.35). Of the 237 patients, 74 were males (27.7%) and 193 females (72.3%).

The test items were developed with the purpose of operationalizing the concept of Self Care Patterns proposed by Gonzalez and Mosquera (2012). Jim Knipe and Andrew Leeds participated in the elaboration and design of the items. In the first version of the scale, the following areas were included: self-destructive behavior, difficulty in receiving and accepting help, lack of tolerance of shared positive affect, physical self-care, absence of positive activities and self-protection.

The level of understanding of the items was analyzed to develop their final version. The power of discrimination of the items was also analyzed. We observed that patients did not understand some of the items because they had been formulated in a negative way, so they were rewritten in positive terms and the negative versions of items were removed. Miguel Angel Santed participated in the reformulation of the items. We modified the scoring scale using a Likert scale with

7 options, from (1) strongly disagree to (7) strongly agree. We added the clarification that the items should be answered based on the usual functioning of the patients and not merely based on one specific moment of their lives. In this redefined version of the scale, with 49 items, we also added an area related to expecting compensation for taking care of others, something that had not been contemplated in the first version.

To evaluate the understanding of the new items, the scale was applied to another group of 40 patients. In this article we analyze 49 items leading to a revised, final version of the scale with 31 items.

Procedure

The study was approved by the Ethic Committee of Galicia (2011/078). The therapists presented the scale to the patients as a part of a larger study to evaluate a variety of instruments. Patients were informed about the study and if they agreed to participate they signed the consent form. Test administration was carried out by professionals with clinical experience who were familiar with the characteristics of the instrument. The scale was individually self-administrated, although the test administrator was available to resolve any uncertainties. The estimated time to complete the test was about 5-10 minutes per subject.

Data analysis

The multivariate normality of the sample was evaluated by Mahalanobis distance, eliminating 12 cases in which an aberrant score trend was observed or that had items not scored. The final sample used for the analysis of the psychometric characteristics of the scale included 265 subjects.

Two exploratory factor analyses were carried out to study the dimensionality of the test. The first factor analysis used the maximum likelihood extraction system and the Oblimin direct rotation, following the recommendations of Osborne and Costello (2009). The results were contrasted with a second factor analysis using the principal component extraction method and the Varimax rotation method to clarify the structure of the factors that had been taken from the questionnaire. The reliability of the questionnaire was calculated using the total and partial Cronbach Alpha Coefficient for each factor extracted from the factor analysis.

Finally, considering that theoretically there could be a difference between males and females in the tendencies of taking care of others and letting themselves be cared for, we carried out a logistic regression analysis taking gender as a dependent variable and the factor scores of the factors extracted from the test as a predictor.

The statistical package used was SPSS.

Results

Reliability analysis: debugging items and internal consistency.

First, we analyzed the initial 49 items and determined the global reliability of the scale was 0.93. Items with an item-total correlation lower than 0.20, which represented items not homogeneous with the rest, were eliminated. We also removed items that in the factor analysis had less weight to obtain a shorter instrument. The final version of the test has 29 items. The Cronbach's Alpha of the final version is 0.91, which is still high.

The Alpha for each factor of the final scale has been summarized in the following **table 1**.

Table 1. *Reliability of each factor of the Self Care Scale*

Factor	Alpha
1 Self-destructive behavior	.855
2 Difficulty in accepting and asking for help	.751
3 Resentment over not receiving reciprocity	.769
4 Absence of positive activities	.667
5 Not taking into account one's own needs	.755
6 Lack of tolerance of shared positive affect	.749

Alpha of the first factor is higher than .80, and the alpha of the other factors is between .60 and .75.

Factor analysis

An exploratory factor analysis was carried out using as extraction methods the maximum likelihood and direct Oblimin rotation. We eliminated the items that did not constitute relevant factors, or which were similarly distributed in different factors to make the test smaller and with a greater discrimination capability. The data from factor analysis were compared to the data derived from an extraction with principal components analysis and Varimax rotation.

The factors initially proposed were: self-destructive behavior, imbalance between one's own needs and duty, resentment about not receiving reciprocity, difficulty in receiving and accepting help, lack of tolerance of shared positive affect, physical self-care, absence of positive activities and self-protection.

The KMO index was .895 and the Bartlett's sphericity test was significant (<.001). We extracted six factors, from which self-destructive behavior, resentment over not receiving reciprocity, difficulty in receiving and accepting help, and lack of tolerance of shared positive affect, remain similar to the initial idea. The items related to physical self-care were reassigned to the factors self-care behavior and absence of positive activities. The rest of the items were related to not taking into account one's own needs, a concept that is clearer than thinking about a balance between needs and duty. Even though factor 5 and 6 add less to explained variance, they were retained for being clinically relevant for performing certain therapeutic procedures.

The final factors selected were: (1) self-destructive behavior, (2) taking into account one's own needs, (3) resentment over not receiving reciprocity, (4) difficulty in receiving and accepting help, (5) lack of tolerance of shared positive affect and (6) absence of positive activities. These 6 factors explain 55.61% of the variance.

Table 2. *Eigenvalues and percentage of variance accounted for by the Six Factors in the Factor Analysis*

	Initial eigenvalues		
Factor	Total	Variance %	Cumulative %
1	8.653	27.914	27.914
2	2.162	6.975	34.888
3	2.049	6.610	41.498
4	1.623	5.235	46.734
5	1.368	4.414	51.148
6	1.314	4.238	55.386

Factor 1 consist of items 1, 8, 12, 16, 23, 28 and 31. These items measure the tendency to treat oneself badly. This factor has been called "Self-destructive behavior".

Factor 2 consists of items 3, 11, 17 and 29. These items evaluate difficulty in asking for help and letting others help you. This factor has been called "Difficulty in receiving and asking for help".

Factor 3 consists of items 4, 9, 13, 18 and 24. These items measure the expectation of receiving reciprocal care from others. This factor has been called "Resentment about not receiving reciprocity".

Factor 4 consists of items 5, 21, 25, and 30. These items evaluate the lack of positive activities. The factor has been called "Absence of positive activities".

Factor 5 consists of items 7, 10, 14, 19 and 26. These items measure the tendency to ignore one's own needs of care. This factor has been called "Not taking into account one´s own needs".

Factor 6 consist of items 2, 6, 15, 20 and 27. These items assess the ability to tolerate positive comments from other people. The factor has been called "Lack of tolerance of shared positive affect".

Identical factors are obtained with extraction by main component analysis and Varimax rotation.

Correlation analysis between scales, correlations with subject's age and mean differences by gender.

As can be seen in **table 4**, there are positive and very significant correlations between different scale factors, supporting the unidimensionality of the self-care construct:

Some factors are more closely related than others. Self-destructive behaviors correlate more with the absence of positive activities and with a low tolerance of shared positive affect. Resentment about not receiving reciprocity correlates with not taking into account one's own needs. Difficulty in receiving and asking for help correlate more with lack of tolerance of shared positive affect, and less with a resentment about not receiving reciprocity.

Regarding the relationship between scale factors and total scores, there are no significant correlations with subject's age. Negative patterns of self-care assessed by Self Care Patterns Scale seem to be independent of subjects' age.

On the other hand, looking at total punctuations of scale factors, there are no significant differences by gender except for the factor lack of tolerance of shared positive affect where women show more difficulties than men.

Given the hypothesis about the relationship between self-care patterns and a personal history of adverse relations, it seems possible that the difference between men and women could be related to differences in gender regarding types of trauma (Dunne et al. 2003,

Table 3. *Factor analysis of Self Care Scale*

AC1 When I don´t feel well, I do things that make me feel worse	.880					
AC12 I behave self-destructively	.813					
AC16 I criticize myself internally all the time	.605					
AC23 I do things that are harmful for me	.598					
AC31 I don´t eat well	.460					
AC8 I always blame myself for everything	.435					
AC28 When I feel bad, I get angry at myself	.418					
AC11 I´m not able to ask for help		.802				
AC3 I don´t let others help me		.594				
AC17 I keep problems for myself		.568				
AC29 I cannot ask for what I need		.423				
AC4 I feel unfairly treated and I don´t know why			.680			
AC9 No one acknowledges how much I do for them			.622			
AC18 People are very ungrateful			.595			
AC24 It bothers me that others do not respond immediately			.595			
AC13 Others should be there when I need them			.537			
AC5 I don´t take time for enjoyable activities				.810		
AC30 I don´t know how to enjoy my free time				.440		
AC25 I don´t exercise				.429		
AC21 I do not have relationships that feel rewarding				.326		
AC14 I can forgive anything					.620	
AC26 I´m unable to say no					.611	
AC19 I have a hard time standing up for my rights					.530	
AC7 Whatever I do must be useful to others					.517	
AC10 I prioritize the needs of others					.460	
AC22 I allow people to invade my space					.438	
AC27 I neutralize compliments						-.758
AC2 Praise makes me feel uncomfortable						-.585
AC15 I tend to believe criticism more than compliments						-.491
AC20 I feel more comfortable helping others						-.347
AC6 I don´t trust people who tell me positive things						-.338

Extraction method: Maximum Likelihood. Rotation Method: Oblimin with Kaiser Normalization.[a]

Table 4. *Intercorrelations between factors*

	Self-destructive	Help	Resentment	Activities	Needs	Positive affect
Self-destructive	1	.406**	.393**	.533**	.508**	.524**
Help		1	.286**	.321**	.357**	.523**
Resentment			1	.319**	.406**	.322**
Activities				1	.409**	.386**
Needs					1	.444**
Positive affect						1

** Significant correlation at 0.01 level

Table 5. *T test for independent groups (men vs women)*

	Men			Women			t-test	
	N	Mean	SD	N	Mean	SD	t	Sig.
Self-destructive behavior	72	3.96	1.25	191	4.19	1.47	-1.24	.22
Dif. recei. and accepting help	72	4.11	1.28	191	4.21	1.32	-0.57	.57
Resentment over not reciprocity	72	3.96	1.31	191	4.15	1.27	-1.07	.29
No positive activities	72	3.53	1.27	191	3.78	1.44	-1.26	.21
Not taking into account one's needs	72	4.06	1.13	191	4.33	1.21	-1.65	.09
No tolerance of shared positive affect	72	4.63	1.14	191	4.99	0.08	-2.38	**.02**

Table 6. *Model of logistic regression*

	B	S. E.	Wald	df	Sig.	Exp(B)
Self-destructive behavior	-0.022	0.145	0.023	1	.881	0.978
Difi. asking or accepting help	-0.177	0.142	1.544	1	.214	0.838
Resentment over non-reciprocity	0.025	0.130	0.038	1	.846	1.026
No positive activities	0.063	0.127	0.246	1	.620	1.065
No attention to one's needs	0.064	0.153	0.176	1	.675	1.066
Lack of tolerance of shared positive affect	0.305	0.174	3.087	1	.079	1.357
Physical abuse	-0.476	0.343	1.930	1	.165	0.621
Sexual abuse	1.558	0.470	10.990	1	.001	4.752
Constant	-0.422	0.731	0.333	1	.564	0.656

Roy and Janal 2006, Esquivel-Santoveña and Dixon 2012, Alvarez-del Arco et al. 2013). In our sample, total scores of negative self-care patterns are related to sexual abuse (p= .028) but not to physical abuse, so this could be a confounding factor in the relationship between self-care and gender. In order to test this hypothesis, we conducted a multiple logistic regression analysis using the enter method. We consider gender as a dependent variable and total scores of each scale factor as an independent variable. When we analyzed the importance of scale factors for the variable gender, only the factor lack of tolerance of shared positive affect showed a statistical significance (p= .046); when we introduce the variables physical and sexual abuse, gender was not significant p= .079). Therefore, differences between males and females may not be related to intrinsic gender factors, but many other factors could be involved, and these should be studied more deeply. The following table shows the model of logistic regression including the variables sexual and physical abuse.

Regression model of the scale

In order to see what dimensions or scales explain the pattern of negative self-care, and how much each one does, we carried out a Stepwise Multiple Regression Analysis. We considered as a dependent variable Negative Self Care, and as independent variables total scores for each dimension of self-care included in the scale. The Regression Model showed that the Negative Self Care Pattern could explain 63.7% of the Self-destructive Behavior (R^2= .637), 14.7% of the Difficulty to accepting and asking for help (R^2= .147), 9% of Not taking into account one's own needs (R^2= .090), 5.7% of Absence of positive activities (R^2= .057), 4.5% of Resentment about not reciprocity (R^2= .045) and 2.4% of Lack of tolerance of shared positive affect (R^2= .024).

Discussion

This study aimed to develop and validate a scale, the Self-Care Scale, for assessing patterns of self-care. This scale responds to the need to operationalize the concept defined by Gonzalez and Mosquera (2012) that conceptualized self-care as including the three dimensions of material self-care, intrapsychic self-care and interpersonal self-care.

In the development of the scale, the initial number of items proposed was reduced while internal consistency of the global scale (Cronbach's Alpha .91) as well as the internal consistency of the subscales (Cronbach's Alpha > .6) remained good, with a maximum of .855 in the subscale Self-destructive behavior.

On the other hand, the results of the exploratory factor analysis of the scales shows total variance explained values of 55.386, which points out the need of exploring more elements that could be related to the concept of self-care patterns. The factors identified in the factor analysis are consistent with the theory from which the scale has been elaborated. The factors self-destructive behavior, resentment over not receiving reciprocity, difficulty for accepting and asking for help, absence of positive activities and lack of tolerance of shared positive affect remain similar to the initial proposal. Items related to physical self-care were included in the factors self-destructive behavior and absence of positive activities. The rest of the items in the final version reflect a factor of not taking into account one's own needs, instead of the previous concept, which was referred to as a balance between the needs and the duty. The significant correlations between subscales supports the multidimensionality of the construct self-care patterns, and also supports the interrelation between the different aspects that compose it.

Regarding the possible influence of age and gender in the scores of the scale, there are no significant differences associated with these variables, except for the relationship between gender and tolerance of shared positive affect. However, the statistical significance of this relationship is lower when we analyze the influence of other factors such as physical or sexual abuse, that show different rates of prevalence according to gender.

In summary, the Self-Care Scale has shown good psychometric properties in its initial evaluation and the results support the validity of a definition of the concept self-care that includes both behavioral, intrapsychic and interpersonal dimensions. In this study we carried out an initial validation of the instrument, but we believe it should be analyzed in different samples of both clinical and non-clinical population to further evaluate its utility.

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