Interpersonal Relationships & Self-Efficacy for Labor

By

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Abstract

TITLE: Interpersonal Relationships & Self-Efficacy for Labor

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This descriptive, correlational study explored the association between abusive interpersonal relationships and maternal self-efficacy for childbirth. It was hypothesized that women who experienced abuse in their relationships would report reduced self-efficacy expectancy for labor and childbirth. Participants were nulliparous women in their third trimester of pregnancy who could read and write in English. The sample of 20 women was recruited between August and October, 1996 during their routine prenatal care at Oregon Health Sciences University (OHSU) or one of its satellite clinics. They completed the Childbirth Self-Efficacy Inventory (CBSEI) followed by the Abuse Risk Inventory (ARI) in a private setting.

Sociodemographic characteristics were analyzed using descriptive statistics. Mean scores from the CBSEI and ARI were correlated and the self-efficacy of abused versus nonabused women were also compared using a t-test ($p<.05$). Abuse was defined as a score of > 46 on the ARI or a positive response to any of the items in questions 13 through 16 on the ARI. Due to the small

sample size, the result of the Pearson's correlation between the IRS scores and the sum of the CBSEI scores showed the anticipated inverse relationship, but did not achieve statistical significance. It is imperative that health care providers assess pregnant women for abuse in a timely and sensitive manner, so that maternal-fetal morbidity and mortality may be prevented, and maternal self-efficacy may be fostered and maintained.

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Tables

Despite the fact that abuse in pregnancy is a significant health problem in the United States, there is evidence that it remains under assessed and under reported. Beyond the obvious detriments to the health of both the pregnant woman and her fetus, there is growing concern among clinicians that abuse may undermine a woman's maternal self-efficacy--her belief in her own ability to cope with the processes of labor and childbirth. The purpose of this study was to explore the relationship between a lifetime incidence of abuse and maternal self-efficacy. To our knowledge, this is the first study of this relationship.

Background

Definitions of Abuse

While most definitions of abuse in the literature focus on physical abuse/assault, some include aspects of psychological and sexual abuse as well. Perhaps because of the difficulties inherent in defining and measuring psychological and sexual abuse, most studies (Hillard, 1985; Helton, 1986; Helton, McFarlane, & Anderson, 1987; Bullock & McFarlane, 1989; Johnson & Oakley, 1991; Parker & McFarlane, 1991; Young & McFarlane, 1991; Campbell, Poland, Waller & Ager, 1992) have measured abuse in terms of physical violence. Stewart & Cecutti (1993) considered the presence of psychological and verbal abuse to be "additional characteristics" of their

physically abused prenatal patients. This was confirmed by Parker, McFarlane, Soeken, Torres & Campbell (1993), who found a significant correlation between psychological and physical abuse in their subjects. Other studies (McFarlane, 1989; Amaro, Fried, Cabral, & Zuckerman, 1990; McFarlane, 1993; Parker, McFarlane, & Soeken, 1994; Norton, Peipert, Zierler, Lima, & Hume, 1995) have included sexual violence in their definitions of abuse. Still others (Helton & Snodgrass, 1987; Bohn, 1990; Sampselle, Peterson, Murtland, & Oakley, 1992) have measured physical, sexual, and/or psychological abuse. Helton & Snodgrass noted that "battering takes on many forms--physical, emotional, psychologic, and economic....from frequent slaps, shoves, and punches to full beatings, sexual assault, and torture. Many batterers isolate, degrade, and humiliate female partners" (1987, p. 142).

Prevalence of Abuse

The reported prevalence of abuse among pregnant women in the United States ranges from 0.9% to 20% (Gazmararian et al., 1996). The range of prevalency rates for women experiencing violence at any time in the past (including pregnancy) is 9.7% to 29.7%. The differences across studies are due to a number of factors, including inconsistencies in the definitions of violence and measurement tools, differences in time frames considered,

diversity in the populations studied, and study methods used. Prevalence rates were highest in studies in which data was collected in person, by skilled interviewers, rather than through self-administered questionnaires. Studies in which women were questioned during the third trimester, or at multiple times during pregnancy, yielded higher prevalency rates than those in which women were questioned once early in pregnancy. A recent review of prevalency rates suggested that at the most commonly cited prevalencies, approximately 156,000 to 332,000 pregnant women are abused in the United States each year (Gazmararian et al., 1996).

Correlates of Abuse during Pregnancy

Various studies have attempted to identify risk factors associated with abuse during pregnancy. Research to date indicates that the most significant predictor of abuse during pregnancy is a history of prior abuse (Helton et al., 1987; Hillard, 1985; Amaro, 1990; McFarlane, 1993; Stewart & Cecutti, 1993). Studies examining demographic correlates of abuse have yielded varying results. While some studies reported no significant differences in demographic characteristics between battered and not battered pregnant women (Helton et al., 1987; Campbell et al., 1992), others suggested that women experiencing abuse were more likely to be of low socio-economic status, unmarried (Amaro et al., 1990; Stewart & Cecutti, 1993), and less

educated (Hillard, 1985; Stewart & Cecutti, 1993) than nonabused women.

Studies by Hillard (1985) and Campbell et al. (1992) reported no correlation between ethnicity and abuse in pregnancy. In a study of 691 ethnically diverse pregnant women, McFarlane (1993) reported the same prevalence of abuse (19%) among white and African-American pregnant women, but found that white women were more at risk for trauma due to a greater frequency, severity, and danger potential of the abuse. Hispanic women had the lowest prevalence of abuse (14%), with a decreased severity of abuse reported by women during pregnancy. It was concluded from these results that the pregnant state may confer some protection from abuse for Hispanic women. Both Amaro and associates (1990) and Berenson and colleagues (1991) found a significantly higher incidence of abuse among white pregnant women than among Hispanic or African-American pregnant women.

As Bowker points out, "wife-beating is not independent of other dimensions of marital relationships" (1983, p. 56). Physical abuse rarely occurs without psychological abuse. An atmosphere of threat in the relationship, with a partner exhibiting behaviors such as extreme jealousy, coercive control and emotional degradation, is also associated with current or potential abuse (Bohn, 1990; Walker, 1984). Battering relationships are often characterized by

continuous disagreements between partners, with more serious disagreements resulting in a higher level of violence. Lack of social, emotional, and family support have also been associated with an increased risk of being a victim of violence during pregnancy (Amaro, 1990; Campbell et al., 1992). Resultant psychological factors correlated with battering include emotional distress, low self-esteem, depression, anxiety, learned helplessness, isolation, attempted suicide and alcohol and drug use (Walker, 1984; Mills, 1984; Amaro et al., 1990; Campbell et al., 1992; Stewart & Cecutti, 1993).

Effects of Abuse on Pregnancy Outcome

Abuse in pregnancy has adverse maternal and fetal outcomes. These may include serious maternal injury, vaginal bleeding, and preterm labor (Stewart & Cecutti, 1993), late or inadequate prenatal care (Campbell et al., 1992; McFarlane, 1993; Parker, McFarlane, & Soeken, 1994), poor maternal weight gain (Parker, McFarlane, & Soeken, 1994), the delivery of low-birth-weight [less than 2,500 grams] infants (Bullock & McFarlane, 1989; McFarlane, 1989; Parker, McFarlane, & Soeken, 1994), abruptio placentae or uterine rupture (Johnson & Oakley, 1990), fetal loss (Hillard, 1985), maternal infections and anemia (Parker, McFarlane, & Soeken, 1994), and maternal depression and vague physical complaints (Helton & Snodgrass, 1987). Abused pregnant women are also more likely to use drugs and alcohol than

their non-abused counterparts (Hillard, 1985; Amaro et al. 1990; Parker et al., 1994; Martin, English, Clark, Cilenti, & Kupper, 1996), and to smoke (Martin et al., 1996) during pregnancy.

Assessment and Intervention Strategies

Pregnancy is one time that healthy women are in frequent contact with health care providers, and so it provides a unique opportunity for abuse assessment. Because some abused women do not access prenatal care until late in their pregnancies (McFarlane, 1993; Parker, McFarlane, & Soeken, 1994), it is clear that each encounter with the pregnant client is precious. Abused women are often reluctant to disclose, or may not have identified themselves as abused. A study by Norton et al. (1995) found an increased identification of abused pregnant women through the use of a structured questionnaire. A standard interview conducted by trained social workers who asked about domestic violence, health behaviors, and psychological risk factors was not as effective. Both detection rates and client safety are increased when the assessment is completed by the care provider, in a private setting, without the presence of the male partner (McFarlane, 1993).

Several abuse assessment screens have been evaluated and compared in the literature. The use of Conflict Tactics Scale (CTS) in research has been

widely reported (McFarlane, 1993; Parker et al., 1993; Gielen, O'Campo, Faden, Kass, & Xue, 1994; McFarlane, Parker, & Soeken, 1995). This self-report instrument measures the frequency of violent tactics within the relationship during the previous year. The Index of Spouse Abuse (ISA), a self-report instrument which measures the severity or magnitude of physical and non-physical male partner abuse, has also been used in research (McFarlane, 1993; Parker et al., 1993; McFarlane, Parker, & Soeken, 1995). The 5-item Abuse Assessment Scale, developed by the Nursing Research Consortium on Violence and Abuse, has been widely studied and found to be clinically as sensitive and reliable as these longer research instruments (McFarlane, 1993; Parker, McFarlane, & Soeken, 1994; McFarlane, Parker, & Soeken, 1995; Norton et al., 1995).

Self-Efficacy and Childbirth: A Review of the Literature

Bandura (1977, 1982) defined self-efficacy as a dynamic cognitive process in which the individual evaluates his/her capabilities to cope with different realities and execute required behaviors. According to Bandura there are four sources of self-efficacy information: performance accomplishments; vicarious experience; verbal persuasion; and emotional arousal. Attention to all four sources can assist birth attendants to assess maternal confidence and provide the opportunity for intervention. The childbirth milieu presents its own

unique challenges to a woman's perceived level of self-efficacy.

Women bring different resources and levels of self-efficacy to the childbirth experience. Research is needed to determine the factors that influence self-efficacy for the birth event. Measurement of maternal self-efficacy could provide data on which to base interventions and develop strategies that enhance self-efficacy for childbirth. A self-efficacy measure for an unpredictable event like childbirth would consider the range of behavioral responses required to cope with labor (Lowe, 1991, 1993).

Summary

This study will explore the association between abusive relationships and maternal self-efficacy for childbirth. The dynamics of an abusive relationship may provide the woman with a consistently negative assessment of her perceived self-efficacy. This can occur through a manipulation of the four sources of self-efficacy information by the abuser. This can also occur as a result of the woman's appraisal of her situation and her perceived inability to change it.

Bandura (1977) proposed that enhanced self-efficacy tends to generalize to other situations. Improvements in self-efficacy can transfer to situations that are substantially different from the behaviors that were the focus of self-efficacy treatment. Theoretically, the reverse could also be true. Diminished

self-efficacy could also generalize to other situations. Therefore, this study proposed that there would be an inverse association between the experience of an abusive relationship and maternal self-efficacy for childbirth

Methods

Participants

Participants for this study were a convenience sample drawn from the population of pregnant women receiving care at the prenatal clinic of an urban teaching hospital or one of its satellite clinics. Participants were nulliparous women in their third trimester of pregnancy who could read and write in English. Of 25 women approached between August and October 1996, 20 women agreed to participate.

Instruments

Abusive interpersonal relationships were measured with the two-part Abuse Risk Inventory (ARI). The first part, titled "Interpersonal Relationship Survey" is a 25-item, 4-point Likert-type questionnaire measuring interrelational characteristics with the current partner thought to correlate with abuse. For example, one item asks, "My husband/partner uses drugs (like marijuana or pills)"; another asks, "My husband/partner and I get upset if we don't have enough money to do the things we enjoy". Scores for this part may range from 25-100 points, with scores >46 indicating the presence of

abuse (Yegidis, 1989). Validity studies done for this part have demonstrated that the ARI correctly classified between 56% and 94% of respondents as abused. The Cronbach's alpha for part one is .88 (Yegidis, 1989).

Part two of the ARI contains 12 research questions designed to obtain demographic information, and five questions concerning the abuse histories of the respondents. These questions ask about abuse: physical abuse (have you been hit, kicked, punched, or physically assaulted); emotional abuse (verbal threats, put-downs); and rape (forced to have sexual intercourse or other forms of sexual penetration) as perpetrated within the past year by the respondent's husband or male partner. One question asks whether the respondent has ever been raped, emotionally abused, or physically abused by a husband, male partner, or other male relative. Another question asks if there is a history of abuse in her family of origin. Women scoring >46 on part one of the ARI, or responding affirmatively to any of the five specific abuse questions on part two of the ARI, were considered abused for the purposes of this study.

Maternal self-efficacy for labor and childbirth was measured with the Childbirth Self-Efficacy Inventory (CBSEI), a self-report questionnaire with four subscales. Subscales one and two measure outcome expectancy and self-efficacy expectancy for active labor with a 15-item, 10-point Likert-type scale.

Subscales three and four measure outcome expectancy and self-efficacy expectancy for second stage with a 16-item, 10-point Likert-type scale. Total self-efficacy scores may range from 31-310, with a reported M=209.7 and SD=46.1 (Lowe, 1993). The CBSEI items of helpful behaviors for coping with childbirth were generated by a panel of experts (Lowe, 1993), rather than by women who were anticipating or who had experienced childbirth. The behaviors are thought to enhance maternal coping (e.g. "use breathing during labor contractions"). Respondents are asked to rate the helpfulness of the behaviors from "not at all helpful" to "very helpful" (outcome expectancy), and their confidence in their ability to use the behaviors from "not at all sure" to "very sure" (self-efficacy expectancy). Construct validity for the CBSEI was supported by factor analysis that suggests unidimensionality of each scale (Lowe, 1991). Criterion-related validity was supported by significantly higher self-efficacy scores for multiparous women as compared to nulliparous pregnant women (Lowe, 1991). Cronbach's alpha scores for the CBSEI were .86 for Outcome-active labor, .93 for Efficacy-active labor, .90 for Outcome-second stage, and .95 for Efficacy-second stage (lowe, 1991). The sum of self-efficacy subscale scores for active labor and second stage was utilized for statistical analysis. All the respondents completed the entire CBSEI.

Data Collection

This study was conducted using procedures approved by an Institutional Review Board. Women meeting criteria for participation were approached by one of the investigators, who described the study. Written consent was obtained for those who agreed to participate. Participants completed the Childbirth Self-Efficacy Inventory (CBSEI, Lowe, 1991), followed by the Abuse Risk Inventory (ARI, Yegidis, 1989), alone in a private setting. After completing the questionnaires, each woman was given a sealed envelope containing a copy of her signed consent, telephone numbers of the investigators, and a domestic violence resource card. A logbook of participants' names and ID numbers was maintained to avoid participant duplication. It was destroyed at the termination of the study to protect confidentiality.

Statistical Analysis

The CRUNCH statistical package was used for data analysis. Descriptive statistics was used to analyze the sociodemographic characteristics of the sample. Mean scores from the CBSEI and ARI were correlated using Pearson's r to evaluate the association between abuse and self-efficacy for childbirth. Self-efficacy scores of abused versus nonabused women were also compared using Student's t-test ($p<.05$).

Results

Participants

The mean age of participants was 22.7 years (SD= 5.5). The range was 18-36 years. Eighty -five percent were single or separated; 15% were married. Fifty-five percent lived with their husband or a male partner. Ten participants were Caucasian, one was African-American, two were Asian-American, two were Hispanic, and one was Mulatta. Six women reported a total family income between $0 - $9,400; two reported a family income between $9,401 - $16,000; four had family incomes between $16,001 - $23,000; and six reported family incomes in excess of $23,001. The mean school grade completed was 12 (SD=1.7). The range was 8 to 16. Fourteen had completed high school. Fifty percent were employed. There were no significant differences in the demographic data between the abused and nonabused women.

Scores on ARI & CBSEI

Seventeen of the 20 participants completed part one of the ARI--the Interpersonal Relationship Survey (IRS). Two of the three women who failed to complete part one did so because it asked about current abuse and they were unpartnered. One participant's score was discarded because greater than 25% of the items were unanswered. Therefore, only 17 ARI part one

questionnaires were analyzed. All 20 women completed part two of the ARI.

The mean score for part one was 41.37 (SD=10.36). The range was 30 to 71. Table 1 shows the number of participants scoring > or < 46 on part one of the ARI and the responses to the specific abuse questions on part two. Table 2 shows the results for the ARI part one and the CBSEI. The sum of the self-efficacy scores on the CBSEI ranged from 54-303 (M= 205.07, SD=67.45). This is consistent with the range for total self-efficacy scores reported by Lowe (1993) of 31-310 (M= 209.7, SD= 46.1).

Table 1

Responses to the ARI (X = a positive response)

Participant	ARI Pt 1 Score >46	ARI Pt 1 Score <46	Physical Abuse Past Year	Emotional Abuse Past Year	Sexual Abuse Past Year	Lifetime History of Abuse
1	X		X	X		X
2		X				
3		X				
4	X					X
5	-	-				X
6	-	-	X	X		X
7		X				
8		X				X
9		X				
10		X			X	
11	X					
12		X				X
13		X				X
14		X				
15		X				
16		X				
17		X				X
18	X			X		X
19	-	-				
20	X		X	X		X

Table 2

Results of the ARI and CBSEI

Variable	N	Mean	Standard Deviation	Range
ARI Part 1	17	41.37	10.36	30.0 - 71.0
Outcome expectancy Active labor	20	118.61	28.46	42.0 - 148.0
Self-efficacy Active labor	20	102.49	29.13	28.0 - 148.0
Outcome expectancy Second stage	20	119.99	36.52	30.0 - 160.0
Self-efficacy Second stage	20	102.58	39.72	26.0 - 155.0
Self-efficacy Sum	20	205.07	67.45	54.0 - 303.0

Research Question

The results of the Pearson's correlation between the scores on part one of the ARI and the sum of the scores on the CBSEI showed the anticipated inverse relationship (r = - 0.30), but did not achieve statistical significance (p=0.24).The group of abused women (n = 12) had a lower mean self-efficacy score (M=195.58, SD=53.37) compared to the nonabused group (n = 8), (M=219.30, SD=86.52). The differences were not statistically significant (p=0.46).

Discussion

The findings suggest that the presence of abuse or a history of abuse may adversely effect maternal self-efficacy for childbirth. The usual rationale

for screening for abuse during pregnancy is to promote the safety and well-being of pregnant women and their fetuses. However, the dynamics of abusive relationships may provide a woman with a consistently negative assessment of her perceived self-efficacy, which provides an additional reason for prenatal care providers to screen for past or current abuse. For women reporting past or current abuse, strategies that enhance maternal self-efficacy, such as intrapartal relaxation or guided imagery techniques may be effective. In addition, the presence of continuous and consistent support may be especially important for these women. Care providers may need to be vigilant to defuse negative feedback from abusive partners.

Limitations

The small number of participants in this study was the major limitation. In addition, the logistics of data collection in busy clinic settings necessitated obtaining the abuse history via a written survey, despite evidence indicating that detection rates are increased when assessments are completed by interview. The ARI did not describe the frequency or intensity of current or past abuse, which may influence the psychological impact of the abuse, including a woman's level of perceived self-efficacy. The IRS (part one of the ARI) is specific for establishing abuse in the current relationship. Four women reported no current abuse and scored <46 on part one, but also

reported a history of prior abuse. It is possible that the impact of their lifetime abuse on self-efficacy could not be appreciated.

The CBSEI items of helpful behaviors for coping with childbirth were generated by a panel of experts (Lowe, 1993) rather than by women who were anticipating or who had experienced childbirth. The measurement of self-efficacy through self-rating on specific tasks is consistent with classic self-efficacy theory (Bandura, 1977). However, self-efficacy can be determined if it is based upon the accomplishment of specific tasks (outcome expectancy). An unpredictable event like childbirth requires a broad range of coping behaviors and strategies which must be individualized for each woman's situation. It may not be possible to reconcile the essentially uncontrollable experience of childbirth with the behavior/specific, task-oriented approach of classic self-efficacy theory.

Recommendations

It is imperative that all pregnant women be screened for past and current abuse. In order to increase both detection rates and client safety, it is recommended that a personal assessment be completed by the provider, in a private setting, without the presence of the male partner (McFarlane, 1993). A questionnaire that focuses specifically on past or current abuse would be more helpful clinically than a longer tool, such as part one of the ARI. It is

recommended that the five questions on part two of the ARI (or similar ones) be used as the initial screen for abuse. Further assessment could be made using the items in part one in instances where current abuse is identified. Research toward the development of a self-efficacy tool in which helpful coping behaviors are generated via qualitative study of women could enhance the assessment of maternal self-efficacy.

Further study regarding interventions that could be implemented prenatally to improve maternal self-efficacy for childbirth and parenting is also warranted. This could benefit all women, as well as those who have experienced abusive relationships.

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Appendices

Appendix A

Childbirth Self-Efficacy Inventory

(CBSEI)

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Subject ID_____ Date_____

CBSEI: Part I (Labor)

Think about how you imagine labor will be and feel when you are having contractions 5 minutes apart or less. For each of the following behaviors, indicate how helpful you feel the behavior could be in helping you cope with this part of labor by circling a number between 1, not at all helpful, and 10, very helpful.

	Not at all Helpful									Very Helpful
1. Relax my body.	1	2	3	4	5	6	7	8	9	10
2. Get ready for each contraction.	1	2	3	4	5	6	7	8	9	10
3. Use breathing during labor contractions.	1	2	3	4	5	6	7	8	9	10
4. Keep myself in control.	1	2	3	4	5	6	7	8	9	10
5. Think about relaxing.	1	2	3	4	5	6	7	8	9	10
6. Concentrate on an object in the room to distract myself.	1	2	3	4	5	6	7	8	9	10
7. Keep myself calm.	1	2	3	4	5	6	7	8	9	10
8. Concentrate on thinking about the baby.	1	2	3	4	5	6	7	8	9	10
9. Stay on top of each contraction.	1	2	3	4	5	6	7	8	9	10
10. Think positively.	1	2	3	4	5	6	7	8	9	10
11. Not think about the pain.	1	2	3	4	5	6	7	8	9	10
12. Tell myself that I can do it.	1	2	3	4	5	6	7	8	9	10
13. Think about others in my family.	1	2	3	4	5	6	7	8	9	10
14. Concentrate on getting through one contraction at a time.	1	2	3	4	5	6	7	8	9	10
15. Listen to encouragement from the person helping me.	1	2	3	4	5	6	7	8	9	10

Part I Continued

Continue to think about how you imagine labor will be and feel when you are having contractions 5 minutes apart or less. For each behavior, indicate how certain you are of your ability to use the behavior to help you cope with this part of labor by circling a number between 1, not at all sure, and 10, completely sure.

	Not at all Sure									Very Sure
16. Relax my body.	1	2	3	4	5	6	7	8	9	10
17. Get ready for each contraction.	1	2	3	4	5	6	7	8	9	10
18. Use breathing during labor contractions.	1	2	3	4	5	6	7	8	9	10
19. Keep myself in control.	1	2	3	4	5	6	7	8	9	10
20. Think about relaxing.	1	2	3	4	5	6	7	8	9	10
21. Concentrate on an object in the room to distract myself.	1	2	3	4	5	6	7	8	9	10
22. Keep myself calm.	1	2	3	4	5	6	7	8	9	10
23. Concentrate on thinking about the baby.	1	2	3	4	5	6	7	8	9	10
24. Stay on top of each contraction.	1	2	3	4	5	6	7	8	9	10
25. Think positively.	1	2	3	4	5	6	7	8	9	10
26. Not think about the pain.	1	2	3	4	5	6	7	8	9	10
27. Tell myself that I can do it.	1	2	3	4	5	6	7	8	9	10
28. Think about others in my family.	1	2	3	4	5	6	7	8	9	10
29. Concentrate on getting through one contraction at a time.	1	2	3	4	5	6	7	8	9	10
30. Listen to encouragement from the person helping me.	1	2	3	4	5	6	7	8	9	10

CBSEI: Part II (Birth)

Think about how you imagine labor will be and feel when you are pushing your baby out to give birth. For each of the following behaviors, indicate how helpful you feel the behavior could be in helping you cope with this part of labor by circling a number between 1, not at all helpful, and 10, very helpful.

	Not at all Helpful									Very Helpful
31. Relax my body.	1	2	3	4	5	6	7	8	9	10
32. Get ready for each contraction.	1	2	3	4	5	6	7	8	9	10
33. Use breathing during labor contractions.	1	2	3	4	5	6	7	8	9	10
34. Keep myself in control.	1	2	3	4	5	6	7	8	9	10
35. Think about relaxing.	1	2	3	4	5	6	7	8	9	10
36. Concentrate on an object in the room to distract myself.	1	2	3	4	5	6	7	8	9	10
37. Keep myself calm.	1	2	3	4	5	6	7	8	9	10
38. Concentrate on thinking about the baby.	1	2	3	4	5	6	7	8	9	10
39. Stay on top of each contraction.	1	2	3	4	5	6	7	8	9	10
40. Think positively.	1	2	3	4	5	6	7	8	9	10
41. Not think about the pain.	1	2	3	4	5	6	7	8	9	10
42. Tell myself that I can do it.	1	2	3	4	5	6	7	8	9	10
43. Think about others in my family.	1	2	3	4	5	6	7	8	9	10
44. Concentrate on getting through one contraction at a time.	1	2	3	4	5	6	7	8	9	10
45. Focus on the person helping me in labor.	1	2	3	4	5	6	7	8	9	10
46. Listen to encouragement from the person helping me.	1	2	3	4	5	6	7	8	9	10

Part II Continued

Continue to think about how you imagine labor will be and feel when you are pushing your baby out to give birth. For each behavior, indicate how certain you are of your ability to use the behavior to help you cope with this part of labor by circling a number between 1, not at all sure, and 10, completely sure.

	Not at all Sure									Very Sure
47. Relax my body.	1	2	3	4	5	6	7	8	9	10
48. Get ready for each contraction.	1	2	3	4	5	6	7	8	9	10
49. Use breathing during labor contractions.	1	2	3	4	5	6	7	8	9	10
50. Keep myself in control.	1	2	3	4	5	6	7	8	9	10
51. Think about relaxing.	1	2	3	4	5	6	7	8	9	10
52. Concentrate on an object in the room to distract myself.	1	2	3	4	5	6	7	8	9	10
53. Keep myself calm.	1	2	3	4	5	6	7	8	9	10
54. Concentrate on thinking about the baby.	1	2	3	4	5	6	7	8	9	10
55. Stay on top of each contraction.	1	2	3	4	5	6	7	8	9	10
56. Think positively.	1	2	3	4	5	6	7	8	9	10
57. Not think about the pain.	1	2	3	4	5	6	7	8	9	10
58. Tell myself that I can do it.	1	2	3	4	5	6	7	8	9	10
59. Think about others in my family.	1	2	3	4	5	6	7	8	9	10
60. Concentrate on getting through one contraction at a time.	1	2	3	4	5	6	7	8	9	10
61. Focus on the person helping me in labor.	1	2	3	4	5	6	7	8	9	10
62. Listen to encouragement from the person helping me.	1	2	3	4	5	6	7	8	9	10

CHILDBIRTH SELF-EFFICACY INVENTORY (CBSEI)

Nancy K. Lowe, CNM, PhD
College of Nursing
The Ohio State University
1585 Neil Avenue, Columbus, OH 43210-1289
(614-292-8479)

Scoring Instructions

The CBSEI is a self-report measure of outcome expectancy and self-efficacy expectancy for labor and birth. In the framework of self-efficacy theory (Bandura, 1982), outcome expectancy for labor and birth is defined as the belief that a given behavior will enhance coping with labor, while self-efficacy expectancy is a personal conviction that one can successfully perform specific behaviors during labor. This distinction is important because a woman may believe that a certain behavior could help a woman cope with labor, but feel incapable of personally performing the behavior during her own labor.

Part I of the CBSEI measures outcome expectancy and self-efficacy expectancy for active labor, while Part II measures the same constructs for second stage or birth. Scale scores are computed by summing the item responses as follows:

Outcome Expectancy Active Labor (Outcome-AL):	items 1 through 15
Self-Efficacy Expectancy Active Labor (Efficacy-AL):	items 16 through 30
Outcome Expectancy Second Stage (Outcome-SS):	items 31 through 46
Self-Efficacy Expectancy Second Stage (Efficacy-SS):	items 47 through 62

A Total Childbirth Outcome Expectancy Score (Outcome-Total) is computed by summing the Outcome-AL and Outcome-SS scale scores. A Total Self-Efficacy Expectancy Score (Efficacy-Total) is computed by summing the Efficacy-AL and Efficacy-SS scale scores.

Interpersonal Relationship Survey

33

Name_____ Date_____

The purpose of this Survey is to secure more in-depth information about how you and your partner related to each other. Please read each item carefully and decide which response most accurately reflects your relationship, using the scale provided. Mark your responses by circling the appropriate number to the right of each statement. Do your best to provide a response to each item.

	Rarely or never	Sometimes	Often	Always
My husband/partner:				
1. finds the role of breadwinner satisfying	1	2	3	4
2. is frustrated about our economic situation	1	2	3	4
3. accuses me of deliberately trying to attract other men	1	2	3	4
4. starts arguments with me about matters in the home	1	2	3	4
5. slaps or pushes me during a fight	1	2	3	4
6. uses drugs (like marijuana or pills)	1	2	3	4
7. gets along well with others	1	2	3	4
8. has problems with sexual functioning	1	2	3	4
9. accepts changes I make in our homelife routine	1	2	3	4
10. drinks alcoholic beverages	1	2	3	4
11. slapped or shoved me while we were dating	1	2	3	4
12. tells me I'm inferior as a homemaker or mother	1	2	3	4
13. is considerate of my sexual needs	1	2	3	4
14. changes jobs or is out of work	1	2	3	4
15. shows concern for my health needs	1	2	3	4
My husband/partner and I:				
16. maintain close contact with our families	1	2	3	4
17. discuss problems when they arise	1	2	3	4
18. get upset if we don't have enough money to do the things we enjoy	1	2	3	4
19. have satisfying sexual relationships with each other	1	2	3	4
20. argue a lot	1	2	3	4
21. share recreational activities	1	2	3	4
22. discuss minor problems before they blow up	1	2	3	4
23. argue about trivial or silly matters	1	2	3	4
24. get upset because we don't have enough money to buy the things we need	1	2	3	4
25. plan for our future needs	1	2	3	4

Interpersonal Relationship Survey Research Questionnaire

This questionnaire is to be used in conjunction with the *Interpersonal Relationship Survey* and is designed for research purposes only to obtain additional information regarding your current marital or intimate relationship together with basic sociodemographic information. All responses are strictly confidential.

1. Current marital status. *Circle one.*
   a. Single
   b. Married
   c. Separated
   d. Divorced
   e. Widowed

2. Number of years married or involved in current relationship:_____years

3. With whom do you live? *Circle one.*
   a. Husband
   b. Male partner
   c. Live alone
   d. Husband with children
   e. Male partner with children
   f. Parents
   g. Other (*please specify*)_____

4. Age____ Husband or partner's age_____

5. Ethnicity_____
   Husband or partner's ethnicity:
   _____

6. Annual household income. *Circle one.*
   a. $0 - $9,400
   b. $9,401 - $16,000
   c. $16,001 - $23,000
   d. $23,001 - $30,000
   e. $30,001 - $37,000
   f. $37,001 - $44,000
   g. $44,001 - $50,000
   h. Over $50,000

7. Your highest grade completed_____
   Are you employed? Yes_____ No_____
   What is your occupation or profession?
   _____

8. Your husband or partner's highest grade completed_____
   Are he employed? Yes_____ No_____
   What is his occupation or profession?
   _____

9. Were you physically abused as a child?
   Yes_____ No _____ Don't Know_____
   If yes, by whom?_____

10. Was your husband or partner physically abused as a child?
    Yes_____ No _____ Don't Know_____
    If yes, by whom?_____

11. Was your mother ever physically abused by your father?
    Yes_____ No _____ Don't Know_____

12. Was your husband's or partner's mother ever physically abused by her husband?
    Yes_____ No _____ Don't Know_____

13. Within the last year, have you been hit, kicked, punched or physically assaulted in other ways by your husband or partner?
    Yes _____ No_____

14. Within the last year, have you been emotionally abused (verbal threats, put-downs) by your husband or partner?
    Yes _____ No_____

15. Within the last year, have been raped (forced to have sexual intercourse or other forms of sexual penetration) by your husband or partner?
    Yes _____ No_____

16. Have you ever been raped, emotionally abused, or physically abused by a husband, male partner or other male relative?
    For rape Yes_____ No_____
    For emotional abuse Yes_____ No_____
    For physical abuse Yes_____ No_____

Abuse Risk Inventory For Women Scoring Key

35

by Bonnie Yegidis

	Scoring Weights			
	Rarely or never	*Sometimes*	*Often*	*Always*
1.	4	3	2	1
2.	1	2	3	4
3.	1	2	3	4
4.	1	2	3	4
5.	1	2	3	4
6.	1	2	3	4
7.	4	3	2	1
8.	1	2	3	4
9.	4	3	2	1
10.	1	2	3	4
11.	1	2	3	4
12.	1	2	3	4
13.	4	3	2	1
14.	1	2	3	4
15.	4	3	2	1
16.	4	3	2	1
17.	4	3	2	1
18.	1	2	3	4
19.	4	3	2	1
20.	1	2	3	4
21.	4	3	2	1
22.	4	3	2	1
23.	1	2	3	4
24.	1	2	3	4
25.	4	3	2	1

Total Score _____

To use this scoring key,
Fold this paper in half and line up next to the appropriate item numbers on the answer sheet. To score, use the scoring weights printed on this key, adding the values that correspond to the circled responses on the test booklet. Enter the total score on the bottom of the key. Refer to the manual for interpretive information.

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Appendix B

T · H · E
OHIO
STATE
UNIVERSITY

College of Nursing
Department of Community,
Parent-Child and Psychiatric Nursing

1585 Neil Avenue
Columbus, OH 43210-1289
Phone 614-292-4800
Fax 614-292-4948

January 23, 1996

Jill Leander, RN, CNM
3016 Southeast Taggart
Portland, OR 97202

Dear Jill:

I enjoyed talking with you the other day and thank you for your interest in the Childbirth Self-Efficacy Inventory (CBSEI). I am enclosing two copies of the tool and scoring instructions for you and Dr. Robrecht. If you decide to use the CBSEI in a research project, you have my permission to do so providing the following conditions are met:

1) The instrument is not altered in any way and will be duplicated from the original.

2) An abstract of your study will be sent to me on its completion.

3) Psychometric data will be sent to me on the instrument including reliability estimates, any relevant validity information, and results of a factor analysis, if done.

4) You will inform me of your decision to use the instrument prior to data collection.

Please give my warm regards to Linda Robrecht. Please do not hesitate to contact me if I can be of any further assistance (614-292-8479) and best wishes for the completion of your master's program in nurse-midwifery.

Sincerely,

Nancy K. Lowe

Nancy K. Lowe, CNM, PhD
Associate Professor
Director, Women's Health/Nurse-Midwifery Graduate Programs

July, 1996

Institutional Review Board/Committee on Human Research
Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Portland, OR 97201-3098

To the Committee members:

Thank you for your concern for this potentially vulnerable population of women. We applaud the efforts of this review board to anticipate and avert further trauma. Covered in this letter will be brief biographies of the co-investigators' experiences with issues of violence and victimization. We have also included corrected forms and enclosures, a discussion of the proposed language change in the consent form, and an introduction of Linda Glenn, MHNP.

The co-investigators of this research project collectively possess over 40 years of experience working with victims/survivors of trauma, including the following:

Sharon Maxey worked for 15 years in Medical ICU, Surgical/Trauma ICU and ER, and is a former CCRN. She has given direct service to women as a volunteer at the Clackamas Women's Shelter for victims of domestic violence. Sharon is also an abuse survivor and an intuitive.

Jill Leander has 15 years experience working in High-Risk Obstetrics/Labor & Delivery. She served on the OHSU Domestic Violence Committee that developed and implemented the hospital-wide DV protocol. Jill wrote and produced an educational video to inform and motivate OHSU staff to respectfully screen clients for violence and victimization. In that video, she interviewed 3 survivors of intimate partner abuse, including Barbara Glidewell, OHSU Patient Advocate. She completed with highest grades Barbara Limandri's graduate course, Dimensions of Family Violence. Barbara Glidewell and Dan Kamada, MHNP and Chair of the OHSU Domestic Violence Committee will attest to her sensitive and respectful care for abuse survivors. Jill has also volunteered at the Oregon Coalition Against Domestic and Sexual Violence.

Our collective commitment to helping abused women leads us to undertake this research project. We have carefully considered the ethics and implications of this study. Pursuant to Sharon Maxey's discussion on 7/3/96 with Committee members Lynda and Dawn, we believe that the following changes and enclosures will address/comply with the review board's concerns:

1) Revised consent form, with changes highlighted.
2) Domestic violence referral card, which lists hotlines, legal advocates, and restraining order information. The card will be given separately from the consent form to minimize risk to participants.
3) Changing the language in the purpose section of the consent form to mention "abuse in pregnancy" may serve to increase risk to the participant, in the event the signed copy of the consent is found in her possession. Also, the title of the proposed abuse assessment tool is, in fact, "Interpersonal Relationship Survey". Alternatively, we propose adding a stronger verbal consent to our existing written consent.

We understand that filling out these questionnaires may cause upset to the client. But in the unlikely event that this occurs, we would like to offer the client the opportunity to speak with Linda Glenn, CNM, MHNP. Among Linda's many skills and qualifications is her work preparing trauma victims/survivors for labor and childbirth processes. We are grateful for the review board's suggestion that such an independent and impartial mental health practitioner be available for our study's participants, and we are pleased that Linda Glenn has agreed to assist us. Out of respect for a client's freedom to choose her own health care provider(s), Linda Glenn may not personally counsel each client referred to her, but may, instead, assist the client to find other appropriate resources.

In conclusion, we believe that by making these changes and additions, we will sufficiently address the review board's concerns. We would like to express our gratitude for the opportunity to improve our project, and for the board's contributory efforts on behalf of our project and its participants. We look forward to a positive response from review board members.

Sincerely,
Jill Leander
Lisa Mattke
Sharon Maxey

OHSU
OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098
Mail Code L106, (503) 494-7887 Fax (503) 494-7787
Institutional Review Board/Committee on Human Research

DATE: August 6, 1996

TO: J.Leander/L Mattke/S Maxe, MSN SON
Mary Ann Curry/4-3847

FROM: The Committee on Human Research
MacHall Rm. 2160, Ext. 7887

SUBJECT: IRB#: 4173
TITLE: Interpersonal Relationships in Pregnancy and Self-Efficacy for Childbirth

This confirms receipt of the revised consent form(s), and/or answers to questions, assurances, etc., for the above-referenced study.

It satisfies the requirements of the Committee on Human Research. The protocol and proposal to use human subjects are herewith approved. The IRB# and the date of this memo must be placed in the top right corner of the first page of the consent form. This is the approval date of this revised consent form.

Investigators must provide subjects with a copy of the consent form, keep a copy of the signed consent form with the research records, and place a signed copy in the patient's hospital/clinic medical record (if applicable).

Approval by the Committee on Human Research does not, in and of itself, constitute approval for implementation of this project. Other levels of review and approval may be required, and the project should not be started until all required approvals have been obtained. Also, studies funded by external sources must be covered by an agreement signed by the sponsor and an authorized official of the University. The Principal Investigator is not authorized to sign.

If this project involves the use of an Investigational New Drug, a copy of the protocol must be forwarded to the Pharmacy and Therapeutics Committee (Pharmacy Services - Investigational Drugs, OP-16A).

Thank you for your cooperation.

Appendix C

IRB#: 4173
Approval Date: 8/6/96

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form

TITLE Interpersonal relationships in pregnancy and self-efficacy for childbirth.

PRINCIPAL INVESTIGATORS Jill Leander, RN, BSN (503) 239-8577
Lisa Mattke, RN, BSN (503) 224-1546
Sharon Maxey, RN, BSN (503) 635-8795
RESEARCH ADVISOR Mary Ann Curry, RN, DNSc (503) 494-3847

PURPOSE You have been invited to participate in this research study because you are in the last three months of your pregnancy. The purpose of this study is to examine the relationship between the interpersonal relationship of a couple approaching childbirth, and the woman's belief or feeling that she will be able to cope with that childbirth.

PROCEDURES If you agree to participate in the study, you will be asked to complete two (2) questionnaires today. It will take about 15-20 minutes to answer the questions, which concern your relationship with your partner, and your feelings about your ability to cope with, or manage, your approaching labor and childbirth.

You will complete the 2 questionnaires in private, after which one of the co-investigators will ask you some sociodemographic questions--questions about yourself--such as age and years of education. When these are completed, you will be given a sealed envelope containing a copy of this consent. You will also receive a card listing some community resources which might be helpful to you or to someone you know.The questionnaires will be coded with a study number known only to the co-investigators. The original questionnaires will be destroyed once the study is completed. Your name, clinic, and questionnaire results will never voluntarily be made available to anyone but the co-investigators.

RISKS AND DISCOMFORTS The questions may give you some things to think about or to worry about. If this happens, you can talk to the person who takes care of you today, (or the person who usually takes care of you at your prenatal visits, if you are taking a childbirth education class today). If any of

the questions cause you distress, you can stop filling out the questionnaires, and let the co-investigator know, so that she may find someone you can talk to if you wish.

BENEFITS A possible benefit of participating in this study is realizing that you may have some issues you wish to discuss with your provider, today, or at another time.
You may or may not personally benefit from participating in this study. However, by serving as a subject, you may contribute new information which may benefit patients in the future.

CONFIDENTIALITY All questionnaires and answers will be kept strictly confidential, and neither your name nor your identity will be used for publication or for publicity purposes. According to Oregon law, suspected child or elder abuse must be reported to appropriate authorities.

COSTS There are no costs to you for participating in this study.

LIABILITY The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation will be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call the Medical Services Director at (503) 494-8014.

PARTICIPATION Your participation in this research study is voluntary. Co-investigators Sharon Maxey (503-635-8795) and Jill Leander (503-239-8577) have offered to answer any other questions you might have about this study. If you have any questions regarding your rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University. Your signature below indicates that you have read the foregoing and agree to participate in this study.

Signed_____
Date_____
Witness_____
Date_____

A copy of the domestic violence resource card, which was given to all study participants, separately from the signed copy of the informed consent:

GREATER PORTLAND AREA DOMESTIC VIOLENCE REFERRALS

Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Portland, Oregon, 97201
494-8311

This card courtesy of OHSU.

24-HOUR A DAY CRISIS & REFERRAL SERVICES	
Portland Women's Crisis Line (Accepts collect calls)	235-5333
Metro Crisis Line	223-6161
Parents Anonymous	238-8818
Elder Abuse Hotline	248-3646
TRI-COUNTY CHILD ABUSE HOTLINE NUMBERS	
Multnomah County (24 hours/day))	731-3100
Clackamas County	657-6802
Washington County (M-F, 8-5)	648-8951
DOMESTIC VIOLENCE LEGAL ADVOCACY/INFORMATION	
Multnomah County Court Advocates	248-3222
Clackamas County Court Advocates	655-8616
Washington County Court Advocates	640-3570

RESTRAINING ORDER INFORMATION	
Multnomah County Courthouse, Room 211	248-3943
Legal Aid/Family Law Center	224-4086
Multnomah County Sheriff's Office	255-3600
HELP FOR MEN WHO ABUSE	
Men's Resource Center	235-3433
William Temple House	226-3021
Raphael House	222-6222
SEXUAL ASSAULT & INCEST SURVIVOR SERVICES	
Council for Prostitution Alternatives	223-4670
Echo's Network (Incest Survivors)	281-8185