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Parenting confidence scale

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Google Scholar Page 2 All (n = 695) Not At Risk (n = 488) Low Risk (n = 207) Average SD Average SD Mother Age**30.14 4.00 00 30.54 3.87 29.09 4.15 Gestation age 39.71 1.74 40.05 1.1 16 38.1 94 2.47 EPDS (0-30) 4.59 3.36 3.46 2.00 7.14 4.29 PSS (0) -90) 32.38 7.78 31.20 6.70 35.16 9.33 Background variable N% N % N % Smoker**28 4216 8 Non-smoker**b 658 95 471 97 187 90 No information 9 1 5 1 4 2 Boys 340 49 228 47 112 54 Girl 350 50 255 52 95 46 Information No 5 1 5 1 1 0 Short Term Education (Grades 9 or 10) 85 12 0 0 85 41 Long Education (&Grade 10) 608 87 486 100 122 59 No Information 2 0 2 0 0 0 "p < 0.000."p < 0.01." p < 0.05;a = An independent t-test that compares dangerous and non-dangerous mothers. b = Chi-square test comparing at-risk and non-at-risk mothers Original paper Open Access Published: July 7, 2017 Journal of Children and Family Studies 26.2960-2978 (2017) This article 13k Access35 citation 2 Altmetric metric parenting self-efficacy (PSE) explains parents' beliefs. Higher levels of PSE have consistently been shown to correlate with a wide range of parenting and child outcomes. As a result, many parenting interventions aim to improve PSE. PSE measurements are usually performed via self-reported measurements. However, the wide range of measures available resulted in its limited use, inconsistent terminology and ambiguous rationale. The purpose of this systematic review was to examine the psychoso measures and administrative qualities of available PSE measures and to clarify the terms underpinning their use and the theories underpinning their use so that future use of PSE measures would be appropriate. 11 electronic databases were searched. The articles were included if they introduced a new measure or were psychoso measured assessments of available measures of PSE for parents of children (from in early childhood to age 18). 34 measures were identified and their psychoso measured and administrative qualities examined. Overall, the quality of the measures available varied. The review makes recommendations on PSE measures from parents of young children to adolescents, but some cautions should be applied when choosing the most appropriate measures. The rationale for each measure was clarified, and appropriate measures could be selected under appropriate circumstances. Discuss the meaning of improvements to available measures and identify further research on improving PSE measurements. The term self-efficacy describes an individual's belief in the ability to successfully perform a particular task. Self-efficacy can inform how an individual behaves, and can indicate whether a task is attempted, how much effort it has put into the task, and how long it lasts in the face of obstacles and evasive experiences (Bandura 1997, 2006). Bandura (1997) makes the term self-efficacy following the development of social cognitive theory (SPT) (Bandura 1997) and provides an explanation of performance in certain tasks based on the interrelationships of a (e.g., cognitive, biological and emotional events), (b)Events and (c) actions (Closers et al. 2008). According to Bandura and Adams (1977), individuals draw four sources to measure self-efficacy: 1.1. interpretation of their own performance (for example, a successful performance is likely to increase self-efficacy, while a successful performance is likely to lower it). 2. Watch others perform tasks and their abilities. 3. Their response to social persuasion (e.g., encouragement or praise from others cultivates self-efficacy, and criticism reduces it) and 4. Their physiological and emotional state (for example, confidence and well-being are more likely to exert higher self-efficacy than anxiety and fear). These four sources were incorporated into a model of the relationship between self-efficacy and performance developed by Gist and Mitchell (1992), based on the SPT approach. They provided evidence that bandura and Adams (1997) were four sources of self-efficacy, in addition to three core processes. First, there is an assessment of the task requirements to reflect the skills required to successfully complete the task. Second, analyze the previous performance and attribution analysis to see why the previous performance occurred in a real way. Third, a detailed analysis of personal and situational factors is performed to assess the resources and constraints required to complete the task. Bandura's (1988) study supported the idea that these processes are integrated with four sources to form self-efficacy. Task performance is feedback to these sources to update an individual's level of self-efficacy. Parenting self-efficacy (PSE) can be defined as caregiver or parent's trust in the ability to succeed in parenting (Jones and Prinz 2005). However, parent or parenting self-efficacy (PSE) is often mislabeled as parent 'confidence', parents' ability and parent's self-esteem (Hess et al. 2004). In addition, these concepts are inconsistent, and one concept is used when another is more appropriate (e.g., Swick and Broadway 1997). Terms are also used interchangeably (e.g., MacPhee et al. 1996) or new terms such as parental self-regulation (Hamilton et al. 2014) and parental self-institution (Dumba et al. 1996). Bandura (1997) argues that while parent confidence refers to the strength of beliefs about tasks, it is not specific to what the strength of belief is, whereas PSE includes both the strength of belief and the interpretation of ability based on that belief. Glidewell and Rivert (1992) described parental trust as stable over time. Situation-dependent or situation-independent. In contrast, they described PSE as situational-specific and variable. Specifies the task and context. In addition, PSE is a theoretically defined structure, whereas confidence is a co-language term unrelated to a particular theory (Pennell et al. 2012). Taking these ideas into account, De Montini and Lacharite (2005) completed a conceptual analysis to demonstrate that parental confidence is indeed a different concept from PSE. Similarly, they claimed that parent's self-esteem was a different concept. Whereas parent self-esteem is a judgment of parenthood's worth, PSE is a judgment of a parent's personal ability to play a role (Bandura 1997). Parent ability is also a different concept from PSE. Like PSE, it refers to the ability to complete tasks successfully and efficiently (Pearsall and Hanks 1998), but based on other people's perspectives on how well the task is completed, rather than the parent's own judgment according to the PSE. The differences in concepts may be subtle, but the correct terminology ensures accuracy and consistency, so it's important to consider. Another concept is parenting satisfaction: a subjective assessment of satisfaction derived from being a parent affecting PSE (Coleman and Caracer 2000; 2000); Rogers and White 1998). Therefore, to remove all ambiguity, the measures in this review specify which concepts (PSE, trust, self-esteem, ability or satisfaction) are being investigated. Hamilton et al. (2014) also included self-regulation, as they refer to similarities between the above concepts, suggesting that the combination results in parenting self-regulation that highlights four different characteristics, including a general sense of parenting ability and self-confidence (self-efficacy, self-management, self-sufficiency, and personal agency). Sanders 2000, 2008). Clinical and research attention has been drawn to the self-efficacy of parenting, with two key reviews in this area to date (Coleman and Karaker 1998; Jones and Prinz 2005). Coleman and Caracer (1998) developed the meaning of the PSE structure, explored relevant experience findings, and explained the effects of PSE on parenting. Coleman and Caracqur (1998) identified eight measures of PSE and provided some psychoso measured information on its reliability and validity. Their review was the first of its kind and has attracted public and clinical interest. An updated review of Jones and Prinz (2005) provided further evidence that PSE strongly correlates with positive parent-child psychological function, child coordination, parenting ability and parenting satisfaction. Both reviews provide consistent evidence that high levels of PSE are adaptively related, fostering an exciting and parenting environment, encouraging social, academic and psychological well-being. The apparent importance of PSE has led to the development of interventions targeting PSE that can be used to raise children/can be improved. Interventions such as group-based parenting programs aimed at parental empowerment have had a positive impact on PSE (see Witkowski et al. for a detailed review), and positive changes have been demonstrated to last for at least another 12 months (e.g., Givond et al. in 2008). Tucker et al. 1998). PSE is usually assessed via appropriate self-reporting measures, given that the PSE reflects the parent's belief or judgment on the ability to successfully perform a given parenting task. Typically, measures evaluate four domains (e.g., Coleman and Karaker 2000): general or trait self-efficacy, domain-specific (also known as task-related), domain general (also known as global) and narrow domain (also known as task-specific). The general PSE measure assesses overall self-efficacy in parenting roles, and the items are not linked to specific parenting tasks (for example, what I do has little effect on a child's behavior). Campis et al. 1986.Črnčec et al. (2010) identified that these scales are suitable for a wide range of children's ages, but less sensitive to tasks faced by parents of children of a certain age. The domain-specific PSE measure assesses parents' beliefs about their ability to complete certain tasks of parenting roles for children of a certain age (for example, How about inging a baby to have fun with you? Teti and Gelfend 1991). These measures provide greater sensitivity to specific tasks and ages and result in greater predictive validity than general PSE measurements (e.g., Marsh et al. 2002). Bandura (1997) claimed that PSE was most accurate when assessed on domain-specific measures. The domain general measure refers to functioning within one area of daily life, but does not specify the tasks or activities that must be performed (for example, I know good parenting tips that I can share with others). Freiberg et al. 2014). Finally, Narrow Area focuses on one particular aspect of parenting roles such as breastfeeding (Dennis and Fake 1999) and childbirth (Lowe 1993). All items are task-specific, age-specific, and situation-specific. Despite continued interest in PSE, there has only been one review of child-rearing trust measures so far. In their review, Črnčec et al. (2010) examined 28 measures of parenting confidence that they used as umbrella terms to capture measures of self-efficacy (recognized by parents of infants up to the age of 12) labeled other ways (e.g., erency, self-definition or self-agency). They described each scale in detail, reported on some aspects of the reliability and validity of each scale, provided standard data when available, and then gave each scale an overall assessment of the quality of the psychoso measures based on the model used. Other (1992). To help clinicians assess changes in PSE and researchers make planning interventions, the current systematic review sought to update and extend current knowledge of PSE measures completed by parents of children from birth to age 18. clarify the terms, and (d) consider the rationale for each scale. A systematic search of 10 online databases was carried out in December 2014 and updated in October 2016: OVID Maternity and Infant Care, Medline, PsycINFO, PsycArticles, EMBASE, Health and Psychosocial Equipment Database, PubMed, Web of Science, CINAHL Plus and Google Scoulour. The search strategy based on prisma guidance (2009) was developed to identify references to the developmental and psychosomatic properties of the PSE's self-reporting scale. The earliest years of publication were limited in 1970 to account for the progress of PSE knowledge. Search terms were developed by combining terms specific to PSE measures. Search terms used alone or in combination were questionnaire*, results, measurement*, parent*, and (self-efficacy or confidence or confidence or self-esteem or satisfaction) and psycho measurement*. The name of the identified measure was used as a term for further searches of the electronic database above. A list of references from all identified papers was consulted along with a review of the measures (Črnčec et al. 2010). In addition, references to the obtained articles were screened for additional relevant studies. The search strategy and its results are described in a high-summary review of this selection based on the inclusion and exclusion criteria of prisma guidance. Measures had to be applied for parents of children between the ages of 0 and 18, including preterm infants. This age group was chosen to cover the span from infancy to adolescence. Measures were included only if the authors thought they focused primarily on self-efficacy (in reviewing scale content), but other relevant structures (ability, self-esteem, confidence, satisfaction, self-regulation) could also be evaluated. Broader measures that had a subscale of self-efficacy were not included unless the relevant subscales were independently verified (e.g., child adjustment and parenting effect scales; CAPES-SE, Morawska et al. 2014) or other subscales were also related to self-efficacy (e.g., parenting sense of competency scale). THE PSOC, Johnstn and Mash 1989 have two subscales and are labeled satisfietd was excluded if the PSE was not investigated and was unpublished or published outside of a peer-reviewed journal. Longitudinal and qualitative studies and studies focusing on narrow areas were also excluded. Quality Assessment There are several criteria for evaluating the results scale (e.g., McDowell and Jenkinson 1996), but some of the most comprehensive criteria have been proposed by Terwee et al. (2007), which pulled the Scientific Advisory Committee (SAC) of the Medical Outcomes Trust (SAC 2002) standard. Terwee et al. defined eight attributes of measurement characteristics that are essential for consideration in a thorough high-standard assessment: (1) content validity, (2) internal consistency, (3) criteria validity, (4) construction validity, (5) reproducibility, (6) responsiveness, (7) floor and ceiling effects and (8) interpretability. As part of the current review, four more criteria have been added regarding the management properties and metrics of changes based on Bot et al. (2004): (9) dosing time, (10) ease of scoring, (11) readability and com understandability, and (12) minimal clinically significant differences (MCID). These additional criteria provide actionable information about countermeasures that Terwee and our checklists are not sensitive to. Consistent with the approach of Terwee et al. (2007), each criterion has a + (clear description, exceeding a certain threshold), - (clear description, below a certain threshold), ? (lack of explanation or suspicious), or 0 (missing information). The above rating is that + achieves a score of 3, - achieves a score of 2, and ? and a score of 0 was coded to achieve a score of 0. Thus, each scale achieves a total score in the range of 0 to 36 and has a higher score that indicates stronger psychoso measured and administrative qualities. This score should only be used as a guide, as it can incorrectly imply that all measurement properties are just as important. All measurements were evaluated across the following domains: content validity (the extent to which areas of interest are comprehensively sampled by items in the questionnaire) providing a clear description of the purpose of the measurement, the population of interest, the concept being measured, and the process of item selection, and obtaining a score of 3. The target population should be involved not only in professionals, but also in the selection of items. If the item selection does not have the involvement of the target population, but other criteria are met, the measure score is 2. If there is a lack of a clear explanation of the aforementioned aspects, if only the population or experts of the subject are involved, or if the design and method adopted is The measure is then given a score of 1. If no information about the involvement of the target population is found, this scale is given a score of 0. Internal consistency (the extent to which items in the (sub) scale correlate and measure the same structure3 score, where factor analysis (FA) is performed at the appropriate sample size (7* number of items and >100), kronbach alpha is calculated between 0.75 and 0.70, decreased to between 0.75.70. If the FA's criteria are met and Cronbach's alpha is calculated, but they do not fit outside the tolerance (despite the proper design and method), the score will be 2. If the FA is not running or there is a questionable design or method issue in the study, this property scores 1. Score 0 is given when there is no information about internal integrity. To get a score of 3 for the effectiveness of the criteria (to the extent that the score for a particular survey is related to the gold standard), you need to include a compelling argument that the gold standard for comparing measures should be gold and that correlation with that gold standard should be at least 0.70. If the argument that the standard is gold is convincing, but the correlation is less than 0.70 despite the proper design or method, the measurement scores 2. If there is no convincing argument that the gold standard is gold, or if the design or method used to test the relationship is in doubt, the measurement scores 1. If no information is found about the validity of the criteria, a major score of 0. In order to score 3 on this property (range related to other measures in a way that matches the theoretically derived hypothesis on the concept in which the score of a particular questionnaire was measured) to score 3, a specific hypothesis must be formulated, and at least 75% of the results must follow these hypotheses. Despite the proper design or method, if more than 75% of the hypotheses made are confirmed, the measurement scores 2. If the design or test method of this property is questionable (for example, if the assumption is not made in a post-hoc interpretation), the measurement scores 1. If no information is found on the effectiveness of the build, major score of 0. Reproducibility: Agreement (if the scores of repeated measurements are close to each other (absolute measurement error) score 3, the reliability contract must be evaluated (test retest or split half) and the author must present one or more of the following: The kappa, the standard error of measurement (SEM), proves other compelling arguments that the smallest significant change (MIC) is less than the minimum detectable change (SDC), or that the MIC is outside the LOA or that an agreement is acceptable. If the MIC is more than or equal to the SDC, or if the MIC is equal to or in the LOA,And the measurement score 2, the way. Measure score 1 if the design or method is in doubt, or if no MIC is defined and no convincing argument is made that an agreement is acceptable. If there is no information about the contract, a score of 0 is given. Reproducibility: The author must report an in-class correlation coefficient (ICC) or weight kappa value (to the extent that the patient is distinguishable from each other, despite the measurement error [relative measurement error]). If the design and method is appropriate but the ICC or weighted kappa is less than 0.70, the measurement scores 2. Measure score 1 if the design and method in which this property was evaluated is in doubt. If you don't get any reliability information, you're given a score of 0. To score a response score of 3 (the ability to detect significant changes in the passage of time in the concept being measured), you must report a MIC outside the SDC, MIC, LOA, or RR of 0.70 or higher, if the SDC is MIC or higher, the MIC is equal to or within the LOA, the RR is 1.96 or less, or if the ALC is less than 0.70 despite the proper design and method, it has a major score of 2. A score of 1 is given if the design or method used to test responsiveness is questionable, but a score of 0 is given if no information about responsiveness is provided. Floor and ceiling effects (the number of respondents who achieved the lowest or highest score) No more than 15% of respondents must have achieved the highest or lowest possible score in a measure with a score of 3. If the number exceeds 15% despite the proper design or method, a score of 2 is given. Measure score 1 if the design or method for checking the effect of the floor or ceiling is in doubt. If you don't contain information about floor or ceiling effects, a measure score of 0. To score 3 (the degree at which qualitative meaning can be assigned to a quantitative score), click or define a clinical diagnostic, such as the mean and standard deviation scores of multiple groups, comparative data about the distribution of scores, information about the relationship between scores with other scales, or clinical diagnostics. Score 2 is not assigned to this property. If the design or method of some of the studies designed to generate information about interpretability is in doubt, less than two of the above are provided, or if no MIC is defined, score 1 is assigned. If you don't get any information about the interpretation, you're given a score of 0. For the dosing time (time required to complete the measurement, see) Bot et al. Score in 2004 3, it was necessary to demonstrate that participants could complete the measurement in less than 10 minutes. If it took more than 10 minutes, The measurement scored 2 and a score of 1 was given if the method used to test the dosing time was in doubt. If the management time did not contain any information, the indicator would have to generate a total score of the scale by summing up the ease of scoring (the extent to which the measurement could be scored by a trained investigator or expert), and the scale required to use a visual analog scale, or the formula used to calculate the total score, had to be simple for a score of 3. Measures scored 2 when using visual analog scales in combination with formulas or complex formulas. If you're not told how to combine items to generate an overall score, the scale scored 1. In the absence of scoring information, the indicator 0. If you get readability and com understandability (e.g. measurements are understandable for all patients), authors with a maximum score of 3 use at least one to test readability Required: (a) Flesch Kinold Reading Ease; (b) Fresh Kincaid Grade Level (c) Gning Fog Score; (d) Coleman Riau Index, or (e) Auto Readability Index. Readability was tested using at least one of these methods, but if the results were insufficient, score 2 was given, and if it was determined that the method of evaluating readability / comedibility was insufficient, the scale was given a score of 1. If you don't get readability information, you're given a score of 0. Minimal clinically significant differences (MCID) measures (minimum differences in scores in areas of interest that patients recognize as beneficial and mandate changes in patient management) were awarded a score of 3 when presented with an MCID. For this property, score 2 is not assigned. If a questionable design or method was used to calculate the MCID, the measure was assigned a score of 1 and no information was presented, the indicator showed that members of a research team (DW) with a 0.2 rater's credibility reviewed the psychoso measured characteristics of each scale, and another researcher independent of the research team reviewed eight of the 34 measures (24%). The intrate correlation coefficient was found to be .91. As mentioned before the examination of domain and theoretical grounding, terms related to PSE (self-efficacy, satisfaction, ability, trust) are not used consistently in the literature. To provide clarification on the components to be measured, the revised components were assigned to each scale by the review authors. Second, based on the evaluation of content of scale, the authors assigned each PSE measurement to one or more domains identified by Coleman and Caracer (2000). The contents of each scale were analyzed according to a comprehensive theoretical model of self-efficacy by Gist and Mitchell (1992) and different components. Was identified. A database search identified 5660 publications. Following the strict application of inclusion and exclusion criteria, a total of 76 studies referring to 34 self-reported PSE measures were included in this review (see Figure 1). The majority of age procedures in children were for parents of infants (preterm -13 months) and infants (14-36 months) (n = 17) (see Figure 2). One scale was designed for infants and preschoolers (Father's Self-Efficacy Scale, FSES; Sevigny et al. 2016). There are no measures against preschool parents (ages 3-5), and the only measure for school-age children (ages 5-12), such as the Parental Empowerment and Effectiveness Scale, PEEM; Freiberg et al. 2014) and special measures for adolescents (13-18 years). Instead, a number of measures were developed for a range of ages. Three measures: Me as a Parent (Maap; Hamilton et al. 2014), Cremenishaw Guidobardi Parenting Satisfaction Scale (C-G PSS, Guido Baldi, Cremenishaw 1989) and Comfort with Parenting Performance (CPP, Valensky and Cook 1982) covered the widest range of children for each scale. Note: GAP and KPSS are omitted because the age range was not identified. Measures are ordered by the shortest to longest number of items and the length of the period from subscale, with the number of items between 3 and 82 (m = 26.74, SD = 18.15). KPSS was the least (3 items), followed by tools to measure child-rearing self-efficacy (TOPSE, Kendall, Bloomfield 2005) the most (82 items). Many measures had only one subscale (n = 16), while others contained multiple subscales (n = 18) from two (e.g. PAP) to 9 (TOPSE). The number of subscales of the two measures was unknown: maternal self-confidence pair comparison (MSPC, Seeshore et al. 1973) and self-efficacy of parenting task index (SEPTI-TS, Van Rijen et al.), 18 (52.94%) of the content validity measures received 3 of the highest ratings for the effectiveness of the content (indicating that the purpose of the measurement, the target population, the concept to be measured, and the process of item selection were clearly described by the author and that the target population was involved in item selection as well as the expert). Score 1, which scored 2 points on one scale (2.94%) and showed that there was no target population involvement in item selection, but other criteria met 10 measures (29.41%), indicates that a clear description of the aforementioned aspects was lacking, that only the target population or experts were involved, or that the design and methods used to ensure the effectiveness of the content were not questioned. Five measures (14.71%) were scored to indicate that no information was found about the target's population involvement. All five of these measures were included in the article where the main objective was made.Measures must be used. In contrast, the 18 measure of the highest possible score 3 was in the article, who the main purpose was a survey of the psychoso measured characteristics of the measure. Floor and ceiling effects Only 10 measures (29.41%) provided information about floor and ceiling effects. Of these,

