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Contraceptive Self-Efficacy Scale

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The Contraceptive Self-Efficacy (CSE) scale assesses motivational barriers to contraceptive use among sexually active teenage women. The self-efficacy construct has been used by Bandura and his associates to understand motivations for apparently dysfunctional or avoidance behavior (Bandura, 1990; Bandura, Adams, Hardy, & Howells, 1980; Kazdin, 1974; McAlister, Perry, & Maccoby, 1979; Rosenthal & Bandura, 1978; Strecher, DeVellis, Becker, & Rosenstock, 1986). The nonuse of contraceptives by sexually active teenage women who say that they do not desire a pregnancy is similar to other types of phobic behaviors. Thus, teenage women’s contraceptive behavior is treated as a special behavioral domain for application of the construct.

According to the self-efficacy construct, a person’s expectations about whether she should and can execute a component behavior will determine initiation and persistence in achieving a desired goal (Bandura, 1977; Fishbein & Ajzen, 1975). The CSE scale measures the strength of a sexually active teenage woman’s conviction that she should and can control sexual and contraceptive situations in order to make contraceptive protection a priority. Stressors are embedded within items to ascertain individual differences among young women who may have different issues that inhibit feelings of self-efficacy. The scale was designed to be used both diagnostically, by educators and clinicians as a tool for designing and assessing interventions, and as a research instrument.

Description

CSE statements evaluate the respondent’s perceptions of her ability to take responsibility for sexual and contraceptive behaviors across a variety of situations. CSE is assessed using 18 items, which respondents rate on a 5-point Likert-type scale ranging from (1) Not at all True of Me to (5) Completely True of Me. The scale has been significantly and independently correlated with contraceptive use among diverse samples of young girls and women ranging in age from 13 to 45 years old, and including inner-city African American youth, predominantly White French Canadian youth, Brazilian youth, Hong Kong Chinese women, and suburban European American and Latina American youth. Research settings have included family planning clinics, high school and college classrooms, hospitals, and institutionalized youth. The results, spanning a 25-year period, indicate that a variety of methods for assessing CSE (e.g., either the sum or the average of the 18-item CSE scale, a four-factor solution, or a LISREL solution) have been predictive of contraceptive behavior among all groups of women (Bilodeau, Forget, & Tétreault, 1994; Heinrich, 1993; Hovsepian, Blais, Manseau, Otis, & Girard, in press; Levinson, 1986, 1995; Levinson, Beamer, & Wan, 1998; Louise, 2005; Nordeen, Mann, & Sullivan, 2005; Wright, 1992).

To determine the best measure of the CSE scale, we explored the scale’s relationship to contraceptive behavior with four diverse samples (for a description of the samples, see Levinson et al., 1998). A series of correlational analyses were conducted with each sample to examine scale properties. A pattern of low correlations among CSE items emerged (averaging near .15 with a small standard deviation), indicating that use of the total item set separately as the basis for CSE was warranted. Zero-order and partial correlations revealed which CSE items were correlated with contraceptive behavior, as well as which items explained unique variance in contraceptive behavior for each sample. This analytic strategy was used owing to the fact that the dependent measure assessing contraceptive behavior was on a different metric in each sample.

These results suggest that diverse groups of women and girls have different issues that inhibit their ability to use contraceptives effectively or to postpone unprotected sexual activity. It is recommended that the CSE scale be used prior to interventions in order to appropriately align interventions to the particular needs of the participants as assessed by the individual items and by the four factors. Another finding of the 1998 study was that Item 8 was consistently predictive of contraceptive behavior across three of the four samples. The predictive power of this one item suggests that the “dis-course of desire” (Fine, 1988) is a very important aspect to be explored in sexuality education for the development of healthy sexual behaviors and skills (Levinson et al., 1998). Other items that were uniquely related to contraceptive behavior were those items assessing confidence in the ability to confront oneself or significant others (e.g., parents, partner, pharmacist) about issues related to sexual needs (e.g., Items 2, 3, 6, 10, 11, 12, 13c, 14). These findings dovetail with earlier research outcomes and have been largely confirmed by subsequent researchers (Nordeen et al., 2005; Hovsepian et al., in press; Louise, 2005), highlighting persistent issues that impact young women’s contraceptive behavior. Educational implications for different samples have been discussed in the research cited above.

Response Mode and Timing

Respondents circle the number indicating how true or not true that statement is for them. The CSE scale requires approximately 10 minutes to complete.

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Scoring
The scale is scored such that higher scores represent higher CSE. The scoring direction requires that Items 2, 5, 6, 8, 9, 11, 12, 14, and 15 be reverse scored.

Reliability
Reliability estimated across research investigations has yielded a Cronbach’s alpha of .73 or higher.

Validity
In the initial phases of instrument construction, CSE items were scrutinized for face and content validity. The validity of the instrument was inspected according to two major criteria: (a) Did the items simulate the events that were both common and critical to teenage women’s successful use of contraceptives, and (b) were the content and response formats of each item conducive to collecting information on expected behavior in a manner that corresponds to self-efficacy assessments of that behavior? The appearance and content of the original CSE instrument were changed several times based on information derived from pretesting the instrument within different populations and from personal communication with Bandura and associates, experts in self-efficacy assessment (Bandura, 1977; Bandura et al., 1980). Additional methods of testing validity have been used when translating the scale into languages other than English (Bilodeau et al., 1994; Louise, 2005).

In current research with the CSE scale, items pertaining to obsolete or infrequently used methods of birth control are deleted from the content of the scale items as presented here (e.g., the sponge, Encare Ovals). We are exploring adding to the scale items content that pertains to more accessible methods of birth control (e.g., the condom, Norplant, Depo-Provera, the hormonal patch, and emergency contraception). The impact of drug use on CSE and contraceptive behavior is under investigation. In addition, a gender-neutral CSE scale and a male version of the CSE scale have been used to explore contraceptive and sexual behavior in young men. Basically, the gender-neutral scale replaces the word “boyfriend” with “partner” and the male pronoun “him” is replaced with “him/her.”

Other Information
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References
Exhibit

**Contraceptive Self-Efficacy Scale**

The items on the following page are a list of statements. Please rate each item on a 1 to 5 scale according to how true the statement is of you. Using the scale, circle one number for each question:

1 = Not at all True of Me
2 = Slightly True of Me
3 = Somewhat True of Me
4 = Mostly True of Me
5 = Completely True of Me

1. 1 2 3 4 5 When I am with a boyfriend, I feel that I can always be responsible for what happens sexually with him.
2. 1 2 3 4 5 Even if a boyfriend can talk about sex, I can’t tell a man how I really feel about sexual things.
3. 1 2 3 4 5 When I have sex, I can enjoy it as something that I really wanted to do.
4. 1 2 3 4 5 If my boyfriend and I are getting “turned on” sexually and I don’t really want to have sexual intercourse (go all the way, get down), I can easily tell him “no” and mean it.
5. 1 2 3 4 5 If my boyfriend didn’t talk about the sex that was happening between us, I couldn’t either.
6. 1 2 3 4 5 When I think about what having sex means, I can’t have sex so easily.
7. 1 2 3 4 5 If my boyfriend and I are getting “turned on” sexually and I don’t really want to have sexual intercourse (go all the way, get down), I can easily stop things so that we don’t have intercourse.
8. 1 2 3 4 5 Sometimes I just go along with what my date wants to do sexually because I don’t think I can take the hassle of trying to say what I want.
9. 1 2 3 4 5 There are times when I should talk to my boyfriend about using contraceptives, but I can’t seem to do it in the situation.
10. 1 2 3 4 5 Sometimes I end up having sex with a boyfriend because I can’t find a way to stop it.

(Thank you very much for your time and thought. The answers you gave will help us prepare better services for others.)