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BOOK OF ABSTRACTS

МИНИСТАРСТВО
ПРОСВЕТЕ, НАУКЕ И
ТЕХНОЛОШКОГ РАЗВОЈА

& Bernzweig, 1990) was used to assess maternal reactions to their children's negative emotions. Our sample included 100 mothers of children with cerebral palsy, aged 2 to 7 years. Our results yielded no statistically significant differences in ways of reacting to manifestations of children's aversive emotions with regard to maternal resolution status $F(6,93)=1.19$, $p=.32$. More precisely, regardless of their resolution status, mothers predominantly used supportive strategies, i.e. strategies focused on the problem and emotionally focused strategies, along with strategies that encourage expressing emotions. The least used strategy was punishment. This is encouraging since children with cerebral palsy and other types of health conditions, particularly neurological, can have difficulties in expressing emotions which makes it harder to recognize their emotional reactions. Parents are faced with difficulties in accurately interpreting manifestations of anger, sadness, fear or any other aversive emotion. It is also conceivable that children subjected from a young age to stressful diagnostic and therapeutic procedures that require regulating negative affect, subsequently tolerate aversive emotions better. It is important to underline the importance of parental resolution for sensitively recognizing and reacting supportively in situations when children with chronic health conditions exhibit aversive emotions.

Keywords: maternal resolution, aversive emotions, children

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The role of past physician-patient communication in passivity normalization during childbirth

One of the most important determinants of patients' adherence to the treatment is the quality of the physician-patient relationship. Studies show that overall positive communication with healthcare workers positively affects treatment adherence and the other desirable patients' behaviors. Therefore, positive experiences of physician-patient interaction increase the frequency of normative behaviors. In this

study, we examined the relationship between experiences of physician-patient communication and the normalization of passivity (i.e. submissiveness and subservience) during childbirth. Thus, if this relation is positive, i.e., if communication quality is positively related to passivity normalization, that would confirm that passivity during labor IS a normative behavior.

A total of 271 women (Mage = 42.4) who gave birth were recruited. They completed 24 items regarding the frequency of physician-patient communication experiences (100-point slider scale). Promax-rotated principal component analysis revealed three dimensions of experience: 1. Aggressiveness (15 items, e.g., When I am at a healthcare facility, it happens that employees threaten patients; $\alpha = .88$), 2. Supportiveness (six items, e.g., When I am at a healthcare facility, it happens that employees sympathize with me; $\alpha = .78$), and 3. Shaming for not having children yet (three items, e.g., When I am at a healthcare facility, it happens that employees shame me for not having children yet; $\alpha = .85$). They also completed seven items that capture normalization of passivity during childbirth (e.g., Women exaggerate their childbirth experiences; $\alpha = .73$; 5-point Likert scale). Both scales were constructed for the purpose of this study.

Multiple linear regression model revealed that communication experience dimensions explained 21% of the variance of passivity normalization ($F(3, 268) = 19.54$, $p < .000$, $R2adj = .21$). More precisely, passivity normalization was positively predicted by Supportiveness ($\beta = .27$, $t(268) = 4.27$, $p < .001$), and negatively by Aggressiveness ($\beta = -.24$, $t(268) = -3.18$, $p = .002$). Shaming did not significantly contribute to the model ($\beta = -.03$, $t(268) = -.37$, $p = .712$).

Our results indicate that the more positive physician-patient communication, the higher passivity normalization is. This pattern suggests that positive experiences tend to silence women in that they do not critically re-examine old-fashioned and strongly established practices that define a birthing woman as a fully inactive agent. However, positive communication experiences are not passivizing per se - it is rather the social system that reinforces passivity during childbirth as a norm. In other words, mental representation of the passive female body seems to be internalized by both patients and health care providers. In that realm experiences of supportive and unaggressive communication can be abused, rather than used in a positive way to make the physician-patient relationship beneficial for both sides.

Keywords: physician-patient relationship, physician-patient communication, passivity normalization, childbirth, women's agency

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