

D050

COMPLETENESS OF DATA IN SELF REPORT HEALTH HISTORY VS. MEDICAL CHART REVIEW

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This study examines health history information obtained by self-report (SR) vs. medical record review (MRR). Participants in the study (R01 NR04749) were HIV positive men and women ages 18 and older. Self report health histories were obtained using the Center for Research in Chronic Disorder's Comorbidity Questionnaire, adapted from the Charlson Comorbidity Inventory. This questionnaire asks the subject to rate 36 different medical conditions. A subset of 62 participants had health histories also compiled from medical record using the same inventory. The range of total comorbidities reported for SR was 1 to 10 (median 3.5) and for MRR was 1 to 16 (median 5.0). The correlation for total number of comorbidities reported between SR and MR was $r=.446$ ($p<.001$, $n=62$). Item analysis indicates that certain conditions were less likely to be self reported with percent disagreements between SR and MR from 0% to 38%. Higher percent disagreements included headaches (37.7%), anxiety (34.4%), bone fractures (33.3%), depression (32.8%), skin disorders (23.0%), anemia (15.3%), irregular heart rate (15.0%), and pneumonia (15.0%) with medical records generally reporting more. Self report was more likely to indicate the conditions of liver troubles (33.9% disagreement) and mental health conditions other than depression and anxiety (23.2%). Other conditions such as heart attack, coronary artery disease, cancer, bladder problems, high blood pressure, thyroid, and heart valve disorders were more likely to have similar reporting with a range of 2 to 7% disagreement. Reasons for disagreement may include participants' memory, participants' understanding of the medical categories, and the quality of training and methods by which the medical record is reviewed. Although medical record review is more resource intensive, it may provide different data than self report. Future research should consider the possibility of combining data from two sources to have more complete health history data.

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D051

AN INSTRUMENT FOR MEASURING PARTICIPATION IN THE HEALTH EDUCATION PROCESS

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The effectiveness of health education and health promotion programs and interventions is contingent upon students' active participation and discussion, and critical understanding (Freire, 1973; Minkler, 2006; Minkler & Wallerstein, 2003). With this in mind, we created the Participation in Class Discussion (PCD) scale (Beric, 2005), a self-report instrument designed to assess the extent to which college students in health education classes perceive themselves as active participants in the discussion process. The instrument was developed according to the framework for community of inquiry (Lipman, 1997; 2003). A 15-item scale emerged following content review by a 4-member expert panel. In order to examine its factor structure, the instrument was administered to two samples: undergraduate students at two universities in the northeastern US ($n_1=191$ and $n_2=86$, respectively). Evidence for reliability of the instrument was provided in both the first ($\alpha=.89$) and second ($\alpha=.90$) samples. A single-factor model was hypothesized and evaluated using covariance modeling software. Following poor fit of the single-factor model in both data sets, a two-factor model specifying a method effect of positively- versus negatively-worded items was tested and provided a good fit to the data in both the first ($\chi^2=137.0$, $df=76$; $CFI=.95$; $RMSEA=.05$; $SRMR=.04$) and second ($\chi^2=124.3$, $df=76$; $CFI=.92$; $RMSEA=.06$; $SRMR=.08$) samples. These results provide initial support for a method effect based two-factor model of the PCD scale as a means for evaluating participants' active engagement, i.e., participation in class discussion. Future work is needed to provide additional evidence for the validity of this scale and its utility in predicting changes in health behaviors following participation in health education.

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D052

THE INJURY RESILIENCE INDEX: DEVELOPMENT AND PSYCHOMETRIC CHARACTERISTICS

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Introduction: Psychological resilience is characterized by one's ability to "bounce back" from negative or traumatic life experiences. Often challenging to measure, resilience has traditionally been operationalized through associated concepts such as optimism, cognitive flexibility (e.g., positive reappraising), hardiness, perceived social support and coping self-efficacy (e.g., mastery). **Objective:** This study examined the psychometric properties of the Injury Resilience Index (IRI), a 19-item measurement tool designed to assess self-reported features of psychological resilience following traumatic physical injury. **Participants:** 167 culturally diverse traumatically injured adults (31% orthopedic hand, 21% burn, 48% orthopedic trauma) were recruited from the orthopedic hand, trauma and burn services at a large Southeastern level-1 trauma center. **Methods:** The IRI was developed with patient and expert involvement and was subsequently field tested along with established measures within 1 week of admission. **Results:** Construct validity was evaluated through exploratory factor analyses (EFA) and correlations with outside measures. EFA extracted 5 separate factors with eigenvalues >1 , which included: hardiness (variance=34%), social support & satisfaction (variance=12%), challenge (variance=8%), optimism (variance=7%) and coping self-efficacy (variance=6%). Pattern and structure coefficients ranged between .44-.95. Cronbach's Alpha coefficients were within an acceptable range. Unlike its original tripartite conceptual definition, hardiness was comprised of control and commitment items, while challenge items (similar to cognitive flexibility) extracted into a distinct factor. Overall, IRI scales correlated in a convergent manner with external measures of the same name (HRHS, SSQ, LOT-R, GPSES, IDI). **Conclusions:** Results support initial psychometric properties for the IRI, which demonstrated acceptable internal consistency and construct validity coefficients with this sample.

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D053

REPLICABILITY OF THE SMOKING EXPECTANCY SCALE FOR ADOLESCENTS: FRENCH-CANADIAN VERSION

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Based on the 2002 Canadian Youth Smoking Survey, 39% of French-speaking adolescents in 5th to 9th grades smoked versus only 18% of English-speaking adolescents. This disparity may be due to different smoking expectancies or beliefs about the consequences of tobacco smoking. The Smoking Expectancy Scale for Adolescents (SESA) is a self-report questionnaire initially developed with an English-speaking Australian sample (M age=14.6; SD age=1.7; 87% nonsmokers). The original scale yielded eight factors: affect control, social benefits, boredom reduction, weight control, appearance costs, health costs, social costs, and addiction; as well as two higher order factors: expected-benefits and -costs. The present study sought to evaluate the factor structure of the French-Canadian version. Using the back translation procedure, the SESA was translated into French and completed by 277 sixth graders (M age=12.3; SD age=0.4; 63% female; 97% nonsmokers). Principal components analysis with varimax rotation was used; items with factor loadings >0.40 were retained. Based on the 27-item version, the items on the French-Canadian version loaded identically across the two higher order factors except for one item ("distract you from negative feelings") which cross-loaded on both expected-benefits and -costs. In contrast, the eight factor solution was not replicated. Age or previous tobacco experience may explain the different factor structures. Alternatively, cultural differences may account for differences in smoking expectancies. Future researchers should examine the factor structure of the French-Canadian version with other ages to evaluate how smoking expectancies may contribute to the disparities in smoking rates between French- and English-speaking Canadians.

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