Handbook of Sexuality-Related Measures

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STD Attitude Scale

Publication details


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Published online on: 12 Aug 2010


Accessed on: 31 Aug 2023

STI Education Efficacy

In teaching about STIs/HIV, please indicate how you feel about the following using this scale:

1. No Confidence at all
2. Very Little Confidence
3. Somewhat Confident
4. Very Confident
5. Extremely Confident

36. The currency and accuracy of my knowledge.
37. The comprehensiveness of my knowledge.
38. My comfort level in talking about these topics with young people.
39. My comfort level in talking about these topics with my colleagues and supervisors.
40. My ability to develop lessons and learning activities to effectively teach about these topics.
41. My skill in developing open communication with young people about these topics.
42. My ability to develop curriculum or programs on these topics.
43. My understanding of the experiences of today’s young people that impact their sexuality and STI risk.

When it comes to STI education, how would you describe your readiness (including your willingness and ability) to:

1. Not Ready at all
2. Hardly Ready
3. Somewhat Ready
4. Very Ready
5. Extremely Ready

44. Advocate for better education and services for teens.
45. Share my knowledge and skills with my colleagues.
46. Serve as a resource person for people who need help with these topics.
47. Influence curriculum/program development in my school or agency related to these topics.
48. Influence policy either in my school, agency, or community related to these topics.

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STD Attitude Scale

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Researchers have found that attitudes are best described as multidimensional, having the three components of cognitive (belief), affective (feeling), and conative (intention to act). Beliefs express one’s perceptions or concepts toward an attitudinal object; feelings are described as an expression of liking or disliking relative to an attitudinal object; and intention to act is an expression of what the individual says he/she would do in a given situation (Bagozzi, 1978; Kothandapani, 1971; Ostrom, 1969; Torabi & Veenker, 1986). Attitudes are one important component determining individual health-risk behavior. More attention is now given by health educators to improving or maintaining health-conducive attitudes. A scale designed specifically to measure the components of attitudes toward sexually transmitted diseases (STDs) can be valuable to educators and researchers in planning STD education and determining risk correlates of individuals.

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Description
The STD Attitude Scale was developed to measure young adults’ beliefs, feelings, and intentions to act regarding sexually transmitted diseases. The scale discriminates between individuals with high-risk attitudes toward STD contraction and those with low-risk attitudes. A summed rating scale utilizing the 5-point Likert-type format and having three subscales reflecting the attitude components was constructed. Items were developed according to a table of specifications containing three conceptual areas: nature of STD, STD prevention, and STD treatment. Each subscale contained items from the three conceptual areas.

An extensive pool of items was generated from the literature, expert contribution, and via item solicitation from students. To avoid the possibility of a response set, both positive and negative items were developed. Attention was given to the readability of each item. From the item pool, three preliminary forms with 45 items each (15 items per subscale) were administered to 457 college students. Following statistical analysis, one scale containing the 45 items (15 per subscale) that best met item selection criteria of internal consistency and discrimination power was given to 100 high school students.

A further refined scale of 33 items (11 items per subscale), subjected to jury review, was given to 2,980 secondary school students. Analysis of these data produced the final scale of 27 items, 9 items for each subscale. The final scale has items with highly significant levels of internal consistency (item score vs. subscales and total scale score) and discriminating power (upper group vs. lower group for each item).

Response Mode and Timing
Respondents indicate whether they strongly agree, agree, are undecided, disagree, or strongly disagree with each statement. The scale takes an average of 15 minutes to complete.

Scoring
Scoring is as follows: Total scale, Items 1–27; Belief subscale, Items 1–9; Feeling subscale, Items 10–18; and Intention to Act subscale, Items 19–27. Calculate total points for each subscale and total scale by using the following point values. For Items 1, 10–14, 16, and 25: strongly agree = 5, agree = 4, undecided = 3, disagree = 2, and strongly disagree = 1. For Items 2–9, 15, 17–24, 26, and 27: strongly agree = 1, agree = 2, undecided = 3, disagree = 4, and strongly disagree = 5.

Higher subscale or total scale scores are interpreted as reflecting an attitude that predisposes one toward high-risk STD behavior, and lower scores predispose the person toward low-risk STD behavior.

Reliability
Yarber, Torabi, and Veenker (1988) reported a test-retest reliability over a 5- to 7-day period to be the following: Total scale = .71; Belief subscale = .50; Feeling subscale = .57; Intention to Act subscale = .63. Cronbach’s alpha was as follows: Total scale = .73; Belief subscale = .53; Feeling subscale = .48; Intention to Act subscale = .71.

Validity
Scale items have evidence of content and face validity as they were developed according to a table of specifications reflecting the behavioral aspects of STD and the content emphasis—preventive health behavior—of an STD education school curriculum (Yarber, 1985). Further, a panel of experts judged each item’s merit. The scale was developed, in part, as one component of a project for assessing the efficacy of a Centers for Disease Control education program (Yarber, 1985). Evidence of construct validity is provided by the fact that secondary school students exposed to the STD curriculum, in contrast to students receiving no STD instruction, showed improvement in scores from pretest to posttest when assessed by the scale (Yarber, 1988).

Other Information
The scale development was supported in part by U.S. Public Health Service grant award #R30/CCR500638–01.

References
### STD Attitude Scale

Directions: Please read each statement carefully. STD means sexually transmitted diseases, once called venereal diseases. Record your reaction by marking an “X” through the letter which best describes how much you agree or disagree with the idea.

Use this key:  
- **SA** = strongly agree  
- **A** = agree  
- **U** = undecided  
- **D** = disagree  
- **SD** = strongly disagree

**Example:** Doing things to prevent getting an STD is the job of each person.

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
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<tbody>
<tr>
<td>1. How one uses his/her sexuality has nothing to do with STD.</td>
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<td>X</td>
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<td>2. It is easy to use the prevention methods that reduce one's chances of getting an STD.</td>
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<td>3. Responsible sex is one of the best ways of reducing the risk of STD.</td>
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<td>4. Getting early medical care is the main key to preventing harmful effects of STD.</td>
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<td>5. Choosing the right sex partner is important in reducing the risk of getting an STD.</td>
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<td>6. A high rate of STD should be a concern for all people.</td>
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<td>7. People with an STD have a duty to get their sex partners to medical care.</td>
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<td>8. The best way to get a sex partner to STD treatment is to take him/her to the doctor with you.</td>
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<td>9. Changing one's sex habits is necessary once the presence of an STD is known.</td>
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<td>10. I would dislike having to follow the medical steps for treating an STD.</td>
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<td>11. If I were sexually active, I would feel uneasy doing things before and after sex to prevent getting an STD.</td>
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<td>12. If I were sexually active, it would be insulting if a sex partner suggested we use a condom to avoid STD.</td>
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<td>13. I dislike talking about STD with my peers.</td>
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<td>14. I would be uncertain about going to the doctor unless I was sure I really had an STD.</td>
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<td>15. I would feel that I should take my sex partner with me to a clinic if I thought I had an STD.</td>
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<td>16. It would be embarrassing to discuss STD with one's partner if one were sexually active.</td>
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<td>17. If I were to have sex, the chance of getting an STD makes me uneasy about having sex with more than one person.</td>
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<td>18. I like the idea of sexual abstinence (not having sex) as the best way of avoiding STD.</td>
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<td>19. If I had an STD, I would cooperate with public health persons to find the sources of STD.</td>
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<td>20. If I had an STD, I would avoid exposing others while I was being treated.</td>
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<td>21. I would have regular STD checkups if I were having sex with more than one person.</td>
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<td>22. I intend to look for STD signs before deciding to have sex with anyone.</td>
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<td>23. I will limit my sex activity to just one partner because of the chances I might get an STD.</td>
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<td>24. I will avoid sex contact anytime I think there is even a slight chance of getting an STD.</td>
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<td>25. The chance of getting an STD would not stop me from having sex.</td>
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<td>26. If I had a chance, I would support community efforts toward controlling STD.</td>
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<td>27. I would be willing to work with others to make people aware of STD problems in my town.</td>
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