Spanish Translation, Adaptation, and Validation of the Multidimensional Condom Attitudes Scale with Young Colombian Men and Women

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Abstract

Infection by HIV/AIDS or other STIs and unplanned pregnancies are sexual health problems of considerable impact around the world. Condoms are the only method that prevents all those risks, and attitudes towards the use of condoms are among the best predictors of their consistent use. The purpose of the present study was to translate, adapt, and validate a Spanish-language version of the Multidimensional Condom Attitudes Scale (MCAS) using a sample of young people from Colombia. A total of 1,441 young people between the ages of 18 and 26 responded to a web-based survey conducted between January 2018 and February 2018. The dimensionality of the scale was explored and confirmed to replicate the original five-factor structure (alphas ranged from .65 to .86). Criterion validity was adequate. Women had worse attitudes toward condom use stigma, while men had more negative attitudes related with shame and reliability. The Spanish-language MCAS is suitable for measuring condom-related attitudes among Columbian youth. Future research is needed to validate the Spanish version of the MCAS with other Spanish-speaking populations.

Keywords: attitudes; condom; scale adaptation; reliability; Colombian; Spanish.

Attitudes toward the use of condoms have been shown to be one of the best predictors of the actual use of the method (Ferguson, 2011; Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Diez, Juárez, Nebot, Cerda, & Villalbi, 2000; Sheeran, Abraham, & Orbel, 1999). The Multidimensional Condom Attitudes Scale (MCAS; Helweg-Larson, & Collins, 1994) is one of the scales employed to evaluate attitudes toward condoms with highest psychometric support. The MCAS consists of 25 items grouped in five dimensions: (a) reliability and effectiveness of condoms, (b) sexual pleasure associated with condom use, (c) stigma associated with people who use condoms, (d) shame associated with condom use negotiation, and (e) shame associated with buying condoms. Each dimension includes five items measured using a seven-point Likert-type scale with answers ranging from 1 = *Completely agree* to 7 = *Completely disagree*. Two items are: "*Condoms are an effective contraceptive method*" and *"using condoms can make sex more stimulating."* If inverted items (1, 2, 3, 5 ,6 ,7, 8, 11, 13, 14, 16, 17, 18, 22, 23, 24, and 25) are reversed, higher scores indicate more positive attitudes. The MCAS was found to be reliable and valid in ethnically diverse samples of college students (Helweg-Larson, & Collins, 1994). The obtained results Cronbach's alpha value ranged from .62 to .80, and it showed a five-factor dimensionality (described above) that explained 65% of the variance. The MCAS has been translated into Spanish by two different research groups: DeSouza, Madrigal, & Millan, (1999) and Unger, Greogory, & Molina (1999). DeSouza et al. (1999), used the scale with Mexican college students, but access to their paper is currently unavailable. As for the second study, Unger et al. (1999) used an ad hoc translation into Spanish which they administered orally to Hispanic women living in the United States who had been scarcely accultured. The psychometric properties of the Spanish scale were mixed with the original English version. The values obtained by the present study were χ^2 (257) = 381.05, p <.0001, GFI = .896, CFI = .935. Model fitting is comparable to the fitting obtained by Helweg-Larsen and Collins (1994) with the college student sample (CFI for women = .90). Starosta, Berghoff, & Earleywine (2014) confirmed the presence of the five factors and observed their lack of gender-based differences; this study pointed out the possible presence of differential item functioning (DIF) due to gender in three items.

Thus, given the importance of evaluating attitudes toward the use of condoms reliably and validly, and since no record of the Spanish version of the MCAS is available,

the present study sought to adapt the MCAS for Spanish and validate the scale using a sample of Colombian young adults.

Method

Participants

A total of 1,441 people aged between 18 and 26 years of age (*M* = 21.3*; DT* = 2.21) participated in the present study. The gender distribution of the sample was as follows: 58.66% women, 41.14% men, and 0.21% of participants identified themselves as neither woman nor man. Figure 1 shows sample distribution over the Colombian territory, and table 1 shows information on the sociodemographic characteristics of the sample. Additionally, the sample was randomly split into two different subsamples; a 600-subject subsample was subjected to exploratory factor analysis (EFA), and an 841-subject subsample was subjected to confirmatory factor analysis (CFA). The rest of the analyses – invariance included- used the full sample. Inclusion criteria were being Colombian, living in Colombia, and being aged between 18 and 26. Exclusion criteria were illiteracy, failing to complete the survey, or not accepting the informed consent agreement.

Instruments

UCLA Multidimensional Condom Attitudes Scale (Helweg-Larsen & Collins, (MCAS; Helweg-Larson, & Collins, 1994). This scale evaluates people's attitudes toward the use of condoms. The MCAS consists of 25 items grouped in five dimensions: See the introduction for further information. (Spanish scale can be consulted in supplemental materials).

Sexual Opinion Survey (SOS-6; Fisher, White, Byrne, & Kelley, 1988). The present study used the brief version adapted by Vallejo-Medina et al. (2016) for Colombia. The scale evaluates general attitudes toward sexuality along the erotophilia-erotophobia axis. It is composed of 6 items with response items on a seven-point Likert-type scale (1= *Totally agree*, 7 = *Totally disagree*). It has been shown to be reliable for Colombia (alpha = .85). Two items are: "*it is exciting for me to think about engaging in sexual intercourse*" and "*I like to have dreams about sex*." People who score low tend to respond with negative

evaluations of sexual stimuli—including condoms—, so they also tend to avoid them. On the contrary, people who score high have more positive emotions toward sexuality, so they tend to evaluate it positively and seek sexual stimulation (Fisher et al., 1988). In the present study, the scale had a Cronbach's alpha of .82.

Sexual Assertiveness Scale (SAS; Morokoff et al., 1997)**.** The present study used the brief version adapted by Vallejo-Medina et al. (2017) for Colombia. The SAS evaluates three dimensions: Initiation, Rejection, and Prevention of Sexually Transmitted Diseases and Unplanned Pregnancies (STI-P P). Present study used only the last dimension, which had a Cronbach's alpha of .83 in the original Colombian study. The dimension consists of three items that evaluate the ability to negotiate the use of condoms, and it is scored using a five-point Likert-type scale (0=*Never* to 4=*Always*). Two items are: "*When I have sex with my couple I make sure that we use a condom*" and "*I refuse to have intercourse if my couple doesn't want to use a condom*." Higher scores represent higher sexual assertiveness. In the present study, the scale had a Cronbach's alpha of .87.

Psycho-sexual scale. Sociodemographic, psychological, and sexual information from the patients was collected using a survey. Information obtained was age, sex, schooling, and marital status, among others. Additionally, various indicators used by the TRA were evaluated, for instance: Condom Use Frequency (CUF), Intention to Obtain a Condom (IOC), Intention to Use a Condom (IUC), Condom Use Negotiation (NUC).

Ad hoc scale on attitudes toward the use of condoms. Following Ajzen & Fishbein (2005), a scale evaluating perceptions about condoms as protection methods for vaginal or oral sex was constructed. The scale included six items and participants had seven response alternatives ranging from very unpleasant to very pleasant, very unhealthy to very healthy, very bad to very good, very harmful to very beneficial, and very uncomfortable to very comfortable, as well as an item focused on general attitudes toward the consistent use of condoms. The scoring system used by the present study consisted in adding the scores of these six items. Alpha was .79.

Condom Associated Erectile Problems (CAEP). We used the two questions (Sanders et al., 2015; Janssen et al., 2014, & Sanders et al., 2014) commonly asked to

evaluate CAEP. First, CAEP occurring during application of the condom (CAEP-Application) "How often in the past 90 days did you lose or start to lose your erection while putting the condom on before vaginal intercourse?" and CAEP occurring during penile-vaginal intercourse while using a condom (CAEP-PVI) "How often in the past 90 days did you lose or start to lose your erection while wearing a condom during vaginal intercourse?". Both items are responded on a five-point Likert-type scale ("*Never*," "*Occasionally*," "*Less than half the time*," "*Most of the time*," and "*Always*"). The overall score was used for analysis. Alpha was .78.

Procedure

The first step in this study was asking MCAS's authors' permission to use the MCAS test. The scale was adapted to Colombian Spanish-speaking population per guidelines by AERA, APA, and NCME (2014) and Muñiz, Elosua, and Hambleton (2013). Two independent forward translations were prepared and then revised by a mixed committee of professionals including culturally aware translators who worked with the English-Spanish language combination and psychologists specialized in psychometry and human sexuality. The next step was a pilot test including 40 subjects (Haladyna, & Downing, 2011; Schmeiser & Welch, 2006), with the purposes of: a) collecting reactions from the people who constructed the test, b) making sure that items and instructions were clearly understandable, c) recording the time needed to complete the test, d) collecting information on possible content or form errors to be corrected before the operational phase, e) obtaining data for an initial item performance analysis. Finally, an online non-probabilistic sampling of the Colombian territory was carried out using the Survey Monkey platform. The survey was distributed by Facebook between January 19 and February 14, 2018. The survey was initially accessed by 2.560 people. Exclusion criteria eliminated 265 subjects because they rejected the informed consent agreement, 374 because they were outside the age range (18-26 years old), 121 because they were not Colombian, and 356 because they failed to complete the test. The number of remaining participants was 1,444. The average survey response time was 14 minutes and 15 seconds. Facebook was paid 200 USD to disseminate the survey.

Statistical Analyses. Analyses were carried out using R software version 3.4.0 (Ihaka, R. & Gentleman R. 1993) running on the Rstudio terminal version 1.1.423 (RStudio Team (2015). The 600-subject subsample was subjected to EFA. The number of factors to be extracted was determined by parallel analysis (PA), and the maximum likelihood (ML) method was selected for extraction. The analysis used the correlation matrix, and Varimax rotation was used as rotation method. The 841-subject subsample was subjected to CFA. A robust extraction method (maximum likelihood estimation with robust standard errors and a Satorra-Bentler scaled test statistic; MLM) was selected to compensate for the lack of multivariate normality. Root mean square error approximation (RMSEA), comparative fit index (CFI), and standardized root mean square residual (SRMR) were employed as indices of fit. Scores under .06 for el RMSEA and SRMR and equal or higher than .90 in CFI were considered indicators of the model's goodness of fit.

Ethical Considerations. The investigation reported in this paper was conducted per the 1975 Helsinki Declaration, revised in 1983 by the Ethics Committee for Clinical Research. Participation was voluntary and anonymous: all participants agreed to participate. The research project associated with the present study was approved by an independent ethics committee from our institution.

Results

Exploratory factor analysis

Results shown in table 2 reflect the five-factor (suggested by PA) item grouping and saturation score over .30. This factorization explained 57% of the variance.

Confirmatory factor analysis

Four different models associated with the previously analyzed model were tested. Model 1 was unidimensional (all 25 items saturate a single factor), Model 2 had five unrelated factors, Model 3 had five first-order factors and a second-order factor, and Model 4 had five related factors.

The five related factors model was found to have the best indices of fit of the four tested models (see table 3). Figure 1 shows the standardized weights and the path diagram for this model.

Gender Invariance

Reliability and Item Psychometric Properties

Table 5 presents some of the items' psychometric properties. Standard deviation was approximately 1, which indicates an adequate response variability. Corrected item-total correlations were higher than .30, and Cronbach's alpha if an item was eliminated (α-item) did not affect the estimated consistency for each factor.

Validity with Respect to a Criterion

Table 6 describes the existing relationships between the five factors of the scale with other theoretically related scales and variables. As can be appreciated, all five factors are associated with tests: the dimensions of negotiation and stigma relate to all criterion scales. The dimension of pleasure is also related with all criteria, except for the SOS. The dimension of reliability presents an adequate association with all the scales except CUI. Finally, the dimension of shame had no relationship with the SAS, CUF, and CUI, but there was no relationship with the rest of the scales.

Discussion

Attitudes towards condoms are among the best predictors of consistent condom use (Glasman & Albarracín, 2006), and the MCAS is a widespread tool to evaluate such attitudes (Starosta et al., 2014). Nevertheless, the scale had not been appropriately adapted and validated for Spanish until now. Therefore, the present study sought to translate, adapt, and validate the MCAS (Helweg-Larsen, & Collins, 1994) for Spanish-speaking populations using a sample of Colombian men and women. In general, the scale showed

adequate psychometric properties: reliability was confirmed, and adequate construct validity indicators and validity concerning other criteria could also be measured. Therefore, the version adapted by our research group is suitable for use with Colombian young people with both research and intervention purposes.

No significant problems were encountered during the scale adaptation process. Initially, the dimensionality of the scale was tested using two complementary procedures: EFA and CFA. EFA suggested the presence of five factors that explained 43% of the variance, and the same five-factor structure was confirmed in an independent subsample. These results concur with the initially proposed dimensional structure (Helweg-Larsen, & Collins, 1994; Starosta et al., 2014). A second order factor with enough guaranties may also be used if a specific research approach or intervention should demand it.

Once the dimensionality of the Colombian MACS version was estab lished, the next step was evaluating some of its psychometric properties. Measured reliability values were adequate, except in the case of stigma (.65). In any case, the values obtained for this dimension were comparable to those found by other studies; the original study by Helweg-Larsen, and Collins, (1994), found a Cronbach's alpha of .62; and Unger et al. (1999) obtained a Cronbach's alpha of .56 for the dimension. All items seem to support the reliability of their corresponding subscales except for two items that dragged the reliability of the subscale by barely one hundredth; therefore, no additional actions in this respect were considered. Additionally, the items showed optimal corrected item-total correlations. Item means are located in the theoretical median of the response scale (4) or slightly above, as could be expected in general populations free of specific problems. The adequate response distribution was indicated by *SD* values between 0.96 and 2.04. Finally, concerning skewness and kurtosis, the multivariate distribution of the items cannot be considered normal.

As for criterion validity, the scale showed a stable behavior, which was expected given the observed significant associations, both low and moderate, in comparison with other scales evaluating similar (or identical) constructs. A consistent association between attitudes toward condoms and general attitudes toward sexuality was observed, except in the case of the pleasure subscale. Nevertheless, these associations were only significant

enough to show a slight trend. Several studies have reported relationships between erotophilia and use of condoms and attitudes toward condoms (Kyes, 1990; Ross, 1992; Sanders et al., 2006), although exceptions where this association was not observed have also been reported (Sakaluk & Gillath, 2016). In the present study, we observed an association between attitudes toward condoms and sexual assertiveness in regard to preventing unplanned pregnancies and avoiding STIs. Except for one subscale (shame), the rest of the relationships were moderate or low, an expected result, since sexual assertiveness has been shown to be a good predictor of condom use and condom use negotiation (Ward, Seabrook, Grower, Giaccardi, & Lippman, 2018; Uribe-Alvarado, Bahamón, Reyes, Trejos, & Alarcón, 2017; Widman, Noar, Choukas-Bradley, & Francis, 2014). Observed relationships between attitudes and the different variables used in the TPB were also as expected according to the theory (Ajzen, 2012; Ajzen, 1991). Thus, condom use frequency, intention to obtain a condom, intention to use a condom, and negotiating the use of condoms showed low or moderate relationships with the different MCAS subscales (except again in the case of the dimension of pleasure). The present study also used an ad hoc convergent validity measure to evaluate attitudes toward condoms. As expected, the highest correlations observed were between these variables. Finally, negative relationships were found between attitudes toward condoms and (CAEP). To the best of our knowledge, this is the first evaluation of CAEP and attitudes towards condoms, and there are few referents in this regard; however, CAEP is associated with low motivation for using condoms (Graham, Crosby, Sanders, Milhausen, & Yarber, 2016; Sanders et al., 2014). As can be appreciated from the previous description, our scale relates to other similar scales as expected.

The present study makes it possible to use the MACS scale to obtain reliable and valid measurements of attitudes toward the use of condoms among Colombian young people. However, the study had certain limitations. The non-randomized sampling approach used in the present study rules out the replicability of results to the general national population. Additionally, the test is not applicable to young people without access to the internet due to the web-based survey method. Future studies should target other Spanish-speaking samples or specific populations (sex workers, LGBT or adolescent populations, among others). Additionally, the presence of differential item functioning

across genders should be explored. The availability of the Spanish-validated MACS represents a new tool for working for the benefit of Colombian youth sexual health, and it opens the possibility of assessing the effectiveness of sexual health promotion programs.

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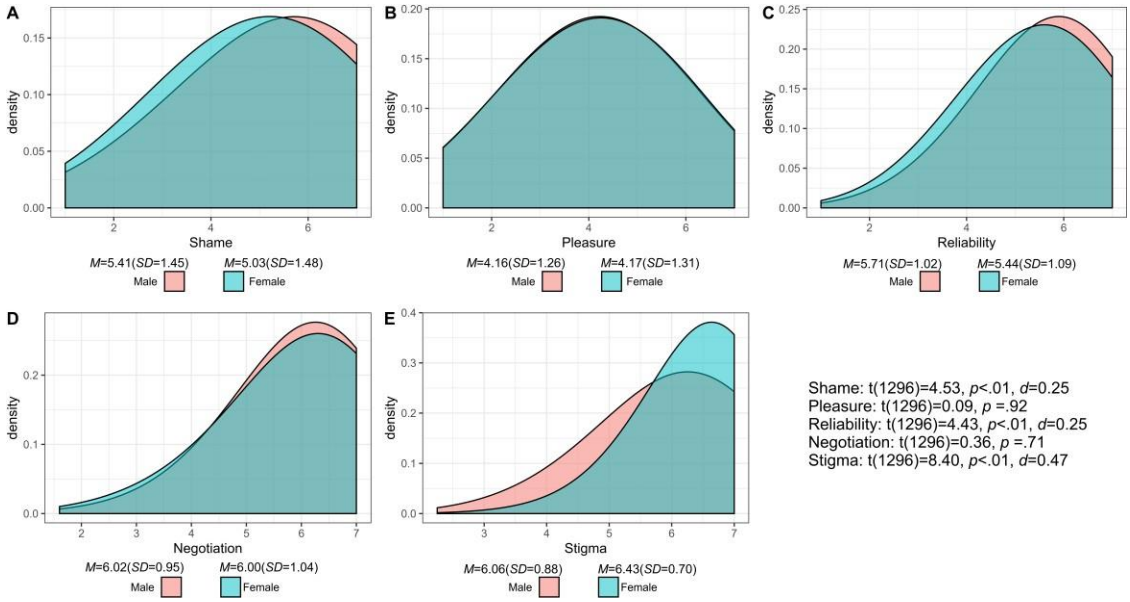

Figure 1.

Sex comparison by gender for the five dimensions of the scale.

Table 1

Sample distribution by demographic characteristics

Characteristics.	Man (n=594).		Woman (n=847).		Total (N= 1441).	
	n	%	N	%	n	%
Age.						
18	59	9.93%	112	13.2%	171	11.84%
19	83	14.0%	102	12.0%	185	12.88%
20	86	14.5%	135	15.9%	221	15.37%
21	73	12.3%	144	17.0%	217	15.03%
22	71	12.0%	119	14.0%	190	13.16%
23	80	13.5%	103	12.2%	183	12.74%
24	64	10.8%	67	7.91%	131	9.07%
25	59	9.93%	52	6.14%	111	7.69%
26	19	3.20%	13	1.57%	32	2.22%
Sexual orientation.						
Exclusively heterosexual.	349	58.75%	685	81.35%	1034	71.88%
Mainly heterosexual, some sporadic homosexual intercourses.	32	5.39%	108	12.75%	140	9.72%
Mainly heterosexual, many sporadic homosexual intercourses.	13	2.19%	23	2.72%	36	2.57%
Approximately the same number of homsexual and heterosexual intercourses.	17	2.86%	12	1.42%	29	2.01%
Mainly homosexual, several sporadic heterosexual intercourses.	13	2.19%	1	0.12%	14	0.97%

Mainly homosexual, several sporadic heterosexual intercourses.	25	4.21%	7	0.83%	32	2.22%
Exclusively homosexual.	141	23.74%	6	0.71%	147	10.28%
Asexual.	4	0.67%	1	0.12%	5	0.35%
Marital status.						
Single.	510	85.86%	725	85.60%	1235	85.91%
Married.	4	0.67%	13	1.53%	17	1.18%
In common law marriage.	75	12.63%	103	12.16%	178	12.35%
Separated.	5	0.84%	2	0.24%	7	0.48%
Widow/Widower.			1	0.12%	1	0.07%
Schooling.						
No schooling.	1	0.17%	1	0.12%	2	0.14%
Primary.	2	0.34%			2	0.14%
High School.	50	8.42%	49	5.79%	99	6.86%
Technical.	56	9.43%	82	9.68%	138	9.56%
Technologist.	35	5.89%	48	5.67%	83	5.75%
In college.	338	56.90%	496	58.56%	834	57.96%
Completed college degree.	82	13.80%	134	15.82%	216	14.96%
Pre-graduate.	19	3.20%	26	3.07%	45	3.12%
Completed graduate degree.	11	1.85%	11	1.30%	22	1.52%
Stable partner*.						
Yes.	285	47.98%	556	65.88%	841	58.39%
No.	309	52.02%	289	34.12%	598	41.61%

Note: * At least six months.

Table 2
Exploratory Factor Analysis

	Factor				
	Shame	Pleasure	Reliability	Negotiation	Stigma
Items					
MCAS5	.80				
MCAS10	.57				
MCAS11	.93				
MCAS17	.86				
MCAS23	.69				
MCAS2		.58			
MCAS8		.69			
MCAS15		.65			
MCAS19		.69			
MCAS25		.69			
MCAS4			.56		
MCAS6			.62		
MCAS9			.81		
MCAS14			.58		
MCAS20			.87		
MCAS1				.67	
MCAS7	.33			.51	.38
MCAS12				.70	
MCAS16				.55	.46
MCAS21				.64	
MCAS3					.58
MCAS13					.57
MCAS18					.75
MCAS22					.78
MCAS24					.59
% of Explained Variance	14%	9%	11%	10%	13%

Note: Values below .30 were omitted.

Table 3

Fit indexes for the four tested models

Model	χ^2 (robust)	df	*p*	RMSEA (90% CI)	CFI	SRMR
Unidimensional model	3447.34	275	<.01	.132(.128 -.136)	.38	.121
5 unrelated factors	1046.91	275	<.01	.064(.060 - .069)	.85	.120
5 factors with 1 second order.	762.66	270	<.01	.052(.048 - .056)	.90	.060
5 related factors	724.42	265	<.01	.051(.046 -.055)	.91	.054

Note: df= degree of freedom; CFI= Comparative Fit Index; RMSEA= Root Mean Square Error Approximation; SRMR = Standardized Root Mean Square Residual (SRMR); CI = Confidence Interval.

Table 4

Psychometric properties of items and reliability of subscales

Factor	Item	*M (SD)*	Citc	Skewness	Kurtosis	α-item	Total α (95%CI)	Total *M* (SD)
Shame	MCAS5	4.43 (2.04)	.68	-0.09	-1.37	.83	.86 (.85 - .87)	25.96 (7.36)
	MCAS10	5.79 (1.62)	.47	-1.46	1.21	.87		
	MCAS11	5.17 (1.89)	.80	-0.61	-1.05	.80		
	MCAS17	4.97 (1.99)	.76	-0.49	-1.20	.81		
	MCAS23	5.60 (1.63)	.68	-1.06	0.05	.83		
Pleasure	MCAS2	4.68 (1.92)	.49	- 0.19	-1.34	.81	.81 (.79 - .82)	20.85 (6.41)
	MCAS8	5.30 (1.65)	.65	-0.60	-0.88	.75		
	MCAS15	3.33 (1.55)	.59	0.13	-0.63	.77		
	MCAS19	3.21 (1.57)	.61	-0.27	-0.60	.77		
	MCAS25	4.32 (1.86)	.66	-0.03	-1.14	.76		
Reliability	MCAS4	6.36 (1.11)	.34	-2.81	9.18	.77	.76 (.74 - .78)	27.79 (5.39)
	MCAS6	5.35 (1.57)	.54	-0.74	-0.54	.71		
	MCAS9	5.42 (1.57)	.57	-1.08	0.41	.70		
	MCAS14	5.21 (1.73)	.56	-0.78	-0.59	.70		
	MCAS20	5.43 (1.49)	.63	-1.15	0.67	.68		
Negotiation	MCAS1	5.98 (1.63)	.47	1.70	1.84	.71	.74	30.08 (5.14)
	MCAS7	6.06 (1.42)	.53	1.74	2.29	.69		
	MCAS12	5.97 (1.50)	.52	1.78	2.54	.69		
	MCAS16	6.18 (1.25)	.52	1.81	2.97	.70		
	MCAS21	5.79 (1.51)	.50	1.49	1.72	.70		
Stigma	MCAS3	6.58 (0.96)	.40	1.90	3.35	.60	.65	31.73 (3.78)
	MCAS13	6.12 (1.36)	.41	2.84	8.62	.59		
	MCAS18	6.52 (0.93)	.43	2.78	9.15	.59		
	MCAS22	6.43 (0.97)	.53	2.35	6.45	.55		
	MCAS24	6.02 (1.51)	.33	1.72	2.09	.65		

Note: M= Mean; SD= Standard deviation; Citc=corrected item-total correlation; α -item: Cronbach's alpha if item is eliminated; α: Cronbach's alpha.

Table 5
Means, standard deviations, and correlations with confidence intervals

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12
1. Sham	25.96	7.40												
2. Plea	20.85	6.46	.13** [.08, .19]											
3. Relia	27.79	5.37	.15** [.09, .20]	.21** [.15, .26]										
4. Nego	30.08	5.05	.30** [.25, .35]	.25** [.20, .30]	.16** [.10, .21]									
5. Stig	31.73	3.71	.20** [.15, .25]	.30** [.25, .35]	.18** [.13, .24]	.41** [.36, .45]								
6. CUF	3.72	2.17	.04 [-.01, .09]	-.37** [-.42, -.32]	-.08** [-.14, -.03]	-.19** [-.25, -.14]	-.13** [-.19, -.08]							
7. CSI	3.85	1.29	.07* [.01, .12]	.29** [.24, .34]	.07** [.02, .13]	.16** [.10, .21]	.14** [.08, .19]	-.55** [-.59, -.51]						
8. CUI	3.72	1.36	-.04 [-.09, .01]	.33** [.28, .38]	.04 [-.01, .10]	.13** [.07, .18]	.10** [.05, .16]	-.75** [-.77, -.72]	.64** [.60, .67]					
9. CCI	3.67	1.40	-.06* [-.11, -.00]	.31** [.26, .36]	.06* [.00, .11]	.11** [.06, .16]	.11** [.06, .16]	-.63** [-.66, -.60]	.56** [.52, .60]	.81** [.79, .82]				
10. SOS	34.31	6.98	.07* [.01, .12]	-.02 [-.07, .04]	.12** [.07, .18]	.10** [.05, .16]	.07* [.01, .12]	-.00 [-.06, .05]	-.01 [-.06, .05]	-.04 [-.10, .01]	-.05 [-.10, .01]			
11. SAS	6.15	4.17	-.02 [-.08, .03]	.42** [.37, .46]	.10** [.05, .16]	.26** [.21, .31]	.24** [.19, .29]	-.77** [-.79, -.75]	.55** [.51, .59]	.68** [.65, .71]	.62** [.59, .66]	.03 [-.02, .09]		
12. Att	33.82	5.46	.10** [.05, .15]	.55** [.51, .59]	.50** [.46, .54]	.19** [.14, .24]	.29** [.24, .34]	-.35** [-.40, -.31]	.31** [.26, .36]	.35** [.30, .40]	.34** [.29, .38]	.05 [-.01, .10]	.37** [.33, .42]	
13. CAEP	1.61	0.73	-.08** [-.13, -.03]	-.36** [-.40, -.31]	-.08** [-.13, -.02]	-.16** [-.21, -.10]	-.16** [-.21, -.10]	.12** [.06, .17]	-.10** [-.16, -.05]	-.14** [-.19, -.08]	-.10** [-.15, -.04]	.07* [.01, .12]	-.15** [-.21, -.10]	-.23** [-.28, -.18]

Note. M and *SD* are used to represent mean and standard deviation, respectively. Values in square brackets indicate the 95% confidence interval for each correlation. The confidence interval is a plausible range of population correlations that could have caused the sample correlation (Cumming, 2014). * indicates $p < .05$. ** indicates $p < .01$. Sham. = Shame; Plea. = Pleasure; Relia. = Reliability; Nego. = Negotiation; Stig. = Stigma; SOS. = Sexual Opinion Survey; SAS. =Sexual Assertiveness Scale; CUF. = Condom Use Frequency; CSI. = Condom Search Intention; CUI= Condom Use Intention; CCI. = Condom Communication Intention; Att. = Attitudes; CAEP. = Condom Associated Erectile Problems.

APENDIX 1

Actitudes multidimensionales frente al condón UCLA.

Cada uno de los enunciados de este cuestionario de opinión expresa un sentimiento o una actitud hacia el uso del condón. Usted debe indicar, en una escala de siete puntos, el grado de concordancia entre las actitudes expresadas en cada enunciado y su propia opinión.

Marque (X) en qué medida está de acuerdo o en desacuerdo con la actitud expresada en cada enunciado como usted lo percibe.	Totalmente en desacuerdo	En desacuerdo	Un poco en desacuerdo	Ni de acuerdo ni en desacuerdo	Un poco en de acuerdo	De acuerdo	Totalmente de acuerdo
1. Es muy difícil tocar el tema de usar condón con mi pareja. *	1	2	3	4	5	6	7
2. El uso del condón interrumpe el juego previo. *	1	2	3	4	5	6	7
3. Las mujeres piensan que los hombres que usan condones son idiotas. *	1	2	3	4	5	6	7
4. El condón es un método efectivo para prevenir la transmisión del SIDA y otras infecciones de transmisión sexual.	1	2	3	4	5	6	7
5. Siempre me siento incomodo/a cuando compro condones. *	1	2	3	4	5	6	7
6. Los condones no son confiables. *	1	2	3	4	5	6	7
7. Cuando sugiero usar un condón casi siempre me da pena. *	1	2	3	4	5	6	7
8. Los condones arruinan el acto sexual. *	1	2	3	4	5	6	7
9. Creo que los condones son un excelente método anticonceptivo.	1	2	3	4	5	6	7
10. No creo que comprar condones sea raro.	1	2	3	4	5	6	7
11. Comprar condones es muy vergonzoso. *	1	2	3	4	5	6	7
12. Es fácil sugerirle a mi pareja que usemos condón.	1	2	3	4	5	6	7
13. Si una pareja está a punto de tener sexo y el hombre sugiere usar condón es menos probable que tengan sexo. *	1	2	3	4	5	6	7
14. Los condones no ofrecen una protección confiable. *	1	2	3	4	5	6	7
15. Los condones son muy divertidos.	1	2	3	4	5	6	7
16. Nunca sé que decir cuando mi pareja y yo tenemos que hablar sobre condones u otro tipo de protección. *	1	2	3	4	5	6	7
17. Seria vergonzoso que me vieran comprando condones en una tienda. *	1	2	3	4	5	6	7
18. La gente que sugiere el uso del condón es un poco ñoña. *	1	2	3	4	5	6	7
19. El usar condón puede hacer que el sexo sea más estimulante.	1	2	3	4	5	6	7
20. Los condones son un método anticonceptivo efectivo.	1	2	3	4	5	6	7
21. Me siento cómodo/a hablando de condones con mi pareja.	1	2	3	4	5	6	7
22. Los hombres que sugieren usar condón son muy aburridos. *	1	2	3	4	5	6	7
23. Cuando necesito condones, con frecuencia me da miedo conseguirlos. *	1	2	3	4	5	6	7
24. Una mujer que sugiere usar condón no confía en su pareja. *	1	2	3	4	5	6	7
25. Los condones son incomodos para ambos. *	1	2	3	4	5	6	7

*ítems que requieren inversión (1, 2, 3, 5 ,6 ,7, 8, 11, 13, 14, 16, 17, 18, 22, 23, 24, y 25). En ese caso, puntuaciones más altas significan mejores actitudes en la escala.