THE ROLE OF COGNITIVE AVOIDANCE OF STIs FOR DISCUSSING SAFER SEX PRACTICES AND FOR CONDOM USE CONSISTENCY

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ABSTRACT: The present research investigates the determinants of the cognitive tendency to avoid thoughts about sexually transmitted infection (STI) and examines the association of this tendency with willingness to engage in discussions of safer sexual practices and with condom use consistency. Findings from two questionnaire-based studies are presented. The first study, with 71 female university students, found that women with low sexual self-efficacy, low assertiveness toward discussing safer sex practices and lower knowledge about STIs had a higher tendency to avoid STI-related thoughts. Moreover, the higher the women’s tendency to avoid STI thoughts the less willing they were to engage in discussions of safer sex practices. The second study, comprised of 26 female and 16 male university students, investigated the association of mental representations of condoms and STI thought avoidance with consistency of condom use. Results indicated that certain mental representations of condoms as well as cognitive avoidance were associated with condom use consistency and that the associations differed for men and women.

Key words: Cognitive avoidance Condom use consistency Mental representations Safer sex communication Sexually transmitted infections (STIs)

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INTRODUCTION

This paper examines how the tendency to avoid thoughts related to sexually transmitted infections (STIs) is associated with communication about safer sex practices and condom use consistency. Many STIs are more easily transmitted from male to female than vice versa. For example, women are more likely to contract HIV from men than vice versa (Royce, Sena, Cates, & Cohen, 1997). Infection rates for common STIs, such as chlamydia and herpes simplex virus, are higher among women than men (Fleming et al., 1997; Patrick, Wong, & Jordan, 2000). In addition to being biologically more susceptible to contracting certain STIs than men (Downs & de Vincenzi, 1996), women with untreated STIs can experience severe long-term health consequences. These consequences can include acute pelvic inflammatory disease (PID), difficulties of conception due to tubal infertility, pregnancy loss due to ectopic pregnancy, spontaneous abortion, premature delivery and stillbirth, and cervical lesions that may lead to cervical cancer (MacDonald & Burnham, 1997; Maticka-Tyndale, 2000). Thus, the present study focuses mainly on STI risk reduction among young women.

A potentially effective method of assessing STI risk in a relationship is if both partners are periodically tested for STIs. However, this is not a common measure that couples take. For example, in a sample of 95 couples in long-term monogamous relationships...
almost one third of the couples reported that they had switched from using condoms to the birth control pill without both partners having been tested for HIV (Misovich, Fisher, & Fisher, 1997).

Consistent condom use significantly reduces the risk of infection with a range of STIs, including HIV (Morris, 1993; Pinkerton & Abramson, 1997; Warner et al., 2004). Consistent condom use is therefore recognized as a beneficial public health measure for STI/HIV prevention (Centers for Disease Control and Prevention, 2002). Researchers have sought to document condom use practices among heterosexually active young adults and to identify factors that contribute to use or non-use of condoms in situations of possible risk. Although there was a decline in many STIs in the early 1990s, reported cases of syphilis, gonorrhea, and chlamydia have increased since 1997, suggesting that the promotion of consistent condom use remains an ever present public health priority (Patrick, Wong, & Jordan, 2000). Because of the serious threat that STIs pose to women’s health it is essential to understand the factors that contribute to the discontinuation of condom use and the discussions that couples have regarding safer sex practices.

Several factors that influence condom use consistency in relationships have been identified. The longer the duration of the relationship the less likely it is that couples will continue using two methods (condom and oral contraceptive) (Anderson, Brackbill, & Mosher, 1996). Couples that infer a reduced risk based upon the length of their relationship may see the pill as a replacement for condoms as their contraceptive method (Beckman, Harvey, & Tiersky, 1996). In a qualitative study by Cleary, Barhman, MacCormack and Herold (2002), twenty-two female university students were interviewed on their health protective sexual communication with their present partner prior to their first sexual intercourse. It was found that little if any discussion about sexual health issues took place prior to the decision to abandon condom use. The first goal of the present study was to examine factors associated with the willingness to discuss safer sex practices. We studied these factors in a sample of female university students who were in a monogamous, heterosexual, relationship and were using condoms with their partner at the time of the study. It was hypothesized that women with low sexual self-efficacy, low assertiveness toward discussing safer sexual practices and low knowledge about STIs would have a greater tendency to avoid STI-related thoughts (hypothesis 1). Furthermore, we hypothesized that the more they avoided STI thoughts the less willing they would be to engage in discussions of safer sex practices (hypothesis 2).

Additional factors influencing condom use in longer-term relationships may be the perceived costs and benefits of condom use. Individuals can have mental representations of condom use as beneficial (e.g., as protecting against STIs and unwanted pregnancy) or as detrimental (e.g., as a barrier to intimacy). It was hypothesized that certain mental representations individuals have of condoms are associated with their consistency of condom use. We tested this hypothesis in Study 2 and we also tested how cognitive avoidance is associated with condom use consistency.

Below, the construct of cognitive avoidance is introduced, and it will be shown how it is associated with women’s willingness to engage in safer sex communication and how it may lead to the discontinuation of condom use.

**Avoidance and Willingness to Engage in Safer Sex Communication**

Research has indicated that individuals hesitate to discuss safer sex issues because in bringing up the topic they feel they risk inferring mistrust, infidelity and a lack of commitment to the relationship (Civic, 1999; Williams, Kimble, Covell, & Weiss, 1992). Individuals may also unconsciously avoid asking questions that are too detailed because they may fear an answer that indicates their partner could pose an STI risk. Becoming aware of partner STI risk may induce individuals to worry that they have already contracted an STI and consequently need to be tested and need to suggest that their partner be tested. Furthermore, it would require refraining from unsafe sexual practices. Consequently, individuals are motivated not to discuss issues regarding safer sex (Civic, 1999).

How do individuals who may know they should discuss safer sex with their partner deal with the possibility
that the partner may react negatively to such discussion? One possibility is that individuals have a motivated tendency to avoid thoughts that their partner could have an STI and that this tendency contributes to the discontinuation of condom use. Cognitive avoidance is defined as a psychological defence mechanism that allows individuals to redirect their attention away from threatening, unpleasant thoughts at the early stages of information processing (Newman & McKinney, 2002). By redirecting attention away from unpleasant thoughts, such as a partner having an STI, individuals do not confront the cognitive, affective or behavioural responses that such thoughts could induce, such as the distress of having to discuss safer sex practices. Successful avoidance of STI-related thoughts renders discussion of safer sex issues unnecessary.

**The Role of Cognitive Avoidance for Relationship Maintenance**

Individuals in intimate and committed relationships are motivated to maintain and enhance the quality of the relationship. One mechanism to ensure relationship maintenance is to engage in cognitive processes that result in continued favourable evaluations of the partner and the relationship (Misovich et al., 1997). Thoughts of one’s partner having an STI may threaten the favourable view of the partner and therefore a person may unconsciously use the cognitive defence mechanism of avoidance to deflect any threats to the relationship from his or her awareness. Evidence for this claim comes, for example, from a qualitative study by Browne and Minichiello (1994) who conducted interviews with 17 women who had been regularly using condoms in their relationship and then engaged in unsafe sex. The authors found that the women subsequently avoided thoughts that their partner posed a risk for STIs. They contended that the STI avoiding thoughts helped the women manage the unsettling feeling that they may have jeopardized their health.

Therefore, the first hypothesis, tested in Study 1 below, focuses on women who are currently using condoms with their partner. It is proposed that women with low sexual self-efficacy, low assertiveness toward discussing safer sex practices, and low knowledge about STIs have a higher tendency to avoid STI-related thoughts. We describe the assumed determinants of the cognitive avoidance of STI thoughts (sexual self-efficacy, assertiveness toward discussing safer sex practices and STI knowledge) below.

**Sexual self-efficacy** refers to the strength of the conviction that one can act upon one’s sexual needs in a relationship, such as enjoying sex and insisting on contraceptive protection (Levinson, 1986). Researchers such as Bandura (1990) have used the self-efficacy construct to better understand the motivations for dysfunctional and avoidant behaviours. We assume that the less self-efficacious a woman perceives herself to be in sexual situations the more likely she should be to avoid STI-related thoughts. Becoming aware of thoughts of their partner as potentially having an STI would likely induce measures such as strongly insisting on continuing condom use. The less self-efficacious a woman is the less likely she would be to perceive herself as capable of continuing condom use in such situations. Therefore, avoiding STI thoughts can act as a coping strategy for women who lack the perceived self-efficacy to negotiate consistent condom use with their partner.

**Assertiveness toward discussing safer sexual practices** refers to the degree to which individuals express thoughts, feelings, or beliefs toward safer sex behaviours in direct, appropriate ways (Yesmont, 1992). Assertiveness toward discussing safer sex practices is considered important in effective communication between partners about protection against STI transmission (Rotheram-Borus & Koopman, 1989). The less assertive a woman is toward discussing safer sex practices the more likely she should be to avoid STI-related thoughts. Women who are less assertive may fear speaking to their partner about potentially very sensitive issues such as STIs.

Finally, the less knowledge a woman has about STIs the more likely she should be to avoid STI-related thoughts. Having relatively more knowledge about the threat posed by STIs likely contributes to individuals taking action to prevent infection including discussing safer sex with partners. Individuals who may be generally aware of STIs but who possess relatively less specific STI information (e.g., prevalence, symptoms, means of transmission, importance of preventive behaviours, etc.) may be
motivated to avoid STI-related thoughts as a way of cognitively neutralizing or offsetting the awareness that they are not knowledgeable about STI risk.

A second hypothesis tested in Study 1 is that women who tend to avoid STI-related thoughts should be less likely to engage in discussions about safer sex practices with their partner than women who do not have this tendency. Successful avoidance of STI-related thoughts renders discussion of safer sex practices unnecessary, as the person will not feel that his or her partner poses an STI threat.

**Avoidance, Mental Representations of Condoms, and Condom Use Consistency**

Study 2 investigates the impact of STI thought avoidance on the consistency of condom use. In addition to STI avoidance, gender differences in the perception of the benefits and costs of condom use in relationships are examined as influences on the consistency with which condoms are used.

**Gender Differences in the Perceived Costs and Benefits of Condom Use**

The perceived costs (e.g., barrier to intimacy, see below) and benefits (e.g., pregnancy and STI prevention, indication of user’s responsibility, see below) of condoms in combination with the tendency to avoid STI thoughts should be associated with the consistency with which condoms are used. Because condoms are perceived differently by men and women (Browne & Minichiello, 1994), we expected gender differences in these relationships. The different mental representations of condoms and their association with STI thought avoidance are discussed below.

**Mental Representations of Condoms**

Mental representations are defined as iconic or symbolically encoded meanings of objects or events that serve as organizers in the formation of thought (Horowitz, 1988). Individuals can mentally conceptualize condoms in a variety of ways, indicating either costs or benefits. In particular, condoms can be mentally represented as: (1) protective devices (against STIs and unwanted pregnancy); (2) indicating that one is a responsible person (by protecting oneself and one’s partner from STIs and unwanted pregnancy); and (3) a barrier to intimacy (by reducing physical closeness and pleasure during intercourse).

The associations between these mental representations and STI thought avoidance with condom use consistency are discussed below.

It is hypothesized that for women, the perception of condoms as protective devices against STIs and unwanted pregnancy should be the predominant representation influencing condom use consistency in their relationship. In particular, women have the incentive to protect themselves from an unwanted pregnancy. In a study among 219 college students (118 men and 101 women), Carter, McNair, Corbin and Williams (1999) found that although men and women had similar reasons for not using condoms, women’s most common reason was that they did not perceive their partner as a risk for pregnancy or STI, whereas for men the most common reason was that they were inconvenient. The second most common reason, endorsed by only 18% of the women, for not using condoms with their partner was that they were using oral contraceptives. We therefore expect that seeing condoms as protective devices against STIs and unwanted pregnancy should be associated with more consistent condom use in women, but not in men.

We also hypothesize that for both men and women, condom use will be seen as an indication of sexual responsibility and respect toward the partner. In a study by Davidson-Harden, Fisher, and Davidson (2000) male and female undergraduate students indicated that women and men who initiated condom use in monogamous, stable relationships were perceived to be more responsible compared with men and women who did not initiate condom use. This study suggests that men and women who initiate and maintain condom use in relationships are likely to be perceived by their partners as acting in a sexually responsible manner. This should be a motivation to continue consistent condom use in order to maintain this positive image of oneself in the eyes of the partner.

For men, condom use consistency may be driven to some extent by mental representations of condoms as interfering with intimacy and pleasure. Hammer, Fisher, Fitzgerald, and Fisher (1996) found that both men and women express a dislike for using condoms; however, men reported a greater number of disadvantages to using condoms compared with
women. Men may be more motivated to discontinue, or inconsistently use condoms to increase sexual pleasure and may perceive condoms as a barrier to becoming more intimate with their partner.

To assess the role of the aforementioned mental representations of condoms for condom use consistency, a scale consisting of seven items was developed (see Table 2 below). The items in this scale address: (1) condoms as protective devices against STIs and unwanted pregnancy, (2) condoms as indicating responsibility and respect toward one’s partner, and (3) condoms as a barrier to intimacy.

As outlined above, gender differences are expected in the way that these mental representations of condoms affect the consistency of condom use. Specifically, the third hypothesis tested here is that the more men perceive condoms as a barrier to intimacy and the less they perceive them as indicating respect and responsibility toward their partner the less consistent they should be in using condoms. It is expected that the representation of condoms as protective devices will not be associated with the consistency of using condoms for men.

The fourth hypothesis states that, for women, the representation of condoms as indicating responsibility and respect toward one’s partner and as a protective device against STIs and unwanted pregnancy will be correlated positively with the consistency of condom use whereas the representation of condoms as a barrier to intimacy will not be significantly correlated with condom use consistency.

The final, fifth, hypothesis is that avoidance of STI-related thoughts will be negatively associated with condom use consistency in men and women. Individuals who are inconsistently using condoms may be avoiding thoughts of STIs as they may fear that they have potentially contracted an STI from their present partner. By engaging in the cognitive process of thought avoidance these individuals can minimize the perceived risk status of their partner and can engage in unprotected sexual intercourse with the impression of being safe from having, or potentially contracting, an STI (Browne & Minichiello, 1994).

In summary, the present research tests in two different samples the following hypotheses: (1) Women with low sexual self-efficacy, low assertiveness toward discussing safer sex practices and lower knowledge about STIs will have a greater tendency to avoid STI-related thoughts; (2) The more women tend to avoid STI thoughts the less willing they should be to engage in discussions of safer sex practices; (3) The more men perceive condoms as a barrier to intimacy and the less they perceive them as indicating respect and responsibility toward their partner the less consistent they should be in using condoms; (4) For women, the representation of condoms as indicating responsibility and respect toward one’s partner and as a protective device against STIs and unwanted pregnancy will be correlated positively with the consistency of condom use; and (5) Avoidance of STI-related thoughts is negatively associated with condom use consistency in men and women.

**METHODS**

**PARTICIPANTS**

The five aforementioned hypotheses were tested in two samples of students recruited for two unrelated larger studies.

*Sample 1:* Hypotheses 1 and 2 were tested in a sample of one hundred and thirty eight female undergraduate students from a large university located in Montreal, Quebec, who were recruited for a larger study on sexual assertiveness by displaying posters on campus and enlisting students from a student paid subject pool. Participants were compensated by either extra course credit or $10.00. Of the 138 female undergraduates who were recruited for the sexual assertiveness study, 71 women met all criteria necessary for inclusion in the present analyses: being currently sexually active, using condoms in their present relationship, and having been in the relationship for at least one month but no longer than one year. The minimum relationship length criterion was applied to increase the likelihood that the participating women would have had sufficient opportunity to discuss safer sex practices with their partner. Limiting the length of the relationship to one year was necessary because the study focused on STI risk assessments for couples when the risk of contracting an STI should still be most salient. Participants included in the analyses reported below
ranged in age from 18 to 24 years ($M = 19.8$, $SD = 1.2$) and ranged in relationship length from 1.5 to 12 months ($M = 6.6$, $SD = 2.65$). The majority of participants were in their second (59.2%) or first (19.7%) year of university. Of the 71 participants, 34 (47.8%) used condoms and the pill, 32 (45.1%) used condoms only 5 (7.0%) used condoms and some other form of contraception. Participants were asked to complete several measures described below as part of a larger questionnaire battery, which altogether took about 40 minutes. Questionnaires were filled out anonymously in groups of up to six students.

Sample 2: Hypotheses 3 to 5 were tested in a sample of male and female students who had been recruited for a larger, unrelated study of cumulative risk perception through advertisements in student run newspapers, on-line classifieds, posters around campus, and the psychology subject pool. The participants had to meet the criterion of being in a sexually active, monogamous, heterosexual relationship that has lasted at least one month but no longer than two years. Paid participants received $10 compensation for their time and subject pool participants received extra course credit. For the present analyses, only participants who indicated that they used condoms as their contraceptive method with their present partner and who completed the mental representation scale for condom users (below) were included. The sample consisted of 26 women and 16 men. At the beginning of their relationship, 20 (47.6%) of the participants reported that they used only condoms, 19 (45.2%) used both the condom and the pill, 2 (4.8%) said initially they used neither the pill nor condoms, one (2.4%) used only the pill. In comparison, at the time of questionnaire administration, 23 (54.7%) of the participants reported that they were currently using condoms and the pill, 18 (42.8%) used only condoms, and one (2.3%) person used condoms and another type of contraception. Male participants ranged in age from 18 to 25 years ($M = 20.44$, $SD = 2.01$) and female participants ranged in age from 18 to 23 years ($M = 20.19$, $SD = 1.52$). There was no significant difference in age $t(40) = 0.44, p = .66$. Relationship length for men ranged from 2 to 23 months ($M = 10.81$, $SD = 6.44$) and for women 2 to 21 months ($M = 6.90$, $SD = 4.02$) with the average length of relationship being significantly longer for men compared to women $t(40) = 2.43, p = .02$.

**Measures**

**Sexual Self-Efficacy.** Seven items were selected from the 18 item Contraceptive Self-Efficacy Scale developed by Levinson (1986). This subset of items was selected because it assesses an individual’s ability to act upon his or her sexual needs in a relationship, such as enjoying sex and insisting on contraceptive protection (e.g., *When I have sex, I can enjoy it as something that I really wanted to do, or There are times when I’d be so involved sexually or emotionally, that I could have sexual intercourse even if I weren’t protected*). Items that were not included assessed women’s perceived control over sexual situations (e.g., *Sometimes I end up having sex with my boyfriend because I can’t find a way to stop it*). Participants responded to the items on a 5-point Likert-type scale with endpoints -2 (strongly disagree) and +2 (strongly agree) and a midpoint of 0 (neither agree nor disagree). All responses were transformed to a 0 to 4 format and then summed to achieve an overall score for sexual self-efficacy that ranged from 0 to 28. Higher scores indicate that a woman feels she is capable of acting upon her sexual needs in a relationship. Cronbach’s alpha for the seven items is .42.

**Assertiveness.** Items were selected from Yesmont’s (1992) Intimate Relationships Questionnaire. The scale assesses men and women’s assertive, aggressive and nonassertive response tendencies toward discussing safer sex practices. For the purposes of this study, only the assertive response tendencies were used. Individuals with assertive response latencies express thoughts, feelings, or beliefs toward safer sex behaviours in direct, appropriate ways. For example, an assertive response to the item, “If your date refuses to use a condom, you think...” would be, “I can find out what he has against them and we can talk about it.” Greater endorsement of this response by a participant would indicate that, in a similar situation, the individual is assertive in discussing condom use. The scale consists of 14 items with 4 of the 14 items as distracters and the remaining 10 items describing situations involving precautionary safe sex behaviours. To reduce the length of the scale, we excluded the distracters. In addition, two of the ten items were not included because the situations described were either too vague or awkwardly worded. Participants were
required to rate on a 5-point Likert-type rating scale ranging from -2 (not like me) to +2 (just like me) with a midpoint of 0 (somewhat like me) on how similar the particular response to the situation given would be to their own thoughts or behaviours in that situation. The responses were transformed to a 0 to 4 format and then summed to achieve an overall score for assertiveness between 0 and 32. Cronbach’s alpha for this scale is .77. Higher scores indicate greater assertiveness toward discussing safer sex practices in relationships.

**STI Knowledge.** Nineteen items assessing knowledge about STIs were chosen from several STI knowledge scales: the Herpes Knowledge Scale (Bruce & McLaughlin, 1986), the Venereal Disease and Knowledge Questionnaire (Arafat & Allen, 1977), and the AIDS Knowledge Test (Koopman, Rotherman-Borus, Henderson, Bradley, & Hunter, 1990). Participants responded to the 19 statements by indicating whether they were true or false. The questions were comprised of both factual (e.g., Some STDs can produce sterility) and behaviourally relevant (e.g., You are safe from AIDS if you have oral sex without a condom). Higher scores on the scale (correct responses) indicate greater knowledge of STIs.

**STI Thought Avoidance.** Fourteen items were chosen from a 43-item scale developed by Yarber, Torabi, and Veenker (1988) to assess young adults’ beliefs, feelings and intentions to act to prevent or seek treatment for STIs. The fourteen items were selected based on face validity to represent statements that could indicate a tendency to avoid thoughts associated with STIs, for example, “It is embarrassing to discuss STDs with one’s partner” and “I feel uneasy doing things before and after sex to prevent an STD.” Answers to these items were assessed on a 5-point Likert-type rating scale ranging from -2 (strongly disagree) to +2 (strongly agree) with a midpoint of 0 (neither agree nor disagree). Eight reversed-scored items, for example, “I avoid sexual contact any time I think there is even a slight chance of getting an STD,” were recoded, values for all items were transformed to a 0 to 4 format and then all items were summed to achieve an overall score for STI thought avoidance that ranged from 0 to 56. Higher scores indicate greater avoidance of STI thoughts. Cronbach’s alpha for this scale is .53.

For the study conducted with Sample 2, five items of the avoidance scale were replaced by items from Yarber, Torabi, and Veenker’s (1988) STD Attitude Scale that appeared to be more valid indicators of avoidant cognitions and behaviours associated with STIs. For example, the item, “If I had a chance, I would support community efforts toward controlling STDs” from the first sample’s questionnaire was replaced with the item, “It would be insulting if a sex partner suggested we use a condom to avoid an STD.” Cronbach’s alpha for this revised scale was .64 in this sample.

**Discussions of Safer Sex Practices.** Participants were asked to respond to five questions that assessed whether or not they had a discussion with their current partner about his sexual history. For example, “Did you ask your current sexual partner if he has ever had an STD?” Respondents were given the option of answering yes or no to each of the five questions. The number of yes-responses were summed up for the five questions to build a summed score where a higher number indicates a greater willingness to discuss safer sex practices with one’s partner. The five items

<table>
<thead>
<tr>
<th>Table 1 Discussion of Safer Sex Practices</th>
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</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Did you ever ask your current sexual partner about the past number of partners he has had?</td>
</tr>
<tr>
<td>Did you ask your current sexual partner if he has ever had an STD?</td>
</tr>
<tr>
<td>Did you ask your current partner if he has ever shot drugs like heroin, cocaine, or speed?</td>
</tr>
<tr>
<td>Did you ever ask your current partner if he has ever had a homosexual experience?</td>
</tr>
<tr>
<td>Did you ask your current partner if he’s ever had unprotected sex with anyone other than you?</td>
</tr>
</tbody>
</table>

N = 71
are listed in Table 1 with the number and percentage of participants that did or did not discuss the respective issue with their partner.

**Mental Representations of Condoms.** A seven-item scale was developed to address three types of mental representations of condoms (see Table 2): (1) condoms as protective devices against STIs and unwanted pregnancy, (2) condom use as indicating responsibility and respect for one’s partner and (3) condoms as a barrier to intimacy. Respondents were asked to what extent each of the seven statements was indicative of how they perceived condom use in their relationship. Possible answers to each item ranged from 0 (not at all true) to 6 (exactly true). Item scores for each category were summed to create three scores, one for each mental representation, so that higher scores indicate greater endorsement of the respective mental representation.

**Condom Use Consistency.** Condom use consistency was assessed by asking participants to respond to the question, “How consistently are you using the contraceptive method(s) you are currently using?” Respondents indicated their consistency along a 7-point Likert-type scale with answers ranging from 0 (not at all consistent) to 6 (extremely consistent). Table 4 (last row) displays the means and standard deviations for condom consistency for men and women.

**RESULTS**

**Analyses**

There was one missing value each for three participants on the avoidance scale and three missing values for one participant on the assertiveness scale. Missing values were replaced by calculating the mean of all participants on the missing item and replacing the missing value with that group mean.

**Hypothesis 1.** Hypothesis 1 stated that STI thought avoidance would be independently associated with lower sexual self-efficacy, lower assertiveness toward discussing safer sex practices and less STI knowledge. A linear regression analysis was conducted in which avoidance was regressed on sexual self-efficacy, assertiveness, and STI knowledge. Table 3 presents the means and standard deviations as well as the intercorrelations between the measures included in the analyses. Results of the regression analysis reveal that sexual self-efficacy significantly predicted STI thought avoidance and accounted for 18% of the variance \( (B = -0.60, S. E. = 0.16, p < .001) \). Assertiveness toward negotiating condom use also significantly predicted STI thought avoidance and accounted for 14% of the variance \( (B = -0.39, S. E. = 0.10, p < .001) \). Together, these two variables accounted for 32% of the variance in STI thought avoidance. The third variable, STI knowledge, approached significance \( (B = -.71, S. E. = .38, p < .07) \) and accounted for an additional 3% of the variance in avoidance.

Thus, the variables most strongly associated with STI thought avoidance are sexual self-efficacy and assertiveness. As hypothesized, being less self-efficacious concerning acting upon one’s sexual needs, and being less assertive in discussing safer sex practices were associated with a greater tendency to avoid STI-related thoughts. Being less knowledgeable about STIs was much less influential in this respect.

**Hypothesis 2.** Hypothesis 2 stated that a greater

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**Table 2 Mental Representations of Condoms**

<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility</td>
<td>(1) Using condoms shows that we are responsible people.</td>
</tr>
<tr>
<td></td>
<td>(2) We are using condoms because we respect each other.</td>
</tr>
<tr>
<td>Protective</td>
<td>(3) I insist on using condoms to prevent an unplanned pregnancy.</td>
</tr>
<tr>
<td></td>
<td>(4) I insist on using condoms to protect myself from sexually transmitted diseases.</td>
</tr>
<tr>
<td>Barrier to Intimacy</td>
<td>(5) Condoms and passionate love are contradictory and cannot be reconciled.</td>
</tr>
<tr>
<td></td>
<td>(6) I would feel closer to my partner if we were not using condoms.</td>
</tr>
<tr>
<td></td>
<td>(7) Always using condoms means that we can never get really as close to each other as we would like.</td>
</tr>
</tbody>
</table>
tendency to avoid STI thoughts would be related to a lower probability of engaging in discussions of safer sex practices with one’s partner. A Pearson correlation between participants’ scores on the avoidance and inquiry scale was conducted and the hypothesis was supported: Participants scores on the STI thought avoidance scale correlated negatively with the number of questions asked to the partner about his sexual history, \( r(71) = -.23, p < .05 \). These results indicate that women with a greater tendency to avoid STI-related thoughts are less likely to inquire into their partner’s sexual history or vice versa.

The tendency to avoid STI-related thoughts may put individuals at risk for infection because they may be less likely to discuss safer sex practices with their partner and may therefore be less likely to take protective measures such as continuing to consistently use condoms. The following three hypotheses address this possibility.

Means and standard deviations for each of the mental representation of condoms categories (from Table 2) and for STI avoidance are reported in Table 4. Independent samples t-tests were conducted comparing men and women for each of the mental representation of condoms categories, STI avoidance and condom consistency (Table 4). No gender differences were found in the overall endorsement of any of the categories.

**Hypothesis 3.** The third hypothesis stated that the more men perceive condoms as barriers to intimacy the less consistent they would be in using condoms. Likewise, the less they endorse the representation of condoms as indicating respect and responsibility toward their partner the less consistent they would be in their condom use. The representation of condoms as protective devices should not be associated with condom use consistency. Pearson correlations were conducted and the results are presented in Table 5. As expected, perceiving

<table>
<thead>
<tr>
<th>Mental Representation</th>
<th>Men* M (SD)</th>
<th>Women* M (SD)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protection</td>
<td>4.63 (0.90)</td>
<td>4.98 (1.04)</td>
<td>-1.13</td>
<td>.27</td>
</tr>
<tr>
<td>Responsibility</td>
<td>5.13 (1.26)</td>
<td>5.10 (0.93)</td>
<td>0.09</td>
<td>.93</td>
</tr>
<tr>
<td>Barrier to Intimacy</td>
<td>3.88 (4.03)</td>
<td>4.19 (4.21)</td>
<td>-0.24</td>
<td>.81</td>
</tr>
<tr>
<td>STI Thought Avoidance</td>
<td>14.66 (6.02)</td>
<td>14.38 (6.10)</td>
<td>0.14</td>
<td>.89</td>
</tr>
<tr>
<td>Condom Use Consistency</td>
<td>5.63 (0.50)</td>
<td>5.46 (1.14)</td>
<td>0.54</td>
<td>.59</td>
</tr>
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Note: Total scores for the subscales could range as follows: Protection: 0 to 12, Responsibility: 0 to 12, Barrier to Intimacy: 0 to 18. The STI Thought Avoidance scale could range from 0 to 56, and Condom use Consistency was a single item on a 7-point Likert type scale (0 = not at all consistent to 6 = extremely consistent).

* \( n = 16 \). *\( n = 26 \).
condoms as barriers to intimacy correlated negatively with condom use consistency $r(16) = -.89, p < .001$, whereas the representation of condoms as indicating respect and responsibility correlated positively with condom use consistency $r(16) = .56, p < .05$. As predicted, the representation of condoms as protective devices was not significantly correlated with condom use consistency, $r(16) = .33, p > .05$.

To determine if the barrier toward intimacy representation was the predominant factor associated with inconsistent condom use compared with the responsibility representation, a Z-test for comparing correlations was conducted. The result from the analysis indicated that the correlation between “barrier to intimacy” and condom use consistency ($r = -.89$) was significantly higher than the correlation between “responsibility” and condom use consistency ($r = .56$), $Z = 2.01, p < .05$. Therefore, for men, the predominant factor associated with inconsistent condom use is indeed the perception of condoms as a barrier to intimacy.

**Hypothesis 4.** The fourth hypothesis stated that the more women perceived condoms as representing respect and responsibility toward their partner and as protective devices against STIs and an unwanted pregnancy the more consistent they would be in using condoms. The results showed that women who were higher in STI thought avoidance were less willing to engage in discussions of safer sex practices with their partner. Avoidance of STI thoughts may put people at risk for unsafe sexual behaviour, such as inconsistent condom use, by allowing them to deflect threatening thoughts, such as the thought that their partner could have an STI.

**Hypothesis 5.** The fifth and final hypothesis stated that the more men and women avoid STI-related thoughts, the less consistent they would be in using condoms. This hypothesis was supported. STI thought avoidance was correlated negatively with condom use consistency in women, $r(26) = -.42, p < .03$, and approach significance in men, $r(16) = -.47, p < .07$.

**DISCUSSION**

The first two hypotheses identified variables that are associated with STI thought avoidance, showing that women with lower sexual self efficacy, assertiveness and STI knowledge are more likely to avoid STI-related thoughts and may therefore be less likely to perceive potential STI risks in their partner. The results also showed that women who were higher in STI thought avoidance were less willing to engage in discussions of safer sex practices with their partner. Avoidance of STI thoughts may put people at risk for unsafe sexual behaviour, such as inconsistent condom use, by allowing them to deflect threatening thoughts, such as the thought that their partner could have an STI.

The remaining three hypotheses investigated the impact of STI thought avoidance on consistency of condom use. In addition to STI thought avoidance, the perception of the benefits and costs of condom use in relationships were examined as influencing factors impacting on the consistency with which condoms were used. The results showed that mental representations of condoms were associated with condom use consistency. As expected, the
associations were different for men and women. For men, the mental representation of condoms as indicating a barrier to intimacy was more highly correlated with condom use consistency than was their perception of condom use as a reflection of responsibility. Although responsibility and respect were found to be important for maintaining consistent condom use, the costs of maintaining condom use (barrier to intimacy) were found to be more strongly correlated with condom use consistency in men. The mental representation of condoms as a barrier to becoming more intimate with one’s partner can thus be regarded as a factor contributing to inconsistent condom use among men.

For women, contrary to what was hypothesized, the main factor contributing to consistent condom use was the mental representation of condoms as indicating respect and responsibility toward one’s partner and oneself and not the representation of condoms as protective devices. The traditional societal gender role that assigns to women the responsibility for pregnancy and STI prevention in a relationship may have a strong impact on women’s perceptions of consistently using condoms as an indicator of responsibility to self and partner.

For both men and women, cognitive avoidance of STI thoughts was associated with less consistent condom use. This correlation was significant for women and approached significance for men. Cognitive avoidance may place individuals at risk for contracting an STI; individuals may engage in cognitive avoidance to eliminate thoughts that their partner may have an STI and this may contribute to the inconsistent use of condoms. Given the correlational nature of the finding it is, however, also conceivable that inconsistent condom use could result in STI avoidance as a defensive mechanism against the fear that one has already contracted an STI from one’s partner as avoiding STI thoughts would minimize this fear.

A limitation of this study is the cross-sectional design, allowing only correlational analyses to be conducted, and the comparably low sample sizes. In addition, there are limitations regarding the scales that were used. Because for several scales (Sexual Self Efficacy Scale, STI Thought Avoidance Scale), only a subset of items were used, the internal consistency for several of the scales was quite low. A further limitation concerning both studies is the use of self-reports to assess STI avoidance. The scale used is an explicit measure of avoidance as it assesses an individual’s avoidance of STIs by assuming that he or she may be consciously aware of their avoidant behaviour. However, individuals may not be aware of their avoidant tendencies. Therefore, more implicit measures of avoidance should be used in future studies to assess avoidance of STI thoughts in relation to one’s partner.

The findings reported here may help in identifying individuals who are more likely to use cognitive avoidance as a defensive mechanism against threatening STI thoughts. They also reinforce the need for sexual health educators to address with their students the ways that perception of condoms can influence consistency of condom use in relationships. In this respect, future studies should investigate the determinants of different mental representations of condoms in men and women so that educational interventions can be tailored specifically toward increasing self awareness of such influences.

References


