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## The Spanish Version of the Self-Statements during Public Speaking Scale: Validation in Adolescents

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### Abstract

Contemporary theories of social anxiety emphasize the role of cognitive processes. Although social anxiety disorder is one of the most common mental health problems in adolescents, there are very few self-report instruments available to measure cognitive processes related to social anxiety in adolescents, let alone non-English instruments. The Self-Statements during Public Speaking Scale (SSPS; Hofmann & DiBartolo, 2000) is a brief self-report measure designed to assess self-statements related to public speaking, the most commonly feared social performance situation. In order to fill this gap in the literature, we translated the SSPS into Spanish and administered it to 1,694 adolescents from a community sample, a clinical sample composed of 71 subjects with a principal diagnosis of social anxiety disorder; and a clinical control group consisting of 154 patients. The scale showed good psychometric properties, supporting the use of the Spanish version of the SSPS in adolescents.

### Keywords

Adolescence; assessment; cognitive processes; self-report; social anxiety disorder

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Social anxiety is common in all age groups. Among adolescents, the lifetime prevalence rate of social anxiety disorder (SAD) ranges between 2 and 9% (Essau, Conradt, & Petermann, 1999; Fehm, Pelissolo, Furmark, & Wittchen, 2005; Wittchen, Stein, & Kessler, 1999). Adolescence is an especially critical time due to the increasing importance and role-defining nature of peer-relationships.

In this age group, SAD is commonly associated with depression, substance abuse, other anxiety disorders, and problems with a person's educational and social development (McLoone, Hudson, & Rapee, 2006; Stein & Kean, 2000; VanAmeringen, Mancini, & Farvolden, 2003). Speaking in front of a classroom is a particularly common social performance situation that can present a particular challenge to many vulnerable adolescents. In fact, of all social situations, public speaking is by far the most prevalent fear both in the general population (Pollard & Henderson, 1988) and among individuals with SAD (Mannuzza et al., 1995; Pollard & Henderson, 1988). Furthermore, individuals with a high degree of fear of public speaking are likely to meet diagnostic criteria for SAD (Stein, Walker, & Forde, 1996).

Contemporary theories of social anxiety and SAD emphasize the role of cognitive processes in the maintenance of the disorder (Clark & Wells, 1995; Heinrichs & Hofmann, 2000; Hofmann, 2007; Leary & Kowalski, 1995; Rapee & Heimberg, 1997). For example, according to one recent model (Hofmann, 2007), individuals with SAD are apprehensive in social situations in part because they perceive the social standard (i.e., expectations and social goals) as being high (Moscovitch & Hofmann, 2007). This leads to further increases in social apprehension and increased self-focused attention (Clark & McManus, 2002; Heinrichs & Hofmann, 2001; Hirsch & Clark, 2004; Woody, 1996), which triggers a number of additional cognitive processes (cf., Hofmann, 2007). Thus, negative self-focused attention is at the heart of cognitive models of SAD.

Supporting evidence for this notion comes from various experimental and treatment outcome studies. For example, a study by Woody, Chambless and Glass (1997) observed a decrease in self-focused attention during the course of cognitive-behavioral group treatment in individuals with SAD. However, external focus of attention remained unchanged. Furthermore, Hofmann and colleagues (Hofmann, 2000; Hofmann et al., 2004) reported that individuals with SAD who underwent successful psychological treatment reported a significant decline of negative self-focused thoughts that was correlated with changes in self-reported social anxiety. Another study by Wells and Papageorgiou (1998) showed that exposure therapy combined with instructions to focus on the external environment is more effective than standard exposure therapy. Wells and colleagues hypothesized that self-focused attention, or evaluating one's responding, is part of the patient's misguided attempts to prevent an embarrassing and humiliating situation.

Despite the theoretical importance of self-focused statements in SAD, relatively few studies on social anxiety have used self-statement questionnaires. In contrast, depression researchers have successfully utilized a number of self-statement questionnaires, such as the Negative Affect Self-Statement Questionnaire (Ronan, Kendall, & Rowe, 1994), and the Automatic Thoughts Questionnaire (Hollon & Kendall, 1980). These instruments have led to further insights into the psychopathology of depression by providing a means of testing basic theory and assessing change in cognitive processes associated with experimental manipulation. Taking all of this together, public speaking is a common social performance situation that presents a particular challenge to adolescents. Cognitive factors, in particular negative self-focused thoughts, appear to be important maintenance factors for social anxiety.

In order to fill this gap in the assessment literature on measuring cognitive processes related to social anxiety among adolescents, Hofmann and DiBartolo (2000) developed a brief self-report instrument (the Self-Statements During Public Speaking Scale; SSPS) to specifically assess typical negative and positive self-statements related to public speaking situations. This 10-item instrument shows good psychometric properties and has been increasingly used in the Anglo-American literature. No such scale exists in the Spanish literature. The present study reports the factor structure, internal consistency, and concurrent and discriminant validity of the scale in a large group of Spanish-speaking adolescents.

## Method

### Participants

The sample consisted of 1,694 adolescents between the ages of 14 and 17 ( $M = 15.14$ ,  $SD = 0.98$ ) who were recruited from four private and twenty public high-schools in several cities of two medium size counties in Spain. Schools were selected by a clustered random sampling method from the school lists of the Department of Education. A total of 753 boys and 941 girls in grades nine through twelve, randomly chosen from 62 classes, participated in the study. Due to the clustered random sampling method, the socioeconomic status and ethnic compositions

of the overall sample was representative of the community. Of the total sample, 225 adolescents, who scored higher than the normative sample obtained by Olivares et al. (2002), were interviewed. The participants in this subsample ranged from 14 to 17 years of age ( $M = 15.13$ ,  $SD = 0.93$ ). Seventy-one adolescents (27 boys, 44 girls) were diagnosed with SAD (mean age: 15.29,  $SD = 0.99$ ), whereas 154 adolescents (72 boys, 82 girls), ( $M = 15.12$ ,  $SD = 1.02$ ) did not meet the DSM-IV criteria for the disorder (control sample). Table 1 displays the age and gender characteristics of the samples.

## Measures

*Self-Statements during Public Speaking Scale (SSPS; Hofmann & DiBartolo, 2000).* This is a 10-item self-report scale measuring negative and positive self-statements associated with a public speech. Each self-statement is rated on a 0 to 5 point scale. Factor analytic studies have reliably identified a 5-item subscale assessing negative self-statements (SSPS-N) and a 5-item subscale measuring positive self-statements (SSPS-P). The scale shows high internal consistency in undergraduate college samples ranging from  $\alpha = .75$  to  $\alpha = .84$  for the SSPS-P and from  $\alpha = .83$  to  $\alpha = .86$  for the SSPS-N (all Cronbach's  $\alpha$ ). Similar findings have been reported in clinical samples. Three-month test-retest reliability in a sample of patients awaiting treatment for social phobia was  $\alpha = .78$  for the SSPS-P subscale and  $\alpha = .80$  for the SSPS-N subscale. The SSPS-P is negatively associated and the SSPS-N is positively associated with social anxiety and fear of negative evaluation. Students who score highly on the SSPS-N report lower expectations for their success in a social stress test (Hofmann & DiBartolo, 2000).

Two independent translators translated the SSPS into Spanish and then the Spanish version was translated back into English. An inter-translation agreement was reached of  $r = 0.98$  in the first case and  $r = 0.99$  in the second. In addition, the entire process was supervised by the last author and by the original author of the scale. The Spanish translation of the SSPS that was used in this study can be found in the Appendix.

**Social Phobia and Anxiety Inventory (SPAI)**—Turner, Beidel, Dancu and Stanley (1989) developed a self-report inventory that assesses behavioral, physiological and cognitive symptoms associated with SAD. The SPAI is composed of two scales: the 32-item Social Phobia (SP) subscale and the 13-item Agoraphobia subscale. Difference scores are calculated by subtracting the Social Phobia and Agoraphobia subscales. Different studies have demonstrated that the SPAI is a valid and reliable measure for Spanish-speaking adolescent populations (Garcia-Lopez, Olivares & Hidalgo, 2005; Garcia-Lopez, Olivares, Hidalgo, Beidel & Turner, 2001; Olivares, Garcia-Lopez, Hidalgo, Turner & Beidel, 1999; Olivares, Garcia-Lopez, Hidalgo et al., 2002). Only the social phobia subscale was used in this study given that the social phobia subscale score and the difference score are highly correlated and a number of studies suggest that the social phobia subscale score has psychometric properties that are superior to those of the difference score (Garcia-Lopez, Olivares & Vera-Villaroel, 2003; Herbert, Bellack & Hope, 1991; Garcia-Lopez et al., 2001; Ries et al., 1998). A brief version of this instrument has recently been published (Garcia-Lopez, Beidel, Hidalgo, Olivares and Turner, 2008).

**Social Anxiety Scale for Adolescents (SAS-A)**—This questionnaire is an adaptation of the Social Anxiety Scale for Children-Revised (SASC-R; La Greca & Stone, 1993) for an adolescent population (LaGreca & Lopez, 1998). Similar to the SASC-R, the SAS-A contains 22 items: 18 descriptive self-statements and 4 filler items. The SAS-A has three subscales: Fear of Negative Evaluation (FNE; 8 items), Social Avoidance and Distress specific to new situations or unfamiliar peers (SAD-New; 6 items) and Social Avoidance and Distress that is experienced more generally in the company of peers (SAD-General; 4 items). A similar factor structure was found in a Spanish-speaking population by Olivares et al. (2005).

**Social Interaction Anxiety Scale (SIAS) and Social Phobia Scale (SPS)**—Mattick and Clarke (1998) designed the SPS to assess fears of being scrutinized or observed by others during routine activities (e.g., eating, drinking, writing, or speaking in public), whereas the SIAS is aimed at measuring anxiety related to interactions with others (e.g., initiating and maintaining conversations). The SIAS is scored by summing the twenty item ratings after reversing three positively-worded items; all SPS items are negatively worded. Several studies have suggested that the two scales have good psychometric properties in Spanish adult and adolescent populations (Olivares, Garcia-Lopez, & Hidalgo, 2001; Rivero, 2005; Zubeidat, Salinas, Sierra, & Fernandez-Parra, 2007).

To our knowledge, these social anxiety scales are the only validated social anxiety measures for Spanish-speaking adolescents. These measures were administered in order to examine the convergent validity of the SSPS. We expected the SSPS-N to be positively and the SSPS-P to be negatively correlated with the SPAI, the SAS-A, the SIAS, and the SPS.

**Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)**—DiNardo, Brown and Barlow (1994) developed this semi-structured interview in order to assess current and lifetime DSM-IV anxiety, mood and substance use disorders. Adequate inter-rater agreement for anxiety, mood and substance use disorders was found in a Spanish-speaking population by Olivares and Garcia-Lopez (1997;  $k \geq 0.75$ ). The social phobia section consists of 13 dimensional ratings that evaluate fear and avoidance using a clinical severity rating (a 9-point scale ranging from 0, *none*, to 8, *very severely disturbing/disabling*). This interview was used as the diagnostic instrument.

## Procedure

After obtaining consent from a parent or legal guardian, two trained research assistants administered the scales and instructions for completing the questionnaire. Students completed all of the measures in a group classroom setting and were assisted by research assistants if needed. The order of the questionnaires was counterbalanced.

The assessment procedure was conducted during one classroom period lasting approximately 50 minutes. Participation was voluntary and students did not receive any compensation. Students who chose not to participate (10 students; 0.6%) engaged in activities such as schoolwork or independent reading.

The diagnostic interview was administered to students ( $n=225$ ) scoring higher than the normative sample obtained by Olivares et al. (2002). Of those, 71 subjects met DSM-IV criteria for SAD (clinical sample) and 154 did not (control sample).

## Results

### Demographic differences

The results of a one-factorial analysis of variance (ANOVA) with sex as the between-subjects factor showed that females had higher scores ( $M = 7.52$ ,  $SD = 6.49$ ) on the SSPS-N than males ( $M = 6.52$ ,  $SD = 5.85$ ),  $F(1, 1686) = 6.08$ ,  $p = .01$ , partial  $\eta^2 = 0.04$ . However, no sex difference was observed in the SSPS-P ( $p = .76$ ). Moreover, participants between the ages of 16 and 17 showed greater SSPS-N scores ( $M = 8.06$ ,  $SD = 6.53$ ) than participants between the ages of 14 and 15 ( $M = 7.72$ ,  $SD = 6.07$ ),  $F(3, 1686) = 4.82$ ,  $p = .002$ , partial  $\eta^2 = 0.09$ . However, no difference between these age groups was observed for the SSPS-P ( $p > .60$ ).

## Item analyses

The item-test correlation mean was  $r = .44$  ( $SD = 0.12$ ), ranging between  $r = .24$  (item 6) and  $r = .58$  (item 10). The mean item-subscale correlation for the SSPS-N was  $r = .80$  ( $SD = 0.04$ ), ranging from  $r = .73$  (item 4) to  $r = .84$  (item 10), whereas the mean item-subscale correlation for the SSPS-P was  $r = .67$  ( $SD = 0.09$ ), ranging between  $r = .61$  (item 6) and  $r = .72$  (item 3).

## Internal consistency

The internal consistency estimates (Cronbach's alpha, Cronbach, 1951) were  $\alpha = .86$  for the SSPS-N subscale and  $\alpha = .69$  for the SSPS-P subscale.

## Confirmatory Factor Analysis

We analyzed the correlation matrix and computed fit indices using maximum likelihood factor analysis estimates to examine the 2-factor structure of the SSPS in adolescents. A fit was considered to be good if: (a) the goodness-of-fit index (GFI) was  $GFI = .90$  or above, (b) the adjusted goodness-of-fit index (AGFI) was  $AGFI = .85$  or greater, (c) the standardized root mean-square residual (SRMR) value was less than  $.10$ . Additional fit indices were the normed fit index (NFI), the non-normed fit index (NNFI) and the comparative fit index (CFI).

The model was assessed using the statistics program LISREL, version 8.12 (Jöreskog & Sörbom, 1993). The two-factor model fit the data well ( $SRMR = .04$ ,  $GFI = .99$ ,  $AGFI = .98$ ,  $NFI = .98$ ,  $NNFI = .98$ ,  $CFI = 0.98$  and  $\chi^2(34) = 360.2$ ). It must be noted that in large samples, the chi-square statistic is very powerful, and even quite a good model fit will produce significant differences. Moreover, all items of the confirmatory factor analysis showed loadings of  $r = .40$  or greater, ranging between  $r = .43$  (item 9) and  $r = .67$  (item 3) for the SSPS-P subscale and between  $r = .67$  (item 4) and  $r = .86$  (item 10) for the SSPS-N subscale. The correlation between the two factors was  $r = -.42$ . This is consistent with the results reported by Hofmann and DiBartolo (2000).

## Concurrent validity

Moderate correlations were observed between the SSPS-N subscale and the Total SAS-A score ( $r = .64$ ), the SPS ( $r = .62$ ), the SIAS ( $r = .61$ ), the SAS-A/FNE ( $r = .60$ ), the SPAI ( $r = .53$ ), the SAD-General subscale ( $r = .52$ ), and the SAD-N subscale ( $r = .51$ ). All of these correlations were significant ( $p < .001$ ).

The SSPS-P subscale showed low negative correlations with the SIAS ( $r = -.26$ ), SAS-A Total score ( $r = -.22$ ), the SPAI ( $r = -.21$ ), the SPS ( $r = -.21$ ), the SAS-A/SAD-N ( $r = -.21$ ), the SAS-A/FNE ( $r = -.19$ ) and the SAD-G subscale ( $r = -.16$ ). All of these correlations were significant ( $p < .001$ ).

## Discriminant validity

Using independent sample  $t$ -tests, we compared SAD and control subjects on the SSPS subscales. Significant differences were found for both subscales. The clinical sample scored higher ( $M = 11.21$ ,  $SD = 6.37$ ) than the control sample ( $M = 5.47$ ,  $SD = 5.20$ ) on the SSPS-N,  $t(223) = 7.15$ ;  $p < .001$ . In contrast, and as expected, the control sample ( $M = 15.15$ ,  $SD = 5.68$ ) scored higher than the clinical sample ( $M = 12.68$ ,  $SD = 4.77$ ) on the SSPS-P,  $t(223) = 3.19$ ;  $p < .001$  (see Table 2). Furthermore, the SSPS-N and the SSPS-P correctly discriminated 71.1% of subjects (Wilks'  $\lambda = 0.81$ ,  $\chi^2 = 47.03$ ,  $df = 2$ ;  $p < .001$ ). The SSPS-N alone correctly classified 69.3% of subjects (Wilks'  $\lambda = 0.81$ ,  $\chi^2 = 45.96$ ,  $df = 1$ ;  $p < .001$ ).

We further examined whether the SSPS subscales could discriminate between feared social situations that induced mild anxiety (0 – 4), moderate anxiety (5 – 9) and severe anxiety (10

and above). Significant differences were found in the SSPS-N,  $F(2, 222) = 20.36, p < .001$ ; and the SSPS-P,  $F(2, 222) = 3.58; p < .03$ . The means of the SSPS-N scores for the mild ( $M = 6.16, SD = 5.49, n = 184$ ), moderate ( $M = 11.82, SD = 6.45; n = 33$ ) and severe ( $M = 14.50; SD = 7.50; n = 8$ ) categories were in line with our expectations. Similarly, the SSPS-P scores for the mild ( $M = 14.82; SD = 5.46; n = 184$ ), moderate ( $M = 12.64; SD = 5.08, n = 33$ ), and severe ( $M = 11.25; SD = 6.92; n = 8$ ) groups were as predicted.

## Discussion

The present study provides support for the utility of the Spanish translation of the SSPS, and particularly the 5-item negative subscale. The results showed that the Spanish translation of the scale is a valid and reliable self-statement measure of public speaking anxiety for adolescents.

The results of the factor analysis supported the two-factor solution, which replicated the factor structure of the original scale. Indeed, all items loaded onto the same factors as in the original study (Hofmann & DiBartolo, 2000). In addition, the alpha coefficients were very similar to those in the data reported by Hofmann and DiBartolo (2000) for the SSPS-N subscale (0.86 vs. 0.83). However, the internal consistency of the Spanish version of the SSPS-P was somewhat lower than in the American sample (0.69 vs. 0.84, respectively).

We further observed that the SSPS-N correlated significantly with the SPAI, the SIAS, the SPS and the SAS-A subscales, supporting the validity of the Spanish SSPS in adolescents. Furthermore, the magnitude of the correlation between the SSPS-N and the SAS-A was higher than the correlations with other measures of social anxiety. The correlation was especially high with the FNE subscale, which is consistent with the development of the SSPS-N as a cognitive measure.

Finally, the SSPS-N subscale demonstrated better psychometric properties among SAD individuals than the SSPS-P, in line with previous studies suggesting that negative self-statements have a stronger relationship to measures of psychopathology than positive self-statements (Arnkoff & Glass, 1989; Glass et al., 1982; Hofmann, 2000; Kendall & Hollon, 1981; Treadwell & Kendall, 1996). We conclude that the SSPS, and in particular the SSPS-N subscale, is a clinically useful measure of socially anxious thoughts and is also a potentially useful measure of treatment outcome for adolescents with social anxiety. Due to the brevity of the SSPS-N, it may be especially valuable as a screening tool because it can be easily administered in both clinical and community settings.

Although our findings strongly support the psychometric soundness of the SSPS, the generalizability of our results is limited to a European-Hispanic population. However, the psychometric data for the Spanish version of the SSPS were remarkably similar to the data for English version. We recommend that future studies further investigate the relationship between social anxiety questionnaires and other measures in order to evaluate the divergent validity of these scales among adolescents.

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## Appendix: Spanish Version of the SSPS

### AUTOVERBALIZACIONES DURANTE LA SITUACIÓN DE HABLAR EN PÚBLICO (AHP)

Por favor, imagina lo que te dirías a ti mismo si tuvieses que **hablar en público**. Teniendo en cuenta esta situación, indica el grado en que estás de acuerdo con las frases que se presentan a continuación. Con este fin te pedimos que puntúes cada una de ellas según la escala que también presentamos, la cual varía entre 0 (en absoluto estás de acuerdo con la frase, no la dices nunca) a 5 (estás totalmente de acuerdo con la frase, la dices siempre).

Table 1

Sex and age of subjects in the study samples.

| <i>Total Sample</i>    |            | 14 years   | 15 years   | 16 years   | 17 years   | Total |
|------------------------|------------|------------|------------|------------|------------|-------|
| Males                  | 229 (13.5) | 255 (15.1) | 188 (11.1) | 81 (4.8)   | 753 (44.5) |       |
| Females                | 307 (18.1) | 299 (17.7) | 245 (14.5) | 90 (5.3)   | 941 (55.6) |       |
| Total                  | 536 (31.6) | 554 (32.7) | 433 (25.6) | 171 (10.1) | 1694 (100) |       |
| <i>Subsample</i>       |            | 14 years   | 15 years   | 16 years   | 17 years   | Total |
| Males                  | 26 (26.3)  | 36 (36.4)  | 25 (25.2)  | 12 (12.1)  | 99 (44)    |       |
| Females                | 34 (27.0)  | 45 (35.6)  | 32 (25.4)  | 15 (12.0)  | 126 (56)   |       |
| Total                  | 60 (26.7)  | 81 (36)    | 57 (25.3)  | 27 (12.0)  | 225 (100)  |       |
| <i>Clinical sample</i> |            | 14 years   | 15 years   | 16 years   | 17 years   | Total |
| Males                  | 7 (25.9)   | 9 (33.3)   | 8 (29.7)   | 3 (11.1)   | 27 (38.0)  |       |
| Females                | 10 (22.7)  | 15 (34.1)  | 14 (31.8)  | 5 (11.4)   | 44 (62.0)  |       |
| Total                  | 17 (23.9)  | 24 (33.8)  | 22 (31.0)  | 8 (11.3)   | 71 (100)   |       |
| <i>Control sample</i>  |            | 14 years   | 15 years   | 16 years   | 17 years   | Total |
| Males                  | 19 (26.4)  | 27 (37.5)  | 17 (23.6)  | 9 (12.5)   | 72 (46.8)  |       |
| Females                | 24 (29.3)  | 30 (36.6)  | 18 (21.9)  | 10 (12.2)  | 82 (53.2)  |       |
| Total                  | 43 (27.9)  | 57 (37.0)  | 35 (22.8)  | 19 (12.3)  | 154 (100)  |       |

Note: The Table shows frequency (percentages) of the subject samples in the various age and sex groups.

**Table 2**

Comparison between the study groups.

|                    | Control Sample | Clinical Sample | <i>t</i> -tests (df: 223) | <i>p</i> -value |
|--------------------|----------------|-----------------|---------------------------|-----------------|
| Number of subjects | 154            | 71              |                           |                 |
| SSPS-N             |                |                 |                           |                 |
| Mean               | 5.47           | 11.21           | 7.15                      | <i>p</i> < .001 |
| SD                 | 5.20           | 6.37            |                           |                 |
| SSPS-P             |                |                 |                           |                 |
| Mean               | 15.15          | 12.68           | 3.19                      | <i>p</i> < .001 |
| SD                 | 5.48           | 4.77            |                           |                 |

*Note:* The Table shows number of subjects, means, standard deviations (SD), and the results of independent *t*-tests.

|  |   |   |   |   |   |   |
|--|---|---|---|---|---|---|
| 1. ¿Qué tengo que perder?. Vale la pena intentarlo                   | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Soy un perdedor   | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Esta es una situación incómoda pero yo puedo manejarla            | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Fracasar en una situación sería una prueba más de mi incapacidad  | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Incluso aunque las cosas no salgan bien, no es una catástrofe     | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Puedo manejarlo todo  | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. Diga lo que diga, probablemente va a sonar estúpido               | 0 | 1 | 2 | 3 | 4 | 5 |
| 8. Probablemente voy a echarlo todo a perder                         | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. En vez de preocuparme, podría concentrarme en lo que quiero decir | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. Seguramente la gente se dará cuenta de que soy torpe y tonto     | 0 | 1 | 2 | 3 | 4 | 5 |