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TESIS DOCTORAL

ASERTIVIDAD SEXUAL: ANÁLISIS DE VARIABLES RELACIONADAS E IMPLICACIONES CLÍNICAS

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El Dr. Juan Carlos Sierra Freire, Profesor Titular de Universidad en el Departamento de Personalidad, Evaluación y Tratamiento Psicológico de la Universidad de Granada (España)

INFORMA

Que la Tesis Doctoral titulada ***Asertividad sexual: análisis de variables relacionadas e implicaciones clínicas***, realizada por el doctorando D. Pablo Santos Iglesias, ha sido realizada bajo la dirección del Dr. Juan Carlos Sierra Freire y que reúne las condiciones de calidad, originalidad, rigor científico y académico necesarios para que se proceda a su defensa pública de acuerdo con la legislación vigente.

Y para que conste, se expide en Granada el presente a día 17 de febrero de 2012

Fdo. Dr. Juan Carlos Sierra Freire

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A mis padres, por su apoyo

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Índice

Resumen

El estudio de la asertividad cuenta con una larga tradición dentro de la investigación en sexualidad humana, sin embargo los estudios que han analizado su papel no son muy numerosos. En líneas generales, se puede sostener que los trabajos que han incluido la asertividad sexual pueden agruparse en dos líneas, la primera y menos numerosa, ha tratado de desarrollar instrumentos de evaluación de la asertividad sexual. La segunda ha analizado el papel que juega la asertividad sexual en la sexualidad humana, concluyendo que es una variable que facilita un buen funcionamiento sexual y que sirve como factor de protección ante los episodios de victimización sexual y las conductas de riesgo para Infecciones de Transmisión Sexual (ITS), VIH y embarazos no deseados. Para ampliar el estudio de esta variable se ha llevado a cabo esta Tesis Doctoral, cuyos objetivos han sido 1) analizar las propiedades psicométricas de la versión española del Hurlbert Index of Sexual Assertiveness (HISA), 2) analizar el papel de la asertividad sexual en las experiencias de revictimización sexual junto con otras variables como la experiencia sexual y el uso de sustancias, y 3) analizar las variables predictoras de la asertividad sexual partiendo de un modelo multidimensional previamente usado.

El primer objetivo se articula en torno a dos trabajos de naturaleza instrumental. En el primero de ellos se analizaron las propiedades psicométricas (i.e., análisis de ítems, validez de constructo, fiabilidad de consistencia interna y validez convergente) de la versión española del HISA. Para ello se empleó una muestra compuesta por 400 hombres y 453 mujeres heterosexuales con una relación de, al menos, seis meses de duración. Todos ellos respondieron al HISA, la Escala de Ajuste Diádico, el Cuestionario de Aserción en la Pareja, y la Escala de Habilidades Sociales. Los resultados mostraron una estructura factorial compuesta por 19 ítems agrupados en dos factores: *Inicio*, o la habilidad para iniciar contactos sexuales deseados y compartir deseos y fantasías sexuales con la pareja; y *Ausencia de Timidez/Rechazo*, que hace referencia a la habilidad para rechazar contactos sexuales no deseados y la capacidad para iniciar y mantener conversaciones sobre temas sexuales. Ambas subescalas mostraron buenos índices de fiabilidad de consistencia interna, con valores omega en torno a 0,80 y buenos indicadores de validez convergente, con correlaciones

estadísticamente significativas de signo positivo con las medidas de ajuste diádico, aserción en la pareja y habilidades sociales.

El segundo estudio tenía como objetivo analizar la invarianza factorial y el funcionamiento diferencial del ítem (DIF) de la versión española del HISA, previamente validado, entre hombres y mujeres. La razón para llevar a cabo este estudio fue que en el pasado se han encontrado diferencias en las estructuras factoriales cuando se han empleado muestras de mujeres o muestras de hombres y mujeres. Y además, que la asertividad ha sido un constructo típicamente comparado entre hombres y mujeres, por lo que es necesario garantizar la equivalencia y ausencia de sesgo de la escala. Participaron en este estudio 1.600 mujeres y 1.598 hombres heterosexuales. Los resultados del análisis de invariaza mostraron ausencia de invarianza fuerte en tres de sus ítems (2, 9, y 13), lo que implica que las interceptas no son similares para hombres y mujeres e indica la posibilidad de funcionamiento diferencial del ítem. El análisis del funcionamiento diferencial del ítem mostró que de esos tres, sólo el ítem 2 ("Pienso que soy tímido/a en el ámbito sexual") mostró DIF moderado uniforme. Concretamente, las mujeres tienen una mayor tendencia a responder "Siempre" a este ítem. Con estos resultados se plantea la necesidad de eliminar los tres ítems, resultando en una versión final compuesta por 16 ítems agrupados en las dos dimensiones: Inicio (8 ítems) y Ausencia de timidez/Rechazo (8 ítems). Los resultados de los baremos para esta versión final muestran que la asertividad sexual aún sigue roles sexuales tradicionales, ya que los hombres puntúan más alto en Inicio, mientras que las mujeres más mayores muestran mayor timidez y menos habilidad para rechazar contactos sexuales.

Respecto al objetivo sobre victimización sexual, se puso a prueba qué variables mediaban entre el abuso sexual en la infancia y la victimización sexual en la adolescencia y edad adulta temprana. Para ello se emplearon cuatro variables que habían sido examinadas en la literatura previa: número de parejas, edad de inicio de los contactos sexuales, asertividad sexual y consumo de sustancias antes de los contactos sexuales. Además, se ofrecen datos sobre las tasas de vicimización sexual en las participantes, así como los tipos de agresores más frecuentes. Un total de 402 mujeres universitarias participaron en el estudio. Los resultados mostraron que un 30,4% había sufrido algún contacto sexual no deseado, mientras que un 3,4% habían sido violadas. Los agresores más frecuentes son parejas o exparejas, conocidos o citas ocasionales, dependiendo del tipo de agresión. Sin embargo, es poco frecuente que la agresión haya sido perpetrada por un extraño. Las variables que mediaron entre el abuso sexual en la infancia y la victimización sexual adulta fueron el número de parejas y la falta de asertividad sexual. Estos resultados ponen de manifiesto la elevada

prevalencia de las agresiones sexuales en muestras de mujeres universitarias y apuntan al número de parejas como un factor de riesgo importante para predecir la revictimización sexual, tal y como se ha encontrado en estudios previos. Sin embargo, a diferencia de los estudios llevados a cabo en Estados Unidos, la asertividad sexual también explica esa revictimización, que puede explicarse por una mayor presencia de roles sexuales tradicionales en mujeres universitarias estadounidenses.

Por último, se planteó la necesidad de estudiar las variables que predicen la asertividad sexual, ya que sólo un estudio previo ha analizado este aspecto. Basándonos en el modelo multifacético de riesgo para el VIH (MMOHR, por sus siglas en inglés) se plantea que la asertividad sexual puede ser predicha a partir de variables interpersonales (abuso en la pareja) y variables actitudinales (erotofilia y actitudes positivas hacia las fantasías sexuales). Además, se plantea la necesidad de introducir componentes de la respuesta sexual humana (deseo sexual y excitación), pues no se han puesto a prueba en modelos multidimensionales. Participaron un total de 1.755 mujeres y 1.619 varones heterosexuales. Los resultados mostraron que en el caso de los hombres la asertividad sexual fue predicha de forma positiva por la excitación, deseo sexual diádico, erotofilia y actitudes positivas hacia las fantasías sexuales, y de forma negativa por el abuso no físico por parte de la pareja. En el caso de las mujeres, la asertividad sexual fue predicha de forma positiva por la excitación, deseo sexual diádico, erotofilia y actitudes positivas hacia las fantasías sexuales y de forma negativa por el abuso no físico y el deseo sexual solitario. Estos resultados ponen de manifiesto la naturaleza multidimensional de la asertividad sexual y la necesidad de evaluar otras variables, como las actitudes o la presencia de abuso en la pareja, cuando se trabaja con la asertividad sexual en programas educativos o de intervención.

Para finalizar, es necesario concluir que los resultados de la presente Tesis Doctoral nos dan una idea más clara acerca del papel que juega la asertividad sexual en la sexualidad humana en el contexto español, pues ha sido una variable poco estudiada en España. Se dispone, ahora, de una versión abreviada del HISA –que es uno de los instrumentos más utilizados a la hora de evaluar la asertividad sexual- con adecuadas garantías psicométricas sobre su funcionamiento y, además, equivalente entre hombres y mujeres. Son necesarios más trabajos que ahonden en el papel de la asertividad en la victimización sexual, así como evaluar más variables relevantes que puedan predecir la presencia de respuestas sexualmente asertivas tanto en hombres como en mujeres.

Summary

The study of assertiveness has a long tradition in research on human sexuality, but studies that have examined its role are scarce. Overall, it is arguable that the scope of work included sexual assertiveness can be grouped into two lines, the first and less numerous, has sought to develop instruments to assess sexual assertiveness. The second has analyzed the role of sexual assertiveness in human sexuality, concluding that it is a variable that provides a good sexual function and serves as a protective factor against sexual victimization episodes and risk behaviors for sexually transmitted infections (STIs), HIV and unwanted pregnancies. To extend the study of this variable this Doctoral Dissertation was carried out, whose main objectives were: 1) to analyze the psychometric properties of the Spanish version of the Hurlbert Index of Sexual Assertiveness (HISA); 2) to analyze the role of sexual assertiveness in experiences of sexual revictimization along with other variables such as sexual experience and substance use, and 3) to analyze the predictors of sexual assertiveness based on a multidimensional model previously used.

The first objective is articulated around two instrumental studies. In the first study we analyzed the psychometric properties (i.e., item analysis, construct validity, internal consistency reliability, and convergent validity) of the Spanish version of HISA. For this purpose we used a sample of 400 men and 453 heterosexual women involved in a heterosexual relationship of at least six months. They responded to HISA, the Dyadic Adjustment Scale, the Assertion Questionnaire in Couples, and the Social Skills Scale. Results showed a factor structure composed of 19 items clustered into two factors: *Initiation*, or the ability to initiate sexual contacts and the expression of sexual desires and fantasies to one's partner, and *No Shyness/Refusal*, which means the difficulty starting and mantaining conversations on sexual issues and an inability to reject undesired sexual contacts. Both subscales showed good internal consistency reliability, with omega values around .80, and good indicators of convergent validity, with significant and positive correlations with measures of dyadic adjustment, assertion in relationships and social skills.

The second study analyzed the factorial invariance and differential item functioning (DIF) of the previously validated Spanish version of the HISA, across men and women. The reason for conducting this study was that past research have found different factor structures

when samples of women or mixed samples (i.e., men and women) have been used. Furthermore, sexual assertiveness is a construct that has been typically compared between men and women, so it is necessary to ensure both the equivalence and lack of bias of this scale. 1,600 heterosexual women and 1,598 heterosexual men participated in this study. Results showed the lack of strong invariance on three items (2, 9, and 13), implying that the intercepts are different for men and women on those three items, and indicating the possibility of differential item functioning. Analysis of the differential item functioning showed that among those three items, only the item 2 ("I feel that I am shy when it comes to sex") flagged moderate uniform DIF. More specifically, women are more likely to answer "Always" to this item. These results suggests the need to eliminate those three items, resulting in a final version composed by 16 items grouped into two dimensions: Initiation (8 items) and No Shyness/Refusal (8 items). Results of the standard scores for this final version show that sexual assertiveness still follows traditional gender roles, as men scored higher on Initiation, while older women showed more sexual shyness and less ability to refuse sexual contact.

Regarding sexual victimization, we tested which variables would mediate between childhood sexual abuse and sexual victimization in adolescence and early adulthood. For this purpose we used four variables that were examined in previous literature: number of partners, age at first sexual contact, sexual assertiveness, and substance use prior to sex. We also offered data on sexual victimization rates and the types of most frequent sexual aggressors. A total of 402 college women participated in the study. The results showed that 30.4% had had an unwanted sexual contact, while 3.4% had been raped. The most frequent offenders were partners or ex-partners, acquaintances, or casual dates, depending on the type of aggression. However, it is rare that the attack was perpetrated by a stranger. The mediators between childhood sexual abuse and adult sexual victimization were the number of sexual partners and lack of sexual assertiveness. These results demonstrate the high prevalence of sexual abuse in samples of college women and pointed to the number of partners as an important risk factor for predicting sexual revictimization, as found in previous research. However, unlike the studies conducted in the U.S., sexual assertiveness also explains revictimization, which can be explained by an increased presence of traditional gender roles in American college women.

Finally, we found it necessary to study the predictors of sexual assertiveness, since only one previous study has analyzed this aspect. Based on the Multifaceted Model of HIV Risk (MMOHR), it is stated that sexual assertiveness can be predicted from interpersonal

variables (e.g., partner abuse) and attitudinal variables (e.g., erotophilia and positive attitudes towards sexual fantasies). It is also necessary to include components of the human sexual response (sexual desire and arousal), which have not been tested in multidimensional models. A total of 1,755 heterosexual women and 1,619 heterosexual men participated in the study. Results showed that in the case of male, sexual assertiveness was positively predicted by arousal, dyadic sexual desire, erotophilia, and positive attitudes toward sexual fantasies, and negatively predicted by non-physical abuse by an intimate partner. For women, sexual assertiveness was positively predicted by arousal, dyadic sexual desire, erotophilia, and positive attitudes toward sexual fantasies, and negatively predicted by non-physical abuse and solitary sexual desire. These results highlight the multidimensional nature of sexual assertiveness. They also stress the need to evaluate variables such as sexual attitudes or the presence of partner abuse when working with sexual assertiveness in educational programs or intervention.

Finally, it is necessary to conclude that these results give us a clearer idea about the role of sexual assertiveness in human sexuality in the Spanish context, because it has not been studied frequently in Spain. An abbreviated version of the HISA, which is one of the most widely used instruments to assess sexual assertiveness, is now available with adequate psychometric guarantees and also equivalent between men and women. More work is needed to further our understanding about the role of assertiveness in sexual victimization, as well as to evaluate more relevant variables that can predict the presence of sexually assertive responses in both men and women.

Introducción

En la actualidad existen diversas definiciones de la asertividad sexual. La mayoría de ellas han realizado una aproximación conductual, delimitando el rango de conductas que implica un comportamiento sexualmente asertivo. Entre estas definiciones, las más generales sostienen que la asertividad sexual es la capacidad para llevar a cabo comportamientos socialmente asertivos en un contexto sexual (Painter, 1997) o que implica el uso de una serie de habilidades conductuales para obtener satisfacción sexual en las relaciones sexuales (Dunn, Lloyd y Phelps, 1979). A pesar de realizar una aproximación de tipo conductual, ninguna de estas dos definiciones deja claro cuáles son las conductas implícitas en un comportamiento sexualmente asertivo, indicando únicamente la segunda de ellas que sería un medio para obtener satisfacción sexual. Una definición más específica y completa, que delimita cuáles son esos comportamientos y la finalidad de los mismos, fue aportada por Morokoff et al. (1997). En ella se afirma que la asertividad sexual es la capacidad para iniciar la actividad sexual, rechazar la actividad sexual no deseada, y emplear métodos anticonceptivos y llevar a cabo comportamientos sexuales saludables.

Las anteriores definiciones derivan en un par de implicaciones. La primera es que circunscriben la asertividad sexual a contextos exclusivamente sexuales frente a otras formas de asertividad más generales o frente a otros contextos que no sean sexuales. En este sentido, Livingston, Testa y VanZile-Tamsen (2007) señalaron que, cuando se quiere analizar el papel que juega la asertividad en experiencias de victimización sexual, es necesario evaluar la asertividad sexual frente a formas más generales de asertividad. La segunda implicación hace referencia a la importancia de la asertividad sexual dentro del concepto de salud sexual, ya que la asertividad sexual tiene como finalidad desarrollar comportamientos sexualmente saludables (Morokoff et al., 1997). Además, es la herramienta que las personas usan para ejercer su derecho a tomar decisiones sobre sus experiencias y conductas sexuales y su sexualidad en general (Sierra, Santos, Gutiérrez-Quintanilla, Gómez y Maeso, 2008), llevando a cabo conductas sexuales seguras, placenteras y actividades sexuales informadas y consentidas, basadas en una visión positiva de la sexualidad y de respeto dentro de las relaciones íntimas (Lottes, 2000).

Sin embargo, esta disparidad de definiciones y conceptualizaciones acerca de qué es la asertividad tiene también sus problemas asociados. El primero, y principal, es la falta de consenso sobre lo qué es y lo qué implica un comportamiento sexual asertivo, llegándose en ocasiones a hablar de la asertividad sexual como una habilidad social o incluso como un rasgo de personalidad. Esto ha supuesto que la asertividad sexual se haya operacionalizado de formas muy diferentes haciendo difícil la comparación de distintos estudios. El segundo problema afecta a la evaluación de la asertividad sexual. Esta disparidad de definiciones genera, por un lado, una gran cantidad de instrumentos de evaluación para un mismo constructo y, por otro, esos diferentes instrumentos evalúan conceptos distintos, componentes diferentes e incluso correlatos mismos de la asertividad sexual, tal y como sucede con la evaluación de otros constructos sexuales (e.g., satisfacción sexual; véase Lawrance y Byers, 1995, 1998). Como ejemplo, se pueden encontrar hasta 20 instrumentos diferentes empleados en la evaluación de la asertividad sexual (eso sin mencionar que en muchos estudios se hayan elaborado ítems ad hoc) que evalúan componentes como el inicio de la actividad sexual, el rechazo de actividades sexuales no deseadas, o conceptos distintos –aunque relacionados- como comunicación sexual o autorrevelación sexual. A estos problemas hay que añadir una seria limitación de los instrumentos de evaluación de la asertividad sexual: la escasez de estudios que avalen sus propiedades psicométricas. En este contexto sólo la Sexual Assertiveness Scale (Morokoff et al., 1997) y –en menor medida- el Sexual Awareness Questionnaire (Snell, Fisher y Miller, 1991) fueron desarrollados a partir de completos estudios instrumentales. En el resto de los casos poca información se tiene sobre la fiabilidad de sus puntuaciones o la validez de su uso. Además, es especialmente importante tener en cuenta que estos instrumentos han sido empleados en varias ocasiones para realizar comparaciones entre grupos (e.g., varones vs. mujeres), por lo que un examen pormenorizado –aunque inexistente- sobre la equivalencia de las escalas y la ausencia de sesgo está más que justificado (Dimitrov, 2010; Wu, Li y Zumbo, 2007). Es, por tanto, necesario llevar a cabo estudios psicométricos con estos instrumentos de evaluación que nos aseguren la fiabilidad y la validez de los resultados obtenidos con ellos.

Al margen de las definiciones y los problemas implícitos en la evaluación de la asertividad sexual anteriormente citados, cabe mencionar los estudios que han analizado el papel que juega la asertividad sexual en la sexualidad humana. A pesar de ser un constructo que cuenta con cerca de 40 años (cfr., Jakubowski-Spector, 1973) no ha sido muy estudiado a lo largo de su historia y, en muchas ocasiones, cuando en algunos estudios se habla de asertividad sexual se está aludiendo a conceptos afines pero no a asertividad sexual de forma

estricta (Santos-Iglesias y Sierra, 2010a). Es importante mencionar también que, salvo algunas excepciones (véase Hurlbert, 1991; Morokoff et al., 1997), la asertividad sexual ha sido usada en estos estudios a modo de variable independiente o bien como variable mediadora, pero no como variable dependiente, por lo que no se tiene una idea clara de cuál es la naturaleza de la misma o cuáles son los factores que determinan o facilitan la aparición de comportamientos sexualmente asertivos. En este orden de cosas, tal y como se mencionaba, no son muy numerosos los estudios que analizan qué función tiene la asertividad sexual en la vida sexual de las personas. Estos estudios se han llevado a cabo de forma generalizada en torno a tres áreas de la sexualidad humana: el funcionamiento sexual, las agresiones sexuales y las conductas sexuales de riesgo para el VIH e ITSs (Santos Iglesias y Castro Vázquez, 2011; Sierra et al., 2008) y permiten afirmar de forma consistente que la asertividad sexual funciona como factor de protección ante conductas sexuales de riesgo y agresiones sexuales y que favorece contactos sexuales positivos y una mayor salud sexual. Por ejemplo, en el caso del funcionamiento sexual, diversos estudios han comprobado que la asertividad sexual es un facilitador de la respuesta sexual humana, ya que se relaciona de forma positiva con el deseo y activación sexual, la satisfacción sexual y el número de orgasmos (Haavio-Mannila y Kontula, 1997; Hurlbert, 1991; Hurlbert, Apt y Rabehl, 1993; Ménard y Offman, 2009; van Anders y Dunn, 2009). Sin embargo, estos estudios han tratado el deseo y la satisfacción sexual al mismo nivel (véase Hurlbert, 1991), cuando el deseo podría ser un determinante de comportamientos sexualmente asertivos, mientras que la satisfacción sexual podría ser la consecuencia de los mismos. De la misma forma, también se encuentra asociada con dimensiones positivas de la sexualidad como la erotofilia (Sierra et al., 2008), un mayor comfort con el propio cuerpo y la imagen corporal (Weaver y Byers, 2006) y mayor autoestima sexual (Oattes y Offman, 2007). Sin embargo, la mayor parte de estos estudios se han llevado a cabo mediante diseños correlacionales y la evidencia no supera en muchos casos la de una correlación. Por este motivo, es difícil conocer cuál es la dirección de esa relación; si el deseo sexual sucede antes del comportamiento asertivo, o si el comportamiento asertivo es previo al deseo sexual, por ejemplo. De la misma forma es difícil encontrar estudios que revelen cuál es la naturaleza de la asertividad sexual. Únicamente el estudio de Morokoff et al. (1997) demostró que la asertividad sexual está determinada por variables interpersonales (e.g., victimización sexual), actitudinales (e.g., autoeficacia para llevar a cabo conductas para evitar ITSs) y conductuales (e.g., experiencia sexual), sin embargo, no se tuvieron en cuenta componentes de la respuesta sexual humana como el deseo

o la excitación, que pueden poner en marcha conductas para el inicio de la actividad sexual (Matsuura, 2008).

En segundo lugar, los estudios sobre victimización y agresiones sexuales han mostrado que la asertividad sexual funciona como un factor de protección ante las experiencias de abuso sexual (Macy, Nurius y Norris, 2006), independientemente del tipo de agresor (Apt y Hurlbert, 1993; Testa, VanZile-Tamsen y Livingston, 2007). No obstante, una de las críticas más comunes ante este tipo de estudios es si la asertividad sexual es una consecuencia o un predictor de las experiencias de abuso sexual. En este sentido, Livingston et al. (2007) realizaron un estudio longitudinal en el que demostraron que la falta de asertividad sexual es tanto una consecuencia del abuso sexual como un factor de riesgo para sufrir abusos posteriores. De la misma manera, también se ha propuesto que la asertividad sexual puede ser un factor mediador que explica la revictimización sexual (Greene y Navarro, 1998; Livingston et al., 2007; Muehlenhard, Highby, Lee, Bryan y Dodrill, 1998), es decir, personas que han sufrido abusos sexuales tienen mayor probabilidad de volver a sufrir abusos en el futuro. Sin embargo, aunque parece que la asertividad puede ser un factor mediador en la revictimización cuando el abuso sucede en la adolescencia y/o edad adulta (Livingston et al., 2007), no está tan claro que lo sea ante sucesos más distales en el tiempo como el abuso sexual en la infancia. Además, la asertividad sexual tiene que competir con muchas otras variables (e.g., experiencia sexual, uso de alcohol o sustancias) a la hora de explicar la revictimización sexual (para una revisión, véase Muehlenhard et al., 1998), ya que son muchas las hipótesis propuestas, pero la mayoría de ellas se han puesto a prueba de forma aislada, nunca de forma conjunta. Por último, estudios más concluyentes se han presentado acerca del papel de la asertividad sexual en la emisión de conductas sexuales de riesgo para el contagio por ITSs, VIH o para embarazos no deseados. Así, no sólo estudios correlacionales han mostrado que la falta de asertividad sexual se relaciona con una mayor emisión de conductas sexuales de riesgo (Hardeman, Pierro y Mannetti, 1997; Morokoff et al., 2009; Sikkema, Winett y Lombard, 1995), sino también programas de intervención destinados a mejorar la asertividad sexual reducen el número de conductas sexuales de riesgo (St. Lawrence et al., 1995; Weinhardt, Carey, Carey y Verdecias, 1998).

Todos los resultados presentados anteriormente ponen de manifiesto que, aunque existe cierta evidencia sobre el papel que juega la asertividad sexual en la sexualidad humana, aún es necesario investigar más sobre su naturaleza y el papel que juega en determinadas áreas de la vida sexual de las personas. Además, es necesario realizar estudios sobre las propiedades psicométricas de los instrumentos de evaluación de la asertividad sexual para

garantizar, no sólo su adecuada fiabilidad y validez, sino también la falta de sesgo a la hora de utilizarlo en diferentes grupos. Por todo ello, se plantea la necesidad de esta Tesis Doctoral, cuyo objetivo es triple. Por una parte, analizar las propiedades psicométricas de la versión española de un instrumento de evaluación de la asertividad sexual (Hurlbert Index of Sexual Assertiveness; HISA; Hurlbert, 1991) y, por otra, analizar el papel de la asertividad sexual en las experiencias de revictimización sexual, y analizar cuáles son las variables que favorecen la aparición de comportamientos sexuales asertivos. Así, el contenido de este trabajo se articuló en torno a cinco estudios independientes.

El primer estudio tuvo como objetivo realizar una revisión sistemática de la literatura relacionada con la asertividad sexual para obtener información sobre los resultados más relevantes relacionados con este constructo, así como información sobre la metodología más empleada en estos estudios, instrumentos de evaluación y muestras empleadas. Los resultados sirvieron para actualizar el estado de la cuestión y desvelar con mayor profundidad qué es lo que se sabe acerca de este constructo.

El segundo estudio se llevó a cabo con el objetivo de analizar las propiedades psicométricas de la versión española de uno de los instrumentos más utilizados para evaluar la asertividad sexual, el Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991). Previa traducción y adaptación lingüística del instrumento, se analizaron sus propiedades psicométricas mediante un análisis de ítems, análisis factorial exploratorio y análisis factorial confirmatorio mediate modelos de ecuaciones estructurales. Una vez que se obtuvo una versión definitiva del instrumento y sus subescalas se ofrecieron evidencias de fiabilidad y validez del instrumento.

El tercero fue un estudio sobre la equivalencia factorial de la versión española del Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991). Mediante un análisis de invarianza factorial se puso a prueba la equivalencia factorial obtenida en el estudio previo entre hombres y mujeres. En segundo lugar, se realizó un análisis del funcionamiento diferencial de sus ítems para estudiar la existencia de posibles sesgos en el uso de esta escala en hombres y mujeres. Por último, de cara a su posible utilidad clínica, se establecieronn baremos de las puntuaciones de la escala en hombres y mujeres diferenciando tres grupos de edad.

Una vez analizadas las propiedades métricas de la escala en muestras españolas, el cuarto estudio tuvo como objetivo analizar el papel de la asertividad sexual en las experiencias de revictimización sexual. En este contexto se plantearon cuatro posibles mediadores –derivados de la literatura previa- entre el abuso sexual en la infancia y la victimización sexual en la adolescencia y edad adulta. Así, se puso a prueba cuál de los

cuatro mediadores propuestos (i.e., número de parejas sexuales, edad de inicio en las relaciones sexuales, uso de sustancias y baja asertividad sexual) explicaría mejor la revictimización sexual. Además, se ofrecieron datos sobre las experiencias de victimización sexual, así como el tipo de abusadores, en una muestra de mujeres estudiantes de la Universidad de Granada.

El quinto, y último estudio, se realizó para analizar la naturaleza de la asertividad sexual. En base al Multifaceted Model of HIV Risk (Harlow, Quina, Morokoff, Rose y Grimley, 1993) se planteó que la asertividad sexual podría ser predicha por variables interpersonales (abuso en la pareja), actitudinales (erotofilia y actitudes hacia las fantasías sexuales) y sexuales (deseo sexual y excitación). Así, a partir de un modelo de ecuaciones estructurales se analizó cuáles son las variables que favorecen una mayor asertividad sexual en hombres y mujeres.

Artículo 1

El Papel de la Asertividad Sexual en la Sexualidad Humana: una Revisión Sistemática

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El papel de la asertividad sexual en la sexualidad humana: una revisión sistemática[1]

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RESUMEN. El estudio de la asertividad sexual ha generado resultados que demuestran su importancia y su papel fundamental en la sexualidad humana. En este estudio teórico se lleva a cabo una revisión sistemática de los principales resultados obtenidos en estos estudios. Después de una búsqueda en las principales bases de datos se obtiene un total de 76 trabajos publicados entre 1980 y 2009, que demuestran que la asertividad sexual es un factor determinante tanto de la respuesta sexual como del funcionamiento sexual humano. Además se relaciona de forma directa con una visión positiva de la sexualidad humana y con algunas variables sociodemográficas como el sexo, aunque esta relación no está clara. Otros estudios ponen de manifiesto que es un factor de protección ante experiencias de abuso y victimización sexual, así como ante conductas sexuales de riesgo. Se discuten los resultados y se plantea la necesidad de incluir la asertividad sexual de forma específica, más que la asertividad general, en los programas educativos y en intervenciones con poblaciones en situación de riesgo.

PALABRAS CLAVE. Asertividad sexual. Respuesta sexual. Victimización. Conductas de riesgo. Estudio teórico.

ABSTRACT. Study on sexual assertiveness has generated results which demonstrates its relevance and fundamental role in human sexuality. In this theoretical study, a systematic revision of the main results derived from these studies on sexual assertiveness was performed. After searching in the main databases a total number of 76 works were retrieved, published from 1980 to 2009. These works show that sexual assertiveness is a crucial factor determining both human sexual response and human sexual functioning. Furthermore, sexual assertiveness is directly related to a positive view of human

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El Papel de la Asertividad Sexual en la Sexualidad Sumana: una Revisión Sistemática

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Resumen.— El estudio de la asertividad sexual ha generado resultados que demuestran su importancia y su papel fundamental en la sexualidad humana. En este trabajo teórico se lleva a cabo una revisión sistemática de los principales resultados obtenidos en estos estudios. Después de una búsqueda en las principales bases de datos se obtienen un total de 76 trabajos publicados entre 1980 y 2009, que demuestran que la asertividad sexual es un factor determinante tanto de la respuesta sexual como del funcionamiento sexual humano. Además se relaciona de forma directa con una visión positiva de la sexualidad humana y con algunas variables sociodemográficas como el sexo, aunque esta relación no está clara. Otros estudios ponen de manifiesto que es un factor de protección ante experiencias de abuso y victimización sexual, así como ante conductas sexuales de riesgo. Se discuten los resultados y se plantea la necesidad de incluir la asertividad sexual de forma específica, más que la asertividad general, en los programas educativos y en intervenciones con poblaciones en situación de riesgo.

Palabras Clave.— Asertividad sexual. Respuesta sexual. Victimización. Conductas de riesgo. Estudio teórico.

Abstract.— Study on sexual assertiveness has generated results which demonstrates its relevance and fundamental role in human sexuality. In this theoretical study, a systematic revision of the main results derived from these studies on sexual assertiveness was performed. After searching in the main databases a total number of 76 works were retrieved, published from 1980 to 2009. These works show that sexual assertiveness is a crucial factor determining both human sexual response and human sexual functioning. Furthermore, sexual assertiveness is directly related to a positive view of human sexuality and various sociodemographical variables such as sex, although this relationship is not very clear. Other studies reveal that sexual assertivenes works as a protective factor from sexual abuse and victimization

experiences, as well as from engage in sexual risk behaviors. Results are discussed and it is purposed to include sexual assertiveness, better than general assertiveness, in educational programs and interventions with risky populations.

Keywords.— Sexual Assertiveness. Sexual response. Victimization. Risk behaviors. Theoretical study.

La asertividad sexual ha sido definida de múltiples formas. Painter (1997) sostiene que es la capacidad para llevar a cabo la asertividad social en un contexto sexual. Por su parte, Dunn, Lloyd y Phelps (1979) defienden que es "la conciencia de uno mismo como ser sexual y el uso, con poca ansiedad, de un conjunto de habilidades conductuales para obtener satisfacción sexual de uno mismo y de su pareja" (p. 294). Pero, sin duda, una de las definiciones más aceptadas sostiene que es la capacidad para iniciar la actividad sexual, rechazar la actividad sexual no deseada, así como negociar las conductas sexuales deseadas, el empleo de métodos anticonceptivos y los comportamientos sexuales más saludables (Morokoff et al., 1997). Todas estas definiciones ponen de manifiesto la especificidad de la asertividad sexual en situaciones sexuales. Asimismo, un gran número de estudios demuestra que la asertividad sexual constituye un componente central de la sexualidad humana, pues se relaciona con diversos aspectos de la respuesta sexual, como el deseo y la satisfacción sexual, con menores niveles y frecuencia de victimización y coerción sexual (véanse Santos-Iglesias y Sierra, 2009; Sierra, Santos, Gutiérrez-Quintanilla, Gómez y Maeso, 2008) y con la ausencia de conductas sexuales de riesgo, hasta el punto de que los principales modelos teóricos de prácticas sexuales de riesgo asumen la importancia que juega este constructo (Fisher y Fisher, 1992).

A pesar de la importancia de la asertividad sexual en la sexualidad humana y a que su estudio se remonta a la década de los años setenta (cfr., Jakubowski-Spector, 1973), no existen hasta la fecha revisiones que sinteticen y agrupen la información disponible sobre la misma, si bien es cierto que en alguna revisión de literatura es tratada de forma tangencial (e.g., Stampley, Mallory y Gabrielson, 2005). Por esta razón se plantea el presente estudio teórico (Montero y León, 2007) que, siguiendo las normas propuestas por Fernández-Ríos y Buela-Casal (2009), tiene como objetivo realizar una revisión bibliográfica y sintetizar la información disponible sobre el papel de la asertividad sexual en la sexualidad humana.

Método

Revisión bibliográfica

La búsqueda de los trabajos se realizó en diferentes bases de datos, con el objetivo de cubrir el mayor número de áreas temáticas, pues existen trabajos enfocados desde la Psicología, la Sociología o la Medicina. Así, las bases de datos empleadas fueron *PsycINFO*, *EBSCOhost*, *ProQuest*, *Scopus*, *JSTOR*, *PubMed* y *Psicodoc*. No se introdujo ninguna restricción en los años de búsqueda, ni en el tipo de documento, pues se pretendía realizar una búsqueda exhaustiva y obtener el mayor número de trabajos posibles. Los términos empleados para la búsqueda fueron: "sexual assertiveness", "sexual assertion", "sexual assertivity" y "sexual assert*" para obtener cualquier otra variante del término "assertiveness". En el caso de bases de datos en castellano, los términos empleados fueron "asertividad sexual", "aserción sexual" y "aser* sexual". Los términos de búsqueda se limitaron al título, resumen y palabras clave.

Criterios de inclusión

- Trabajos en los que se analizaba la asertividad sexual de forma específica y claramente operacionalizada. Este criterio permitió descartar todos aquellos trabajos que incluían asertividad general o social, comunicación sexual o habilidades de comunicación y aquellos en los que la operacionalización no dejaba claro si se trataba de asertividad sexual.
- Trabajos que empleaban la asertividad sexual como variable independiente o dependiente, ya fuese mediante su manipulación en programas de prevención o en experimentos, o su evaluación a través de cuestionarios estandarizados, preguntas diseñadas ad hoc o mediante role playing.
- Trabajos que aportasen datos empíricos originales, descartando trabajos teóricos previos en los que apareciese la asertividad sexual.

Procedimiento

La búsqueda se realizó entre febrero y noviembre de 2009. Una vez recuperados todos los trabajos se procedió a su revisión con el objetivo de analizar cuáles cumplían los criterios de inclusión, los cuales fueron revisados de forma exhaustiva con el objetivo de extraer la información pertinente. Los datos obtenidos fueron codificados en una base de datos para su posterior análisis y discusión.

Codificación de los resultados

De cada uno de los trabajos se extraía la siguiente información:

- Autor/es y año de publicación.
- Metodología del trabajo. Debido a que cada trabajo expone la metodología siguiendo clasificaciones diferentes, se unificaron todas ellas aproximándolas a la clasificación propuesta por Montero y León (2007).
- Muestra. De la que se extraía el número de participantes, sexo, y origen de la muestra (estudiantes universitarios vs. muestra comunitaria; muestra clínica vs. muestra no clínica).
- Evaluación/manipulación de la asertividad sexual. En el caso de tratarse de diseños descriptivos, instrumentales, ex post facto o experimentales se analizaba el instrumento empleado para la evaluación de la asertividad sexual, las posibles modificaciones del mismo, así como su fiabilidad (si se informa de ella). En el caso de estudios cuasi-experimentales y experimentales en los que se manipulaba la asertividad sexual también se informaba del tipo de manipulación.
- Principales resultados. Haciendo énfasis en las relaciones y efectos observados por y sobre la asertividad sexual.

Resultados

El procedimiento detallado dio lugar a un total de 76 documentos: 72 artículos de investigación, tres Tesis Doctorales y un resumen de una comunicación oral publicado en el *Journal of Pediatric and Adolescent Gynecology*. Todos estos trabajos se agrupan en tres temáticas principales: 30 relacionados con la respuesta y funcionamiento sexual, 16 relacionados con experiencias de coerción y victimización sexual, y 37 relacionados con conductas sexuales de riesgo. La suma de trabajos por temática alcanza el valor 83 debido a que algunos (e.g., Morokoff et al., 1997) aportan resultados clasificables en más de una temática. A pesar de que los trabajos de la primera temática incluyen, en su mayoría, resultados relacionados con la respuesta y funcionamiento sexual, también se han incluido entre éstos resultados referentes a variables sociodemográficas y actitudinales.

Respecto al diseño, 12 estudios (15,78%) son experimentales, 11 (14,47%) cuasi-experimentales, 48 (63,16%) de tipo ex post facto y 5 (6,59%) instrumentales. El tipo de muestra se ha organizado en base a tres categorías (sexo, procedencia y muestra clínica). En función del sexo, 5 (6,59%) trabajos incluyen únicamente varones, 46 (60,52%) sólo mujeres

y 25 (32,89%) a varones y mujeres. En cuanto a la procedencia, en el 38,15% de los estudios (*n* = 29) los participantes son universitarios y en el 61,85% (*n* = 47) de procedencia comunitaria; cinco trabajos (6,59%) emplean muestras clínicas y otros cinco muestras mixtas (clínica y no clínica), siendo la gran mayoría realizados con muestras no clínicas (*n* = 66; 86,82%). Para finalizar, de los veinte instrumentos que se emplearon para evaluar la asertividad sexual, los más utilizados son por este orden: Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991; *n* = 18; 23,68%), Sexual Assertiveness Scale (Morokoff et al., 1997; *n* = 17; 22,36%), evaluación mediante role playing (*n* = 8; 10,52%), instrumentos desarrollados ad hoc (*n* = 7; 9,21%) y Sexual Awareness Questionnaire (Snell, Fisher y Miller, 1991; *n* = 6; 7,89%).

Los resultados principales obtenidos en cada trabajo se pueden observar en la Tabla 1, los cuales son descritos a continuación de forma general agrupados en las distintas temáticas.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS).

Autor	Diseño	Muestra	Evaluación/manipulación AS	Principales resultados
Respuesta y funcionamiento sexual				
Apt, Hurlbert y Powell (1993)	Ex post facto	21 parejas comunitarias. Los hombres acudían a terapia por deseo sexual hipoactivo.	HISA (Hurlbert, 1991).	La diferencia entre la AS de los dos miembros de la pareja (AS mujer – AS varón) es un predictor significativo del deseo sexual del varón, pero no de la mujer.
Gentry (1998)	Experimental	254 estudiantes (varones y mujeres) universitarios.	Janda, O'Grady y Barnhart (1981). Factor Subordination (α = 0,94).	Las mujeres más activas sexualmente, también eran más asertivas sexualmente.
Greene y Faulkner (2005)	Ex post facto	698 parejas comunitarias.	HISA (Hurlbert, 1991). Versión de 19 ítems. Tres factores: Inicio (α = 0,86), Rechazo (α = 0,81); Conversación sexual asertiva (α = 0,79).	Mayor AS-Inicio se relaciona con menor doble moral sexual. Mayor AS se relaciona con mayor satisfacción en la relación. AS se relaciona de forma positiva con la negociación en la pareja, comunicación sexual y discusión sexual.
Haavio-Mannila y Kontula (1997)	Ex post facto	Dos muestra comunitarias: 2.250 varones y mujeres, y 2.188 varones y mujeres.	No se informa del instrumento.	Las mujeres muestran menos AS que los hombres. La satisfacción sexual se relaciona de forma positiva con la AS, tanto en hombres como en mujeres.

Hammond y Oei (1982)	Experimental	29 mujeres comunitarias.	Sexual Assertiveness Rating Form (11 ítems). Sexual Assertiveness Role-playing Test: compuesto por 16 escenarios, 8 de Inicio y 8 de Rechazo.	La combinación de entrenamiento en habilidades sociales (comunicación asertiva) y reestructuración cognitiva fue el tratamiento más efectivo para incrementar la asertividad sexual, seguido por el entrenamiento en habilidades sociales. Sin embargo, estas intervenciones no mejoraron la asertividad general.
Hurlbert (1991)	Cuasi-experimental	100 mujeres comunitarias.	HISA (Hurlbert, 1991; α = 0,91).	Las mujeres sexualmente asertivas informan de mayor actividad sexual y orgasmos, mayor deseo sexual y mayor satisfacción sexual y marital.
Hurlbert y Apt (1993)	Ex post facto	68 mujeres comunitarias.	HISA (Hurlbert, 1991).	Las mujeres con orientación heterosexual mostraron mayor AS que las mujeres con orientación homosexual.
Hurlbert, Apt y Rabehl (1993)	Ex post facto	98 mujeres casadas comunitarias.	HISA (Hurlbert, 1991).	La AS se relaciona de forma positiva con la erotofilia, la consistencia experimentando orgasmos, la cercanía en la relación, la excitabilidad sexual y la satisfacción sexual. Además, es uno de los mejores predictores de la satisfacción sexual.
Hurlbert, Apt y White (1992)	Cuasi-experimental	32 mujeres borderline y 32 no borderline.	HISA (Hurlbert, 1991).	Las mujeres borderline mostraron mayor AS.
Hurlbert et al. (2005)	Ex post facto	66 mujeres con deseo sexual hipoactivo.	HISA (Hurlbert, 1991).	La AS se relaciona de forma positiva con el estatus socioeconómico, la satisfacción marital, compatibilidad sexual y satisfacción sexual.
Hurlbert, White, Powell y Apt (1993)	Experimental	57 mujeres con trastorno por deseo sexual hipoactivo.	HISA (Hurlbert, 1991).	La AS mejoró debido a un entrenamiento en consistencia del orgasmo en el grupo en el que participaban los dos miembros de la pareja, pero no cuando participaban sólo las mujeres.

Jacobs y Thomlison (2009)	Ex post facto	572 mujeres comunitarias.	SAS (Morokoff et al., 1997; α = 0,83).	La AS se relaciona con mayor autoestima y búsqueda de sensaciones y con menor supresión de pensamientos o acciones contrarios a los de la pareja para evitar conflictos y creencias negativas, vergüenza y prejuicios sociales hacia personas con VIH.
Ménard y Offman (2009)	Ex post facto	25 varones y 46 mujeres comunitarios.	Sexual Assertiveness Scale (Shafer, 1977). 28 ítems.	La AS es un mediador parcial de la relación entre la autoestima sexual sobre la satisfacción sexual. La relación de la AS sobre la satisfacción sexual está mediada parcialmente por la autoestima sexual.
Morokoff et al. (1997)	Instrumental	Dos muestras de mujeres comunitarias: 503 y 714.	SAS (Morokoff et al., 1997).	La AS se relaciona con una mayor satisfacción en la relación de pareja, buen intercambio con la pareja y mayor experiencia sexual.
Murphy, Coleman, Hoon y Scott (1980)	Cuasi-experimental	74 mujeres alcohólicas.	Entrenamiento en AS.	Las mujeres que completaron el programa que incluía entrenamiento en AS mejoraron en satisfacción marital, activación sexual y educación sexual.
Oattes y Offman (2007)	Ex post facto	27 varones y 47 mujeres comunitarios.	Sexual Assertiveness Scale (Shafer, 1977).	Existe una correlación moderada entre la AS y la comunicación sobre cuestiones generales en la pareja. La autoestima sexual es mejor predictor de la AS que la autoestima general.
Onuoha y Munakata (1999)	Ex post facto	101 adolescentes varones y mujeres.	AIDS Social Assertiveness Scale (ASAS; α = 0,82) y AIDS Self-Assertion Questionnaire (ASAQ; α = 0,82).	No hay diferencias estadísticamente significativas en AS entre australianos y japoneses, aunque los japoneses muestran menor AS.
Pierce y Hurlbert (1999)	Instrumental	54 participantes no clínicos y 46 clínicos (acudían a terapia de pareja).	HISA (Hurlbert, 1991).	Los hombres mostraron mayor AS que las mujeres, tanto en la muestra clínica como en la no clínica.
Rickert, Neal, Wiemann y Berenson (2000)	Ex post facto	904 mujeres comunitarias.	13 ítems que evaluaban asertividad sexual.	Las mujeres con baja AS creen que su pareja es monógama, están casadas o viven con su pareja y han tenido menos de tres parejas sexuales en su vida.

Rickert, Sanghvi y Wiemann (2002)	Ex post facto	904 mujeres comunitarias.	Cuestionario ad hoc. Uno de los componentes era AS percibida.	La historia sexual y reproductiva y la historia de abuso previo son los mejores predictores de la AS, concretamente el número de parejas es el mejor predictor. Pertenecer a una minoría étnica, menor edad, bajo nivel escolar, inexperiencia sexual y el uso inconsistente de métodos anticonceptivos se relacionan con baja AS.
Schooler y Ward (2006)	Ex post facto	184 varones universitarios.	HISA (Hurlbert, 1991; α = 0,92)	La AS se relacionó de forma negativa con la religiosidad y con ser de origen asiático y de forma positiva con el confort con el propio cuerpo y con el cuerpo de las mujeres.
Schooler, Ward, Merriwether y Caruthers (2005)	Ex post facto	199 mujeres universitarias.	HISA (Hurlbert, 1991; α = 0,92)	Las mujeres con actitudes más favorables hacia la menstruación, mayor confort con el propio cuerpo y con más experiencia sexual, muestran más AS. La AS ejerce un efecto mediador entre el confort con el propio cuerpo y la experiencia sexual.
Sierra et al. (2008)	Instrumental	530 mujeres.	HISA (Hurlbert, 1991; α = 0,90)	La AS correlacionó de forma positiva con la erotofilia y con la autoestima.
Snell, Fisher y Miller (1991)	Instrumental	173 varones y mujeres universitarios.	SAQ (Snell et al., 1991). Subescala de AS (α = 0,81-0,83).	Los hombres informan de mayor AS que las mujeres. La AS correlacionó de forma negativa con culpabilidad sexual, ansiedad sexual y ansiedad para el contacto heterosexual. En mujeres correlacionó de forma negativa con depresión y locus de control externo (creencia en la suerte) y de forma positiva con autoestima, erotofilia y locus de control interno.
Snell y Wooldridge (1998)	Ex post facto	253 varones y mujeres universitarios.	SAQ (Snell et al., 1991) Subescala AS.	Tanto en varones como en mujeres la AS se relaciona con mayor experiencia sexual.

van Anders y Dunn (2009)	Ex post facto	177 varones y mujeres comunitarios.	HISA (Hurlbert, 1991).	La AS no muestra relación con los niveles de testosterona y estradiol, ni en hombres ni mujeres. Los participantes con alta AS informaron de mayor número de orgasmos en la pareja.
Walker (2006)	Ex post facto	447 mujeres universitarias.	SAQ-W (Walker, 2006; α = 0,74- 0,93).	La baja AS actúa como predictor de una identidad sexual negativa y de la conducta sexual no motivada para la sexualidad.
Weaver y Byers (2006)	Ex post facto	214 mujeres universitarias.	HISA (Hurlbert, 1991; α = 0,82).	La AS baja se relaciona con insatisfacción con el propio cuerpo general y en situaciones sexuales.
Yamayima, Cash y Thompson (2006)	Ex post facto	384 mujeres universitarias.	SAQ (Snell et al., 1991 ; α = 0,84).	Las mujeres con mayor preocupación por la imagen corporal y por la apariencia corporal en situaciones sexuales muestran menor AS.
Yoder, Perry y Saal (2007)	Ex post facto	165 mujeres comunitarias.	SAS (Morokoff et al., 1997 ; α = 0,76–0,86).	Las mujeres con puntuaciones elevadas en aceptación pasiva (sumisión) muestran puntuaciones más bajas en AS global, AS-Inicio y AS-prevención embarazo/STD.
Victimización sexual				
Apt y Hurlbert (1993)	Cuasi-experimental	120 mujeres: 60 sufrían abuso de pareja y 60 no.	HISA (Hurlbert, 1991; α = 0,84).	Las mujeres que sufrían abuso de pareja mostraban menor AS.
Corbin, Bernat, Calhoun, McNair y Seals (2001)	Ex post facto	238 mujeres universitarias.	SAS (Morokoff et al., 1997).	Las mujeres que han sufrido alguna experiencia de victimización sexual muestran menor habilidad para rechazar actos sexuales no deseados (menor AS-Rechazo).
Kiefer y Sánchez (2007)	Experimental	48 varones universitarios.	Percepción de ser sexualmente asertivo (α = 0,73).	La percepción de una mayor necesidad de ser sexualmente asertivo se relaciona con una menor inhibición ante conceptos relacionados con dominancia sexual.
Livingston, Testa y VanZile-Tamsen (2007)	Ex post facto	937 mujeres comunitarias.	SAS-Rechazo (Morokoff et al., 1997; α = 0,77).	La victimización sexual predice de forma negativa la AS-Rechazo, y ésta predice de forma negativa la subsecuente victimización sexual.

Greene y Navarro (1998)	Ex post facto	274 mujeres universitarias.	Asertividad sexual. Añadiendo "con el sexo opuesto" a los ítems del Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno y Villasenor, 1988; fiabilidad dos mitades = 0,92–0,94).	La victimización sexual correlacionó de forma negativa con la AS. La baja AS con el sexo opuesto es uno de los factores principales (junto con la victimización previa) en la predicción de la victimización sexual.
Macy, Nurius y Norris (2006)	Ex post facto	202 mujeres universitarias.	2 ítems del SAS (Harlow, Quina, Morokoff, Rose y Grimley, 1993).	La AS funciona como un factor de protección que modula la respuesta de escape y resistencia ante una agresión sexual, pues se relaciona de forma negativa con las barreras que favorecen una agresión.
Miner, Flitter y Robinson (2006)	Ex post facto	230 mujeres comunitarias.	9 ítems dicotómicos (α = 0,73).	No se encontraron diferencias en AS en función del tipo de victimización (abuso sexual en la infancia, victimización adulta y revictimización).
Morokoff et al. (1997)	Instrumental	Dos muestras de mujeres comunitarias: 503 y 714.	SAS (Morokoff et al., 1997).	La AS se relaciona de forma negativa con la victimización, coerción y asalto sexual y con historia de abuso en la infancia.
Rickert et al. (2000)	Ex post facto	904 mujeres comunitarias.	13 ítems que evaluaban asertividad sexual.	Las mujeres con baja AS informan de contactos sexuales forzados en los últimos 12 meses, pero ausencia de abuso físico.
Sierra, Ortega, Santos y Gutiérrez (2007)	Instrumental	300 mujeres comunitarias.	HISA (Hurlbert, 1991 ; α = 0,89).	La AS se relaciona de forma negativa con las experiencias de abuso físico y no físico dentro de la pareja.
Stoner et al. (2008)	Experimental	161 mujeres comunitarias.	SAS (Morokoff et al., 1997 ; α = 0,80).	Hay una relación negativa entre AS y agresión sexual adulta y violencia de pareja.
Testa y Dermen (1999)	Ex post facto	190 mujeres comunitarias.	Health Protective Communication Scale (Catania, 1998). Asertividad relacionada con VIH (α = 0,83).	Las mujeres que han sufrido coerción sexual informan de menor AS. Sin embargo, haber sufrido una violación no influye en la AS.
Testa, VanZile-Tamsen y Livingston (2007)	Ex post facto	927 mujeres comunitarias.	SAS-Rechazo (Morokoff et al., 1997; α = 0,77)	Bajos niveles de AS predicen la victimización sexual por parte de la pareja.

VanZile-Tamsen, Testa y Livingston (2005)	Experimental	318 mujeres comunitarias.	SAS-Rechazo (Morokoff et al., 1997; α = 0,77).	La victimización adolescente/adulta y el CSA se relacionan de forma negativa con AS-Rechazo y ésta a su vez actúa como mediador entre la resistencia directa o la no resistencia ante una agresión.
Walker (2006)	Ex post facto	447 mujeres universitarias.	SAQ-W (Walker, 2006; α = 0,74- 0,93)	La AS mantiene una relación negativa con la coerción sexual.
Yagil, Karnielli-Miller, Eisikovits y Enosh (2006)	Experimental	374 varones y mujeres universitarios.	Presentación de escenarios asertivos vs. no-asertivos.	Las respuestas asertivas son más efectivas en la reducción de avances sexuales no deseados.
Conductas de riesgo				
Artz, Demand, Pulley, Posner y Macaluso (2002)	Cuasi-experimental	1.159 mujeres comunitarias.	Entrevista cualitativa.	Las mujeres que tienen dificultades para introducir el condón femenino muestran menores niveles de AS que aquellas sin dificultades.
Auslander, Perfect, Succop y Rosenthal (2007)	Ex post facto	106 adolescentes varones y mujeres.	SAS (Morokoff et al., 1997).	Las adolescentes con historia de embarazo previo inician más frecuentemente la conducta sexual. Un mayor número de parejas sexuales se asocia con menor frecuencia de conductas asertivas de rechazo. Una mayor experiencia sexual previa, un mayor número de parejas y un mayor número de contactos sexuales desprotegidos se relacionan con un menor número de conductas de prevención de embarazo/ITS.
Baele, Dusseldorp y Maes (2001)	Ex post facto	424 adolescentes varones y mujeres: con experiencia sexual (*n* = 165) y sin experiencia (*n* = 255).	Escala ad hoc (6 ítems; α = 0,76).	La AS se relaciona con la intención y la consistencia en el uso del preservativo en adolescentes con y sin experiencia sexual.
Bay-Cheng y Zucker (2007)	Ex post facto	430 mujeres universitarias.	Escala de Asertividad del SAQ (Snell et al., 1991; α = 0,90).	No existen diferencias entre mujeres con ideología feminista, igualitaria y no feminista en su AS para el uso del preservativo.
Bertens, Eiling, van den Borne y Schaalma (2009)	Cuasi-experimental	273 mujeres comunitarias	Sexual Self-Efficacy Scale (Rosenthal, Moore y Flynn, 1991); RBD (Witte, Cameron, McKeon y Berkowitz, 1996).	La intervención para la prevención de ITS/VIH mejoró la AS de las participantes.

Caruthers (2005)	Ex post facto	Dos muestras: 361 y 171 mujeres comunitarias.	HISA (Hurlbert, 1991; α = 0,92 y 0,93).	Las mujeres en relaciones con pareja ocasional muestran menos AS que las mujeres en relaciones estables. Correlación negativa entre AS y edad de la menarquia y religiosidad, y positiva con la edad.
Crowell (2004)	Cuasi-experimental	40 pacientes VIH positivo y 40 VIH negativo.	Intimate Relationships Questionnaire (IRQ ; α = 0,90 – 0,91).	La AS se relaciona de forma positiva con el uso del condón en sexo oral, vaginal y anal, con la frecuencia de comunicación sobre sexo seguro y el deseo de comunicación sobre sexo seguro.
DiNoia y Schinke (2007)	Cuasi-experimental	204 mujeres adolescentes.	Escala AS del SAQ (Snell et al., 1991; α = 0,80).	En el postest las mujeres que pasaron por el programa de prevención del VIH (Keepin' it Safe) aumentaron su AS.
Dolcini y Catania (2000)	Cuasi-experimental	209 mujeres con pareja en riesgo sexual y 209 con pareja sin riesgo.	Sexual Assertiveness Scale (Kirby, 1998). 5 ítems (α = 0,83).	Las mujeres con pareja de riesgo mostraron menos AS que las mujeres con pareja sin riesgo.
Hardeman, Pierro y Mannetti (1997)	Ex post facto	274 estudiantes universitarios y de educación superior.	5 ítems que evalúan asertividad en las relaciones sexuales (α = 0,44).	Las mujeres muestran mayor asertividad sexual que los hombres. La asertividad sexual es un predictor fiable de la intención para evitar relaciones sexuales casuales.
Jenkins (2008)	Ex post facto	111 mujeres comunitarias.	SAS (Morokoff et al., 1997 ; α = 0,71 – 0,83).	Las mujeres que no han tenido pareja manifiestan menos AS-Rechazo que las que han tenido una pareja. Correlación positiva entre las escalas Rechazo y Prevención embarazo/STD.
Kelly, Lawrance, Hood y Brasfield (1989)	Experimental	104 varones comunitarios (homosexuales).	AS role play.	La intervención con un componente de entrenamiento en AS redujo el rechazo de actividades sexuales de riesgo y conductas de riesgo para el VIH/sida
Kelly, Murphy y Washington (1994)	Experimental	197 mujeres comunitarias.	AS role play.	Las mujeres en el grupo experimental mejoraron sus habilidades de comunicación y negociación sexual. Los contactos sexuales desprotegidos disminuyeron y el uso del preservativo aumentó de un 26 a un 56% en los contactos sexuales.

Klein y Knäuper (2003)	Ex post facto	71 mujeres universitarias.	14 ítems del Intimate Relationships Questionnaire (Yesmont, 1992).	Las mujeres con baja AS tienden a evitar pensamientos relacionados con las ITS.
Morokoff et al. (1997)	Instrumental	Dos muestras de mujeres comunitarias: 503 y 714.	SAS (Morokoff et al., 1997).	La AS se relaciona con una mayor autoeficacia en la prevención del VIH.
Morokoff et al. (2009)	Ex post facto	473 varones y mujeres comunitarios.	SAS-prevención embarazo/STD (Morokoff et al., 1997; α = 0,78).	La AS correlaciona de forma positiva con el uso del condón, la fase de cambio para el uso del condón y la ratio de sexo protegido. Es un predictor significativo del sexo desprotegido y ejerce un papel mediador entre éste y la victimización sexual en hombres y entre éste y la depresión y victimización sexual en mujeres.
Mosack, Weeks, Sylla y Abbott (2005)	Ex post facto	109 mujeres comunitarias.	SAS-Prevención embarazo/STD (Morokoff et al., 1997; α = 0,70).	La AS-prevención embarazo/STD es un predictor de la intención de uso de microbicidas en las relaciones sexuales.
Noar, Morokoff y Harlow (2002)	Ex post facto	471 varones y mujeres universitarios.	SAS-Prevención embarazo/STD (Morokoff et al., 1997).	La AS-prevención embarazo/STD se relaciona con diversas estrategias de influencia para el uso del preservativo (interrupción del sexo, petición directa, seducción, insistencia en la importancia de la relación, información sobre el riesgo).
Noar, Morokoff y Redding (2002)	Ex post facto	Tres muestras: 272 y 152 varones universitarios; 62 varones en riesgo para el VIH.	SAS-Prevención embarazo/STD (Morokoff et al., 1997; α = 0,73-0,78).	Existen diferencias en AS-prevención embarazo/STD en función de la etapa de cambio para el uso del condón; mayor AS quienes lo usan de forma más consistente. Los varones con mayor AS tienen menor tendencia a involucrarse en actividad sexual desprotegida.
Onuoha y Munakata (2005)	Ex post facto	1.957 varones y mujeres universitarios.	7 ítems derivados del Becoming A Responsible Teen (BART; St. Lawrence, 1998).	Tanto la AS como la asertividad social son predictores de la evitación del VIH, siendo mayor el efecto de la AS.
Parks, Hsieh, Collins, King y Levonyan-Radloff (2009)	Ex post facto	241 mujeres comunitarias.	SAS (Morokoff et al., 1997 ; α = 0,66-086).	Niveles bajos de AS-Embarazo/STD se relacionan con un menor uso del condón tanto con parejas estables como ocasionales.

Quina, Harlow, Morokoff, Burkholder y Deiter (2000)	Ex post facto	816 mujeres comunitarias.	SAS-Inicio y SAS-Rechazo (Morokoff et al., 1997; α = 0,77 y 0,74, respectivamente).	La comunicación sexual asertiva sobre las preferencias sexuales se relaciona más con AS-Inicio que con Rechazo. La comunicación sexual asertiva que busca información en la pareja sobre su riesgo para el VIH se relaciona más con la AS-Rechazo que con Inicio.
Rickert et al. (2000)	Ex post facto	904 mujeres comunitarias.	13 ítems que evaluaban asertividad sexual.	Las mujeres con baja AS informan de un uso inconsistente de mecanismos de control de embarazo.
Roberts y Kennedy (2006)	Ex post facto	100 mujeres universitarias.	11 ítems. Adaptación de Wingood y DiClemente (1998b; α = 0,77). Evalúa la habilidad de la mujer para sugerir usar el condón a su pareja.	La AS correlaciona de forma positiva con el uso del condón, mayor control sexual y la intención del uso del condón.
Sikkema, Winett y Lombard (1995)	Experimental	43 mujeres universitarias.	Entrenamiento cognitivo-conductual de habilidades sociales para mejorar la AS. AS role play.	El entrenamiento en habilidades sociales mejoró la asertividad sexual de los participantes y redujo el número de conductas sexuales de riesgo.
Snell y Wooldridge (1998)	Ex post facto	253 varones y mujeres universitarios.	SAQ (Snell et al., 1991) Subescala AS.	Tanto en hombres como en mujeres la AS se relacionó con un mayor uso de métodos contraceptivos.
Somlai et al. (1998)	Cuasi-experimental	114 varones y mujeres con enfermedad mental severa.	AS Role play.	Los participantes con menor AS mostraron menor porcentaje de uso del condón, mayor número de actos sexuales desprotegidos, parejas sexuales diferentes y ocasionales.
St. Lawrence et al. (1995)	Experimental	246 varones y mujeres adolescentes.	AS Role play.	El programa de intervención que incluye entrenamiento en AS disminuye los intercambios sexuales desprotegidos y aumenta el uso del preservativo.
Stoner et al. (2008)	Experimental	161 mujeres comunitarias.	SAS (Morokoff et al., 1997 ; α = 0,80).	Las participantes con menor AS insistían menos en el uso del condón, independientemente del grado de intoxicación alcohólica.
Stulhofer, Graham, Bozievic, Kufrin y Ajdukovic (2007)	Ex post facto	1.093 hombres y mujeres comunitarias.	3 ítems dicotómicos (α = 0,52).	Las mujeres muestran más AS que los hombres. Sólo en el caso de las mujeres, la AS predice de forma negativa las conductas sexuales de riesgo.

Treffke, Tiggemann y Ross (1992)	Ex post facto	83 hombres homosexuales y 128 heterosexuales comunitarios.	Condom Assertiveness Scale (CAS) 26 ítems (α = 0,94).	AS para el uso del condón correlaciona de forma positiva con las actitudes positivas hacia el uso del condón.
Weinhardt, Carey, Carey y Verdecias (1998)	Cuasi experimental	20 mujeres con trastornos psiquiátricos.	Escenarios de role play. Entrenamiento en AS (Kelly, 1995).	Las mujeres que recibieron el entrenamiento en AS mejoraron su AS del pre al post y en seguimiento. Además mejoraron la frecuencia de sexo desprotegido.
Weinstein, Walsh y Ward (2008)	Ex post facto	347 varones y mujeres universitarios.	HISA (Hurlbert, 1991; α = 0,92).	La AS se relaciona de forma positiva con mayor conocimiento sobre contracepción, uso del preservativo, ITS, VIH/sida.
Wingood y DiClemente (1998a)	Ex post facto	128 mujeres comunitarias.	7 ítems que evalúan su capacidad de comunicarse asertivamente con sus parejas sexuales (α = 0,77).	La AS se relaciona con un uso consistente del condón en mujeres.
Workman, Robinson, Cotler y Harper (1997)	Experimental	111 mujeres adolescentes.	AS y habilidades de comunicación. Sexual Assertiveness Scale (Kirby, 1984; α = 0,78).	Las adolescentes afroamericanas mostraron mayores niveles de AS que las hispanas.
Yesmont (1992)	Ex post facto	253 varones y mujeres universitarios.	Intimate Relationships Questionnaire (IRQ).	Las mujeres muestran más respuestas asertivas que los varones. La AS correlaciona con la precaución, preguntas a la pareja sobre conductas de riesgo, y el uso del preservativo.
Zamboni, Crawford y Williams (2000)	Ex post facto	227 varones y mujeres universitarios.	SAQ (Snell et al., 1991).	La AS es el principal predictor de la frecuencia del uso del condón en sexo vaginal. Correlaciona con asertividad general y comunicación sexual. La relación entre AS y uso del condón está mediada por las actitudes hacia el preservativo; la relación es positiva cuando las actitudes hacia el condón son positivas.

Respuesta y funcionamiento sexual

Los resultados muestran que la asertividad sexual se relaciona de forma positiva con el deseo sexual (Hurlbert, 1991), tanto en varones como en mujeres. Una mayor asertividad sexual en la mujer es un predictor del deseo sexual del varón (Apt et al., 1993). También se

encuentra una relación positiva con la satisfacción sexual y marital (Greene y Faulkner, 2005; Haavio-Mannila y Kontula, 1997; Hurlbert, 1991; Ménard y Offman, 2009), con el número de orgasmos y, sobre todo, con la consistencia en alcanzarlo (Hurlbert, 1991; Hurlbert, Apt et al., 1993; Hurlbert, White et al., 1993), y con la actividad y experiencia sexual (Gentry, 1998; Morokoff et al., 1997; Rickert et al., 2000; Snell y Wooldridge, 1998). Sin embargo, no parece existir una relación entre la asertividad sexual y los niveles hormonales, ni en hombres ni en mujeres (van Anders y Dunn, 2009).

Al margen de la respuesta y funcionamiento sexual, se ha informado de mayor asertividad sexual en varones (Haavio-Mannila y Kontula, 1997; Pierce y Hurlbert, 1999), en mujeres heterosexuales frente a mujeres homosexuales (Hurlbert y Apt, 1993), en personas de estatus socioeconómico elevado (Hurlbert et al., 2005), en mujeres con trastorno de personalidad borderline (Hurlbert, Apt et al., 1992) y en personas poco religiosas (Schooler y Ward, 2006). Por otra parte, diversas variables actitudinales relacionadas con la respuesta sexual se encuentran asociadas con la asertividad sexual. Así, las personas con alta asertividad muestran menor doble moral sexual, mayor autoestima global y sexual, menor búsqueda de sensaciones y mayor erotofilia (Greene y Faulkner, 2005; Hurlbert, Apt et al., 1993; Jacobs y Thomlison, 2009; Oattes y Offman, 2007; Sierra et al., 2008), tienen actitudes más favorables hacia la menstruación, muestran menor culpabilidad sexual y menor sumisión ante la pareja y manifiestan una identidad sexual más positiva, experimentando un mayor confort con su propio cuerpo (Schooler y Ward, 2006; Schooler et al., 2005; Walker, 2006; Weaver y Byers, 2006; Yamamiya, Cash y Thompson, 2006; Yoder et al., 2007).

Victimización y coerción sexual

En líneas generales, los estudios demuestran que la asertividad sexual funciona como un factor de protección frente a la victimización y coerción sexual (Macy et al., 2006), ya que es una estrategia eficaz en la reducción de avances sexuales no deseados (Corbin et al., 2001; Yagil et al., 2006). Además, se ha demostrado una relación negativa con distintos tipos de conductas de abuso, como abuso sexual en la infancia, coerción sexual, victimización (Greene y Navarro, 1998; Morokoff et al., 1997; Rickert et al., 2000; Sierra et al., 2007; Stoner et al., 2008; Testa y Dermen, 1999; Testa et al., 2007; VanZile-Tamsen et al., 2005; Walker, 2006), sin que existan diferencias en asertividad sexual en función del tipo de abuso (Miner et al., 2006), encontrándose también esa relación con distintos tipos de agresores, ya sean personas desconocidas, citas ocasionales, relaciones de pareja estable o matrimonios (Apt y Hurlbert, 1993; Testa et al., 2007). Se ha señalado además que la baja asertividad

sexual puede ser tanto una consecuencia de la victimización como un factor de riesgo para la misma (Livingston et al., 2007).

Conductas sexuales de riesgo

De la misma forma que sucede con la victimización sexual, la asertividad funciona como un factor de protección ante conductas sexuales de riesgo (Hardeman et al., 1997; Kelly et al., 1989; Kelly et al., 1994; Sikkema et al., 1995). Los estudios demuestran que una mayor asertividad sexual se relaciona no sólo con el uso del preservativo de forma consistente (Baele et al., 2001; Bay-Cheng y Zucker, 2007; Crowell, 2004; Morokoff et al., 2009; Wingood y DiClemente, 1998a), sino también con la intención de uso del mismo (Baele et al., 2001; Roberts y Kennedy, 2006) independientemente de si se ha ingerido alcohol (Stoner et al., 2008), las actitudes positivas hacia su uso (Treffke et al., 1992; Zamboni et al., 2000), la intención para usar microbicidas (Mosack et al., 2005) y mejores estrategias de influencia para el uso del preservativo (Noar et al., 2002). Además, puede actuar como mediador en la relación que se establece entre la victimización sexual y las conductas sexuales de riesgo (Morokoff et al., 2009). Por el contrario, la baja asertividad sexual se relaciona con dificultades para usar el condón fenemino (Artz et al., 2002; Lameiras-Fernández, Núñez-Mangana, Rodríguez-Castro, Bretón-López y Agudelo, 2007) y con un uso inconsistente de mecanismos útiles para la prevención de embarazos (Rickert et al., 2000; Snell y Wooldridge, 1998), razón por la cual se asocia con historia de embarazo previo (Auslander et al., 2007).

También se ha señalado que las personas con baja asertividad sexual tienen un mayor número de parejas sexuales (Auslander et al., 2007), suelen tener más parejas en riesgo para el contagio por VIH (Dolcini y Catania, 2000), tienen mayor número de relaciones sexuales casuales (Somlai et al., 1998) y evitan pensamientos acerca de las infecciones de transmisión sexual (ITS; Klein y Knäuper, 2003). Además, la asertividad sexual es menor en mujeres que tienen encuentros ocasionales que en aquellas con pareja estable (Caruthers, 2005). Por último, también se ha puesto de manifiesto que intervenciones destinadas a prevenir el contagio de ITS/VIH producen mejoras en la asertividad sexual (Bertens et al., 2009; Di Noia y Schinke, 2007) y que programas destinados a mejorar la asertividad sexual reducen el número de conductas de riesgo emitidas por una persona (Kelly et al., 1989; Kelly et al., 1994; Sikkema et al., 1995; St. Lawrence et al., 1995; Weinhardt et al., 1998).

Discusión

La importancia de la asertividad sexual dentro de la sexualidad humana constituye un hecho relevante y constatado (Hammond y Oei, 1982); sin embargo, hasta la fecha no existen estudios que agrupen y analicen la información obtenida acerca de este constructo. Los resultados obtenidos en esta revisión de trabajos publicados hasta la fecha demuestran que la asertividad sexual es un elemento fundamental en el funcionamiento y respuesta sexual, y que es sumamente relevante como factor de protección ante conductas sexuales de riesgo y experiencias de victimización y coerción sexual.

A nivel descriptivo encontramos que la mayoría de los estudios son de diseño ex post facto, mientras que pocos son de tipo experimental o cuasi-experimental. Si bien es cierto que los estudios experimentales son los que permiten establecer relaciones de causalidad (Montero y León, 2007; Ramos-Alvarez, Moreno-Fernández, Valdés-Conroy y Catena, 2008) y, por tanto, descubrir el auténtico papel de la asertividad sexual, también es verdad que en determinadas áreas como en victimización sexual es difícil plantear estudios experimentales dotados de la suficiente validez ecológica. Por otra parte, también es notorio que a pesar de la cantidad de instrumentos encontrados para evaluar de una u otra forma la asertividad sexual, los estudios instrumentales son muy escasos, es decir, que la mayoría de los instrumentos empleados no han sido desarrollados siguiendo unos estándares mínimos que garanticen su adecuado funcionamiento.

Respecto a las muestras empleadas destacan sobre todo los estudios realizados con mujeres, echándose en falta estudios con varones, así como trabajos que analicen las relaciones diádicas. También, al igual que sucede con otros constructos sexuales (e.g., satisfacción sexual) el empleo de muestras de homosexuales o de ancianos es prácticamente inexistente (Delamater, Hyde y Fong, 2008; Henderson, Lehavot y Simoni, 2009). Por último, también hay que destacar que algo más de un 45% de los estudios se realizan con los mismos instrumentos: el SAS (Morokoff et al., 1997) y el HISA (Hurlbert, 1991), que son justamente los que se han desarrollado a través de estudios instrumentales. Sin embargo, hay que destacar la elevada utilización de instrumentos desarrollados ad hoc carentes, en la mayoría de los casos, de las garantías psicométricas necesarias.

Los resultados del primer grupo de estudios ponen de manifiesto la asociación de la asertividad sexual con las distintas fases de la respuesta sexual humana, como el deseo, el orgasmo y la satisfacción (Haavio-Mannila y Kontula, 1997; Hurlbert, 1991; Hurlbert, Apt et al., 1993; Hurlbert, White et al., 1993). Sin embargo, estos estudios han sido elaborados mediante diseños ex post facto, lo que impide conocer los mecanismos o procesos por los cuales se da esta asociación y mucho menos cuál es la dirección de la misma. Por ejemplo,

las personas que tienen mayor asertividad sexual, ¿se comunican más con la pareja solicitando aquello que les resulta placentero y, por tanto, consiguen mayores niveles de satisfacción o, por el contrario, la satisfacción sexual crea un mayor vínculo en la pareja y es este vínculo el que favorece la asertividad sexual? Respecto al primer ejemplo algunos estudios han demostrado que la autorrevelación sexual favorece la satisfacción (Byers y MacNeil, 2008; MacNeil y Byers, 2005), pero no se han llevado a cabo estudios similares con asertividad sexual. Respecto al segundo, sí se ha demostrado que un mayor vínculo y compromiso en la pareja se asocia con la satisfacción sexual (Warehime y Bass, 2008), pero no se sabe si esta relación esta mediada por la asertividad sexual. De la misma manera también se echan en falta más estudios sobre el papel de los niveles hormonales y de la excitación –medida a través de registros psicofisiológicos- en las respuestas asertivas.

Respecto a variables sociodemográficas, los resultados más interesantes tienen que ver con el papel del sexo. Aquí se encuentran resultados contradictorios, pues mientras algunos estudios sostienen una mayor asertividad sexual en varones (Haavio-Mannila y Kontula, 1997; Pierce y Hurlbert, 1999) otros lo hacen en mujeres (Hardeman et al., 1997; Stulhofer et al., 2007), si bien desde una perspectiva de género lo esperable es que las mujeres muestren menos asertividad sexual, pues iniciar interacciones asertivas en situaciones sexuales no es una habilidad que se haya enseñado con frecuencia a las mujeres (Muehlenhard y McCoy, 1991). Además algunos estudios demuestran que las mujeres que discuten sus deseos sexuales y toman decisiones basadas en sus propias necesidades corren el riesgo de ser etiquetadas como "zorras" (*sluts*; Holland, Ramazanoglu, Scott, Sharpe y Thompson, 1990). Por ello, sería necesario investigar cuál es el papel real que juega el sexo en la asertividad sexual. Por el contrario, sí queda claro el papel de las actitudes sexuales y otros factores que favorecen el funcionamiento sexual, como la autoestima, una imagen corporal positiva o la búsqueda de sensaciones sexuales.

Los estudios relacionados con la victimización y la coerción sexual no dejan lugar a dudas de que la asertividad sexual, en líneas generales, es un factor de protección frente a las experiencias de abuso (Macy et al., 2006). Además, la principal ventaja es que estos resultados se han encontrado en distintas modalidades de abuso, así como ante diferentes tipos de agresores. Sin embargo, existe un aspecto discutido que es conveniente aclarar y sobre el que se han realizado pocos estudios y es si la baja asertividad surge como consecuencia de las experiencias de victimización o si la baja asertividad es la causa de las mismas. En este sentido, en el estudio de Livingston et al. (2007) se encontró que la asertividad es tanto causa como consecuencia de la victimización sexual, razón por la que son

necesarios más estudios al respecto, que tal y como señalan dichas autoras, deben ser de tipo longitudinal.

Por último, tal y como muestran los resultados relativos a la victimización, los estudios sobre conductas sexuales de riesgo coinciden en señalar el papel preventivo de la asertividad sexual ante dichas conductas (Hardeman et al., 1997; Kelly et al., 1989; Kelly et al., 1994; Sikkema et al., 1995). A pesar de ello, estos estudios han sido en su mayoría desarrollados con poblaciones heterosexuales, por lo que es necesario trabajar con poblaciones homosexuales y bisexuales para comprobar si los resultados coinciden, siempre teniendo en cuenta que es la asertividad sexual y no la general la que funciona como factor de protección y, por tanto, los estudios y las estrategias de intervención –que también se han mostrado efectivas- tienen que ser diseñadas sobre la asertividad sexual.

Para finalizar, es necesario volver a insistir en el papel fundamental de la asertividad sexual humana, tal y como se desprende de los resultados obtenidos y revisados en el presente trabajo. De esto se deriva también la necesidad de contemplar la inclusión de la misma en programas de prevención e intervención (véase, por ejemplo, Carrera-Fernández, Lameiras-Fernández, Foltz, Núñez-Mangana y Rodríguez-Castro, 2007), tal y como se ha venido haciendo de forma generalizada con los entrenamientos en habilidades sociales que incluían componentes de asertividad general. Sin duda, las conclusiones extraídas del presente trabajo serían mucho más valiosas si se hubiese empleado una metodología meta-analítica (Cooper y Rosenthal, 1980), pero la heterogeneidad de variables tratadas, instrumentos y diseños empleados en un número tan reducido de trabajos, favorecieron la realización de una revisión sistemática descartando la posibilidad de realizar un estudio meta-analítico, que será más pertinente cuando se disponga un mayor número de trabajos (Botella y Gambara, 2006; Cooper, 1998).

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Artículo 2

Hurlbert Index of Sexual Assertiveness: a study of psychometric properties in a Spanish sample

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HURLBERT INDEX OF SEXUAL ASSERTIVENESS: A STUDY OF PSYCHOMETRIC PROPERTIES IN A SPANISH SAMPLE[1, 2]

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Summary.—The study analyzed psychometric properties of a Spanish version of the Hurlbert Index of Sexual Assertiveness in a Spanish sample of 400 men and 453 women who had had a partner for the last 6 mo. or longer at the time of the study. Exploratory and confirmatory factor analyses suggested a two-factor solution with the factors Initiation and No shyness/Refusal. Internal consistency values for total scores were .87 and .83 for the factors, respectively. Convergent validity tests were also satisfactory. It is therefore reasonable to conclude that the Spanish version of the scale has appropriate psychometric properties.

Sexual assertiveness implies that people have the right to make independent decisions about their own sexual experiences and activities (Morokoff, Quina, Harlow, Whitmire, Grimley, Gibson, & Burkholder, 1997). It reflects people's ability to initiate sexual activity, reject unwanted sexual activity, use contraceptive methods, and develop healthy sexual behaviors (Morokoff, *et al*., 1997). It also refers to awareness of oneself as a sexual being and to the use of various behavioral skills to obtain and provide satisfaction in sexual relations (Dunn, Lloyd, & Phelps, 1979). In short, sexual assertiveness is an essential component of sexual health. It allows people to make decisions about their own sexuality (Sierra, Santos, Gutiérrez-Quintanilla, Gómez, & Maeso, 2008) and to engage in safe, pleasant, and informed sexual activity based on a positive view of sexuality with mutual respect in intimate relationships (Lottes, 2000).

Sexual assertiveness is related to three key aspects of human sexuality: sexual functioning, sexual coercion, and risky sexual behaviors. With regard to sexual functioning, most treatment programs for sexual dysfunctions use components of sexual assertiveness training (Ellis, 1975; Kerr, 1975; Sierra & Buela-Casal, 2001). Moreover, the results of various studies have shown sexual assertiveness to be negatively related to guilt and sexual anxiety (Snell, Fisher, & Miller, 1991) and positively related to the ability to give and receive pleasure in sexual encounters (Dunn, *et al*., 1979). More specifically, lack of sexual assertiveness has been related to anorgasmy (Kuriansky, Sharpe, & O'Connor, 1982; Cotten-Houston

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Hurlbert Index of Sexual Assertiveness: A Study of Psychometric Properties in a Spanish Sample

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Abstract.— The study analyzed psychometric properties of a Spanish version of the Hurlbert Index of Sexual Assertiveness in a Spanish sample of 400 men and 453 women who had had a partner for the last 6 months or longer at the time of the study. Exploratory and confirmatory factor analyses suggested a two-factor solution with the factors Initiation and No shyness/Refusal. Internal consistency values for total scores were .87 and .83 for the factors, respectively. Convergent validity tests were also satisfactory. It is therefore reasonable to conclude that the Spanish version of the scale has appropriate psychometric properties.

Sexual assertiveness implies that people have the right to make independent decisions about their own sexual experiences and activities (Morokoff et al., 1997). It reflects people's ability to initiate sexual activity, reject unwanted sexual activity, use contraceptive methods, and develop healthy sexual behaviors (Morokoff et al., 1997). It also refers to awareness of oneself as a sexual being and to the use of various behavioral skills to obtain and provide satisfaction in sexual relations (Dunn, Lloyd, & Phelps, 1979). In short, sexual assertiveness is an essential component of sexual health. It allows people to make decisions about their own sexuality (Sierra, Santos, Gutiérrez-Quintanilla, Gómez, & Maeso, 2008) and to engage in safe, pleasant, and informed sexual activity based on a positive view of sexuality with mutual respect in intimate relationships (Lottes, 2000).

Sexual assertiveness is related to three key aspects of human sexuality: sexual functioning, sexual coercion, and risky sexual behaviors. With regard to sexual functioning, most treatment programs for sexual dysfunctions use components of sexual assertiveness training (Ellis, 1975; Kerr, 1975; Sierra & Buela-Casal, 2001). Moreover, the results of

various studies have shown sexual assertiveness to be negatively related to guilt and sexual anxiety (Snell, Fisher, & Miller, 1991) and positively related to the ability to give and receive pleasure in sexual encounters (Dunn et al., 1979). More specifically, lack of sexual assertiveness has been related to anorgasmy (Cotten-Houston & Wheeler, 1983; Hurlbert, 1991; Kuriansky, Sharpe, & O'Connor, 1982); high sexual assertiveness is associated with greater activity, sexual desire, orgasms, and sexual and marital satisfaction (Greene & Faulkner, 2005; Haavio-Mannila & Kontula, 1997; Hite, 1976; Hurlbert, 1991; Hurlbert et al., 2005; Whitley & Poulsen, 1975;). Positive correlations have also been noted between sexual assertiveness and body satisfaction and comfort (Schooler, Ward, Merriweather, & Caruthers, 2005), which indirectly contribute to positive sexual experiences. As far as social coercion is concerned, most researchers agree that sexual assertiveness is a protective factor (Bohmer & Parrot, 1993; Parrot, 1990; Ullman, 1998; Fisher, Cullen, & Turner, 2000). In fact, a negative association has been reported between sexual assertiveness and experiences of abuse and sexual and verbal coercion (Livingston, Testa, & VanZile-Tamsen, 2007; MacGreene & Navarro, 1998; Morokoff, et al., 1997; Rickert, Neal, Wiemann, & Berenson, 2000; Sierra, Ortega, Santos, & Gutiérrez, 2007; Stoner et al., 2008; ; Testa & Dermen, 1999), even in married couples (Apt & Hurlbert, 1993). Finally, lack of sexual assertiveness is also a risk factor for HIV, sexually transmitted infections (STIs), and unwanted pregnancies (Somlai et al., 1998). Likewise, sexual assertiveness is a significant predictor of condom use in adolescent and young adult samples (Auslander, Perfect, Succop, & Rosenthal, 2007; Catania et al., 1992; Crowell, 2004; Ehrhardt et al., 2002; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Wingood & DiClemente, 1998), of intention to use microbicides for HIV and STI prevention (Mosack, Weeks, Sylla, & Abbott, 2005), and of the absence of sexual risk behaviors (Noar, Morokoff, & Redding, 2002; Rickert et al., 2000; Thompson, Geher, Stevens, Stem, & Lintz, 2001; Zamboni, Crawford, & Williams, 2000).

Because sexual assertiveness is a very important component of human sexuality, reliable and valid tests are necessary, given that the interpretations of studies and interventions could be based on the scores (Padilla, Gómez, Hidalgo, & Muñiz, 2006, 2007). In the Spanish context, the only test to measure sexual assertiveness with some psychometric evidence is the Hurlbert Index of Sexual Assertiveness (Sierra et al., 2008), the measure of sexual assertiveness most frequently used (Santos-Iglesias & Sierra, 2010).

The Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991) has 25 items and provides a unidimensional measure of sexual assertiveness in couples. Studies of the English

version have reported adequate psychometric properties, with internal consistency reliability values ranging from .84 to .92 (Apt & Hurlbert, 1993; Hurlbert, 1991; Schooler et al., 2005) and a test-retest reliability of .85 over a four week interval (Pierce & Hurlbert, 1999). Nevertheless, none of these studies have replicated the unidimensional factor structure. With regard to construct validity, a correlation of .82 was found with the Gambrill-Richey Assertion Inventory (Hurlbert, 1991). A psychometric assessment of the Spanish version (Sierra et al., 2008) showed a single factor with an internal consistency reliability estimate of .90 and significant positive correlations with measures of erotophilia and self-esteem. However, this study was only based on adult female participants, half of whom were Salvadorian. Since there may be cultural as well as gender-based differences in sexual assertiveness, the reliability and validity of the Spanish version need to be assessed with a Spanish sample of men and women.

The present instrumental study (Montero & León, 2007) was carried out to analyze the psychometric properties of the Hurlbert Index of Sexual Assertiveness in a nonrepresentative Spanish sample. In conducting this study, the recommendations made by Hambleton, Merenda, and Spielberger (2005) and Carretero-Dios and Pérez (2007) were followed. The psychometric properties of the items in the scale were analyzed and the factor structure of the scale was examined through exploratory factor analysis and later confirmed through confirmatory factor analysis. After confirming the final structure of the scale in the Spanish population, internal consistency reliability and convergent validity indicators were analyzed. To assess convergent validity, correlations of scores on the Hurlbert Index of Sexual Assertiveness with those on the Questionnaire on Assertion in Couples (Carrasco, 1998), the abbreviated Spanish version of the Dyadic Adjustment Scale (Santos-Iglesias, Vallejo-Medina, & Sierra, 2009), and the Social Skills Scale (Gismero, 2002) were calculated; all these tests measure different constructs (assertion in couples, dyadic adjustment, and social skills) related to sexual assertiveness.

The following hypotheses about the relations between scores on the Hurlbert Index of Sexual Assertiveness and the various measures were developed: (1) Since Apt and Hurlbert (1993) argued that women who experience abuse and male dominance in their marriages show lower assertiveness, scores on the Hurlbert Index of Sexual Assertiveness were hypothesized to correlate positively with the Assertion subscale of the Questionnaire on Assertion in Couples and negatively with the subscales Aggression, Submission, and Passive aggression. (2) Sexual assertiveness was hypothesized to correlate positively with marital satisfaction (Hurlbert, 1991), and marital adjustment was hypothesized to correlate with

assertive interactions in couples (Epstein, 1981; Smolen, Spiegel, Bakker-Rabdan, Bakker, & Martin, 1985). A positive correlation was expected between scores on the Hurlbert Index of Sexual Assertiveness and the abbreviated Spanish version of the Dyadic Adjustment Scale. (3) Since sexual assertiveness is related to communication skills and other social skills that are useful to negotiate safe sexual behaviors (Hammond & Oei, 1982; Quina, Harlow, Morokoff, Burkholder, & Deiter, 2000; Salazar et al., 2004), Hurlbert Index of Sexual Assertiveness scores were hypothesized to correlate positively with those of the Social Skills Scale.

Method

Participants

The sample was recruited from the general population through a convenience sampling procedure and consisted of 400 men and 453 women (N = 853) who had been involved in stable sexually active heterosexual relationships for at least 6 months at the time of the study. Ages of participants ranged from 18 to 71 years (M = 30.8; SD = 9.6); men's mean age was 32.1 years (SD = 10.0; range 18–71) and women's mean age was 29.7 years (SD = 9.0; range 18–65). A total of 65.7% of the participants had a university education (64.4% men, 68.8% women), 24.7% had secondary school (27.2% men, 22.7% women), and 9.6% had primary school education (8.2% men, 7.2% women). Due to the sampling procedure and participants' distribution across different educational levels, the sample is not representative of the Spanish population.

For the statistical analysis, the sample was randomly divided into two subsamples. The first subsample consisted of 300 participants (137 men, 163 women) selected through a random sampling procedure without replacement using SPSS software. This sample size is considered "good" for an exploratory factor analysis (Tabachnick & Fidell, 2001). The other subsample consisted of 490 participants (232 men, 258 women) and was used for the confirmatory factor analysis. The data of 63 participants (7.38%) could not be used in the factor analyses because their responses were incomplete. These 63 participants did not show statistically significant differences in age (Mann-Whitney U = 20,461.5, p = .4), sex (U = .008, p = .8), or education (U = .8, p = .2).

Instruments

Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991). The version used was the corrected Spanish translation by Sierra et al. (2008). This version, which was previously used

with Salvadoran women, was sent to four Spanish experts in human sexuality, who were asked to analyze the meaning of the items in the Spanish context. After making the changes suggested by the experts, the result was administered to 28 participants (13 university students, 15 nonstudents) who assessed the meaning of the items again and suggested new changes. The resulting version was used in the present study. The 25-item scale uses a 5-point response format with anchors of 0 (*never*) and 4 (*always*), so scores could range from 0 to 100. High scores indicate high sexual assertiveness. The psychometric properties of the scale have been described above.

Questionnaire on Assertion in Couples (Carrasco, 1998). This questionnaire is a 40-item scale that uses a 5-point response format with anchors of 1 (*very rarely*) and 5 (*very often*). Higher scores reflect higher assertion. The Questionnaire on Assertion in Couples provides scores on four different subscales: Assertion, direct expression of feelings and opinions without forcing others' agreement by means of punishment or punishment threat; Aggression, coercive expression of feelings and opinions using coercive tactics to obtain others' agreement; Submission, lack of direct expression of feelings and opinions or automatic subjugation to others' opinions and preferences; and Passive aggression, lack of direct expression of preferences and opinions, while coercing indirectly by means of punishment or punishment threat. The author of the questionnaire reported internal consistency values between $\alpha = .75$ and .90 (in the present study, McDonald's omega values ranged from .86 to .78) and adequate convergent validity, with statistically significant positive correlations with scores on the Dyadic Adjustment Scale ranging from .33 to .46 (Carrasco, 1998).

Dyadic adjustment. The abbreviated version of the Dyadic Adjustment Scale (Santos-Iglesias, Vallejo-Medina et al., 2009), which has 13 items that provide a global score on dyadic adjustment as well as specific scores on three: subscales Consensus, Satisfaction, and Cohesion. The scale also uses a Likert-type response format with six response options (with anchors of 0: a*lways disagree* and 5: *always agree*) and five response options (with anchors of 0: *never* and 4: *every day*). Higher scores indicate greater adjustment. The authors reported adequate internal consistency reliability, with a value of .83 for the global scale, and values of .73, .70, and .63 for the three subscales, as listed above, respectively (Santos-Iglesias, Vallejo-Medina et al., 2009). In the present study, estimates of McDonald's omega were .92 for the global scale and .71, .72, and .62, respectively, for the three subscales.

Social Skills Scale (Gismero, 2002). This scale has 33 items and uses a 5-point Likert response format with anchors of 1 (*I don't identify at all*) and 5 (*I strongly agree and would*

feel or act this way in most cases). High scores indicate greater assertiveness and social skills. Internal consistency reliability was α = .88; in the present study, McDonald's omega was .91. Convergent validity was indicated by significant correlations with scores on assertive self-descriptions (from .48 to .50) and scores on neuroticism (−.40) and extraversion (.52; Gismero, 2002).

Procedure

Participants were recruited through convenience sampling from the general population. A quota convenience sampling method was used to obtain the same number of men and women, distributed across different ages and education. The only requirement for participating was involvement in a stable heterosexual relation with sexual activity for at least 6 months at the time of the study. This sampling method does not allow generalizing results to the Spanish population.

Testing was conducted individually, except in university classrooms, where it was performed collectively, by eight well-trained researchers who recruited participants in different settings (university classrooms, public libraries, social centers, and public places). The purpose of the study was explained briefly to all participants; after obtaining verbal informed consent, each participant was given a booklet with the questionnaires in the same order as described above and a response sheet. Anonymity and confidentiality were guaranteed, as well as the exclusive use of the tests for research purposes. Since participants were recruited from the general population, no institutional review board was required.

Results

Item Analysis and Exploratory Factor Analysis

The item analysis was carried out with SPSS Statistics, Version 17.0, software and showed all response options were chosen for all of the items. In every case, the means obtained were above the theoretical midpoint of the response scale (which was 2, with anchors of 0: *never* and 4: *always*). Standard deviations were greater than 1.00 for all items except 1, 2, 10, 11, 14, 19, 23, and 25, for which they were slightly below 1.00. Skewness and kurtosis values ranged between -2.3 (Item 19) and -0.2 (Item 20) for skewness, and between 0.03 (Item 18) and 5.1 (Item 19) for kurtosis, so there were no extreme problems with skew and kurtosis (Kline, 2005). Corrected item-total correlations were above .30 (Nunnally & Bernstein, 1995), except for Items 15 (r_{it} = .28), 20 (r_{it} = .01), and 22 (r_{it} = .27). Eliminating some of these items increased internal consistency reliability for Items 20 and

22, although the increase was not statistically significant. The low item-total correlation of Item 20 ("Pleasing my partner is more important than my pleasure"/"Dar placer a mi pareja es más importante que mi propio placer"), the inconsistency of the content of Item 22 ("I enjoy masturbating myself to orgasm"/"Disfruto masturbándome hasta llegar al orgasmo") with the construct of sexual assertiveness led to eliminating these two items from later analyses.

The exploratory factor analysis was carried out with Factor 7.02 software (Lorenzo-Seva & Ferrando, 2006) after eliminating Items 20 and 22. The coefficient of multivariate normality showed the nonnormal distribution of the data (Z = 37.56, p < .001). Thus, an unweighted least squares procedure was used to extract the factors. Promin, an oblique rotation procedure (Lorenzo-Seva, 1999), was used, given that a correlation between the possible factors was expected. The Kaiser-Meyer-Olkin measure of sampling adequacy (KMO = .87) and Bartlett's test of sphericity (χ^2 = 1,971.90, p < .001) showed the adequacy of the data for this type of analysis (Carretero-Dios & Pérez, 2007; Catena, Ramos, & Trujillo, 2003).

The analysis yielded a two-factor structure, Initiation and No shyness/Refusal. Initiation is related to the beginning of sexual contact and the expression of sexual desires and fantasies to one's partner, and No shyness/Refusal means the difficulty starting and maintaining conversations on sexual issues and an inability to reject undesired sexual contact. The correlation between both factors was .64 (p < .001). Except Items 8 and 15, all factors loaded above .30 on either of the two factors (see Table 1). Items 8 and 15 were therefore eliminated from the scale. Items 12 and 23 loaded on the factor No shyness/Refusal, although their content was more typical of the factor Initiation. Moreover, the difference in the loadings of these items on both factors was lower than .15. Thus, they were retained in the analysis and tested in various models with confirmatory factor analysis.

TABLE 1. Factor loadings, communalities (h^2), percent of variance, and eigenvalue of each factor.

Item	English	Spanish Translation	Initiation	No shyness/ Refusal	h^2
1 (R)	I feel uncomfortable talking during sex	Me siento incómodo/a al hablar durante mis relaciones sexuales	.30	**.37**	.38
2 (R)	I feel that I am shy when it comes to sex	Creo que soy tímido en el ámbito sexual	.32	**.36**	.39
3	I approach my partner for sex when I desire it	Le propongo sexo a mi pareja cuando lo deseo	**.66**	-.05	.39

4	I think I am open with my partner about sexual needs	Creo que soy abierto/a con mi pareja acerca de mis necesidades sexuales	**.59**	.11	.45
5	I enjoy sharing my sexual fantasies with my partner	Disfruto compartiendo mis fantasías sexuales con mi pareja	**.55**	-.13	.23
6 (R)	I feel uncomfortable talking to my friends about sex	Me siento incómodo/a hablando de sexo con mis amigos/as	-.10	**.56**	.25
7	I communicate my sexual desires to my partner	Le comunico mis deseos sexuales a mi pareja	**.59**	.15	.49
8 (R)	It is difficult for me to touch myself during sex	Me resulta difícil tocarme durante mis relaciones sexuales	.23	**.29**	.22
9 (R)	It is hard for me to say no even when I do not want sex	Me resulta difícil decir que no, incluso cuando no deseo tener relaciones sexuales	-.10	**.54**	.23
10 (R)	I am reluctant to describe myself as a sexual person	Soy reacio/a a describirme como una persona sexualmente activa	.03	**.55**	.32
11 (R)	I feel uncomfortable telling my partner what feels good	Me siento incómodo/a al decirle a mi pareja lo que me gusta	.08	**.61**	.44
12	I speak up for my sexual feelings	Expreso mis sensaciones sexuales	**.24**	.37	.30
13 (R)	I am reluctant to insist that my partner satisfy me	Soy reacio/a a insistirle a mi pareja para que me satisfaga sexualmente	.001	**.43**	.19
14 (R)	I find myself having sex when I do not really want it	Suelo tener relaciones sexuales cuando realmente no quiero	-.05	**.47**	.19
15	When a technique does not feel good, I tell my partner	Cuando no me gusta una práctica sexual, se lo digo a mi pareja	**.06**	.27	.10
16	I feel comfortable giving sexual praise to my partner	Me siento cómodo/a diciendo piropos sexuales a mi pareja	**.64**	-.20	.28
17	It is easy for me to discuss sex with my partner	Me resulta fácil hablar de sexo con mi pareja	**.45**	.06	.24
18	I feel comfortable in initiating sex with my partner	Me siento cómodo/a tomando la iniciativa en las relaciones sexuales con mi pareja	**.65**	-.19	.29
19 (R)	I find myself doing sexual things that I do not like	Tiendo a realizar actividades sexuales que no me gustan	-.09	**.52**	.22
21	I feel comfortable telling my partner how to touch me	Me siento cómodo/a indicándole a mi pareja cómo tocarme	**.46**	.01	.22
23	If something feels good, I insist on doing it again	Si algo me gusta, insisto en volver a hacerlo	**.27**	.30	.26
24 (R)	It is hard for me to be honest about my sexual feelings	Me resulta difícil ser sincero/a acerca de mis sensaciones sexuales	.16	**.39**	.27
25 (R)	I try to avoid discussing the subject of sex	Trato de evitar hablar de sexo	.06	**.60**	.41
% variance			28.17	7.65	
Eigenvalue			6.48	1.76	

Note. (R): The socores of these items are reversed. Content coherence is indicated with loadings in bold. The reversal of the scores of the factor No shyness/Refusal implies that higher scores show an absence of sexual shyness, that is, greater sexual assertiveness.

Confirmatory Factor Analysis

AMOS 7.0 software was used to perform a confirmatory factor analysis. Three different models were compared: (1) a one-factor model, justified by the high correlation between both factors and the results obtained in earlier studies (Sierra et al., 2008); (2) a two-factor model from the exploratory factor analysis; and (3) a two-factor model in which Items 12 and 23 were eliminated, since their content did not fit that of the factor No shyness/Refusal and their loadings on the factor Initiation were lower than .30. These models were compared using the generalized least squares procedure. To assess the fitness of the proposed models, a joint assessment of a group of indexes was used (Kline, 2005; Tanaka, 1993). Given that the value of χ^2 is highly influenced by sample size, the χ^2/df ratio was analyzed (Kline, 2005). Moreover, following the recommendations of Jöreskog and Sörbom (1993), the Goodness of Fit Index and Adjusted Goodness of Fit Index were used as absolute indicators of adjustment, since no comparison was made with the independence model (Kline, 2005), and the Root Mean Square Error of Approximation as the best overall fit index (Marsh, Balla, & Hau, 1996). Good fit is shown by values below 3 in the χ^2/df ratio, above .90 in the Goodness of Fit Index and Adjusted Goodness of Fit Index (Hu & Bentler, 1999; Kline, 2005), and below .05 in the Root Mean Square Error of Approximation (Browne & Cudeck, 1993). Table 2 shows the fit indexes of the three models compared. The two-factor model in which Items 12 and 23 were eliminated showed the best fit, as its χ^2/df ratio was lowest and was the only one with values above .90 in the Adjusted Goodness of Fit Index and below .05 in the Root Mean Square Error of Approximation (Browne & Cudeck, 1993). Modification indexes suggested relations between Items 7 and 17, and 9 and 14. Such relations were included in the model given their theoretical consistency (Batista Foguet & Coenders, 2000). Thus, Items 7 and 17 correspond to the same factor (Initiation) and refer to the beginning of sexual communication with one's partner. Items 9 and 14 correspond to the factor No shyness/Refusal and are both related to the inability to reject unwanted sexual contact, as stated by Morokoff et al. (1997). Therefore, 19 items, which clustered into two factors (see Figure 1), were included in the Spanish version of the Hurlbert Index of Sexual Assertiveness.

TABLE 2. Fit indexes of the comfirmatory models compared.

Model	χ2	df	χ2/df	GFI	AGFI	RMSEA
1 factor	488.9*	189	2.58	.905	.884	.057
2 factors of the exploratory factor analysis	460.9*	188	2.45	.910	.890	.054
2 factors eliminating items 12 and 23	320.3*	149	2.14	.931	.912	.048

* $p < .001$.

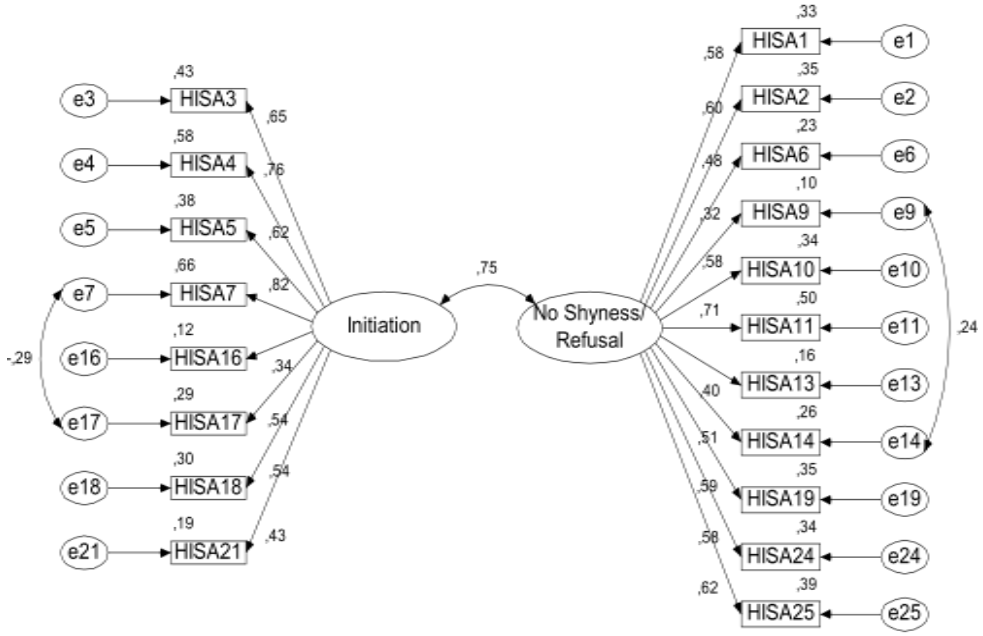

FIGURE 1. Two-factor structure of the Hurlbert Index of Sexual Assertiveness.

Before analyzing the reliability and validity of the Spanish version of the Hurlbert Index of Sexual Assertiveness (19 items clustered into two factors), it was considered that the underlying structure might be showing a methodological artifact rather than the true structure of the scale. As demonstrated in studies with other tests, such as the Hurlbert Index of Sexual Fantasies or the Index of Sexual Satisfaction (Desvarieux, Salamanca, Ortega, & Sierra, 2005; Marsh, 1996; Santos-Iglesias et al., 2009), this artifact consists of separating the positive and negative items of a unidimensional scale into two different factors (Carmines & Zeller, 1979; Marsh, 1996; Morales, 2000). A hierarchical multiple regression analysis of the various criteria (scores on the Social Skills Scale, the abbreviated version of the Dyadic Adjustment Scale, and the subscales of the Questionnaire on Assertion in Couples) was performed. It showed that when the second factor is introduced as a predictor in the model, the change of prediction is significant, except in the Aggression subscale of the Questionnaire on Assertion in Couples, as shown by the *F* change (see Table 3). This result implies that both factors form different constructs.

TABLE 3. Summary of hierarchical multiple regression models.

Criterion/Predictor	R^2	β	Partial r	Semipartial r	R^2 change	F
ASPA Assertion						
1. No shyness/Refusal	.13	.25	.23	.21	.13	119.66*
2 Initiation	.17	.21	.19	.18	.04	31.66*
ASPA Aggression						
1. No shyness/Refusal	.09	-.27	-.23	-.23	.09	75.99*
2 Initiation	.09	-.05	-.04	-.04	.002	1.82
ASPA Submission						
1. No shyness/Refusal	.22	-.39	-.35	-.33	.22	219.74*
2 Initiation	.23	-.14	-.14	-.12	.001	15.42*
ASPA Passive aggression						
1. No shyness/Refusal	.07	-.18	-.16	-.15	.07	61.38*
2 Initiation	.09	-.16	-.15	-.14	.02	17.81*
EAD-13						
1. No shyness/Refusal	.09	.20	.18	.17	.09	75.73*
2 Initiation	.11	.18	.17	.16	.02	21.95*
EHS						
1. No shyness/Refusal	.18	.31	.29	.29	.18	172.02*
2 Initiation	.22	.22	.21	.19	.04	35.15*

Note. ASPA: Questionaire on Assertion in Couples; EAD-13; Spanish abbreviated version of the Dyadic Adjustment Scale; EHS: Social Skills Scale. * $p < .001$.

Internal Consistency Reliability and Convergent Validity

Internal consistency reliability (McDonald's omega) of the global scale was .87, whereas McDonald's omega of both subscales was .83. Convergent validity indicators confirmed the three hypotheses. Indeed, statistically significant positive correlations were found with all the subscales of the Questionnaire on Assertion in Couples, the abbreviated version of the Dyadic Adjustment Scale, and the Social Skills Scale, except with the subscales Aggression, Submission, and Passive aggression of the Questionnaire on Assertion in Couples, which showed negative correlations (see Table 4).

TABLE 4. Pearson correlations between both factors of Hurlbert Index of Sexual Assertiveness and subscales of teh Questionnaire on Assertion in Couples, Dyadic Adjustment Scale, and Social Skills Scale.

Subscale	Initiation	No shyness/Refusal
Questionnaire on Assertion in Couples		
Assertion	.34*	.36*
Aggression	-.19*	-.30*
Submission	-.34*	-.47*
Passive aggression	-.26	-.27*
Dyadic Adjustment Scale		
Consensus	.22*	.22*
Satisfaction	.28*	.33*
Cohesion	.23*	.18*
Social Skills Scale	.39*	.43*

* $p < .001$

Discussion

Sexual assertiveness, as an essential component of people's sexual health (Sierra et al., 2008), has many implications for human sexuality. Therefore, it is important to have appropriate scales to assess this construct. Although there are many measures of sexual assertiveness available in English, no psychometrically adequate scale is available in Spanish. This study has been carried out to assess the internal consistency reliability and construct validity of a Spanish version of the Hurlbert Index of Sexual Assertiveness, the most frequently used sexual assertiveness test (Santos-Iglesias & Sierra, 2010).

First of all, it is important to note that sampling procedure and sample distribution across education do not guarantee a representative sample, and therefore results cannot be generalized to the Spanish population. Nevertheless, results show appropriate psychometric properties of the items. Response means were above the theoretical midpoint of the scale, probably due to the use of nonclinical instead of clinical samples, because the former show higher scores on sexual assertiveness (Pierce & Hurlbert, 1999). In this item analysis, two items (20 and 22) were eliminated from the scale due to problems with item-total correlations and content coherence. It should be noted that these two items also showed the same problems in earlier studies (Sierra et al., 2008).

Results of the exploratory and confirmatory factor analyses show a structure formed by 19 items clustered into two correlated factors, after eliminating six items of the scale. The factor Initiation refers to the ability to initiate sexual activity pointed out by Morokoff et al.

(1997) and the use of behavioral skills to obtain and provide satisfaction in sexual relations (Dunn et al., 1979). The factor No shyness/Refusal refers both to the difficulty starting and maintaining conversations on sexual issues and the inability to reject undesired sexual contact (Morokoff et al., 1997). This two-factor structure is not consistent with the proposal by Sierra et al. (2008) or the original proposal by Hurlbert (1991). However, Hurlbert did not study the dimensionality of the scale. In a later study, Greene and Faulkner (2005) found a structure composed of three highly correlated factors (Initiation, Refusal, and Sexual assertive talk). Although the exact distribution of the items is not known, since it was not a strictly psychometric study, there might be correspondence between the factors Initiation (in Greene and Faulkner and the present study) and between the factors Refusal and Sexual assertive talk, found by Greene and Faulkner, and No shyness/Refusal in this study.

One of the problems raised by this factor structure is that the high correlation observed between both factors may suggest overlap between them and therefore the existence of one single factor. The two-factor structure has been maintained for several reasons. The first one is theoretical, given that the contents included in both factors reflect different components of sexual assertiveness such as the beginning of sexual activity, the rejection of unwanted sexual contact (Morokoff et al., 1997), or the use of behavioral skills to obtain satisfaction in sexual relations (Dunn et al., 1979), given that sexual satisfaction has often been found to be related to the expression of sexual desires (Haavio-Mannila & Kontula, 1997; Hurlbert, 1991; Hurlbert, Apt, & Rabehl, 1993; Hurlbert et al., 2005; Ménard & Offman, 2009). Secondly, the two-factor structure was found using an exploratory factor analysis and confirmed through a confirmatory factor analysis, unlike the one-factor structure, which provides evidence of better fit of the two-factor model to the data. Thirdly, the results of the multiple hierarchical multiple regression model show that after introducing one of the factors as a predictor over one criterion, the second factor is still able to significantly contribute to the percentage of variance explained by the first factor. This suggests the existence of two different factors.

Finally, previous studies performed with sexual assertiveness (Greene & Faulkner, 2005) and other constructs (e.g., social anxiety or gelotophobia) have shown that highly correlated dimensions can form isolated factors (Carretero-Dios, Ruch, Agudelo, Platt, & Proyer, 2010). Finally, results showed an internal consistency reliability of .87 in the global scale. This is slightly lower than the reliability found in earlier studies (Hurlbert, 1991; Schooler et al., 2005; Sierra et al., 2008). Yet, in the present study, the final version of the Hurlbert Index of Sexual Assertiveness was formed by a lower number of items. The

reliability of its two factors was .83, a very adequate value that guarantees that they can be used separately. Likewise, the convergent validity tests confirmed the hypotheses, since positive correlations were found with social skills (Hammond & Oei, 1982; Quina et al., 2000; Salazar et al., 2004), marital adjustment (Epstein, 1981; Hurlbert, 1991; Smolen et al., 1985), and assertion in couples, and negative correlations were found with the subscales Aggression, Submission, and Passive aggression of the Questionnaire on Assertion in Couples (Apt & Hurlbert, 1993).

In short, this 19-item abbreviated version of the Hurlbert Index of Sexual Assertiveness shows a consistent internal structure with adequate indicators of internal consistency reliability and convergent validity. However, this scale should be the subject of further research to verify the stability of its factor structure and the possible invariance of the scale between sexes. It is also highly important to analyze other forms of validity, such as discriminant or predictive validity, and other forms of reliability, such as test-retest reliability. Once again, it should be noted that these results must be interpreted with caution because of the nonrepresentative sample and cannot be generalized to the Spanish population.

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Artículo 3

Equivalence and Standard Scores of the Hurlbert Index of Sexual Assertiveness Across Spanish Men and Women

Santos-Iglesias, P., Vallejo-Medina, P. y Sierra, J.C. (2012). Equivalence and standard scores of the Hurlbert Index of Sexual Assertiveness across Spanish men and women. *Manuscrito sometido a revisión*.

Equivalence and Standard Scores of the Hurlbert Index of Sexual Assertiveness Across Spanish Men and Women

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Abstract.— The purpose of the present study was to analyze the measurement invariance and differential item functioning of the Spanish version of the Hurlbert Index of Sexual Assertiveness across gender. The sample was composed of 1,600 women and 1,598 men from Spain, with ages ranging from 18 to 84 years old. The Hurlbert Index of Sexual Assertiveness showed partial strong invariance for men and women, as items 2, 9, and 13 had different intercept values between groups. The differential item functioning analysis showed that only item 2 ("I feel that I am shy when it comes to sex") flagged moderate uniform differential item functioning. More specifically, women tended to respond "Always" to this item more frequently than did men. Results strongly suggested eliminating those three items (2, 9, and 13), resulting in a final version with 16 items clustered into two dimensions. Standard scores for both Initiation and No Shyness/Refusal reflected traditional sexual scripts for men and women.

Keywords.— Sexual assertiveness. Hurlbert Index of Sexual Assertiveness. Measurement invariance. Differential item functioning. Standard scores.

Sexual assertiveness has been defined in a variety of ways. Painter (1997) stated that sexual assertiveness is the ability to develop assertive behaviors in a sexual context. Dunn, Lloyd, and Phelps (1979) noted that it involves using "behavioral skills to obtain sexual satisfaction for yourself and your partner" (p. 294). Morokoff et al. (1997) provided a clearer picture of sexual assertiveness by stating that it embraces the ability to initiate desired sexual contacts, refuse unwanted sexual contacts, and the ability to prevent pregnancy or STIs with a regular partner. In line with this definition, several studies have explored the relevance of

sexual assertiveness for human sexual life (for a review, see Santos-Iglesias & Sierra, 2010a) and concluded that it helps develop sexual healthy behaviors (e.g., use of condom) and obtain greater sexual satisfaction. Finally, sexual assertiveness training programs help promote positive sexual outcomes and behaviors (Kelly, St. Lawrence, Hood, & Brasfield, 1989; Murphy, Coleman, Hoon, & Scott, 1980, St. Lawrence et al., 1995).

According to the sexual script theory (Simon & Gagnon, 1984, 1986, 2003), men are typically initiators of sexual encounters, while women are supposed to be restrictors of such contacts. Thus, men should score high on initiation sexual assertiveness (i.e., the ability to initiate desired sexual contacts) while women should score high on refusal sexual assertiveness (i.e., the ability to refuse undesired sexual contacts). This traditional sexual script has generated some research to analyze whether men or women scored higher on sexual assertiveness. In general, results have usually found that men scored higher than women on sexual assertiveness (Haavio-Mannila & Kontula, 1997; Pierce & Hurlbert, 1999; Snell, Fisher, & Miller, 1991), although results have been mixed (Stulhofer, Graham, Bozicevic, Kufrin, & Ajdukovic, 2007). For example, Pierce and Hurlbert (1999) interviewed 54 non-clinical individuals and 46 clinical individuals attending sex therapy and showed that men in both clinical and non-clinical samples scored higher on sexual assertiveness than women. On the other hand, Sutlhofer et al. (2007) interviewed a nationally representative sample of young men and women and found that women scored higher than men on sexual assertiveness. These results can be explained by the fact that the studies by Hurlbert et al. and Snell et al. were based on sexual assertiveness scores mostly composed of initiation items, while Stulhofer et al. used refusal assertiveness items (A. Stulhofer, personal communication, March 22, 2011). Moreover, a study by Sierra, Santos-Iglesias, and Vallejo-Medina (in press) showed that, as age increased, initiation sexual assertiveness was higher in men compared to women. These authors also found that refusal sexual assertiveness was higher in women than men regardless of age. These results suggest that sexual assertiveness might follow traditional sexual scripts. They also noted that men and women have usually been compared on the basis of their sexual assertiveness. However, to our knowledge, there is no psychometric evidence, such as measurement invariance or lack of differential item functioning, to allow researchers to make such comparisons using those instruments.

Measurement invariance means that the probability of an observed score does not depend on the person's group membership (Meredith, 1993), that is: "respondents from different groups, but with the same true score, will have the same observed score" (Wu, Li, & Zumbo, 2007, p. 2). This concept implies that measuring constructs with the same instrument

will reflect differences based on the performance/attribute between groups, and not differences based on confounding variables. Differential item functioning (DIF) is related to the conditional probability of answering an item in two or more groups after matching on the underlying ability (Hidalgo & Gómez, 2006; Zumbo, 1999). In the context of sexual assertiveness, for example, measurements should be invariant and show lack of DIF for comparisons between men and women to really reflect differences in sexual assertiveness and not differences based on sexist items or item comprehension, for example. Both procedures are strongly related (Dimitrov, 2010; Holland & Wainer, 1993) and are supposed to be tested together as evidence of validity, especially when test scores are used to compare groups.

The Hurlbert Index of Sexual Assertiveness (HISA; Hurlbert, 1991) is one of the instruments used most frequently to assess sexual assertiveness (Santos-Iglesias & Sierra, 2010a). In its original version, it was composed of 25 items providing an one-dimensional measure of sexual assertiveness in couples. The Spanish adaptation was shortened to a 19-item version clustered into two dimensions: (1) Initiation, which reflects the ability to begin sexual contacts and to express sexual desires and fantasies; and (2) No Shyness/Refusal, which means the difficulty starting and maintaining sexual conversations and the inability to reject undesired sexual contacts (Santos-Iglesias & Sierra, 2010b). Although the HISA has shown adequate psychometric properties (Santos-Iglesias & Sierra, 2010b; Sierra, Santos, Gutiérrez-Quintanilla, Gómez, & Maeso, 2008) and has been used to compare men and women (see Pierce & Hurlbert, 1999), no studies have tested whether its psychometric properties are the same for men and women. Thus, the main aim of the present study was to assess the measurement invariance and DIF of the Hurlbert Index of Sexual Assertiveness across gender using a Spanish sample. Due to the lack of normative data and its potential usefulness for clinical and epidemiological assessments, standard scores were developed for both the Initiation and No Shyness/Refusal subscales for both men and women across three different age groups (18-34, 35-49, and 50 years old or older).

Method

Participants

Participants were recruited from the general population in Spain. The final sample was composed of 1,598 men and 1,600 women, all of them involved in a romantic relationship that included sexual activity at the time of the study. The mean age of men was 39.47 years (*SD* = 13.38, range 18-81), while that of women was 36.98 years (*SD* = 13.41,

range 18-84). Educational level, religion, and frequency of religious practice are reported in Table 1.

TABLE 1. Educational level, religion, and religious practice of both men and women.

Variables	Men		Women	
	n	%	N	%
Educational level				
No education	25	1.6	20	1.3
Primary	274	17.1	267	16.8
Secondary	490	30.7	353	22.1
University	809	50.6	954	59.8
Religion				
Christian	1,135	71.2	1,237	77.6
Islamic	2	0.1	2	0.1
Hindu	1	0.1	3	0.2
Buddhist	2	0.1	3	0.2
None	455	28.5	350	21.9
Religious practice				
Daily	6	0.4	9	0.6
Once a week	67	4.2	119	7.4
Once a month	127	7.9	156	9.8
Once a year	754	47.2	841	52.6
Never	644	40.3	473	29.6

Measures

A background questionnaire was administered to obtain information about sex, age, whether participants were involved on a romantic relationship, whether they had sexual activity with their partners, educational level, religion, and frequency of religious practice.

Hurlbert Index of Sexual Assertiveness (HISA; Hurlbert, 1991). The Spanish version by Santos-Iglesias and Sierra (2010b) was used. It includes 19 items clustered into two factors: Initiation and No Shyness/Refusal. Participants responded using a 5-point Likert scale from 0 (*never*) to 4 (*always*). Higher scores indicated greater initiation assertiveness (Initiation subscale), and lack of shyness and greater refusal assertiveness (No Shyness/Refusal subscale). Santos-Iglesias and Sierra reported an internal consistency of .83 for each factor and .87 for the global scale. It is correlated with the Spanish version of the Sexual Assertiveness Scale (Sierra, Vallejo-Medina, & Santos-Iglesias, 2011) and the Spanish abbreviated version of the Dyadic Adjustment Scale (Santos-Iglesias, Vallejo-Medina, & Sierra, 2009).

Procedure

Participants were recruited from the Spanish general population. A quota convenience sampling method was used to obtain the same number of men and women, distributed across different groups according to age (18-34 years old, 35-49 years old, and 50 years old or older), size of the town or city of residence (a population lesser than 50,000 and greater than 50,000), and geographical area (north and south of Spain). Participants were required to be involved in a stable heterosexual relation with sexual activity for at least 6 months at the time of the study. Testing was conducted individually in different settings by well-trained researchers (public libraries, social centers, and public places). In university classrooms, participants were tested collectively. The purpose of the study was briefly explained to all participants. Verbal informed consent was obtained, and anonymity and confidentiality were guaranteed, as well as the exclusive use of the tests for research purposes.

Data analysis

Measurement invariance was tested using LISREL 8.51 (Jöreskog & Sörbom, 2001) following the procedure described by Wu et al. (2007) for multi-group confirmatory factor analysis (MG-CFA). Four models were assessed: (1) configural invariance constrained the number of factors and the pattern of free and fixed loadings across both groups; (2) weak invariance tested equality of factor loadings across groups; (3) strong invariance tested equality of intercepts for both groups; and (4) strict invariance assumed that residual variances for all items were equal across groups. These four steps were estimated using maximum likelihood. In order to avoid problems with sample size, three main indices were used to assess adjustment: the Root Mean Square Error of Approximation (RMSEA), Non-Normed Fit Index (NNFI), and Comparative Fit Index (CFI). In this context, NNFI and CFI values above .85 and RMSEA values below .08 were used as indicators of good fit (Browne & Cudeck, 1993). Additionally, to assess the fit of nested models –such as the MG-CFA–, changes in the fit indices were examined (Cheung & Rensvold, 2002; Wu, et al., 2007). Cheung and Rensvold (2002) recommended using ΔCFI and proposed $\Delta CFI \leq -.01$ as a good indicator of measurement invariance.

Differential item functioning was tested using discriminant logistic analysis (Hidalgo & Gómez, 2006; Hidalgo & Gómez-Benito, 2010) through SPSS 17.0. A 3-step hierarchical procedure was followed. Step 1 tested the contribution of each subscale score (Initiation and No shyness/Refusal). Step 2 tested whether item score significantly contributed to differences between men and women (dependent variable), and Step 3 tested the interaction between

subscale score and item score. Significance of Step 2 - Step 1 (Step 2 itself) indicated uniform DIF, while significance of Step 3 - Step 2 (Step 3 itself) was considered evidence of non-uniform DIF. Effect size was tested through the increase in Nagelkerke's R^2, so that values up to .035 indicated negligible DIF, values between .035 and .070 showed moderate DIF, and values above .070 indicated large DIF (Jodoin & Gierl, 2001). A stepwise purification procedure was performed for all the items showing DIF. Finally, to analyze the response category in which the DIF did exist, a discriminant logistic analysis using a cumulative probability model was performed on each item showing DIF (Mellenberg, 1995).

Results

Measurement invariance

Measurement invariance started by testing configural invariance. Results showed that the model was the same for men and women (see Table 2). Although the χ^2 value was extremely high due to the large sample size, the NNFI, CFI, and RMSEA showed good fit. Step 2 involved testing whether weak invariance, or factor loading equivalence, was supported. The NNFI, CFI, and RMSEA showed good fit, and the increase in CFI was -.002, indicating good fit for nested models between model 1 and model 2. Step 3 tested strong invariance or equivalence of intercepts across groups. Results showed an increase in the RMSEA and a decrease in the GFI, NNFI, and CFI. Furthermore, changes in the CFI reached .023, which meant that this nested model did not fit the data and therefore that strong invariance was not supported. At this point, the modification indices in the Tau-x matrix were assessed and revealed that items 2, 9, and 13 had large modification values (110.19, 62.58, and 57.39, respectively) and large expected change values too (.149; -.152; and -.149, respectively). This suggested testing strong invariance again without restrictions for these three items. Results showed good fit and a slight non-significant decrease in the CFI (ΔCFI = -.01), which showed support for partial strong invariance (Byrne, Shavelson, & Muthén, 1989). At this point, strict invariance was tested without restrictions for intercepts on items 2, 9, and 13. As shown in Table 2, strict invariance without restrictions for intercepts on items 2, 9, and 13 showed good fit.

TABLE 2. Goodness-of-fit indices for measurement invariance models.

Model	χ2	df	NNFI	CFI	ΔCFI	RMSEA
1. Configural invariance	2,006.75***	305	.890	.902		.059
2. Weak invariance	2,063.30***	322	.894	.900	-.002	.058
3. Strong invariance	2,482.13***	341	.876	.877	-.023	.062

3a. Partial strong invariance[a]	2,231.16***	338	.889	.890	-.01	.059
4. Strict invariance[a]	2,379.52***	357	.885	.880	-.01	.059

Note. [a] Without restrictions on intercepts in items 2, 9, and 13. *** $p < .001$.

Differential item functioning

As shown in Table 3, the only item flagging moderate uniform DIF across gender was item 2 ($\Delta R^2 = .059$; "I feel that I am shy when it comes to sex"). The purification process showed that, after deleting item 2 from the matching score, uniform DIF was still moderate ($\chi^2 = 144.55$, $p < .001$, $\Delta R^2 = .059$). Results of the discriminant logistic analysis performed on response scale categories revealed moderate uniform DIF in response category 4 (*always*) for item 2 ($\chi^2 = 158.56$, $p < .001$, $\Delta R^2 = .065$), indicating that women chose this anchor more frequently than men ($OR = 0.37$).

TABLE 3. Differential item functioning of the Initiation and No Shyness/Refusal subscales.

Scale	Item	Step 2 - Step 1			Step 3 - Step 2		
		$\chi2$	p	ΔR2	$\chi2$	p	ΔR2
Initiation	3	8.75	.003	.003	22.79	< .001	.009
	4	2.53	.11	.001	15.14	< .001	.006
	5	0.35	.55	.000	1.60	.20	.000
	7	1.83	.17	.000	11.19	< .001	.005
	16	7.87	.005	.003	1.20	.27	.000
	17	35.54	< .001	.014	1.81	.17	.001
	18	23.78	< .001	.009	29.81	< .001	.012
	21	2.40	.12	.001	2.74	.10	.001
No Shyness/ Refusal	1	2.72	.09	.001	1.88	.17	.001
	2	145.49	< .001	.059	5.29	.02	.002
	6	1.12	.28	.001	1.16	.28	.000
	9	57.65	< .001	.024	2.09	.14	.001
	10	4.42	.03	.002	4.18	.04	.002
	11	4.79	.02	.002	2.36	.12	.001
	13	44.09	< .001	.018	12.88	< .001	.006
	14	.02	.88	.000	3.55	.06	.002
	19	.30	.58	.000	2.23	.13	.001
	24	.56	.45	.000	6.97	.008	.003
	25	.06	.80	.000	6.10	.013	.003

Standard scores

Standard scores for Initiation and No Shyness/Refusal were created from *z* score transformations due to the violation of normality (see Table 4 and Table 5, respectively). It must be noted that items 2, 9 and 13 were eliminated from the No Shyness/Refusal subscale before calculating standard scores. Results showed that men scored slightly higher on

initiation assertiveness in the 18-34 year-old group, t (1307) = 4.64, $p < .001$, $d = 0.07$. This effect was stronger in the middle-aged group (35-49 years old), t (1059) = 3.15, $p = .002$, $d = 0.19$, and especially stronger in participants 50 years old or older, t (818) = 9.41, $p < .0001$, $d = 0.65$ (see Table 4). Regarding the No Shyness/Refusal subscale, young women scored slightly higher than younger men, t (1307) = -2.28, $p = .023$, $d = 0.12$, but older men scored higher than older women, t (818) = 5.87, $p < .001$, $d = 0.40$ (see Table 5). No significant differences were found between men and women in the middle-aged group.

TABLE 4. Standard scores of the Initiation subscale.

Initiation		Men			Women	
	18-34	35-49	50-	18-34	35-49	50-
M	24.40	22.53	21.62	22.84	21.20	16.73
SD	5.68	6.25	6.96	6.35	7.35	7.86
Cent						
99	32	32	32	32	32	32
95	32	32	32	32	32	30
85	30	29	29	30	30	25
75	29	27	27	28	28	23
65	28	26	25	26	25	21
55	26	24	23	24	23	18
50	25.50	23	23	24	22	16
45	25	22	22	23	20	15
35	23	21	19	21	18	13
25	21	18	17	19	16	10
15	18	16	14	16	13	8
5	13	11	9	10	7	4
1	8.06	6	4	6.08	5	0

TABLE 5. Standard scores of the No Shyness/Refusal subscale.

No Shyness		Men			Women	
	18-34	35-49	50-	18-34	35-49	50-
M	27.28	26.53	25.97	27.80	26.38	23.76
SD	4.37	4.74	4.80	3.89	4.94	5.94
Cent						
99	32	32	32	32	32	32
95	32	32	32	32	32	31
85	31	31	31	31	31	30
75	31	30	30	31	30	29
65	29.95	29	28	30	29	27
55	28	28	27	20	28	26
50	28	27.50	27	29	28	25
45	28	27	26	28	27	24
35	27	25	25	27	25	23
25	25	24	24	26	24	20
15	24	22	21	24	21	18

5	19	18	17	20	16	12.10
1	12	8.70	9.60	14	11	6

Discussion

When assessment instruments are used to compare groups (i.e., cultures, gender, etc.) it is essential for such instruments to operate in the same way for each group (Dimitrov, 2010). The main purpose of the present study was to analyze the measurement invariance and differential item functioning of the Spanish version of the Hurlbert Index of Sexual Assertiveness (Santos-Iglesias & Sierra, 2010b), because it is a construct that has typically been compared across men and women. Results show that, except for items 2, 9, and 13, this scale can be used to compare men and women on the underlying constructs. Therefore, we highly recommend deleting these items from the scale.

Regarding measurement invariance, results show that the model proposed by Santos-Iglesias and Sierra (2010b) is the same for men and women, as proven by the configural invariance test. Furthermore, not only is the structure the same but factor loadings are also equivalent across gender. Strict invariance also showed good fit, so the regression residual variances for all items were the same across groups. Nevertheless, when testing for strong invariance, the present results did not support the same item intercepts for men and women. More specifically, items 2, 9, and 13 showed different intercepts for men and women. Strong invariance was tested again without restricting item 2, 9, and 13 intercept values to be the same across groups. Results showed support for partial strong invariance, which, according to Dimitrov (2010) and Wu et al. (2007) could be an indicator of differential item functioning in such items.

Differential item functioning confirmed measurement invariance results. As mentioned earlier, item 2 showed uniform differential item functioning, which means that men and women have different probabilities of endorsing a response even if they belong to the same attribute level. More specifically, women have a greater probability of responding "Always" to item 2 ("I feel that I am shy when it comes to sex") compared to men. These results are related with traditional sexual scripts and gender-role stereotypes, in which women are supposed to follow traditionally feminine attributes like being sympathetic or shy (Bem, 1974; Holt & Ellis, 1998) and are encouraged not to talk overtly about sex (Quina, Harlow, Morokoff, Burkholder, & Deiter, 2000).

Finally, standard scores are provided. Results of mean scores reveal that assertiveness still follows traditional sexual scripts and gender-role stereotypes, especially among older participants. According to this, men assertively initiate sexual contacts more frequently than women (Haavio-Mannila & Kontula, 1997; Pierce & Hurlbert, 1999; Snell, et al., 1991) because they are supposed to initiate sexual contacts while women are supposed to act as restrictors of such contacts (Simon & Gagnon, 1984, 1986, 2003). In addition, young women scored slightly higher than young men on the No Shyness/Refusal subscale, which indicates that young women are less shy and refuse sexual contacts more often than young men. Regarding older men and women, results reveal that older women are shyer and less able to refuse undesired sexual contacts than older men. These results, although contrary to traditional sexual scripts, are consistent with some gender stereotypes, such as shyness in women (Bem, 1974; Holt & Ellis, 1998) actually show that sexual assertive skills were not traditionally taught to women (Muehlenhard & McCoy, 1991). This is particularly true in the case of Spanish women, who were taught to be "good wives" and comply with their partners' sexual desires in the past (Vázquez García & Moreno Mengíbar, 1997).

Some implications of these results must be noted. First, the factor structure found by Santos-Iglesias and Sierra (2010b) has been replicated in a sample of Spanish men and women, which is an indicator of construct validity of the scale. Second, some items (i.e., 2, 9, and 13) are problematic when the purpose is to compare men and women's factor scores. In such cases, it is highly recommended to eliminate those items and use either the total score or factor scores based on this abbreviated Spanish version, which is finally composed of 16 items clustered into two dimensions. It is also possible to use the Spanish version of the Sexual Assertiveness Scale (Sierra, Vallejo-Medina, et al., 2011), whose equivalence across gender has been proven. Third, standard scores provided here are useful tools for clinicians and applied psychologists who want to assess individuals' sexual assertiveness. Finally, some limitations must be noted. For example, results are based on a non-representative sample with a large proportion of participants with high educational level, which implies that these results cannot be generalized to the entire Spanish population. Second, such results only apply to the Spanish version of the HISA, so no inferences can be made about the original English version.

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Artículo 4

Sexual Victimization Among Spanish College Women and Risk Factors for Sexual Revictimization

Santos-Iglesias, P., & Sierra, J. C. (in press). Sexual victimization among Spanish college women and risk factors for sexual revictimization. *Journal of Interpersonal Violence*.

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Dear Mr. Santos-Iglesias:

It is a pleasure to accept your manuscript entitled "Sexual Victimization among Spanish College Women and Risk Factors for Sexual Revictimization" in its current form for publication in the Journal of Interpersonal Violence.

Thank you for your fine contribution. On behalf of the Editors of the Journal of Interpersonal Violence, we look forward to your continued contributions to the Journal.

Sincerely,
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Sexual Victimization among Spanish College Women and Risk Factors for Sexual Revictimization

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Abstract.— Sexual revictimization is frequent among victims of child sexual abuse. Several variables, such as sexual experience, substance abuse, and sexual assertiveness, have been proposed to explain the link between child sexual abuse and adolescent and adult sexual victimization, although they have typically been tested separately. The main objective of this study was to analyze which of these variables better explains the revictimization phenomenon using a multiple mediation analysis. The study also tested the frequency of sexual victimization experiences in a Spanish sample of college women. Four hundred and two women were interviewed. Results showed that 30.4% of them engaged in undesired sexual contact while almost 4% were victims of rape. The most frequent perpetrators were partners or ex-partners, acquaintances, or dating partners, but not strangers. Finally, the relationship between child sexual abuse and adolescent and adult sexual victimization was mediated by number of consensual sexual partners and sexual assertiveness. Results reflect some cultural differences from previous research.

Keywords.— Sexual revictimization. Sexual experience. Sexual assertiveness. Substance use. Multiple mediation.

Sexual victimization experiences encompass different "violent, coercive, and developmentally inappropriate sexual experiences including incest, rape, and other forms of sexual abuse such as fondling and sexual exposure; use of physical force, authority, or age differentials to obtain sexual contact; and verbally coerced sexual contact" (Greene & Navarro, 1998, p. 590). Previous studies have shown that the female college population is at high risk for sexual victimization (Bureau of Justice Statistics, 2007; Christopher & Kisler,

2004; National Victim Center, 1992; Tjaden & Thoennes, 2000). For example, it has been shown that 13% to 78% of college women have been victims of different forms of sexual victimization that in some cases meet the legal definition of rape (Fisher, Cullen, & Turner, 2000; Kanin & Parcell, 1977; Kirkpatrick & Kanin, 1957; Koss, Gidycz, & Wisniewski, 1987; Koss & Oros, 1982; Muehlenhard & Linton, 1987). In Spain, only a few studies have examined sexual victimization rates among the female college population. Sipsma, Carrobles-Isabel, Montorio Cerrato, and Everaerd (2000) revealed that 33.2% of college women had been victims of some form of sexual victimization and 3.2% had been raped. Fuertes et al. noted that 30.9% and 42.7% of college women had been sexually coerced or sexually victimized, respectively (Fuertes, Ramos, Martínez, López, & Tabernero, 2006; Ramos, Fuertes, & De la Orden, 2006). Regarding perpetrators, research studies have consistently found that partners and new acquaintances are more frequent perpetrators than strangers (Koss, Dinero, Seibel, & Cox, 1988; Krahé, Scheinberger-Olwig, Waizenhöfer, and Kolpin, 1999). In Spain, these issues have only been explored by Ramos et al. (2006), who found that 24% were victimized by a friend, 17% were victimize by a partner, and 16% were victimized by a new acquaintance.

Regarding risk factors, past research proposed child sexual abuse (CSA) as the main risk factor for adolescent or adult sexual victimization (AASV) –known as the revictimization hypothesis– (Messman & Long, 1996). For example, Barnes, Noll, Putnam, and Trickett (2009) found that female victims of CSA were 1.99 times more likely than females who had not experienced CSA to be sexually revictimized as adults. In a meta-analytic review, Roodman and Clum (2001) found an overall effect size of .59 regarding sexual revictimization. Many other studies have shown similar results (for a review, see Arata, 2000; Classen, Palesh, & Aggarwal, 2005; Messman & Long, 1996; Muehlenhard, Highby, Lee, Bryan, & Dodrill, 1998; Roodman & Clum, 2001). A number of variables have been proposed to explain why women who have experienced CSA are at increased risk for sexual victimization in adolescence and young adulthood. Muehlenhard et al. (1998) suggested that the relationship between CSA and adolescent and adult sexual victimization (AASV) might be mediated by third variables, such as sexual experience, sexual assertiveness, and substance use prior to sex.

First, regarding sexual experience, it has been proposed that the number of consensual sexual partners mediates the relationship between CSA and AASV. That is, women who have experienced CSA have a larger number of consensual sexual partners, which in turn increases the risk for AASV. This is because the higher the number of sexual partners, the greater the

probability of finding an aggressive one (Muehlenhard et al., 1998). This has been supported by the results of several studies. For example, Arata (2000) discovered that consensual sexual behavior mediated the relationship between CSA and sexual revictimization, and Krahé et al. (1999) also found that both number of intercourse partners and number of non-intercourse partners mediated between CSA and AASV. This effect has also been supported by studies assessing the role of early consensual sexual activity as a mediator between CSA and AASV. Fergusson, Horwood, and Lynskey (1997) found that CSA was associated with early consensual sexual activity, and early sexual activity was related to adolescent sexual victimization. Himelein, Vogel, and Wachowiak (1994) found that age of first consensual experience was related to both CSA and AASV, although they did not strictly test mediation.

Sexual assertiveness has also been proposed as a mediator between CSA and AASV. In this regard, Russell (1986) stated that child sexual abuse "socializes a child into the role of a victim... [leaving her] less able to muster the confidence and assertiveness required to reject unwanted sexual advances from others" (p. 169). Finkelhor (1984) also stressed the significance of lack of sexual assertiveness and suggested that CSA victims "... also lack assertiveness to short-circuit at an early stage encounters where they sense some risk" (p. 194). Although this hypothesis has existed for a long time and has a very intuitive appeal (Livingston, Testa, & VanZile-Tamsen, 2007), to date we have only found two studies examining the mediator role of sexual assertiveness (Greene & Navarro, 1998; Livingston et al., 2007). Neither study found that sexual assertiveness mediated the relationship between CSA and AASV, basically because CSA did not predict low sexual assertiveness. However, this hypothesis was tested using the causal steps approach to assess mediation. Compared to the differences in coefficients and the product of coefficients approach, this approach is known to have less power to detect mediation effects (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002).

Substance use may also mediate between CSA and AASV (Muehlenhard et al., 1998). Various studies have shown that CSA is a risk factor for substance use (see Muehlenhard et al., 1998) and substance use is a risk factor for AASV (Fisher & Cullen, 2006; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Moreover, Kilpatrick et al. (1997) found that revictimization in women was mediated by alcohol and substance consumption together. In this context, it is also relevant to examine substance abuse prior to sex. For example, Testa et al. (1999) demonstrated this effect with alcohol. They found that women who had been raped or coerced into sex reported higher frequency of alcohol consumption in conjunction with sexual activity. Furthermore, Livingston, Hequembourg, Testa, and VanZile-Tamsen (2009)

found that substance abuse prior to sex was a common risk factor for sexual victimization. Thus, it would be interesting to explore whether substance use prior to sex can mediate the relationship between CSA and AASV.

Most of these previous studies tested mediation effects individually (Fargo, 2009). However, it is important to test all of these potential mediation effects together for several reasons. First, the relationship between an independent variable and an outcome is usually mediated by more than one single variable (Preacher & Hayes, 2008a). For example, Livingston et al. (2007) recognized that sexual assertiveness "is not the only mechanism through which sexual revictimization occurs" (p. 310) and added that other mechanisms should be considered as well. Along the same lines, Ullman (2003) suggested the need to simultaneously test the relevance of different mediators between child and adult sexual assault. In fact, testing each mediator individually limits our understanding of the multiple pathways by which CSA enhances women's risk for AASV. In contrast, including all these mediators in one model provides a test of the total indirect effect (all mediators taken together) as well as specific indirect effects (the independent contribution of each mediator) (Preacher & Hayes, 2008b). This also makes it possible to test differential effect sizes between specific indirect effects and thus to analyze which variables or effects are most plausible (Preacher & Hayes, 2008a).

As we mentioned, little is known about rates of sexual victimization experiences and risk factors for sexual revictimization among Spanish college women. Moreover, most studies on sexual revictimization have been performed in the United States, so the present study has the potential to further our understanding about cultural differences regarding the revictimization phenomenon. Thus, the main objective was to analyze which variables mediate the relationship between CSA and AASV using a multiple mediation test (Preacher & Hayes, 2008a) in a Spanish sample of college women. The study simultaneously assessed the mediation effect of sexual experience (both number of consensual sexual partners and age of onset of consensual sex), substance use before sexual intercourse, and sexual assertiveness, following the model depicted in Figure 1. The second objective was to analyze rates of sexual victimization experiences in a Spanish sample of college women. Specifically, the present study analyzed rates of undesired sexual contacts, sexual coercion, attempted rape, and rape, as well as the frequencies of each experience committed by different kinds of perpetrators (i.e., stranger, acquaintance, occasional date, and partner or ex-partner).

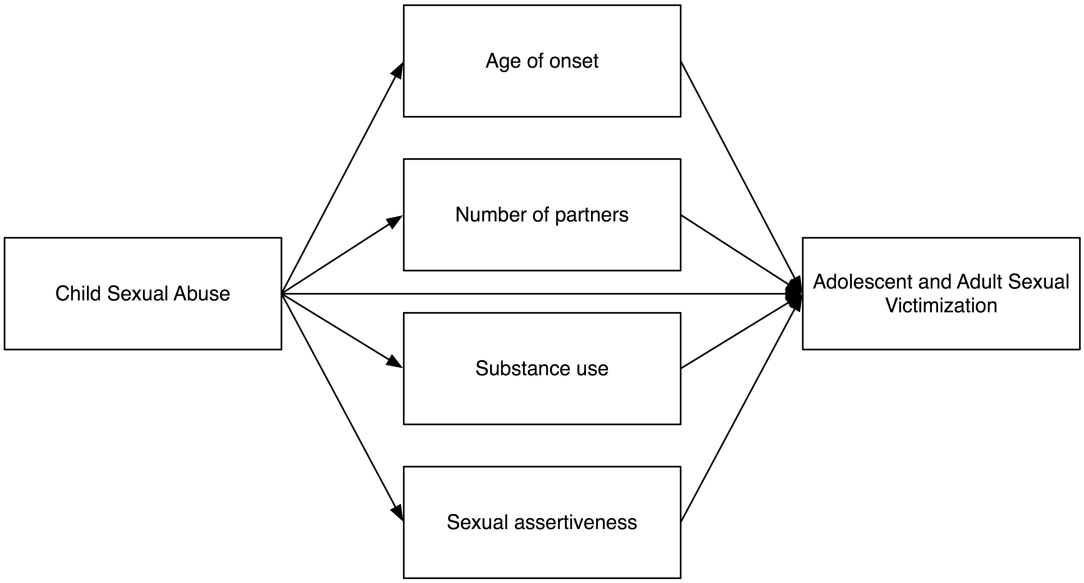

FIGURE 1. Path diagram of the full multiple mediation model.

Method

Participants

The sample was composed of 402 women recruited in 13 different schools of a major Spanish university. The age of participants ranged from 18 to 24 years old (M = 20.82; SD = 1.60). Among participants, 73.3% were Catholic (n = 293), 24.8% (n = 99) reported no religious beliefs, and 2.2% (n = 8) reported other religions. A total of 62% of participants were currently involved in a romantic relationship; 94.3% were heterosexual, 2% were homosexual, and 3.7% were bisexual.

Materials

A socio-demographic background questionnaire assessed age, religion, and sexual orientation of participants and whether they were currently involved in a romantic relationship.

Sexual assertiveness. The study used the Refusal subscale of the Spanish validation of Morokoff's Sexual Assertiveness Scale (Sierra, Vallejo-Medina, & Santos-Iglesias, 2011). The subscale is comprised of six items aimed at assessing the ability to refuse undesired sexual contacts using a 5-point Likert scale from 0 (*never*) to 4 (*almost always*). Higher scores indicate greater sexual assertiveness. Morokoff et al. (1997) reported internal consistency values from .71 to .80. Sierra et al. reported an omega value of .76. Validity

evidence showed positive correlations with the No Shyness/Refusal subscale of the Spanish Hurlbert Index of Sexual Assertiveness (Santos-Iglesias & Sierra, 2010b). In the present study, Cronbach's alpha reached .66.

Sexual experience. Two questions were used to assess sexual experience. The first one assessed the age of onset of consensual sexual intercourse (anal or vaginal) ("At what age did you have sexual intercourse for the first time?"). The second one assessed the number of consensual sexual partners since that age of onset ("With how many different consensual partners have you engaged in sexual intercourse?").

Substance use prior to sex. Frequency of substance use prior to sex was assessed through one question: "In general, when you engage in sexual intercourse (anal or vaginal) how often do you use any kind of drug or substance before having sex?" Participants responded using a 5-point Likert scale from 1 (*never*) to 5 (*always*).

Child sexual abuse (CSA). The Sexual victimization subscale of the Spanish translation (Pereda, Gallardo-Pujol, & Forero, 2008) of the Juvenile Victimization Questionnaire (JVQ; Hamby, Finkelhor, Ormrod, & Turner, 2005) was used. Given that contact CSA has a stronger relationship with revictimization (Roodman & Clum, 2001), we decided to include only 4 items assessing offenses involving sexual contact that occurred during childhood. Participants responded using a 6-point Likert scale from 0 (*never*) to 5 (*5 times or more*). A total score was computed, with higher scores indicating higher frequency of CSA. Finkelhor, Hamby, Ormrod, and Turner (2005) found moderated correlations with trauma symptoms (anxiety, depression, and anger). They also reported good test-retest and high internal consistency reliability. Following the Spanish penal code (*Título VIII Cap. II. De los abusos sexuales, art. 181/2*), CSA was defined as sexual abuse experienced before the age of 13 years.

Adolescent and adult sexual victimization (AASV). The Sexual Experiences Survey (SES; Koss & Oros, 1982) was used. It is composed of ten items aimed at assessing sexual victimization experienced after the age of 14 years , and considers four different subtypes of victimization experiences: a) sexual contact, which means having engaged in sexual contact (kissing, fondling, etc.) without penetration when the woman did not want it, using pressure, drugs or alcohol and threatening or using force; b) sexual coercion, which involves having had sexual intercourse without a woman wishing it, by means of verbal pressure or use of authority; c) attempted rape, which involves having attempted to have coitus without a woman wishing it, using alcohol or drugs and threatening with the use of force or using it; and d) rape, which means having engaged in coitus when the woman did not want to, using

alcohol/drugs and threatening or using force. In the present study, participants were asked about the frequency of experiencing each item using a Likert-type scale from 0 (*never*) to 5 (*5 times or more*) since the age of 14 years. A global score was computed by summing up each item frequency, which indicates the number of times the participant was victimized. Koss et al. reported an internal consistency index of .79 and good test-retest reliability after one week. After each question, an extra item was added asking who perpetrated each experience: a stranger (i.e., totally unknown person), an acquaintance (i.e., someone the victim knows but does not have an intimate relationship with), an occasional date (i.e., someone the victim has recently met and is involved to some degree of intimacy with), or a partner or ex-partner (i.e., a current partner or ex partner).

Procedure

Participants were recruited from various schools of the university. One lecturer from each school was randomly selected from all possible departments at the university. The lecturers were contacted by e-mail, given information about the study, and asked for permission to attend one of their lectures to assess the female students. After obtaining permission, the researchers attended the lectures and asked the male students to leave the classroom. Once only female students were left in the classroom (the lecturer was not present either), the aim of the study was briefly explained and female students were asked for their anonymous and confidential collaboration. These students had the option to refuse (only three students declined to participate) and no incentives were given to those who decided to participate. Questionnaires did not include information that could identify participants, and participants were asked to put them all together in a box once the questionnaires had been completed. Finally, participants were debriefed and students were given the researchers' contact details to ask any questions or share any concerns about the topic of the study.

Results

As can be seen in Table 1, the most frequent sexual victimization experiences were sexual contact (30.4%), followed by sexual coercion (19.1%), attempted rape (3.9%), and rape (3.4%). The most frequent perpetrators were ex/current partners in the case of sexual contact and sexual coercion, acquaintances in attempted rape, and dating partners in rape. Descriptive statistics in Table 2 show that the mean age of onset of sexual intercourse was nearly 17 years old, while the mean number of partners was 3.57. Sexual assertiveness scores

were high, while those of child sexual abuse were very low. Most participants reported no substance use prior to sex.

TABLE 1. Frequency and percentage of each sexual victimization experience and perpetrators.

Sexual victimization		n	%	Perpetrator	n	%
Sexual contact	Yes	125	30.4	Stranger	4	3.2
				Acquaintance	27	21.6
				Dating partner	30	24
				Ex/Current partner	64	51.2
	No	286	69.6			
Attempted rape	Yes	16	3.9	Stranger	2	15.4
				Acquaintance	7	53.9
				Dating partner	3	23
				Ex/Current partner	1	7.7
	No	397	96.1			
Sexual coercion	Yes	79	19.1	Stranger	1	1.5
				Acquaintance	5	7.7
				Dating partner	12	18.5
				Ex/Current partner	47	72.3
	No	334	80.9			
Rape	Yes	14	3.4	Acquaintance	5	35.7
				Dating partner	6	42.8
				Ex/Current partner	3	21.5
	No	399	96.6			

TABLE 2. Descriptive statistics for all variables in the study.

Variables		Scale range	Observed range		M	SD
			min	Max		
Sexual experience	Age of onset	--	7	21	16.85	1.67
	No. of partners	--	1	50	3.57	4.72
Substance use		1-5	1	5	1[a]	0.53
Sexual assertiveness		0-24	2	24	17.18	4.40
Child sexual abuse		0-20	0	5	0.12	0.50

Note. [a] = Median

At the same time, a test was conducted to determine which variables mediated the relationship between CSA and AASV. Table 3 shows a correlation among variables. Because age of onset of consensual sexual intercourse was not related either to CSA or to AASV, it was decided not to include this variable in subsequent analyses. A multiple mediation analysis was run following the bootstrapping procedure described and recommended by

Preacher and Hayes (2008a) using SPSS 17.0. CSA was entered as a predictor variable. Global score on the SES was used as an indicator of AASV (criterion). Number of partners, substance use, and sexual assertiveness were introduced as mediators. Five thousand bootstrap samples were extracted using the BCa procedure with a 95% confidence interval. Results showed that higher frequency of CSA was associated with higher number of partners (B = 2.57, t = 4.91, p < .001), more substance use prior to sex (B = .12, t = 2.09, p = .03), and lower sexual assertiveness (B = -1.22, t = -2.49, p = .01). In addition, higher number of partners (B = .06, t = 1.97, p = .05) and lower sexual assertiveness (B = -.08, t = -2.60, p = .009) were associated with higher frequency of AASV. The total (c path) and direct (c' path) effects of CSA on sexual victimization were 1.33 (t = 4.67, p < .001) and 1.04 (t = 3.58, p = .004), respectively. Thus, the total indirect effect of the four mediators was .28 (Z = 2.85, p = .004), which led to the conclusion that these mediators taken as a whole mediated the relationship between CSA and AASV. A closer examination of specific indirect effects showed that number of partners (95% bootstrap CI: .002 - .589) and sexual assertiveness (95% bootstrap CI: .016 - .285) individually mediated that relationship. This model (see Figure 2) had a R^2_{adj} of .09, F (4, 344) = 9.23, p < .001.

TABLE 3. Pearson correlations among variables in the multiple mediation model.

	1	2	3	4	5	6
1. CSA	1					
2. Age of onset	-.04 n.s.	1				
3. Number of partners	.21***	-.35***	1			
4. Sexual assertiveness	-.13**	.009 n.s.	-.07 n.s.	1		
5. Substance use	.08 n.s.	-.16**	.24***	-.02 n.s.	1	
6. AASV	.30***	-.08 n.s.	.18**	-.17**	.13**	1

Note. n.s. = non-significant, ** p < .01, *** p < .001

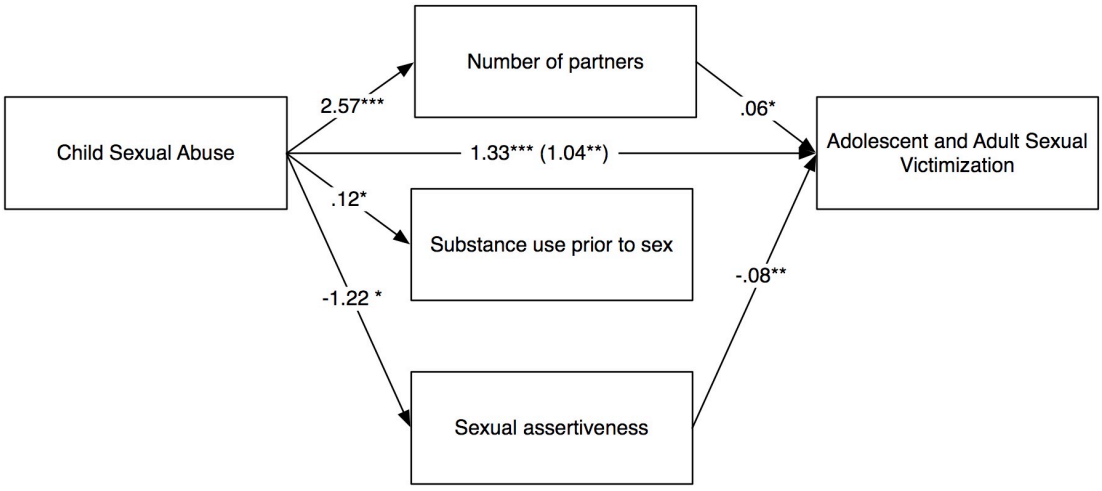

FIGURE 2. Path diagram of the multiple mediation model (The c' path is shown between brackets. * p < .05, ** p < .01, *** p < .001)

Discussion

The present study was performed to analyze a series of mediators between child sexual abuse and adolescent and adult sexual victimization. It also explored the frequency of sexual victimization experiences in a sample of Spanish college women. Results showed that number of partners and sexual assertiveness mediate the relationship between CSA and AASV, that is, victims of CSA have a higher number of partners and lower sexual assertiveness, which in turn makes them more vulnerable to experiencing AASV. Results also showed high rates of victimization experiences, particularly in the case of undesired sexual contacts and sexual coercion.

The results obtained in this study show high rates of sexual victimization that are similar to those found in previous studies in Spain (Ramos et al., 2006; Sipsma et al., 2000), except for sexual coercion. In this case (i.e., sexual coercion) our results are more similar to those found in the United States (see Testa, Livingston, & VanZile-Tamsen, 2005; Testa, VanZile-Tamsen, Livingston, & Koss, 2004). It is also important to note the difference in rates of rape and attempted rape between the United States and Spain, which call for differences in traditional sexual scripts between the two cultures, that is, those different expectations for men's and women's behavior and attitudes in sexual situations that make men to be more oversexed, aggresive, instrumental and taught not to accept a "no" for an answer in comparison to the unassertive and passive women, "who is trying to protect her worth by restricting access to her sexuality while still appear interested in sex" (Byers, 1996, p. 11). For example, it seems that the token refusal myth (i.e., belief that a women desires sex

even after saying "no") is hardly accepted by Spanish students in comparison to American students (Fuertes et al., 2005; Sipsma et al., 2000), which may lead to differences in victimization, because American men would continue to pursue their sexual needs by using strategies to overcome women's initial reluctance. Although this may be due to a difference in traditional sexual scripts endorsement, it could be due to a difference in reporting caused by social desirability (Testa, et al., 2005) or perhaps some questions of the Spanish adaptation of the SES have been interpreted in a different way with respect to the original scale (Fuertes et al., 2005). Regarding perpetrators, as shown by previous studies in Spain, the United States, and Europe, the present results show that strangers are less frequent perpetrators (Koss et al., 1988; Krahé et al., 1999) while partners/ex-partners and acquaintances are more frequent offenders (Koss et al., 1988; Krahé et al., 1999; Ramos et al., 2006). These results dismiss the myth of the batterer as a male stranger (Arata, 2000; Koss et al., 1994).

A multiple mediation test was run to analyze which variables mediate between child sexual abuse and adolescent and adult sexual victimization, as a way to explain the revictimization hypothesis (see Muehlenhard et al., 1998). Results showed that higher frequency of CSA, higher number of consensual sexual partners, and lower sexual assertiveness were associated with higher frequency of AASV, as found in previous research (Arata, 2000; Barnes et al., 2009; Greene & Navarro, 1998; Krahé et al., 1999; Livingston et al., 2007; Messman & Long, 1996). This means that both child sexual abuse and number of sexual partners are risk factors for AASV, while sexual assertiveness is a protective factor for sexual victimization (see Santos-Iglesias & Sierra, 2010a). Child sexual abuse was found to increase the risk for substance use prior to sex and the number of sexual partners (Krahé, 1998; Muehlenhard et al., 1998) and to decrease sexual assertiveness (Miner, Flitter, & Robinson, 2006; Morokoff et al., 1997, VanZile-Tamsen, Testa, & Livingston, 2005). Thus, according to the causal steps procedure to test mediation (see MacKinnon et al., 2002), number of consensual sexual partners and sexual assertiveness were able to mediate between CSA and AASV. Mediation results confirmed that number of consensual sexual partners mediated between CSA and AASV, as found by previous research (Arata, 2000; Krahé et al., 1999). Surprinsingly, sexual assertiveness also mediated between CSA and AASV. It should be noted that previous research (Greene & Navarro, 1998; Livingston et al., 2007) did not found this mediation effect and that such differences may be due to methodological and cultural factors. First, studies by Greene and Navarro (1998) and Livingston et al. (2007) assessed mediation with a causal steps approach, which is less powerful to find statistical effects than the product of coefficients approach used in the present study (MacKinnon et al.,

2002). Second, as mentioned above, American students have been found to endorse the traditional sexual script more than Spanish ones. Therefore, lower sexual assertiveness is only a risk factor for AASV, and then female American students may feel obliged to fulfil their partners' sexual needs (VanZile-Tamsen et al., 2005) instead of protect her worth and restrict access to her sexuality (Byers, 1996). Lack of sexual assertiveness in American students depends on traditional sexual scripts that make women less able to directly refuse undesired sexual contact. In Spain, however, lower sexual assertiveness is associated with higher frequency of CSA, it does not depend on the traditional sexual script as it does in the United States, and therefore can – and actually does – mediate between CSA and AASV.

Substance use did not work as a mediator. CSA was found to predict higher substance use, but substance use did not predict AASV. Similar results have been found when testing for alcohol consumption as a mediator; Gidycz, Hanson, and Layman (1995) and Merrill et al. (1999) found that alcohol consumption did not mediate the relation between CSA and AASV.

Although these results are interesting, some limitations must be noted. First, prospective designs rather than cross-sectional ones are preferred for testing the revictimization hypothesis. Prospective designs are useful to analyze whether the predictor has a truly adverse effect on criterion variables (Livingston et al., 2007), which means that previous events have an adverse effect on later ones. However, although prospective designs are preferred, CSA assessments are typically retrospective in this kind of studies. Second, the sample only included college women. Previous research using these samples has been the target of severe criticism (Muehlenhard et al., 1998), because the broader and more representative samples are used, the fewer generalization problems emerge. Third, the amount of variance of AASV accounted for by these variables is low, which suggests the need to include more variables (e.g., alcohol abuse, rape-supportive attitudes) in future research. These limitations suggest other directions for research. First, it would be interesting to carry out a prospective study to assess multiple mediators. This would provide certainty that both predictor and mediation effects are temporarily consistent. Second, more sexual victimization assessments should be made. This would probably show, for example, that sexual assertiveness mediates between more recent victimization events (Greene & Navarro, 1998; Livingston et al., 2007) over and above more distant ones. Finally, more representative samples should be used in future research so that the results can be generalized to the general population.

Finally, we wish to conclude that the present study contributes substantially to the literature on revictimization, given that different mediators were simultaneously tested on the same model. Moreover, the presence of a cultural component and the comparisons made between Spain and the United States provide a different picture of the risk factors for sexual revictimization in Spain and show that it may be useful to train and increase sexually assertiveness skills in health promotion interventions.

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Artículo 5

Predictors of Sexual Assertiveness: The Role of Sexual Desire, Arousal, Attitudes, and Partner Abuse

Santos-Iglesias, P., Sierra, J. C. y Vallejo-Medina, P. (in press). Predictors of sexual assertiveness: The role of sexual desire, arousal, attitudes, and partner abuse. *Archives of Sexual Behavior*.

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February 5, 2012

Pablo Santos-Iglesias, Ph.D.
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SPAIN

Dear Dr. Santos-Iglesias,

RE: MS# ASEB-11-223R.2

I have now reviewed the second revision of your manuscript, "Predictors of Sexual Assertiveness: The Role of Sexual Desire, Arousal, Attitudes, and Partner Abuse," and assess that you have adequately addressed reviewer and editor concerns,

The manuscript is now accepted for publication with the proviso that you attend to the following grammatical/stylistic issues before submitting the final draft. Please make changes/additions as requested.

Introduction

Page 3 - Line 7 - should be <communication about sexual issues>
Page 3 - Line 8 - should be <and form the construct of sexual assertiveness>
Page 3 - Line 9 - almost no correlations are perfect so you may want to say <correlations among these components are not always high>
Page 3 - second paragraph - first sentence - edit as follows: A recent systematic review has shown that the construct of sexual assertiveness is relevant to our understanding of sexual behavior as it is related to better...>
Page 4 - second paragraph - second line - replace <amount> with <number>
Page 4 - second paragraph - second to last line - replace <STD> with <STI>
Page 5 - last paragraph - Delete <This required setting the following bases:> and

Predictors of Sexual Assertiveness: the Role of Sexual Desire, Arousal, Attitudes, and Partner abuse

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Abstract.— This study was conducted to test interpersonal, attitudinal, and sexual predictors of sexual assertiveness in a Spanish sample of 1,619 men and 1,755 women aged 18-87 years. Participants completed measures of sexual assertiveness, dyadic and solitary sexual desire, sexual arousal, erection, sexual attitudes, and frequency of partner abuse. In men, higher sexual assertiveness was predicted by less non-physical abuse, more positive attitudes toward sexual fantasies and erotophilia, higher dyadic desire, and higher sexual arousal. In women, higher sexual assertiveness was predicted by less non-physical abuse, less solitary sexual desire and higher dyadic sexual desire, arousal, erotophilia, and attitudes towards sexual fantasies. Results are discussed in the light of prevention and educational programs that include training in sexual assertiveness skills.

Keywords.— Sexual assertiveness. Sexual desire. Sexual arousal. Sexual attitudes. Partner abuse.

Sexual assertiveness is a social skill that involves exhibiting assertive behaviors in sexual situations (Painter, 1997). Morokoff et al. (1997) argue that it consists of three different components: the ability to initiate desired sexual activity, refuse unwanted sexual contact, and discuss the use of contraceptive methods to avoid unwanted pregnancies and sexually transmitted infections. Other authors such as Hurlbert (1991, see also Santos-Iglesias & Sierra, 2010b) include components related to initiation of sexual activity, refusal of unwanted contact, and communication about sexual issues. These components are interrelated and form the construct of sexual assertiveness. Yet, the fact that correlations

among these components are not always high (see Morokoff et al., 1997; Sierra, Vallejo-Medina, & Santos-Iglesias, 2011) may suggest, for example, that an individual who is assertive in initiation of contact may not be assertive in refusal of unwanted sexual activity.

A recent systematic review has shown that the construct of sexual assertiveness is relevant to our understanding of sexual behavior as it is related to better sexual functioning, fewer sexual victimization experiences, and less risky sexual behavior (see Santos-Iglesias & Sierra, 2010a). Thus, sexual assertiveness facilitates the attainment of sexual goals, such as sexual autonomy and satisfaction (Dunn, Lloyd, & Phelps, 1979), and protects individuals from unsafe sexual practices. According to traditional sexual roles (Simon & Gagnon, 1984, 1986, 2003), men and women should differ in sexual assertiveness (i.e., men being more sexually assertive) because sexual scripts tend to dictate that men initiate sexual contact and women respond to these initiations. In a recent study, Santos-Iglesias, Vallejo-Medina, and Sierra (2012) found that men reported greater ability to initiate sexual contacts than women did. In contrast, only older women reported lower ability to reject undesired contacts and more sexual shyness (i.e., talking overtly about sexual topics). These results imply that women and individuals who are less sexually assertive will be less likely to express their sexual interests and will experience more unwanted sex (Morokoff et al., 1997).

Predictors of Sexual Assertiveness

In most cases, predictors of sexual assertiveness have been studied in isolation. In other words, there is evidence of a large number of constructs related to sexual assertiveness explored separately but there have been few attempts to build a predictor model of sexual assertiveness. Consequently, the present study aimed to overcome this limitation and include the results of various studies in a single model. To the best of our knowledge, only Morokoff et al. (1997) have attempted to design a comprehensive model to predict sexual assertiveness. They did so using the Multifaceted Model of HIV Risk (Harlow, Quina, Morokoff, Rose, & Grimley, 1993). According to this study (Morokoff et al., 1997), sexual assertiveness can be explained using attitudinal, behavioral, and interpersonal variables. Their results indicated that individuals who were more sexually assertive reported less sexual victimization, were less likely to anticipate a negative partner response, and had more sexual experience and higher self-efficacy for STI-preventive behaviors. However, this study was limited to a female sample and did not explore sexual responses.

Previous studies partially support the findings of Morokoff et al. (1997). In general terms, people with traditional sexual attitudes have shown lower levels of sexual

assertiveness. More specifically, some studies have found that people who report higher erotophilia show greater sexual assertiveness (Hurlbert, Apt, & Rabehl, 1993; Sierra, Santos, Gutiérrez-Quintanilla, Gómez, & Maeso, 2008; Snell, Fisher, & Miller, 1991). Similar results have been obtained with more specific sexual attitudes such as positive attitudes toward condom use (Treffke, Tiggemann, & Ross, 1992) and attitudes toward menstruation (Schooler, Ward, Merriwether, & Caruthers, 2005). All these results support the idea that general sexual attitudes (i.e., erotophilia) as well as more specific ones (i.e., attitudes toward condom use or attitudes toward menstruation) are relevant to sexual assertiveness. Therefore, including both general and specific sexual attitudes may be useful to predict sexual assertiveness.

Regarding interpersonal variables, studies have shown that women with a history of partner abuse are less sexually assertive (Apt & Hurlbert, 1993; Sierra, Ortega, Santos, & Gutiérrez, 2007; Stoner et al., 2008). For example, Apt and Hurlbert (1993) compared 60 women who experienced partner abuse and 60 who did not and found that women in abusive marriages reported less sexual assertiveness.

Objectives of the Present Study

The main objective of the present study was to examine predictors of sexual assertiveness in a sample of Spanish men and women while overcoming some of the limitations of past research. First, we strove to develop a multivariate predictive model of sexual assertiveness; second, we included a sample of both men and women; and lastly we investigated aspects of the sexual response as possible predictors of sexual assertiveness. Our results may help us understand the nature of sexual assertiveness and why some individuals are at increased risk of unwanted sex and/or risky sexual behaviors.

Following the guidance of Morokoff et al. (1997), the present study proposed a series of predictors clustered into three categories: sexual attitudes, interpersonal variables, and components of the sexual response. Attitudinal variables included general sexual attitudes (i.e., erotophilia) and specific attitudes such as attitudes toward sexual fantasies. Instruments to assess sexual assertiveness have considered the sharing of sexual fantasies with one's partner to be an example of sexual assertiveness (Hurlbert, 1991). In regard to interpersonal variables, abuse in intimate relationships was included as a predictor variable, as per Hurlbert et al. (1993). Finally, sexual desire and arousal – and erection in men – were included as predictors, since high levels of desire and arousal can lead to sexually assertive behaviors to satisfy such urges (Matsuura, 2008). In support of this contention, Hurlbert (1991) showed

that sexually assertive women in his sample reported greater sexual desire compared to sexually nonassertive women. Regarding sexual arousal, Hurlbert et al. (1993) interviewed 98 married women and found that sexual assertiveness was positively correlated with sexual excitability and Murphy et al. (1980) found that women increased their sexual arousability after a sexual assertiveness training program.

Thus, based on previous research, we predicted that greater erotophilia and attitudes toward sexual fantasies (i.e., attitudinal variables), greater sexual arousal, sexual desire and erection in the case of men (i.e., sexual responses), and lower frequency of partner abuse would be related to greater sexual assertiveness. The criterion variables used were Initiation assertiveness and No shyness/refusal assertiveness included in the scale developed by Hurlbert (1991; see also Santos-Iglesias & Sierra, 2010b).

Method

Participants

The sample consisted of 1,619 men and 1,755 women from the general Spanish population. The mean age of men was 41.02 years (*SD* = 13.39; range 18-87) and that of women was 38.09 years (*SD* = 13.84; range 18-79). All participants were involved in a romantic relationship at the time of the study and had sexual activity with their current partners. Approximately half of men and women (50.1% and 57.6%, respectively) reported some university education. Thirty percent of men and 22% of women reported secondary education, while around 18% of men and women reported elementary education. Only 2% of men and women reported no formal education. Most participants (71.1% of men and 78.4% of women) were Catholic, and 28.7% of men and 21% of women reported no religious beliefs. Finally, about 50% (45.8% of men and 51.2 of women) practiced religion once a year, and more men (40%) than women (29%) did not practice religion.

Measures

Background socio-demographic questionnaire. This questionnaire gathered information on participants' gender, age, relationship status, sexual activity with their partner, educational level, religion, and frequency of religious practice.

Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991). The Spanish version by Santos-Iglesias, Vallejo-Medina, et al. (2012) was used. It is composed of 16 items clustered into two factors: Initiation and No shyness/Refusal (Santos-Iglesias & Sierra, 2010b). Initiation refers to the ability to begin sexual contact and to express sexual desires and

fantasies to one's partner (e.g., "I approach my partner for sex when I desire it"; "I enjoy sharing my sexual fantasies with my partner"). No shyness/Refusal refers to the ability to start and maintain conversations on sexual issues and reject undesired sexual contact (e.g., "I feel that I am shy when it comes to sex"; "It is hard for me to say no even when I do not want sex"). Participants responded using a 5-point Likert scale ranging from 0 (*never*) to 4 (*always*). Higher scores indicated greater sexual assertiveness. The original scale by Hurlbert (1991) showed good internal consistency (from .84 to .92; Apt & Hurlbert, 1993; Hurlbert, 1991) and good test-retest reliability (.84; Pierce & Hurlbert, 1999). Regarding construct validity, a correlation of .82 was found with the Gambrill-Richey Assertion Inventory (Hurlbert, 1991). Santos-Iglesias and Sierra (2010b) reported an internal consistency of .83 for each factor and .87 for the global scale for the Spanish version. Both subscales were positively correlated with the Spanish version of the Sexual Assertiveness Scale (Sierra, Vallejo-Medina, & Santos-Iglesias, 2011) and the Spanish abbreviated version of the Dyadic Adjustment Scale (Santos-Iglesias, Vallejo-Medina, & Sierra, 2009), supporting the validity of the scale. In the present study, Cronbach's alpha values were .78 for men and .83 for women in the Initiation subscale, and .73 and .78 respectively in the No shyness/Refusal subscale.

Sexual Desire Inventory (Spector, Carey, & Steinberg, 1996). The Spanish version by Ortega, Zubeidat, and Sierra (2006) was used. It is composed of 13 items assessing two dimensions: Dyadic desire (9 items), which means an interest in or a wish to engage in sexual activity with another person, and Solitary desire (4 items), that is, an interest in sexual activities that do not involve a partner. Higher scores indicate greater sexual desire. Ortega et al. reported high internal consistency values above .87 for both subscales. In the current study, internal consistency was .73 and .83 for men and women, respectively, on Dyadic desire, and .90 and .92, respectively on Solitary desire.

Massachusetts General Hospital Sexual Functioning Questionnaire (Fava, Rankin, Alpert, Nierenberg, & Worthington, 1998). The Spanish version (Bobes, Portilla, Bascarán, Saiz, & Bousoño, 2002) was used. It is composed of five items assessing sexual functioning in five areas: interest, arousal, orgasm, erection, and overall sexual satisfaction. Only the items on arousal and on erection (only for men) were used in the present study. Responses were given on a 5-point Likert scale ranging from 0 (*totally absent*) to 4 (*normal*), with higher scores indicating better sexual functioning. This scale has shown good concurrent validity with the Changes in Sexual Functioning Questionnaire (Labbate & Lare, 2001). In this study, Cronbach's alpha values were .88 for men and .92 for women.

Sexual Opinion Survey (Fisher, Byrne, White, & Kelley, 1988). The Spanish version by Carpintero and Fuertes (1994) was used. This scale is composed of 21 items to assess erotophilia (i.e., positive disposition and attitudes toward sexual topics and sexuality). Participants responded using a 7-point Likert scale ranging from 1 (*totally disagree*) to 7 (*totally agree*). Higher scores indicate greater erotophilia. The Spanish validation showed good reliability, with internal consistency values ranging from .80 to .86. Internal consistency in the present study was .82 for men and .85 for women.

Hurlbert Index of Sexual Fantasy (Hurlbert & Apt, 1993). The Spanish validation (Desvarieux, Salamanca, Ortega, & Sierra, 2005) is composed of 10 items assessing attitudes towards sexual fantasies. Participants responded using a 5-point Likert scale from 0 (*never*) to 4 (*always*). Higher scores indicate greater positive disposition toward sexual fantasies. Cronbach's alpha value was .85, and this scale was positively correlated with frequency in sexual fantasies and sexual desire (Desvarieux et al., 2005). Cronbach's alpha in the present study was .89 for men and .91 for women.

Index of Spouse Abuse (Hudson & McIntosh, 1981). The Spanish validation was used to assess frequency of experienced partner abuse in women (Sierra, Monge, Santos-Iglesias, Bermúdez, & Salinas, 2011). This version is composed of 19 items clustered into two dimensions assessing the frequency of experiences of Physical and Non-physical abuse. For men, the 30-item-Spanish version was used (Santos-Iglesias, Sierra, & Vallejo-Medina, 2012) to assess Non-Physical and Physical abuse. In both cases, Non-physical abuse includes items such as "My partner belittles me" or "My partner acts like I am his/her personal servant." Physical abuse include items such as "My partner punches me with his/her fists" or "My partner beats me so badly that I must seek medical help." Participants respond on a 5-point Likert scale ranging from 0 (*never*) to 4 (*always*). Higher scores indicated more frequent abuse. Internal consistency reliability was good in the female version, with Cronbach's alpha values of .89 and .93, for Physical and Non-physical abuse respectively. In the male version, Cronbach's alpha values were .81, and .80, respectively. In the present study, internal consistency of the female version was .73 for Physical abuse and .87 for Non-physical abuse. In the male version, values were .78 for Physical abuse, and .88 for Non-physical abuse.

Procedure

Participants were recruited from the general Spanish population in 2009 and 2010. A quota convenience sampling method was used to obtain the same number of men and women,

distributed across three different groups according to age (18-34 years old, 35-49 years old, and 50 years old or older), size of the town or city of residence (a population less than 50,000 and greater than 50,000), and geographical area (northern and southern Spain). Participants were required to be involved in a sexually active, stable, heterosexual relationship of at least 6 months duration at the time of the study.

Ethical approval was obtained from the Ethics Board on Human Research of the university. Testing was conducted individually in different settings (e.g., public libraries, social centers, and public places) by well-trained researchers. Group testing occurred in university classrooms. Participants were approached by researchers and were asked to participate in the study. Researchers introduced themselves and briefly explained the purpose of the study. Once anonymity and confidentiality as well as the exclusive use of test scores for research purposes were guaranteed, verbal informed consent was obtained and then participants completed the questionnaires on their own.

Data analysis

Descriptive statistics and gender differences were calculated for all variables included in the study. Pearson correlations were computed between dependent variables (Initiation sexual assertiveness and No shyness/Refusal sexual assertiveness) and predictor variables (partner abuse, erotophilia, attitudes toward sexual fantasies, solitary and dyadic sexual desire, arousal, and erection). Only significantly correlated variables were included in a structural equation model that was run separately for men and women. All analyses were performed using SPSS 17.0 and LISREL 8.51 (Jöreskog & Sörbom, 2001). Due to the large sample size and violation of multivariate normality, a robust maximum likelihood estimation was used. To assess the fit of the proposed models, a joint assessment of a group of indexes was used (Tanaka, 1993). Values above .90 in the Comparative Fit Index (CFI) and Non-Normed Fit Index (NNFI) and values below .05 in the Root Mean Square Error of Approximation (RMSEA) were used as indicators of fit (Byrne, 2010).

Results

Descriptive Statistics and Gender Differences

Results of descriptive statistics revealed that both men and women in this study showed high scores on initiation assertiveness, no shyness/refusal assertiveness, dyadic desire, erotophilia, attitudes toward sexual fantasies, and arousal. On the other hand, scores on all forms of abuse were low in both men and women. Men also showed high scores on

erection and moderate scores on solitary sexual desire. Women had low scores on solitary sexual desire (see Table 1).

Gender comparisons showed that men scored higher than women on initiation assertiveness, t (3062) = 7.64, $p < .001$, Cohen's $d = 0.28$; dyadic desire, t (3039) = 14.68, $p < .001$, Cohen's $d = 0.53$; solitary desire, t (3058) = 14.20, $p < .001$, Cohen's $d = 0.51$; erotophilia, t (2765) = 7.61, $p < .001$, Cohen's $d = 0.29$; and positive attitudes toward sexual fantasies, t (3093) = 12.70, $p < .001$, Cohen's $d = 0.46$. No significant differences were found in no shyness/refusal assertiveness, t (3101) = 1.62, $p < .10$, Cohen's $d = 0.06$ (see descriptives in Table 1). No comparisons could be made between non-physical and physical abuse, because the number of items on each component for men and women were different.

TABLE 1. Means, standard deviations, and ranges for self-report measures for men and women.

	Men						Women					
			Range		Observed range				Range		Observed range	
	M	SD	Min	Max	Min	Max	M	SD	Min	Max	Min	Max
Initiation	22.64	6.46	0	32	0	32	20.69	7.56	0	32	0	32
No shyness/Refusal	26.52	4.69	0	32	4	32	26.23	5.18	0	32	0	32
Dyadic	49.96	8.94	0	70	0	70	44.70	11.39	0	70	0	68
Solitary	15.34	7.90	0	31	0	31	11.07	8.68	0	31	0	31
Erotophilia	109.30	18.68	7	147	33	147	103.54	21.01	7	147	22	145
Attitudes toward fantasies	30.24	7.41	0	40	0	40	26.48	8.90	0	40	0	40
Arousal	3.55	0.88	0	4	0	4	3.29	1.15	0	4	0	4
Erection	3.69	0.75	0	4	0	4						
Non-physical	6.30	7.20	0	68	0	62	3.07	4.99	0	48	0	41
Physical	0.50	1.55	0	28	0	22	0.71	1.87	0	28	0	26

The correlations in Table 2 showed that, in men, initiation assertiveness and no shyness/refusal were positively correlated with dyadic desire, arousal, erection, erotophilia, and attitudes toward sexual fantasies, and negatively correlated with non-physical and physical abuse. In the case of women (see Table 3), greater initiation and no shyness/refusal assertiveness were positively correlated with greater dyadic and solitary sexual desire, arousal, erotophilia, and attitudes toward sexual fantasies; sexual assertiveness was negatively correlated with physical and non-physical abuse. Physical abuse was removed from subsequent analyses to avoid problems with multicollinearity, due to its high correlation with non-physical abuse (Cohen, Cohen, West, & Aiken, 2003; Tabachnik & Fidell, 2007). We decided to remove it rather than combine them into a single measure, because it has been

demonstrated that non-physical abuse has greater impact than physical abuse on sexual assertiveness (Testa & Dermen, 1999).

TABLE 2. Correlation matrix for men.

	1	2	3	4	5	6	7	8	9	10
1. Initiation	1									
2. No shyness/ Refusal	.45***	1								
3. Dyadic	.35***	.33***	1							
4. Solitary	.03	.01	.38***	1						
5. Erotophilia	.28***	.34***	.43***	.47***	1					
6. Attitudes toward fantasies	.41***	.32***	.54***	.39***	.57***	1				
7. Arousal	.28***	.23***	.38***	.13***	.20***	.28***	1			
8. Erection	.25***	.22***	.35***	.15***	.26***	.29***	.59***	1		
9. Non-physical	-.13***	-.16***	-.06*	.07**	-.06*	-.06*	-.06*	-.10***	1	
10. Physical	-.05*	-.10***	-.04	.06*	-.07**	-.04	-.04	-.10***	.53***	1

* $p < .05$, ** $p < .01$, *** $p < .001$

TABLE 3. Correlation matrix for women.

	1	2	3	4	5	6	7	8	9
1. Initiation	1								
2. No shyness/ Refusal	.55***	1							
3. Dyadic	.49***	.40***	1						
4. Solitary	.14***	.08**	.35***	1					
5. Erotophilia	.41***	.43***	.48***	.49***	1				
6. Attitudes toward fantasies	.58***	.44***	.64***	.41***	.64***	1			
7. Arousal	.32***	.32***	.53***	.13***	.20***	.36***	1		
8. Non-physical	-.23***	-.24***	-.13***	.006	-.11***	-.13***	-.23***	1	
9. Physical	-.13***	-.21***	-.07**	.04	-.08**	-.09***	-.14***	.71***	1

** $p < .01$, *** $p < .001$

In men, results of the structural equation model (see Figure 1) showed that greater initiation assertiveness ($R^2 = .24$) was associated with higher sexual arousal, dyadic sexual desire, and attitudes towards sexual fantasies, and lower non-physical abuse. Greater no

shyness/refusal assertiveness (R^2 = .21) was associated with greater sexual arousal, more dyadic desire, more erotophilia, more positive attitudes towards sexual fantasies, and lower frequency of partner non-physical abuse (χ^2 = 0.92, p = .34, CFI = 1, NNFI = 1, RMSEA = 0).

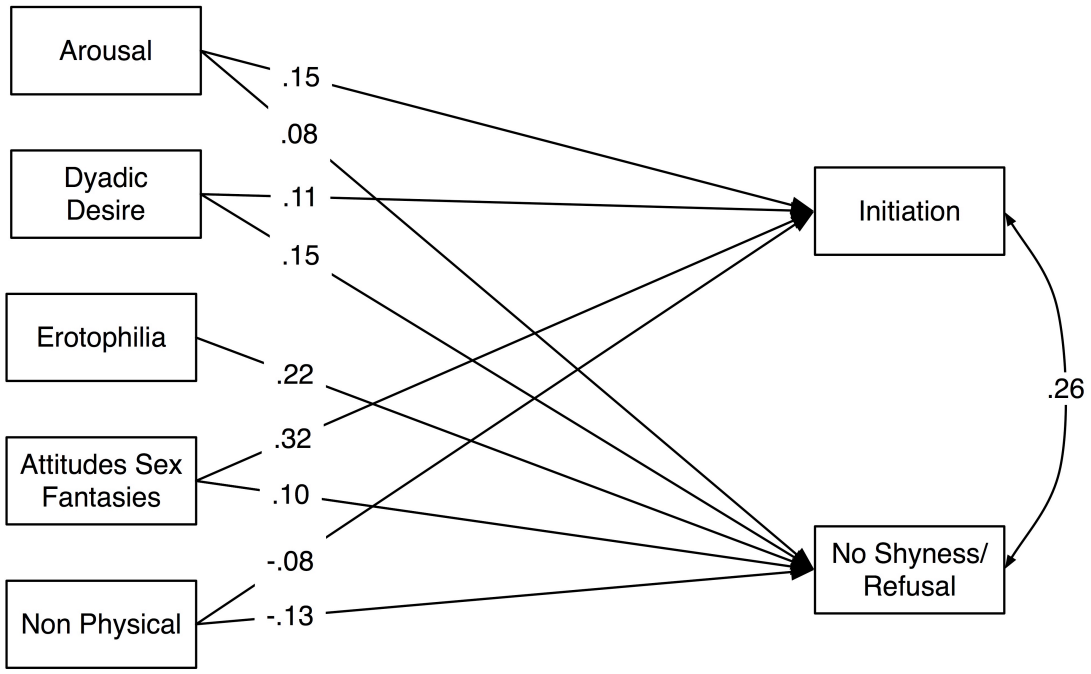

FIGURE 1. Path diagram of sexual assertiveness in men.

In women, greater initiation (R^2 = .41) and no shyness/refusal (R^2 = .33) assertiveness were associated with higher sexual arousal, dyadic desire, erotophilia, and attitudes towards sexual fantasies, and lower solitary sexual desire and frequency of non-physical partner abuse (see Figure 2). Fit was perfect because the model was saturated.

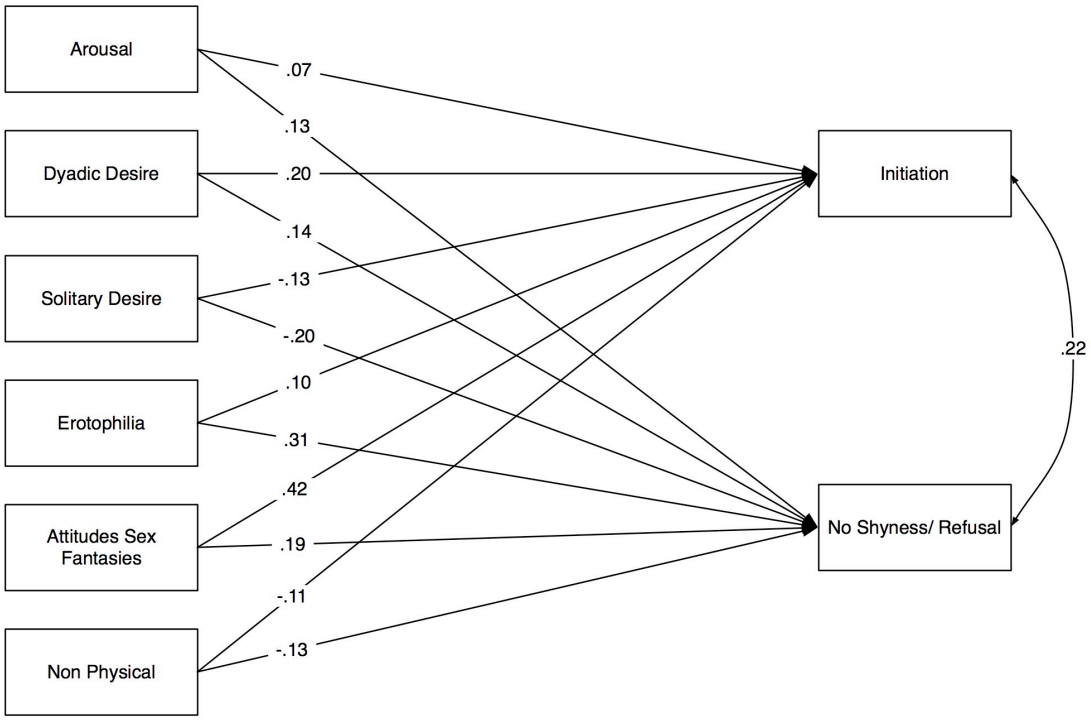

FIGURE 2. Path diagram of sexual assertiveness in women.

Discussion

The goal of this study was to test a set of predictors of sexual assertiveness. The present results demonstrate that greater sexual assertiveness is associated with lower frequency of partner abuse and more positive sexual attitudes, and higher levels of sexual arousal and desire. This supports the multidimensional nature of sexual assertiveness shown previously (Morokoff et al., 1997) but also demonstrates the relevance of sexual response components such as desire or arousal for sexual assertiveness. These results may help us understand why some individuals are less sexually assertive and thus at increased risk for undesired sex and risky sexual behaviors (Morokoff et al., 1997; Santos-Iglesias & Sierra, 2010a).

First, both men and women scored high on all variables, except for solitary desire and abuse dimensions. However, these scores are similar to scores obtained on these measures with Spanish samples. Previous research with Spanish samples has yielded similar scores on sexual assertiveness, dyadic and solitary desire, arousal, erotophilia, positive attitudes toward sexual fantasies, and physical and non-physical partner abuse (Ortega et al., 2006; Perla, Sierra, Vallejo-Medina, & Gutiérrez-Quintanilla, 2009; Santos-Iglesias, Calvillo, & Sierra, in press; Santos-Iglesias & Sierra, 2010b; Sierra, Vallejo-Medina, Santos-Iglesias, & Lameiras

Fernández, 2011; Torres, Navarro, García-Esteve, Tarragona, Ascaso, Herreras et al., 2010; Zubeidat, Ortega, del Villar, & Sierra, 2003).

Gender comparisons showed similar patterns to those found in previous studies. For example, in keeping with traditional sexual roles, men scored higher on initiation assertiveness, which makes them more likely to express their sexual interest and to initiate sexual activity (Byers & Heinlein, 1989; Morokoff et al., 1997; Stulhofer, Graham, Bozicevic, Kufrin, & Ajdukovic, 2007). Similarly, Santos-Iglesias, Vallejo-Medina, et al. (2012) found greater initiation assertiveness in men, while only women over 50 years old reported less no shyness/refusal assertiveness. These results have major implications for men and women. It has been noted that sexual assertiveness is a protective factor against sexual aggression and risky sexual behaviors (Santos-Iglesias & Sierra, 2010a). Therefore, individuals with less sexual assertiveness in general and women in particular are less likely to escape or avoid those situations. It is also interesting to note that individuals who are more sexually assertive are likely to be more sexually satisfied (Santos-Iglesias & Byers, 2011), which suggests that less sexually assertive individuals have fewer chances of increasing their sexual satisfaction (Dunn et al., 1979). Gender differences in the other constructs also support past research. For example, it has consistently been shown that men report more sexual desire than women (Regan & Atkins, 2006) and women also have greater erotophobic attitudes (Carpintero & Fuertes, 1994; Sierra et al., 2008).

Results of structural equation modeling reveal that different variables have a different impact on sexual assertiveness. While some variables increase the likelihood of sexual assertiveness, others do not. For example, individuals who reported more non-physical abuse tended to report lower initiation and no shyness/refusal sexual assertiveness. This supported our hypothesis and demonstrates that, in keeping with previous research, victimization and abuse experiences diminish the ability to assert oneself in sexual contexts (Apt & Hurlbert, 1993; Sierra et al., 2007; Testa, VanZile-Tamsen, & Livingston, 2007). The fact that non-physical abuse instead of physical abuse was associated with sexual assertiveness is related to results that have found that sexual coercion experiences but not rape –which involves using physical force– are related to lower sexual assertiveness (Testa & Dermen, 1999). These results imply that sexual coercion experiences may damage the belief that sexual assertiveness can serve as a way to escape or avoid victimization.

Regarding attitudinal factors, results show that higher initiation assertiveness was associated with a positive disposition towards sexual fantasies. On the other hand, higher no shyness/refusal assertiveness was associated with both higher erotophilia and more positive

attitudes towards sexual fantasies, although standardized coefficients were higher for erotophilia. These results confirm that sexual attitudes are able to predict sexual assertiveness (Hurlbert et al., 1993; Schooler et al., 2005; Sierra et al., 2008; Snell et al., 1991; Treffke et al., 1992), but also indicate some specificity in these relationships. For example, initiation assertiveness was predicted strongly by attitudes towards sexual fantasies, because the initiation factor includes communication about fantasies and sexual desires. Hurlbert, Apt, Hurlbert, and Pierce (2000) found that attitudes towards sexual fantasies were positively related to sexual motivation. In the study by Hurlbert et al. (2000), sexual motivation was assessed with items such as "I told my partner I wanted sex" or "I approach my partner for sex," which in some instances is the same as initiation assertiveness, so attitudes toward sexual fantasies were related to initiation assertiveness. In contrast, no shyness/refusal was more related to erotophilia than to positive attitudes toward sexual fantasies, supporting previous research (Hurlbert et al., 1993; Sierra et al., 2008; Snell et al., 1991) and suggesting that shyness about sexual topics or communication about sexual topics is a general trait that is more determined by general attitudes, such as erotophilia, rather than more specific ones (i.e., attitudes toward sexual fantasies).

Finally, as predicted, we found that dyadic sexual desire positively predicted both initiation and no shyness/refusal assertiveness in men and women, as found by Hurlbert (1991). This suggests that people who experience greater sexual desire to engage in sexual activities with another person are more likely to be sexually assertive, which means that sexual assertiveness can serve to satisfy an initial desire for sexual contact (Matsuura, 2008). The same pattern was found for arousal, so that people who feel more aroused are more likely to initiate sexual contacts (Hurlbert et al., 1993). Finally, in women, solitary sexual desire negatively predicted sexual assertiveness, although zero-order correlations were positive. In this case, a negative suppression effect was found (Kline, 2011; Tabachnick & Fidell, 2007), which means that after controlling for dyadic sexual desire, the relationship between solitary sexual desire and sexual assertiveness was negative. This could be explained by arguing that sexual guilt, which is more frequent in women (Ortega, Ojeda, Sutil, & Sierra, 2005; Sierra, Perla, & Santos-Iglesias, 2011) and is negatively related to sexual assertiveness (Snell et al., 1991), may mediate the relationship between dyadic solitary desire and sexual assertiveness. Yet, this hypothesis needs to be tested in the future. The fact that solitary sexual desire predicted sexual assertiveness in women may explain the difference between men and women in the amount of variance accounted for.

In conclusion, it is important to note that sexual assertiveness is determined by different variables. The present study shows, in line with previous research (Morokoff et al., 1997), that both sexual attitudes and abuse have a strong impact on sexual assertiveness, but also that sexual response components such as sexual desire and arousal predict sexual assertiveness. These results have two main implications. First, sexual experiences are still influenced by traditional sexual scripts (Vannier & O'Sullivan, 2010), which, as previously stated, place women and less assertive individuals at greater risk for unwanted sexual experiences. Second, education and prevention programs including sexual assertiveness training need to consider sexual attitudes or history of partner abuse. Training sexual assertiveness (Leiblum, 2007), which has proven to be effective for increasing condom use and risky sexual behaviors (Crowell, 2004; Kelly et al., 1994; Sikkema, Winett, & Lombard, 1995; St. Lawrence et al., 1995; Stoner et al., 2008) and reducing unwanted sexual advances (Yagil, Karnieli-Miller, Eisikovits, & Enosh, 2006) may be less effective in individuals who do not have positive sexual attitudes. Finally, implications also exist for positive outcomes. Given that sexual assertiveness is based on the right to choose what we want in our sexual lives, feeling sexual desire or arousal may be followed by an assertion to engage in sexual contact as a way to increase sexual satisfaction and sexual health (Lottes, 2000; Murphy et al., 1980).

Despite the results, it is important to note that, although sample size was very large and scores were similar to those that could be found in previous research, the sample was recruited through a non-random procedure and, thus, generalization to the Spanish population is limited. The sample was taken from a high educational environment, which should be taken into account by future research. Another limitation is related to some of the instruments used in this research, which are not frequently used and are quite dated. However, they had been previously validated in Spain and there was evidence of their appropriate psychometric properties for use on our sample. Also, more studies with individuals with sexual problems would provide greater insight about factors that place individuals at risk for undesired sexual activities, since our sample was based on functional individuals. The present research was based on self-report data so future studies should include other forms of assessment. For example, it would be useful to analyze how sexual arousal influences both initiation and refusal of sexual contacts, while controlling for relevant variables (e.g., attitudes, patterns of excitation/inhibition). Therefore, more research is needed to address the role of sexual assertiveness in the human sexual response and its effectiveness to increase not only sexual satisfaction but also sexual health.

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Discusión

Con el objetivo de profundizar en el estudio de la asertividad sexual y su influencia en la sexualidad humana se ha llevado a cabo esta Tesis Doctoral compuesta por cinco estudios. Estos se agrupan en un primer estudio teórico que aporta una descripción de los principales resultados obtenidos en estudios sobre asertividad sexual. A continuación se presentan dos estudios psicométricos que suponen la adaptación española del Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991), uno de los instrumentos empleados con más frecuencia en el estudio de la asertividad sexual (Santos-Iglesias y Sierra, 2010a). Los resultados de estos dos estudios muestran una versión española final compuesta por 16 ítems que evalúa dos componentes de la asertividad sexual: Inicio y Ausencia de timidez/Rechazo. Los dos últimos trabajos analizan la influencia que la asertividad sexual tiene en distintos ámbitos de la sexualidad humana. Así, el cuarto estudio centrado en los procesos de victimización sexual muestra que, la relación entre el abuso sexual en la infacia y la victimización sexual en la adolescencia y edad adulta temprana se explica a través del número de parejas sexuales y de la falta de asertividad sexual. Por último, en el quinto estudio se propone un modelo explicativo de la asertividad sexual basado en el Multifaceted Model of HIV Risk (MMOHR; Harlow et al., 1993) y muestra que tanto variables interpersonales (i.e., abuso en la pareja), actitudinales (i.e., actitudes sexuales y actitudes hacia las fantasías sexuales), como sexuales (i.e., deseo sexual y excitación sexual) son relevantes a la hora de predecir respuestas sexualmente asertivas. Por tanto, esta Tesis Doctoral ofrece una serie de resultados interesantes acerca de la asertividad sexual, tanto desde el punto de vista de su evaluación, como desde su naturaleza y papel en la sexualidad humana.

El primer trabajo pone de manifiesto la falta de estudios sobre asertividad sexual de forma generalizada y, más concretamente, la escasa variabilidad de metodologías empleadas en los mismos, pues casi el 64% de estos estudios son de naturaleza ex post facto (Montero & León, 2007), mientras que sólo un 6,59% son instrumentales. Esto demuestra que de todos los instrumentos empleados para la evaluación de la asertividad sexual (20 instrumentos distintos), sólo dos de ellos han sido elaborados mediante un estudio psicométrico más o menos riguroso: el Sexual Awareness Questionnaire (Snell et al., 1991) y la Sexual Assertiveness Scale (Morokoff et al., 1997), subrayando las importantes carencias existentes

en la evaluación de la asertividad sexual. Primero, la ausencia, en la mayoría de los casos, de una conceptualización de base a la hora de desarrollar una batería de ítems para evaluar la asertividad sexual, de lo que se deriva, tal y como se comentaba en la introducción, que los diferentes instrumentos de evaluación que se han encontrado incluyen diferentes componentes de la asertividad sexual (e.g., inicio de la actividad sexual, uso de preservativos) o constructos asociados como la autorrevelación sexual o la timidez, más relacionados con un componente global de comunicación que con la asertividad propiamente dicha. En segundo lugar, encontramos también que muchos de estos instrumentos no informan sobre sus propiedades psicométricas o simplemente dan un dato de fiabilidad de consistencia interna, sin llegar a conocer datos sobre distintas formas de validez de los mismos. Por tanto, los estudios realizados hasta la fecha demuestran que una de las grandes debilidades de la asertividad sexual es la evaluación de la misma y, por tanto, uno de los aspectos en los que es necesario trabajar.

En otro orden de cosas, la revisión teórica también muestra otras dos grandes evidencias. La primera es que, a pesar de conocer que la asertividad sexual funciona como un factor de protección ante experiencias de victimización sexual (Macy et al., 2006) y que puede ser tanto una causa como una consecuencia de las mismas (Livingston et al., 2007), no se sabe mucho acerca de su papel dentro del fenómeno de la revictimización sexual, a pesar de que se ha planteado como un posible mecanismo explicativo (Muehlenhard et al., 1998). Mucho menos se conoce acerca del papel que juega frente a otras hipótesis explicativas de la revictimización que han sido contrastadas con mayor frecuencia, como la experiencia sexual y el consumo de sustancias (Arata, 2000; Fergusson, Horwood y Lynskey, 1997; Kilpatrick, Acierno, Resnick, Saunders y Best, 1997). En segundo lugar, es preciso señalar que la mayoría de los estudios han usado la asertividad como variable predictora o mediadora, pero en pocos casos ha sido estudiada como variable dependiente (e.g., Morokoff et al., 1997). Es decir, se sabe muy poco sobre su naturaleza o sobre cuáles son las variables que favorecen la aparición de respuestas sexualmente asertivas o no. Por tanto, esta revisión teórica, además de dejar abiertos muchos frentes de investigación, confirma la necesidad de ahondar en tres campos diferentes. Primero, la investigación instrumental sobre las características psicométricas de los instrumentos de evaluación de la asertividad sexual, especialmente en España, en donde no disponemos de adaptaciones de dichos instrumentos. Segundo, el papel de la asertividad sexual en las experiencias de revictimización sexual. Tercero, el estudio sobre la naturaleza y las variables predictoras de la asertividad sexual.

En relación a la primera cuestión se desarrollan dos estudios psicométricos. El primero de ellos constituye la validación española del Hurlbert Index of Sexual Assertiveness (HISA; Hurlbert, 1991), que es el instrumento de evaluación de asertividad sexual más usado (Santos-Iglesias y Sierra, 2010a). Este estudio parte de la versión anglosajona compuesta por 25 ítems, de la que no se tiene información sobre la elaboración de los ítems ni de su estructura factorial. Únicamente se informa de su fiabilidad de consistencia interna y test-retest. Un estudio posterior elaborado por Greene y Faulkner (2005) descubre tres factores mediante análisis factorial exploratorio: Inicio, Rechazo y Conversación sexual asertiva. Sin embargo, estos autores no proporcionan detalles sobre los ítems que componen dicha estructura. Posteriormente, Sierra et al. (2008) en un estudio con mujeres hispanas encuentran un sólo factor que explica cerca de un 32% de varianza. Ante la diversidad de resultados, la validación española del HISA (Santos-Iglesias y Sierra, 2010b) parte de un análisis de ítems para seguir con un análisis factorial exploratorio y confirmar posteriormente mediante análisis factorial confirmatorio la estructura encontrada. Los resultados del análisis factorial exploratorio y confirmatorio muestran una versión final compuesta por 19 ítems que se agrupan en dos factores: Inicio y Ausencia de timidez/Rechazo. Ambos muestran buenos índices de fiabilidad de consistencia interna y adecuada validez convergente con otras medidas de asertividad en la pareja, ajuste diádico y habilidades sociales. Esta solución final bien podría asemejarse a la encontrada por Greene y Faulkner (2005) con la equivalencia entre las dimensiones Conversación sexual asertiva y Ausencia de timidez. Sin embargo, el hecho de que no se disponga de los ítems que componen aquella dimensión en el estudio de Greene y Faulkner hace que sea imposible su comprobación. Por otra parte, el resultado obtenido dista mucho de la solución encontrada por Sierra et al., pero es necesario recordar que en el estudio de Sierra et al. se emplearon únicamente mujeres de dos países distintos (España y El Salvador), mientras que en el estudio de esta tesis se evalúan tanto hombres como mujeres españoles. Esta diferencia entre los estudios llevados a cabo sólo con mujeres (Hurlbert, 1991; Sierra et al., 2008) y los llevados a cabo con hombres y mujeres (Greene y Faulkner, 2005; Santos-Iglesias y Sierra, 2010b), que demuestran una sola dimensión en el primer caso y varias dimensiones en el segundo, despierta la sospecha de que puedan existir diferencias en la estructura factorial entre hombres y mujeres y la posibilidad de que el instrumento de evaluación esté sesgado en función del género. Con el propósito de desvelar esta incógnita se lleva a cabo el segundo estudio psicométrico que analiza la equivalencia de la estructura del HISA entre hombres y mujeres.

Debido al planteamiento anterior y a que la asertividad sexual es un constructo que típicamente se ha comparado entre hombres y mujeres, se evalúa la equivalencia de la estructura factorial de la versión española del HISA (Santos-Iglesias y Sierra, 2010b) y se analiza la ausencia de sesgo en sus ítems entre hombres y mujeres, ya que es necesario que se cumplan estos dos requisitos cuando las puntuaciones de un instrumento de evaluación van a ser empleadas para comparar distintos grupos (Dimitrov, 2010). Lo primero que se desprende de los resultados de este estudio es que la estructura encontrada por Santos-Iglesias y Sierra (2010b) se confirma de nuevo, tanto en hombres como en mujeres españoles, en el nivel más bajo de invarianza (invarianza configural). Por tanto, se obtiene una segunda evidencia confirmatoria de la estructura de la versión española del HISA. Sin embargo, tres de los ítems (2, 9 y 13) no cumplen la invarianza fuerte (i.e., muestran interceptas diferentes en hombres y mujeres) indicando la posible presencia de funcionamiento diferencial del ítem (Dimitrov, 2010). Los resultados del análisis de funcionamiento diferencial del ítem muestran que de esos tres ítems, sólo el ítem 2 ("Creo que soy tímido/a en el ámbito sexual") muestra funcionamiento diferencial y, por tanto, sesgo entre hombres y mujeres. Concretamente, cuando se analizan las categorías de respuesta se encuentra que las mujeres tienen una mayor tendendia a responder "siempre" a este ítem en comparación con los hombres. Así, hombres y mujeres con el mismo nivel de timidez no responderían de la misma forma a este ítem, pues debido a los roles tradicionales de género, las mujeres responderían "siempre" con más frecuencia ya que se espera que sean más tímidas (Bem, 1974; Holt y Ellis, 1998), que muestren menos sus preferencias y deseos sexuales y que conversen de forma menos abierta sobre el sexo (Quina, Harlow, Morokoff, Burkholder y Deiter, 2000). Por esta razón, y en base a los resultados obtenidos, se recomienda eliminar los ítems 2, 9 y 13 de la escala, obteniendo una versión final compuesta por 16 ítems agrupados en las dimensiones Inicio (8 ítems) y Ausencia de timidez/Rechazo (8 ítems). Con esta versión definitiva y equiparable por sexos se elaboran los baremos españoles del HISA diferenciando a hombres y mujeres en tres grupos de edad. Los resultados de los baremos muestran que la asertividad sexual aún sigue roles tradicionales de género, pues los hombres muestran mayor asertividad de inicio (Simon y Gagnon, 1984, 1986, 2003), mientras que las mujeres mayores en comparación con mujeres jóvenes, muestran comportamientos más estereotipados como timidez a la hora de hablar sobre sexualidad (Bem, 1974; Holt y Ellis, 1998).

Los resultados de estos dos estudios suponen, en general, un avance en la evaluación de la asertividad sexual mediante el uso del Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991). En este sentido, partiendo de su estructura unidimensional inicial, la ausencia de una

definición clara sobre el constructo evaluado por el instrumento y la escasez de evidencias empíricas sobre su funcionamiento, propiedades psicométricas o la presencia de sesgo, se llega finalmente a una versión española depurada más breve y formada por dos componentes claramente definidos. El primero, Inicio, hace referencia al inicio de contactos sexuales y la comunicación de deseos sexuales y fantasías a la pareja. El segundo de los componentes, Ausencia de timidez/Rechazo, es la dificultad para iniciar y mantener conversaciones sobre temas sexuales y la incapacidad para rechazar contactos sexuales no deseados. A este respecto hay que señalar que, tal y como se ha comentado anteriormente, este segundo factor incluiría un componente que no sería puramente asertividad sexual (i.e., ausencia de timidez), sino un factor asociado a la misma y, así, se desaconseja el uso de este instrumento cuando lo que se precisa es una evaluación pura de la asertividad sexual. Al margen de esto hay que sumar que las propiedades psicométricas demostradas garantizan un adecuado funcionamiento en muestras españolas y, aún más, garantizan la equivalencia de las puntuaciones cuando dicha escala se emplea para comparar a hombres y mujeres.

Además del estudio sobre la evaluación de la asertividad sexual, se propone investigar su papel en los procesos de victimización. La investigación previa ha demostrado que la asertividad sexual es un factor de protección ante las experiencias de coerción y victimización sexual (véase Santos-Iglesias y Sierra, 2010a). Los resultados obtenidos en esta Tesis Doctoral muestran que la falta de asertividad sexual explica la relación entre el abuso sexual en la infancia y la victimización sexual en la adolescencia y edad adulta temprana. Este resultado no coincide con estudios previos llevados a cabo, principalmente, en Estados Unidos, sin embargo la metodología de análisis de datos empleada en este estudio es más potente a la hora de detectar efectos de mediación que la que se ha empleado en estudios previos (véase, Greene y Navarro, 1998; Livingston et al., 2007). Otra posible explicación tiene que ver con los roles tradicionales de género, pues estudios previos han encontrado que las estudiantes estadounidenses muestran más roles tradicionales de género (e.g., satisfacer las necesidades y deseos de la pareja, token-refusal; Fuertes, Ramos, de la Orden, del Campo y Lázaro, 2005; Sipsma, Carrobles-Isabel, Montorio Cerrato y Everaerd, 2000, VanZile-Tamsen, Testa y Livingston, 2005) que afectan directamente a la asertividad sexual, de forma que esas creencias disminuyen la asertividad sexual en estudiantes estadounidenses, mientras que en España la falta de habilidades asertivas está más asociada al abuso sexual en la infancia. Esta puede ser la razón por la que se encuentran diferencias entre los estudios en Estados Unidos y en España.

Los resultados muestran, además, que el número de parejas sexuales explica también la revictimización sexual, dando credibilidad a la hipótesis de la exposición y a la impotencia dentro de las dinámicas traumatogénicas propuestas por Finkelhor y Browne (1985). No obstante, a pesar de los resultados de este trabajo, aún queda por delante realizar una mejora en este estudio. Una de las principales críticas a este tipo de trabajos es que, debido a su naturaleza transversal, no es posible saber si la falta de asertividad sexual desencadena experiencias de victimización sexual o si, por el contrario, sufrir experiencias de victimización sexual disminuye la asertividad sexual. A este respecto, varios autores ponen de manifiesto la necesidad de llevar a cabo estudios longitudinales con el objetivo de dilucidar este problema (Greene y Navarro, 1998; Livingston et al., 2007). Así, el estudio que aquí se presenta es una primera aproximación a la evaluación conjunta de una serie de posibles mediadores de la revictimización, pero sería mucho más recomendable la realización de este tipo de estudios mediante un diseño longitudinal que permita contrastar qué variables preceden a otras y si existe dicha mediación.

Para finalizar con este trabajo, es necesario señalar las elevadas cifras de victimización sexual encontradas en el mismo. Los resultados muestran que algo más de un 30% de las mujeres entrevistadas informaron haber sufrido algún contacto sexual no deseado después de los 14 años de edad, un 19% habían sufrido un episodio de coerción sexual, y casi un 4% habían sufrido un intento de violación y violación completa. Estos resultados ponen de manifiesto, al igual que estudios previos realizados tanto en España (Ramos, Fuertes y de la Orden, 2006; Sipsma et al., 2000) como en Estados Unidos (Testa, Livingston y VanZile-Tamsen, 2005; Testa, VanZile-Tamsen, Livingston y Koss, 2004), las elevadas cifras de prevalencia de las agresiones sexuales en mujeres universitarias, que son, precisamente, la población con una mayor vulnerabilidad para este tipo de episodios (Bureau of Justice Statistics, 2007; Tjaden y Thoennes, 2000). Además, se vuelve a encontrar falta de apoyo para el mito del violador extraño, pues la mayoría de las agresiones son cometidas por exparejas o parejas actuales, conocidos con los que no se tiene una relación romántica y/o citas ocasionales (Koss et al., 1994; Muehlenhard, Goggins, Jones y Satterfield, 1991).

Por último, sólo resta analizar la naturaleza de la asertividad sexual. Como punto de partida es necesario señalar la ausencia, a excepción de contados casos (Morokoff et al., 1997), de trabajos que analicen los predictores de la asertividad sexual de forma multidimensional como se ha realizado con otras variables sexuales (e.g., deseo sexual; Santos-Iglesias, Calvillo y Sierra, en prensa). En este sentido, Morokoff et al. (1997) aplicaron el Multifaceted Model of HIV Risk (MMOHR; Harlow et al., 1993) pero no

incluyeron variables sexuales como el deseo o la excitación, que han mostrado estar relacionadas con la asertividad sexual (Hurlbert, 1991; Hurlbert et al., 1993). No es de extrañar si se piensa que personas con elevados niveles de deseo y de excitación tenderán a iniciar más contactos sexuales con el objetivo de satisfacer ese deseo o excitación previos (Matsuura, 2008). Por ello se pone a prueba un modelo multidimensional en hombres y mujeres que pretende analizar los predictores de la asertividad sexual a partir de una serie de variables interpersonales, actitudinales y sexuales.

Los resultados ponen de manifiesto la naturaleza multidimensional de la asertividad sexual, tal y como fue demostrado en el estudio de Morokoff et al. (1997). Así, tanto en el caso de los hombres como en el de las mujeres los tres grupos de variables son significativos a la hora de predecir la asertividad sexual, aunque sí se encuentran algunas pequeñas diferencias. Se encuentra que las variables sexuales son relevantes a la hora de predecir la asertividad sexual, de forma que hombres y mujeres con elevados niveles de excitación y de deseo sexual diádico muestran mayor asertividad sexual. Es importante señalar que aunque uno de los componentes es la asertividad de rechazo y ausencia de timidez, el factor tiene una gran carga de ítems que evalúan ausencia de timidez (que se definió como la capacidad para expresar los deseos y fantasías sexuales). De esta forma es comprensible que personas que con mayor deseo muestren también mayores puntuaciones en esta dimensión. Sin embargo, es importante señalar que sólo en el caso de las mujeres el deseo sexual solitario predice de forma negativa la asertividad sexual. La explicación sobre este resultado se podría encontrar en la posible culpabilidad sexual asociada al deseo solitario en el caso de las mujeres, aunque es una hipótesis que habría que comprobar. En segundo lugar, tanto actitudes sexuales generales como la erotofilia, como actitudes más específicas, como las actitudes positivas hacia las fantasías sexuales, muestran una relación positiva con la asertividad sexual tanto en hombres como en mujeres, indicando que la especificidad de las actitudes es, a veces, más importante a la hora de predecir el comportamiento que las actitudes más generales. Además, debido al componente de comunicación de fantasías sexuales se entiende fácilmente la relación entre las actitudes específicas y este componente. Por último, el abuso de la pareja ejerce un efecto demoledor sobre la asertividad sexual, especialmente, en el caso del abuso no físico. En este sentido, estudios previos han mostrado que la asertividad sexual es menor en víctimas de agresiones sexuales que implican un componente verbal para ejercer presión, pero no cuando existe una agresión física (Testa y Dermen, 1999), ya que en estos casos es más dificil escapar mediante respuestas verbales asertivas. Por último, es necesario señalar que de los tres grupos de variables añadidas en el modelo, las más importantes son las

actitudinales, de manera que sin la presencia de actitudes positivas el resto de variables no van a ser tan relevantes a la hora de provocar respuestas sexualmente asertivas.

A modo de síntesis general, se puede concluir que los resultados hallados en esta Tesis Doctoral ofrecen una herramienta útil para la evaluación de la asertividad sexual en el contexto español. Respecto a la versión original anglosajona (Hurlbert, 1991), la adaptación española supone una triple ventaja. En primer lugar, los ítems están agrupados en dos dimensiones conceptualmente coherentes y que representan dos componentes de la asertividad sexual. En segundo lugar, la adaptación española supone la eliminación de 9 ítems que no muestran un adecuado funcionamiento. Esto implica una versión más corta y de más fácil aplicación, con suficientes garantías psicométricas sobre su adecuado funcionamiento. Por último, los resultados implican que la adaptación española permite su uso y la comparación de las puntuaciones entre hombres y mujeres debido a la obtención de una versión no sesgada. Además, los baremos obtenidos a partir de esta última versión ofrecen información relevante sobre las puntuaciones normativas para hombres y mujeres en tres grupos de edad distintos. Sin embargo, los resultados de ambos estudios serían mucho más valiosos en el caso de contar con muestras respresentativas de la población españolas, ya que permitirían asegurar que los resultados obtenidos y la utilización de la versión española del Hurlbert Index of Sexual Assertiveness, así como sus baremos, serían aplicables con total garantía a la población española.

En segundo lugar, se ha encontrado también que la asertividad sexual sirve como factor de protección frente a la victimización sexual en la adolescencia y edad adulta, además de ser un mecanismo que sirve para explicar la revictimización sexual entre el abuso sexual en la infacia y la victimización adulta. A pesar de la información que ofrecen estos resultados es necesario poner a prueba estas hipótesis mediante el uso de diseños longitudinales (véase Livingston et al., 2007) que permitan establecer un orden en la sucesión de los eventos y las consecuencias de los mismos.

Por último, el estudio sobre la naturaleza de la asertividad sexual pone de manifiesto la relevancia de variables interpersonales, actitudinales y sexuales, con especial relevancia de las actitudinales. Por tanto, los programas de intervención que incluyan la mejora de la asertividad sexual tendrían que trabajar siempre el plano actitudinal, mejorando la disposición hacia la sexualidad tanto de forma general como específica. De esta forma, podrían darse mayores cambios en la asertividad sexual de las personas y, por tanto, desarrollar mecanismos que contribuyan a una mayor salud sexual.

Conclusiones

1. La asertividad sexual es un elemento clave en la vida sexual de las personas, ya que está relacionado con la respuesta sexual, las conductas sexuales de riesgo y las experiencias de victimización sexual.
2. La asertividad sexual está al servicio de la salud sexual, ya que permite poner en marcha conductas sexualmente saludables y defender los derechos sexuales de las personas.
3. Existen muchos instrumentos para la evaluación de la asertividad sexual, aunque pocos han sido elaborados siguiendo un procedimiento adecuado y muchos apenas informan de sus propiedades psicométricas. En este contexto, la versión española del Hurlbert Index of Sexual Assertiveness se postula como un instrumento breve para la evaluación de la asertividad sexual, con adecuadas índices de fiabilidad y validez, así como la ausencia de sesgo a la hora de comparar las puntuaciones de hombres y mujeres.
4. El inicio y rechazo de las actividades sexuales sigue en la actualidad en España los roles tradicionales de género. Así, se muestra que los varones tienden a iniciar más los contactos sexuales, mientras que las mujeres jóvenes son más restrictoras del contacto sexual y las mujeres mayores muestran mayor timidez sexual.
5. Las tasas de victimización sexual en España siguen siendo elevadas y muestran la misma tendencia que estudios anteriores, con cifras que oscilan entre el 3,4% de violaciones y un 30,4% de contactos sexuales no deseados.
6. La mayor parte de las experiencias de victimización sexual se llevan a cabo por conocidos o parejas actuales, destruyendo el mito del violador/agresor desconocido.
7. La asertividad sexual es un factor de protección contra las agresiones sexuales en la adolescencia y edad adulta, y funciona como mecanismo explicativo de la revictimización sexual cuando la primera experiencia fue abuso sexual en la infancia.
8. La asertividad sexual es de naturaleza multidimensional y está determinada por factores interpersonales (como el abuso en la pareja), factores actitudinales y componentes de la respuesta sexual humana (como el deseo y la excitación).

9. El abuso en la pareja, sobre todo de naturaleza no física, disminuye la capacidad de respuesta sexualmente asertiva tanto en hombres como en mujeres.
10. Las actitudes sexuales generales y actitudes más específicas, como las actitudes hacia las fantasías sexuales, son factores facilitadores de respuestas sexuales asertivas tanto en hombres como en mujeres.
11. El deseo sexual y la excitación favorecen respuestas sexualmente asertivas tanto en hombres como en mujeres. Sin embargo, en las mujeres el deseo sexual solitario dificulta la asertividad sexual, posiblemente debido a la culpabilidad sexual que aquel genera.

Conclusions

1. Sexual assertiveness is a key component in human sexual life, as it is related to human sexual response, risky sexual behavior, and sexual victimization experiences.
2. Sexual assertiveness serves sexual health, since it empowers the ability to engage in healthy sexual behaviors and defense human sexual rights.
3. There are many instruments to assess sexual assertiveness. However, only a few have been developed following appropriate psychometric procedures and most of them do not give information about their psychometric properties. In such a context, the Spanish validation of the Hurlbert Index of Sexual Assertiveness is a short instrument to assess sexual assertiveness. It has demonstrated good reliability and validity properties and its validity and lack of bias when it is used to compare scores between men and women.
4. Currently, initiation and refusal of sexual contacts follow traditional gender roles in Spain. It has been showed that males typically are initiators of sexual contacts, while young females are restrictors of such contacts and older females show greater sexual shyness.
5. Sexual victimization rates in Spain are still high and show similar rates as previous studies; rates range from 3,4% of rapes and 30,4% of undesired sexual contacts.
6. Most of the sexual victimization experiences are perpetrated by known people or actual partners, ruling the stranger rapist myth out.
7. Sexual assertivness is a protective factor against sexual aggressions in adolescence and young adulthood, and it does work as an explaining mechanism for sexual revictimization when first offence was child sexual abuse.
8. Sexual assertiveness has a multidimensional nature and it is determined by interpersonal factors, such as partner abuse, attitudinal factors and components of the human sexual response (such as desire and arousal).
9. Partner abuse, specially non-physical abuse, lessens the ability to sexually assert in men and women.
10. General sexual attitudes and specific sexual attitudes, such as attitudes towards sexual fantasies, facilitate sexually assertive responses in men and women.

11. Sexual desire and arousal facilitate sexually assertive responses in men and women. However, among women, solitary sexual desire difficults sexual assertiveness, probably due to the sexual guilt caused by solitary sexual desire.

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Anexo

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El papel de la asertividad sexual en la sexualidad humana: una revisión sistemática[1]

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RESUMEN. El estudio de la asertividad sexual ha generado resultados que demuestran su importancia y su papel fundamental en la sexualidad humana. En este estudio teórico se lleva a cabo una revisión sistemática de los principales resultados obtenidos en estos estudios. Después de una búsqueda en las principales bases de datos se obtiene un total de 76 trabajos publicados entre 1980 y 2009, que demuestran que la asertividad sexual es un factor determinante tanto de la respuesta sexual como del funcionamiento sexual humano. Además se relaciona de forma directa con una visión positiva de la sexualidad humana y con algunas variables sociodemográficas como el sexo, aunque esta relación no está clara. Otros estudios ponen de manifiesto que es un factor de protección ante experiencias de abuso y victimización sexual, así como ante conductas sexuales de riesgo. Se discuten los resultados y se plantea la necesidad de incluir la asertividad sexual de forma específica, más que la asertividad general, en los programas educativos y en intervenciones con poblaciones en situación de riesgo.

PALABRAS CLAVE. Asertividad sexual. Respuesta sexual. Victimización. Conductas de riesgo. Estudio teórico.

ABSTRACT. Study on sexual assertiveness has generated results which demonstrates its relevance and fundamental role in human sexuality. In this theoretical study, a systematic revision of the main results derived from these studies on sexual assertiveness was performed. After searching in the main databases a total number of 76 works were retrieved, published from 1980 to 2009. These works show that sexual assertiveness is a crucial factor determining both human sexual response and human sexual functioning. Furthermore, sexual assertiveness is directly related to a positive view of human

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sexuality and various sociodemographical variables such as sex, although this relationship is not very clear. Other studies reveal that sexual assertivenes works as a protective factor from sexual abuse and victimization experiences, as well as from engage in sexual risk behaviors. Results are discussed and it is purposed to include sexual assertiveness, better than general assertiveness, in educational programs and interventions with risky populations.

KEYWORDS. Sexual assertiveness. Sexual response. Victimization. Risk behaviors. Theoretical study.

La asertividad sexual ha sido definida de múltiples formas. Painter (1997) sostiene que es la capacidad para llevar a cabo la asertividad social en un contexto sexual. Por su parte, Dunn, Lloyd y Phelps (1979) defienden que es «la conciencia de uno mismo como ser sexual y el uso, con poca ansiedad, de un conjunto de habilidades conductuales para obtener satisfacción sexual de uno mismo y de su pareja» (p. 294). Pero, sin duda, una de las definiciones más aceptadas sostiene que es la capacidad para iniciar la actividad sexual, rechazar la actividad sexual no deseada, así como negociar las conductas sexuales deseadas, el empleo de métodos anticonceptivos y los comportamientos sexuales más saludables (Morokoff *et al*., 1997). Todas estas definiciones ponen de manifiesto la especificidad de la asertividad sexual en situaciones sexuales. Asimismo, un gran número de estudios demuestra que la asertividad sexual constituye un componente central de la sexualidad humana, pues se relaciona con diversos aspectos de la respuesta sexual, como el deseo y la satisfacción sexual, con menores niveles y frecuencia de victimización y coerción sexual (véanse Santos-Iglesias y Sierra, en prensa; Sierra, Santos, Gutiérrez-Quintanilla, Gómez y Maeso, 2008) y con la ausencia de conductas sexuales de riesgo, hasta el punto de que los principales modelos teóricos de prácticas sexuales de riesgo asumen la importancia que juega este constructo (Fisher y Fisher, 1992).

A pesar de la importancia de la asertividad sexual en la sexualidad humana y a que su estudio se remonta a la década de los años setenta (*cfr*., Jakubowski-Spector, 1973), no existen hasta la fecha revisiones que sinteticen y agrupen la información disponible sobre la misma, si bien es cierto que en alguna revisión de literatura es tratada de forma tangencial (*e.g.*, Stampley, Mallory y Gabrielson, 2005). Por esta razón se plantea el presente estudio teórico (Montero y León, 2007) que, siguiendo las normas propuestas por Fernández-Ríos y Buela-Casal (2009), tiene como objetivo realizar una revisión bibliográfica y sintetizar la información disponible sobre el papel de la asertividad sexual en la sexualidad humana.

Método

Revisión bibliográfica

La búsqueda de los trabajos se realizó en diferentes bases de datos, con el objetivo de cubrir el mayor número de áreas temáticas, pues existen trabajos enfocados desde la Psicología, la Sociología o la Medicina. Así, las bases de datos empleadas fueron

PsycINFO, *EBSCOhost*, *ProQuest*, *Scopus*, *JSTOR*, *PubMed* y *Psicodoc*. No se introdujo ninguna restricción en los años de búsqueda, ni en el tipo de documento, pues se pretendía realizar una búsqueda exhaustiva y obtener el mayor número de trabajos posibles. Los términos empleados para la búsqueda fueron: «*sexual assertiveness*», «*sexual assertion*», «*sexual assertivity*» y «*sexual assert**» para obtener cualquier otra variante del término «*assertiveness*». En el caso de bases de datos en castellano, los términos empleados fueron «asertividad sexual», «aserción sexual» y «aser* sexual». Los términos de búsqueda se limitaron al título, resumen y palabras clave.

Criterios de inclusión

- Trabajos en los que se analizaba la asertividad sexual de forma específica y claramente operacionalizada. Este criterio permitió descartar todos aquellos trabajos que incluían asertividad general o social, comunicación sexual o habilidades de comunicación y aquellos en los que la operacionalización no dejaba claro si se trataba de asertividad sexual.
- Trabajos que empleaban la asertividad sexual como variable independiente o dependiente, ya fuese mediante su manipulación en programas de prevención o en experimentos, o su evaluación a través de cuestionarios estandarizados, preguntas diseñadas *ad hoc* o mediante *role playing*.
- Trabajos que aportasen datos empíricos originales, descartando trabajos teóricos previos en los que apareciese la asertividad sexual.

Procedimiento

La búsqueda se realizó entre febrero y noviembre de 2009. Una vez recuperados todos los trabajos se procedió a su revisión con el objetivo de analizar cuáles cumplían los criterios de inclusión, los cuales fueron revisados de forma exhaustiva con el objetivo de extraer la información pertinente. Los datos obtenidos fueron codificados en una base de datos para su posterior análisis y discusión.

Codificación de los resultados

De cada uno de los trabajos se extraía la siguiente información:

- Autor/es y año de publicación.
- Metodología del trabajo. Debido a que cada trabajo expone la metodología siguiendo clasificaciones diferentes, se unificaron todas ellas aproximándolas a la clasificación propuesta por Montero y León (2007).
- Muestra. De la que se extraía el número de participantes, sexo y origen de la muestra (estudiantes universitarios *vs*. muestra comunitaria; muestra clínica *vs*. muestra no clínica).
- Evaluación/manipulación de la asertividad sexual. En el caso de tratarse de diseños descriptivos, instrumentales, *ex post facto* o experimentales se analizaba el instrumento empleado para la evaluación de la asertividad sexual, las posibles modificaciones del mismo, así como su fiabilidad (si se informa de ella). En el caso de estudios cuasi-experimentales y experimentales en los que se manipulaba la asertividad sexual también se informaba del tipo de manipulación.

– Principales resultados. Haciendo énfasis en las relaciones y efectos observados por y sobre la asertividad sexual.

Resultados

El procedimiento detallado dio lugar a un total de 76 documentos: 72 artículos de investigación, tres Tesis Doctorales y un resumen de una comunicación oral publicado en el *Journal of Pediatric and Adolescent Gynecology*. Todos estos trabajos se agrupan en tres temáticas principales: 30 relacionados con la respuesta y funcionamiento sexual, 16 relacionados con experiencias de coerción y victimización sexual, y 37 relacionados con conductas sexuales de riesgo. La suma de trabajos por temática alcanza el valor 83 debido a que algunos (*e.g.*, Morokoff *et al*., 1997) aportan resultados clasificables en más de una temática. A pesar de que los trabajos de la primera temática incluyen, en su mayoría, resultados relacionados con la respuesta y funcionamiento sexual, también se han incluido entre éstos resultados referentes a variables sociodemográficas y actitudinales.

Respecto al diseño, 12 estudios (15,78%) son experimentales, 11 (14,47%) cuasi-experimentales, 48 (63,16%) de tipo *ex post facto* y 5 (6,59%) instrumentales. El tipo de muestra se ha organizado en base a tres categorías (sexo, procedencia y muestra clínica). En función del sexo, 5 (6,59%) trabajos incluyen únicamente varones, 46 (60,52%) sólo mujeres y 25 (32,89%) a varones y mujeres. En cuanto a la procedencia, en el 38,15% de los estudios (n = 29) los participantes son universitarios y en el 61,85% (n = 47) de procedencia comunitaria; cinco trabajos (6,59%) emplean muestras clínicas y otros cinco muestras mixtas (clínica y no clínica), siendo la gran mayoría realizados con muestras no clínicas (n = 66; 86,82%). Para finalizar, de los veinte instrumentos que se emplearon para evaluar la asertividad sexual, los más utilizados son por este orden: *Hurlbert Index of Sexual Assertiveness* (Hurlbert, 1991) (n = 18; 23,68%), *Sexual Assertiveness Scale* (Morokoff *et al*., 1997) (n = 17; 22,36%), evaluación mediante *role playing* (n = 8; 10,52%), instrumentos desarrollados *ad hoc* (n = 7; 9,21%) y *Sexual Awareness Questionnaire* (Snell, Fisher y Miller, 1991) (n = 6; 7,89%).

Los resultados principales obtenidos en cada trabajo se pueden observar en la Tabla 1, los cuales son descritos a continuación de forma general agrupados en las distintas temáticas.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS).

Autor	Diseño	Muestra	Evaluación/manipulación AS	Principales resultados
Respuesta y funcionamiento sexual				
Apt, Hurlbert y Powell (1993)	*Ex post facto*	21 parejas comunitarias. Los hombres acudían a terapia por deseo sexual hipoactivo.	HISA (Hurlbert, 1991).	La diferencia entre la AS de los dos miembros de la pareja (AS mujer – AS varón) es un predictor significativo del deseo sexual del varón, pero no de la mujer.
Gentry (1998)	Experimental	254 estudiantes (varones y mujeres) universitarios.	Janda, O´Grady y Barnhart (1981). Factor *Subordination* (α = 0,94).	Las mujeres más activas sexualmente, también eran más asertivas sexualmente.
Greene y Faulkner (2005)	*Ex post facto*	698 parejas comunitarias.	HISA (Hurlbert, 1991). Versión de 19 ítems. Tres factores: *Inicio* (α = 0,86), *Rechazo* (α = 0,81); *Conversación sexual asertiva* (α = 0,79).	Mayor AS-Inicio se relaciona con menor doble moral sexual. Mayor AS se relaciona con mayor satisfacción en la relación. AS se relaciona de forma positiva con la negociación en la pareja, comunicación sexual y discusión sexual.
Haavio-Mannila y Kontula (1997)	*Ex post facto*	Dos muestra comunitarias: 2250 varones y mujeres, y 2188 varones y mujeres.	No se informa del instrumento.	Las mujeres muestran menos AS que los hombres. La satisfacción sexual se relaciona de forma positiva con la AS, tanto en hombres como en mujeres.
Hammond y Oei (1982)	Experimental	29 mujeres comunitarias.	*Sexual Assertiveness Rating Form* (11 ítems). *Sexual Assertiveness Role-playing Test*: compuesto por 16 escenarios, 8 de Inicio y 8 de Rechazo.	La combinación de entrenamiento en habilidades sociales (comunicación asertiva) y reestructuración cognitiva fue el tratamiento más efectivo para incrementar la asertividad sexual, seguido por el entrenamiento en habilidades sociales. Sin embargo, estas intervenciones no mejoraron la asertividad general.
Hurlbert (1991)	Cuasi-experimental	100 mujeres comunitarias.	HISA (Hurlbert, 1991) (α = 0,91)	Las mujeres sexualmente asertivas informan de mayor actividad sexual y orgasmos, mayor deseo sexual y mayor satisfacción sexual y marital.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Hurlbert y Apt (1993)	*Ex post facto*	68 mujeres comunitarias.	HISA (Hurlbert, 1991)	Las mujeres con orientación heterosexual mostraron mayor AS que las mujeres con orientación homosexual.
Hurlbert, Apt y Rabehl (1993)	*Ex post facto*	98 mujeres casadas comunitarias.	HISA (Hurlbert, 1991)	La AS se relaciona de forma positiva con la erotofilia, la consistencia experimentando orgasmos, la cercanía en la relación, la excitabilidad sexual y la satisfacción sexual. Además, es uno de los mejores predictores de la satisfacción sexual.
Hurlbert, Apt y White (1992)	Cuasi-experimental	32 mujeres borderline y 32 no borderline.	HISA (Hurlbert, 1991)	Las mujeres borderline mostraron mayor AS.
Hurlbert *et al.* (2005)	*Ex post facto*	66 mujeres con deseo sexual hipoactivo.	HISA (Hurlbert, 1991)	La AS se relaciona de forma positiva con el estatus socioeconómico, la satisfacción marital, compatibilidad sexual y satisfacción sexual.
Hurlbert, White, Powell y Apt (1993)	Experimental	57 mujeres con trastorno por deseo sexual hipoactivo.	HISA (Hurlbert, 1991)	La AS mejoró debido a un entrenamiento en consistencia del orgasmo en el grupo en el que participaban los dos miembros de la pareja, pero no cuando participaban sólo las mujeres.
Jacobs y Thomlison (2009)	*Ex post facto*	572 mujeres comunitarias.	SAS (Morokoff *et al.*, 1997) (α = 0,83)	La AS se relaciona con mayor autoestima y búsqueda de sensaciones y con menor supresión de pensamientos o acciones contrarios a los de la pareja para evitar conflictos) y creencias negativas, vergüenza y prejuicios sociales hacia personas con VIH.
Ménard y Offman (2009)	*Ex post facto*	25 varones y 46 mujeres comunitarios.	Sexual Assertiveness Scale (Shafer, 1977). 28 ítems.	La AS es un mediador parcial de la relación entre la autoestima sexual sobre la satisfacción sexual. La relación de la AS sobre la satisfacción sexual está mediada parcialmente por la autoestima sexual.
Morokoff *et al.* (1997)	Instrumental	Dos muestras de mujeres comunitarias: 503 y 714.	SAS (Morokoff *et al.*, 1997)	La AS se relaciona con una mayor satisfacción en la relación de pareja, buen intercambio con la pareja y mayor experiencia sexual.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Murphy, Coleman, Hoon y Scott (1980)	Cuasi-experimental	74 mujeres alcohólicas.	Entrenamiento en AS.	Las mujeres que completaron el programa que incluía entrenamiento en AS mejoraron en satisfacción marital, activación sexual y educación sexual.
Oattes y Offman (2007)	*Ex post facto*	27 varones y 47 mujeres comunitarios.	*Sexual Assertiveness Scale* (Shafer, 1977).	Existe una correlación moderada entre la AS y la comunicación sobre cuestiones generales en la pareja. La autoestima sexual es mejor predictor de la AS que la autoestima general.
Onuoha y Munakata (1999)	*Ex post facto*	101 adolescentes varones y mujeres.	*AIDS Social Assertiveness Scale* (ASAS) ($\alpha = 0,82$) y *AIDS Self-Assertion Questionnaire* (ASAQ) ($\alpha = 0,82$)	No hay diferencias estadísticamente significativas en AS entre australianos y japoneses, aunque los japoneses muestran menor AS.
Pierce y Hurlbert (1999)	Instrumental	54 participantes no clínicos y 46 clínicos (acudían a terapia de pareja).	HISA (Hurlbert, 1991).	Los hombres mostraron mayor AS que las mujeres, tanto en la muestra clínica como en la no clínica.
Rickert, Neal, Wiemann y Berenson (2000)	*Ex post facto*	904 mujeres comunitarias.	13 ítems que evaluaban asertividad sexual.	Las mujeres con baja AS creen que su pareja es monógama, están casadas o viven con su pareja y han tenido menos de tres parejas sexuales en su vida.
Rickert, Sanghvi y Wiemann (2002)	*Ex post facto*	904 mujeres comunitarias.	Cuestionario *ad hoc*. Uno de los componentes era AS percibida.	La historia sexual y reproductiva y la historia de abuso previo son los mejores predictores de la AS, concretamente el número de parejas es el mejor predictor. Pertenecer a una minoría étnica, menor edad, bajo nivel escolar, inexperiencia sexual y el uso inconsistente de métodos anticonceptivos se relacionan con baja AS.
Schooler y Ward (2006)	*Ex post facto*	184 varones universitarios.	HISA (Hurlbert, 1991) ($\alpha = 0,92$)	La AS se relacionó de forma negativa con la religiosidad y con ser de origen asiático y de forma positiva con el confort con el propio cuerpo y con el cuerpo de las mujeres.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Schooler, Ward, Merriwether y Caruthers (2005)	*Ex post facto*	199 mujeres universitarias.	HISA (Hurlbert, 1991) (α = 0,92)	Las mujeres con actitudes más favorables hacia la menstruación, mayor confort con el propio cuerpo y con más experiencia sexual muestran más AS. La AS ejerce un efecto mediador entre el confort con el propio cuerpo y la experiencia sexual.
Sierra *et al.* (2008)	Instrumental	530 mujeres.	HISA (Hurlbert, 1991) (α = 0,90)	La AS correlacionó de forma positiva con la erotofilia y con la autoestima.
Snell et al. (1991)	Instrumental	173 varones y mujeres universitarios.	SAQ (Snell *et al.*, 1991). Subescala de AS (α = 0,81-0,83)	Los hombres informan de mayor AS que las mujeres. La AS correlacionó de forma negativa con culpabilidad sexual, ansiedad sexual y ansiedad para el contacto heterosexual. En mujeres correlacionó de forma negativa con depresión y locus de control externo (creencia en la suerte) y de forma positiva con autoestima, erotofilia y locus de control interno.
Snell y Wooldridge (1998)	*Ex post facto*	253 varones y mujeres universitarios.	SAQ (Snell *et al.*, 1991) Subescala AS	Tanto en varones como en mujeres la AS se relaciona con mayor experiencia sexual.
Van Anders y Dunn (2009)	*Ex post facto*	177 varones y mujeres comunitarios.	HISA (Hurlbert, 1991)	La AS no muestra relación con los niveles de testosterona y estradiol, ni en hombres ni mujeres. Los participantes con alta AS informaron de mayor número de orgasmos en la pareja.
Walker (2006)	*Ex post facto*	447 mujeres universitarias.	SAQ-W (Walker, 2006) (α = 0,74-0,93)	La baja AS actúa como predictor de una identidad sexual negativa y de la conducta sexual no motivada para la sexualidad.
Weaver y Byers (2006)	*Ex post facto*	214 mujeres universitarias.	HISA (Hurlbert, 1991) (α = 0,82)	La AS baja se relaciona con insatisfacción con el propio cuerpo general y en situaciones sexuales.
Yamayima, Cash y Thompson (2006)	*Ex post facto*	384 mujeres universitarias.	SAQ (Snell *et al.*, 1991) (α = 0,84)	Las mujeres con mayor preocupación por la imagen corporal y por la apariencia corporal en situaciones sexuales muestran menor AS.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Yoder, Perry y Saal (2007)	*Ex post facto*	165 mujeres comunitarias.	SAS (Morokoff *et al.*, 1997) (α = 0,76–0,86).	Las mujeres con puntuaciones elevadas en aceptación pasiva (sumisión) muestran puntuaciones más bajas en AS global, AS-Inicio y AS-prevención embarazo/STD.
Victimización sexual				
Apt y Hurlbert (1993)	Cuasi-experimental	120 mujeres: 60 sufrían abuso de pareja y 60 no.	HISA (Hurlbert, 1991) (α = 0,84)	Las mujeres que sufrían abuso de pareja mostraban menor AS.
Corbin, Bernat, Calhoun, McNair y Seals (2001)	*Ex post facto*	238 mujeres universitarias.	SAS (Morokoff *et al.*, 1997)	Las mujeres que han sufrido alguna experiencia de victimización sexual muestran menor habilidad para rechazar actos sexuales no deseados (menor AS-Rechazo).
Greene y Navarro (1998)	*Ex post facto*	274 mujeres universitarias.	Asertividad sexual. Añadiendo "con el sexo opuesto" a los ítems del *Inventory of Interpersonal Problems* (Horowitz, Rosenberg, Baer, Ureno y Villasenor, 1988). (Fiabilidad dos mitades = 0,92–0,94).	La victimización sexual correlacionó de forma negativa con la AS. La baja AS con el sexo opuesto es uno de los factores principales (junto con la victimización previa) en la predicción de la victimización sexual.
Kiefer y Sánchez (2007)	Experimental	48 varones universitarios.	Percepción de ser sexualmente asertivo (α = 0,73)	La percepción de una mayor necesidad de ser sexualmente asertivo se relaciona con una menor inhibición ante conceptos relacionados con dominancia sexual.
Livingston, Testa y VanZile-Tamsen (2007)	*Ex post facto*	937 mujeres comunitarias.	SAS-Rechazo (Morokoff *et al.*, 1997) (α = 0,77)	La victimización sexual predice de forma negativa la AS-Rechazo, y ésta predice de forma negativa la subsecuente victimización sexual.
Macy, Nurius y Norris (2006)	*Ex post facto*	202 mujeres universitarias.	2 ítems del SAS (Harlow, Quina, Morokoff, Rose y Grimley, 1993)	La AS funciona como un factor de protección que modula la respuesta de escape y resistencia ante una agresión sexual, pues se relaciona de forma negativa con las barreras que favorecen una agresión.
Miner, Flitter y Robinson (2006)	*Ex post facto*	230 mujeres comunitarias.	9 ítems dicotómicos (α = 0,73)	No se encontraron diferencias en AS en función del tipo de victimización (abuso sexual en la infancia, victimización adulta y revictimización).

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Morokoff *et al.* (1997)	Instrumental	Dos muestras de mujeres comunitarias: 503 y 714.	SAS (Morokoff *et al.*, 1997).	La AS se relaciona de forma negativa con la victimización, coerción y asalto sexual y con historia de abuso en la infancia.
Rickert *et al.* (2000)	*Ex post facto*	904 mujeres comunitarias.	13 ítems que evaluaban asertividad sexual.	Las mujeres con baja AS informan de contactos sexuales forzados en los últimos 12 meses, pero ausencia de abuso físico.
Sierra, Ortega, Santos y Gutiérrez (2007)	Instrumental	300 mujeres comunitarias.	HISA (Hurlbert, 1991) (α = 0,89)	La AS se relaciona de forma negativa con las experiencias de abuso físico y no físico dentro de la pareja.
Stoner *et al.* (2008)	Experimental	161 mujeres comunitarias.	SAS (Morokoff *et al.*, 1997) (α = 0,80).	Hay una relación negativa entre AS y agresión sexual adulta y violencia de pareja.
Testa y Dermen (1999)	*Ex post facto*	190 mujeres comunitarias.	*Health Protective Communication Scale* (Catania, 1998). Asertividad relacionada con VIH (α = 0,83).	Las mujeres que han sufrido coerción sexual informan de menor AS. Sin embargo, haber sufrido una violación no influye en la AS.
Testa, VanZile-Tamsen y Livingston (2007)	*Ex post facto*	927 mujeres comunitarias.	SAS-Rechazo (Morokoff *et al.*, 1997) (α = 0,77)	Bajos niveles de AS predicen la victimización sexual por parte de la pareja.
VanZile-Tamsen, Testa y Livingston (2005)	Experimental	318 mujeres comunitarias.	SAS-Rechazo (Morokoff *et al.*, 1997) (α = 0,77).	La victimización adolescente/adulta y el CSA se relacionan de forma negativa con AS-Rechazo y ésta a su vez actúa como mediador entre la resistencia directa o la no resistencia ante una agresión.
Walker (2006)	*Ex post facto*	447 mujeres universitarias.	SAQ-W (Walker, 2006) (α = 0,74-0,93)	La AS mantiene una relación negativa con la coerción sexual.
Yagil, Karnieli-Miller, Eisikovits y Enosh (2006)	Experimental	374 varones y mujeres universitarios.	Presentación de escenarios asertivos *vs.* no-asertivos.	Las respuestas asertivas son más efectivas en la reducción de avances sexuales no deseados.
Conductas de riesgo				
Artz, Demand, Pulley, Posner y Macaluso (2002)	Cuasi-experimental	1.159 mujeres comunitarias.	Entrevista cualitativa.	Las mujeres que tienen dificultades para introducir el condón femenino muestran menores niveles de AS que aquellas sin dificultades.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Auslander, Perfect, Succop y Rosenthal (2007)	*Ex post facto*	106 adolescentes varones y mujeres.	SAS (Morokoff *et al.*, 1997).	Las adolescentes con historia de embarazo previo inician más frecuentemente la conducta sexual. Un mayor número de parejas sexuales se asocia con menor frecuencia de conductas asertivas de rechazo. Una mayor experiencia sexual previa, un mayor número de parejas y un mayor número de contactos sexuales desprotegidos se relacionan con un menor número de conductas de prevención de embarazo/ITS.
Baele, Dusseldorp y Maes (2001)	*Ex post facto*	424 adolescentes varones y mujeres: con experiencia sexual (*n* = 165) y sin experiencia (*n* = 255).	Escala *ad hoc* (6 ítems) (α = 0,76).	La AS se relaciona con la intención y la consistencia en el uso del preservativo en adolescentes con y sin experiencia sexual.
Bay-Cheng y Zucker (2007)	*Ex post facto*	430 mujeres universitarias.	Escala de Asertividad del SAQ (Snell *et al.*, 1991) (α = 0,90).	No existen diferencias entre mujeres con ideología feminista, igualitaria y no feminista en su AS para el uso del preservativo.
Bertens, Eiling, Van den Borne y Schaalma (2009)	Cuasi-experimental	273 mujeres comunitarias	*Sexual Self-Efficacy Scale* (Rosenthal, Moore y Flynn, 1991); RBD (Witte, Cameron, McKeon y Berkowitz, 1996).	La intervención para la prevención de ITS/VIH mejoró la AS de las participantes.
Caruthers (2005)	*Ex post facto*	Dos muestras: 361 y 171 mujeres comunitarias.	HISA (Hurlbert, 1991) (α = 0,92 y 0,93).	Las mujeres en relaciones con pareja ocasional muestran menos AS que las mujeres en relaciones estables. Correlación negativa entre AS y edad de la menarquia y religiosidad, y positiva con la edad.
Crowell (2004)	Cuasi-experimental	40 pacientes VIH positivo y 40 VIH negativo.	*Intimate Relationships Questionnaire* (IRQ) (α = 0,90 – 0,91).	La AS se relaciona de forma positiva con el uso del condón en sexo oral, vaginal y anal, con la frecuencia de comunicación sobre sexo seguro y el deseo de comunicación sobre sexo seguro.
DiNoia y Schinke (2007)	Cuasi-experimental	204 mujeres adolescentes.	Escala AS del SAQ (Snell *et al.*, 1991) (α = 0,80).	En el postest las mujeres que pasaron por el programa de prevención del VIH (*Keepin' it Safe*) aumentaron su AS.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Dolcini y Catania (2000)	Cuasi-experimental	209 mujeres con pareja en riesgo sexual y 209 con pareja sin riesgo.	*Sexual Assertiveness Scale* (Kirby, 1998). 5 ítems (α = 0,83).	Las mujeres con pareja de riesgo mostraron menos AS que las mujeres con pareja sin riesgo.
Hardeman, Pierro y Mannetti (1997)	*Ex post facto*	274 estudiantes universitarios y de educación superior.	5 ítems que evalúan asertividad en las relaciones sexuales (α = 0,44).	Las mujeres muestran mayor asertividad sexual que los hombres. La asertividad sexual es un predictor fiable de la intención para evitar relaciones sexuales casuales.
Jenkins (2008)	*Ex post facto*	111 mujeres comunitarias.	SAS (Morokoff *et al*., 1997) (α = 0,71 – 0,83).	Las mujeres que no han tenido pareja manifiestan menos AS-Rechazo que las que han tenido una pareja. Correlación positiva entre las escalas *Rechazo* y *Prevención embarazo/STD*.
Kelly, Lawrance, Hood y Brasfield (1989)	Experimental	104 varones comunitarios (homosexuales).	AS *role play*.	La intervención con un componente de entrenamiento en AS redujo el rechazo de actividades sexuales de riesgo y conductas de riesgo para el VIH/sida
Kelly, Murphy y Washington (1994)	Experimental	197 mujeres comunitarias.	AS *role play*.	Las mujeres en el grupo experimental mejoraron sus habilidades de comunicación y negociación sexual. Los contactos sexuales desprotegidos disminuyeron y el uso del preservativo aumentó de un 26 a un 56% en los contactos sexuales.
Klein y Knäuper (2003)	*Ex post facto*	71 mujeres universitarias.	14 ítems *del Intimate Relationships Questionnaire* (Yesmont, 1992).	Las mujeres con baja AS tienden a evitar pensamientos relacionados con las ITS.
Morokoff *et al*. (1997)	Instrumental	Dos muestras de mujeres comunitarias: 503 y 714.	SAS (Morokoff *et al*., 1997).	La AS se relaciona con una mayor autoeficacia en la prevención del VIH.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Morokoff *et al.* (2009)	*Ex post facto*	473 varones y mujeres comunitarios.	SAS-prevención embarazo/STD (Morokoff *et al.*, 1997) (α = 0,78)	La AS correlaciona de forma positiva con el uso del condón, la fase de cambio para el uso del condón y la ratio de sexo protegido. Es un predictor significativo del sexo desprotegido y ejerce un papel mediador entre éste y la victimización sexual en hombres y entre éste y la depresión y victimización sexual en mujeres.
Mosack, Weeks, Sylla y Abbott (2005)	*Ex post facto*	109 mujeres comunitarias.	SAS-Prevención embarazo/STD (Morokoff *et al.*, 1997) (α = 0,70)	La AS-prevención embarazo/STD es un predictor de la intención de uso de microbicidas en las relaciones sexuales.
Noar, Morokoff y Harlow (2002)	*Ex post facto*	471 varones y mujeres universitarios.	SAS-Prevención embarazo/STD (Morokoff *et al.*, 1997)	La AS-prevención embarazo/STD se relaciona con diversas estrategias de influencia para el uso del preservativo (interrupción del sexo, petición directa, seducción, insistencia en la importancia de la relación, información sobre el riesgo).
Noar, Morokoff y Redding (2002)	*Ex post facto*	Tres muestras: 272 y 152 varones universitarios; 62 varones en riesgo para el VIH.	SAS-Prevención embarazo/STD (Morokoff *et al.*, 1997) (α = 0,73-0,78).	Existen diferencias en AS-prevención embarazo/STD en función de la etapa de cambio para el uso del condón; mayor AS quienes lo usan de forma más consistente. Los varones con mayor AS tienen menor tendencia a involucrarse en actividad sexual desprotegida.
Onuoha y Munakata (2005)	*Ex post facto*	1.957 varones y mujeres universitarios.	7 ítems derivados del *Becoming A Responsible Teen* (BART; St. Lawrence, 1998).	Tanto la AS como la asertividad social son predictores de la evitación del VIH, siendo mayor el efecto de la AS.
Parks, Hsieh, Collins, King y Levonyan-Radloff (2009)	*Ex post facto*	241 mujeres comunitarias.	SAS (Morokoff *et al.*, 1997) (α = 0,66-086).	Niveles bajos de AS-Embarazo/STD se relacionan con un menor uso del condón tanto con parejas estables como ocasionales.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Quina, Harlow, Morokoff, Burkholder y Deiter (2000)	*Ex post facto*	816 mujeres comunitarias.	SAS-Inicio y SAS-Rechazo (Morokoff *et al.*, 1997) (α = 0,77 y 0,74, respectivamente).	La comunicación sexual asertiva sobre las preferencias sexuales se relaciona más con AS-Inicio que con Rechazo. La comunicación sexual asertiva que busca información en la pareja sobre su riesgo para el VIH se relaciona más con la AS-Rechazo que con Inicio.
Rickert *et al.* (2000)	*Ex post facto*	904 mujeres comunitarias.	13 ítems que evaluaban asertividad sexual.	Las mujeres con baja AS informan de un uso inconsistente de mecanismos de control de embarazo.
Roberts y Kennedy (2006)	*Ex post facto*	100 mujeres universitarias.	11 ítems. Adaptación de Wingood y DiClemente (1998b) (α = 0,77). Evalúa la habilidad de la mujer para sugerir usar el condón a su pareja.	La AS correlaciona de forma positiva con el uso del condón, mayor control sexual y la intención del uso del condón.
Sikkema, Winett y Lombard (1995)	Experimental	43 mujeres universitarias.	Entrenamiento cognitivo-conductual de habilidades sociales para mejorar la AS. AS *role play.*	El entrenamiento en habilidades sociales mejoró la asertividad sexual de los participantes y redujo el número de conductas sexuales de riesgo.
Snell y Wooldridge (1998)	*Ex post facto*	253 varones y mujeres universitarios.	SAQ (Snell *et al.*, 1991) Subescala AS.	Tanto en hombres como en mujeres la AS se relacionó con un mayor uso de métodos contraceptivos.
Somlai *et al.* (1998)	Cuasi-experimental	114 varones y mujeres con enfermedad mental severa.	AS *Role play.*	Los participantes con menor AS mostraron menor porcentaje de uso del condón, mayor número de actos sexuales desprotegidos, parejas sexuales diferentes y ocasionales.
St. Lawrence *et al.* (1995)	Experimental	246 varones y mujeres adolescentes.	AS *Role play.*	El programa de intervención que incluye entrenamiento en AS disminuye los intercambios sexuales desprotegidos y aumenta el uso del preservativo.
Stoner *et al.* (2008)	Experimental	161 mujeres comunitarias.	SAS (Morokoff *et al.*, 1997) (α = 0,80).	Las participantes con menor AS insistían menos en el uso del condón, independientemente del grado de intoxicación alcohólica.

TABLA 1. Principales resultados de los estudios de asertividad sexual (AS). (Cont.).

Stulhofer, Graham, Bozievic, Kufrin y Ajdukovic (2007)	*Ex post facto*	1.093 hombres y mujeres comunitarias.	3 ítems dicotómicos (α = 0,52).	Las mujeres muestran más AS que los hombres. Sólo en el caso de las mujeres, la AS predice de forma negativa las conductas sexuales de riesgo.
Treffke, Tiggemann y Ross (1992)	*Ex post facto*	83 hombres homosexuales y 128 heterosexuales comunitarios.	*Condom Assertiveness Scale* (CAS) 26 ítems. (α = 0,94).	AS para el uso del condón correlaciona de forma positiva con las actitudes positivas hacia el uso del condón.
Weinhardt, Carey, Carey y Verdecias (1998)	Cuasi experimental	20 mujeres con trastornos psiquiátricos.	Escenarios de *role play* Entrenamiento en AS (Kelly, 1995).	Las mujeres que recibieron el entrenamiento en AS mejoraron su AS del pre al post y en seguimiento. Además mejoraron la frecuencia de sexo desprotegido.
Weinstein, Walsh y Ward (2008)	*Ex post facto*	347 varones y mujeres universitarios.	HISA (Hurlbert, 1991) (α = 0,92).	La AS se relaciona de forma positiva con mayor conocimiento sobre contracepción, uso del preservativo, ITS, VIH/sida.
Wingood y DiClemente (1998a)	*Ex post facto*	128 mujeres comunitarias.	7 ítems que evalúan su capacidad de comunicarse asertivamente con sus parejas sexuales (α = 0,77).	La AS se relaciona con un uso consistente del condón en mujeres.
Workman, Robinson, Cotler y Harper (1997)	Experimental	111 mujeres adolescentes.	AS y habilidades de comunicación. *Sexual Assertiveness Scale* (Kirby, 1984) (α = 0,78).	Las adolescentes afroamericanas mostraron mayores niveles de AS que las hispanas.
Yesmont (1992)	*Ex post facto*	253 varones y mujeres universitarios.	*Intimate Relationships Questionnaire* (IRQ).	Las mujeres muestran más respuestas asertivas que los varones. La AS correlaciona con la precaución, preguntas a la pareja sobre conductas de riesgo y el uso del preservativo.
Zamboni, Crawford y Williams (2000)	*Ex post facto*	227 varones y mujeres universitarios.	SAQ (Snell *et al.*, 1991).	La AS es el principal predictor de la frecuencia del uso del condón en sexo vaginal. Correlaciona con asertividad general y comunicación sexual. La relación entre AS y uso del condón está mediada por las actitudes hacia el preservativo; la relación es positiva cuando las actitudes hacia el condón son positivas.

Respuesta y funcionamiento sexual

Los resultados muestran que la asertividad sexual se relaciona de forma positiva con el deseo sexual (Hurlbert, 1991), tanto en varones como en mujeres. Una mayor asertividad sexual en la mujer es un predictor del deseo sexual del varón (Apt *et al*., 1993). También se encuentra una relación positiva con la satisfacción sexual y marital (Greene y Faulkner, 2005; Haavio-Mannila y Kontula, 1997; Hurlbert, 1991; Ménard y Offman, 2009), con el número de orgasmos y, sobre todo, con la consistencia en alcanzarlo (Hurlbert, 1991; Hurlbert, Apt *et al*., 1993; Hurlbert, White *et al*., 1993), y con la actividad y experiencia sexual (Gentry, 1998; Morokoff *et al*., 1997; Rickert *et al*., 2000; Snell y Wooldridge, 1998). Sin embargo, no parece existir una relación entre la asertividad sexual y los niveles hormonales, ni en hombres ni en mujeres (Van Anders y Dunn, 2009).

Al margen de la respuesta y funcionamiento sexual, se ha informado de mayor asertividad sexual en varones (Haavio-Mannila y Kontula, 1997; Pierce y Hurlbert, 1999), en mujeres heterosexuales frente a mujeres homosexuales (Hurlbert y Apt, 1993), en personas de estatus socioeconómico elevado (Hurlbert *et al*., 2005), en mujeres con trastorno de personalidad *borderline* (Hurlbert, Apt *et al*., 1992) y en personas poco religiosas (Schooler y Ward, 2006). Por otra parte, diversas variables actitudinales relacionadas con la respuesta sexual se encuentran asociadas con la asertividad sexual. Así, las personas con alta asertividad muestran menor doble moral sexual, mayor autoestima global y sexual, menor búsqueda de sensaciones y mayor erotofilia (Greene y Faulkner, 2005; Hurlbert, Apt *et al*., 1993; Jacobs y Thomlison, 2009; Oattes y Offman, 2007; Sierra *et al*., 2008), tienen actitudes más favorables hacia la menstruación, muestran menor culpabilidad sexual y menor sumisión ante la pareja y manifiestan una identidad sexual más positiva, experimentando un mayor confort con su propio cuerpo (Schooler y Ward, 2006; Schooler *et al*., 2005; Walker, 2006; Weaver y Byers, 2006; Yamamiya *et al.,* 2006; Yoder *et al*., 2007).

Victimización y coerción sexual

En líneas generales, los estudios demuestran que la asertividad sexual funciona como un factor de protección frente a la victimización y coerción sexual (Macy *et al*., 2006), ya que es una estrategia eficaz en la reducción de avances sexuales no deseados (Corbin *et al*., 2001; Yagil *et al*., 2006). Además, se ha demostrado una relación negativa con distintos tipos de conductas de abuso, como abuso sexual en la infancia, coerción sexual victimización (Greene y Navarro, 1998; Morokoff *et al*., 1997; Rickert *et al*., 2000; Sierra *et al*., 2007; Stoner *et al*., 2008; Testa y Dermen, 1999; Testa *et al*., 2007; VanZile-Tamsen *et al*., 2005; Walker, 2006), sin que existan diferencias en asertividad sexual en función del tipo de abuso (Miner *et al*., 2006), encontrándose también esa relación con distintos tipos de agresores, ya sean personas desconocidas, citas ocasionales, relaciones de pareja estable o matrimonios (Apt y Hurlbert, 1993; Testa *et al*., 2007). Se ha señalado además que la baja asertividad sexual puede ser tanto una consecuencia de la victimización como un factor de riesgo para la misma (Livingston *et al*., 2007).

Conductas sexuales de riesgo

De la misma forma que sucede con la victimización sexual, la asertividad funciona como un factor de protección ante conductas sexuales de riesgo (Hardeman *et al*., 1997; Kelly *et al*., 1989; Kelly *et al*., 1994; Sikkema *et al*., 1995). Los estudios demuestran que una mayor asertividad sexual se relaciona no sólo con el uso del preservativo de forma consistente (Baele *et al*., 2001; Bay-Cheng y Zucker, 2007; Crowell, 2004; Morokoff *et al*., 2009; Wingood y DiClemente, 1998a), sino también con la intención de uso del mismo (Baele *et al*., 2001; Roberts y Kennedy, 2006) independientemente de si se ha ingerido alcohol (Stoner *et al*., 2008), las actitudes positivas hacia su uso (Treffke *et al.*, 1992; Zamboni *et al.*, 2000), la intención para usar microbicidas (Mosack *et al.*, 2005) y mejores estrategias de influencia para el uso del preservativo (Noar, *et al.,* 2002). Además, puede actuar como mediador en la relación que se establece entre la victimización sexual y las conductas sexuales de riesgo (Morokoff *et al*., 2009). Por el contrario, la baja asertividad sexual se relaciona con dificultades para usar el condón fenemino (Artz *et al.*, 2002; Lameiras-Fernández, Núñez-Mangana, Rodríguez-Castro, Bretón-López y Agudelo, 2007) y con un uso inconsistente de mecanismos útiles para la prevención de embarazos (Rickert *et al*., 2000; Snell y Wooldridge, 1998), razón por la cual se asocia con historia de embarazo previo (Auslander *et al.*, 2007).

También se ha señalado que las personas con baja asertividad sexual tienen un mayor número de parejas sexuales (Auslander *et al*., 2007), suelen tener más parejas en riesgo para el contagio por VIH (Dolcini y Catania, 2000), tienen mayor número de relaciones sexuales casuales (Somlai *et al*., 1998) y evitan pensamientos acerca de las infecciones de transmisión sexual (ITS) (Klein y Knäuper, 2003). Además, la asertividad sexual es menor en mujeres que tienen encuentros ocasionales que en aquellas con pareja estable (Caruthers, 2005). Por último, también se ha puesto de manifiesto que intervenciones destinadas a prevenir el contagio de ITS/VIH producen mejoras en la asertividad sexual (Bertens *et al.*, 2009; Di Noia y Schinke, 2007) y que programas destinados a mejorar la asertividad sexual reducen el número de conductas de riesgo emitidas por una persona (Kelly *et al*., 1989; Kelly *et al*., 1994; Sikkema *et al*., 1995; St. Lawrence *et al*., 1995; Weinhardt *et al.*, 1998).

Discusión

La importancia de la asertividad sexual dentro de la sexualidad humana constituye un hecho relevante y constatado (Hammond y Oei, 1982); sin embargo, no existen estudios que agrupen y analicen la información obtenida acerca de este constructo. Los resultados obtenidos en esta revisión de trabajos publicados hasta la fecha demuestran que la asertividad sexual es un elemento fundamental en el funcionamiento y respuesta sexual, y que es sumamente relevante como factor de protección ante conductas sexuales de riesgo y experiencias de victimización y coerción sexual.

A nivel descriptivo encontramos que la mayoría de los estudios son de diseño *ex post facto*, mientras que pocos son de tipo experimental o cuasi-experimental. Si bien es cierto que los estudios experimentales son los que permiten establecer relaciones de causalidad (Montero y León, 2007; Ramos-Alvarez, Moreno-Fernández, Valdés-Conroy

y Catena, 2008) y, por tanto, descubrir el auténtico papel de la asertividad sexual, también es verdad que en determinadas áreas como en victimización sexual es difícil plantear estudios experimentales dotados de la suficiente validez ecológica. Por otra parte, también es notorio que a pesar de la cantidad de instrumentos encontrados para evaluar de una u otra forma la asertividad sexual, los estudios instrumentales son muy escasos, es decir, que la mayoría de los instrumentos empleados no han sido desarrollados siguiendo unos estándares mínimos que garanticen su adecuado funcionamiento.

Respecto a las muestras empleadas destacan sobre todo los estudios realizados con mujeres, echándose en falta estudios con varones, así como trabajos que analicen las relaciones diádicas. También, al igual que sucede con otros constructos sexuales (*e.g.*, satisfacción sexual) el empleo de muestras de homosexuales o de ancianos es prácticamente inexistente (Delamater, Hyde y Fong, 2008; Henderson, Lehavot y Simoni, 2009). Por último, también hay que destacar que algo más de un 45% de los estudios se realizan con los mismos instrumentos: el *SAS* (Morokoff *et al*., 1997) y el *HISA* (Hurlbert, 1991), que son justamente los que se han desarrollado a través de estudios instrumentales. Sin embargo, hay que destacar la elevada utilización de instrumentos desarrollados *ad hoc* carentes, en la mayoría de los casos, de las garantías psicométricas necesarias.

Los resultados del primer grupo de estudios ponen de manifiesto la asociación de la asertividad sexual con las distintas fases de la respuesta sexual humana, como el deseo, el orgasmo y la satisfacción (Haavio-Mannila y Kontula, 1997; Hurlbert, 1991; Hurlbert, Apt *et al.*, 1993; Hurlbert, White *et al*., 1993). Sin embargo, estos estudios han sido elaborados mediante diseños *ex post facto*, lo que impide conocer los mecanismos o procesos por los cuales se da esta asociación y mucho menos cuál es la dirección de la misma. Por ejemplo, las personas que tienen mayor asertividad sexual, ¿se comunican más con la pareja solicitando aquello que les resulta placentero y, por tanto, consiguen mayores niveles de satisfacción o, por el contrario, la satisfacción sexual crea un mayor vínculo en la pareja y es este vínculo el que favorece la asertividad sexual? Respecto al primer ejemplo, algunos estudios han demostrado que la autorrevelación sexual favorece la satisfacción (Byers y MacNeil, 2008; MacNeil y Byers, 2005), pero no se han llevado a cabo estudios similares con asertividad sexual. Respecto al segundo, sí se ha demostrado que un mayor vínculo y compromiso en la pareja se asocia con la satisfacción sexual (Warehime y Bass, 2008), pero no se sabe si esta relación esta mediada por la asertividad sexual. De la misma manera también se echan en falta más estudios sobre el papel de los niveles hormonales y de la excitación –medida a través de registros psicofisiológicos- en las respuestas asertivas.

Respecto a variables sociodemográficas, los resultados más interesantes tienen que ver con el papel del sexo. Aquí se encuentran resultados contradictorios, pues mientras algunos estudios sostienen una mayor asertividad sexual en varones (Haavio-Mannila y Kontula, 1997; Pierce y Hurlbert, 1999) otros lo hacen en mujeres (Hardeman *et al*., 1997; Stulhofer *et al.*, 2007), si bien desde una perspectiva de género lo esperable es que las mujeres muestren menos asertividad sexual, pues iniciar interacciones asertivas

en situaciones sexuales no es una habilidad que se haya enseñado con frecuencia a las mujeres (Muehlenhard y McCoy, 1991). Además algunos estudios demuestran que las mujeres que discuten sus deseos sexuales y toman decisiones basadas en sus propias necesidades corren el riesgo de ser etiquetadas como «zorras» (*sluts*) (Holland, Ramazanoglu, Scott, Sharpe y Thompson, 1990). Por ello, sería necesario investigar cuál es el papel real que juega el sexo en la asertividad sexual. Por el contrario, sí queda claro el papel de las actitudes sexuales y otros factores que favorecen el funcionamiento sexual, como la autoestima, una imagen corporal positiva o la búsqueda de sensaciones sexuales.

Los estudios relacionados con la victimización y la coerción sexual no dejan lugar a dudas de que la asertividad sexual, en líneas generales, es un factor de protección frente a las experiencias de abuso (Macy *et al*., 2006). Además, la principal ventaja es que estos resultados se han encontrado en distintas modalidades de abuso, así como ante diferentes tipos de agresores. Sin embargo, existe un aspecto discutido que es conveniente aclarar y sobre el que se han realizado pocos estudios y es si la baja asertividad surge como consecuencia de las experiencias de victimización o si la baja asertividad es la causa de las mismas. En este sentido, en el estudio de Livingston *et al*. (2007) se encontró que la asertividad es tanto causa como consecuencia de la victimización sexual, razón por la que son necesarios más estudios al respecto, que tal y como señalan dichas autoras, deben ser de tipo longitudinal.

Por último, tal y como muestran los resultados relativos a la victimización, los estudios sobre conductas sexuales de riesgo coinciden en señalar el papel preventivo de la asertividad sexual ante dichas conductas (Hardeman *et al*., 1997; Kelly *et al*., 1989; Kelly *et al*., 1994; Sikkema *et al*., 1995). A pesar de ello, estos estudios han sido en su mayoría desarrollados con poblaciones heterosexuales, por lo que es necesario trabajar con poblaciones homosexuales y bisexuales para comprobar si los resultados coinciden, siempre teniendo en cuenta que es la asertividad sexual y no la general la que funciona como factor de protección y, por tanto, los estudios y las estrategias de intervención –que también se han mostrado efectivas- tienen que ser diseñadas sobre la asertividad sexual.

Para finalizar, es necesario volver a insistir en el papel fundamental de la asertividad sexual humana, tal y como se desprende de los resultados obtenidos y revisados en el presente trabajo. De esto se deriva también la necesidad de contemplar la inclusión de la misma en programas de prevención e intervención (véase, por ejemplo, Carrera-Fernández, Lameiras-Fernández, Foltz, Núñez-Mangana y Rodríguez-Castro, 2007), tal y como se ha venido haciendo de forma generalizada con los entrenamientos en habilidades sociales que incluían componentes de asertividad general. Sin duda, las conclusiones extraídas del presente trabajo serían mucho más valiosas si se hubiese empleado una metodología meta-analítica (Cooper y Rosenthal, 1980), pero la heterogeneidad de variables tratadas, instrumentos y diseños empleados en un número tan reducido de trabajos favorecieron la realización de una revisión sistemática descartando la posibilidad de realizar un estudio meta-analítico, que será más pertinente cuando se disponga un mayor número de trabajos (Botella y Gambara, 2006; Cooper, 1998).

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HURLBERT INDEX OF SEXUAL ASSERTIVENESS: A STUDY OF PSYCHOMETRIC PROPERTIES IN A SPANISH SAMPLE[1, 2]

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Summary.—The study analyzed psychometric properties of a Spanish version of the Hurlbert Index of Sexual Assertiveness in a Spanish sample of 400 men and 453 women who had had a partner for the last 6 mo. or longer at the time of the study. Exploratory and confirmatory factor analyses suggested a two-factor solution with the factors Initiation and No shyness/Refusal. Internal consistency values for total scores were .87 and .83 for the factors, respectively. Convergent validity tests were also satisfactory. It is therefore reasonable to conclude that the Spanish version of the scale has appropriate psychometric properties.

Sexual assertiveness implies that people have the right to make independent decisions about their own sexual experiences and activities (Morokoff, Quina, Harlow, Whitmire, Grimley, Gibson, & Burkholder, 1997). It reflects people's ability to initiate sexual activity, reject unwanted sexual activity, use contraceptive methods, and develop healthy sexual behaviors (Morokoff, *et al*., 1997). It also refers to awareness of oneself as a sexual being and to the use of various behavioral skills to obtain and provide satisfaction in sexual relations (Dunn, Lloyd, & Phelps, 1979). In short, sexual assertiveness is an essential component of sexual health. It allows people to make decisions about their own sexuality (Sierra, Santos, Gutiérrez-Quintanilla, Gómez, & Maeso, 2008) and to engage in safe, pleasant, and informed sexual activity based on a positive view of sexuality with mutual respect in intimate relationships (Lottes, 2000).

Sexual assertiveness is related to three key aspects of human sexuality: sexual functioning, sexual coercion, and risky sexual behaviors. With regard to sexual functioning, most treatment programs for sexual dysfunctions use components of sexual assertiveness training (Ellis, 1975; Kerr, 1975; Sierra & Buela-Casal, 2001). Moreover, the results of various studies have shown sexual assertiveness to be negatively related to guilt and sexual anxiety (Snell, Fisher, & Miller, 1991) and positively related to the ability to give and receive pleasure in sexual encounters (Dunn, *et al*., 1979). More specifically, lack of sexual assertiveness has been related to anorgasmy (Kuriansky, Sharpe, & O'Connor, 1982; Cotten-Houston

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& Wheeler, 1983; Hurlbert, 1991); high sexual assertiveness is associated with greater activity, sexual desire, orgasms, and sexual and marital satisfaction (Whitley & Poulsen, 1975; Hite, 1976; Hurlbert, 1991; Haavio-Mannila & Kontula, 1997; Greene & Faulkner, 2005; Hurlbert, Singh, Menendez, Fertel, Fernández, & Salgado, 2005). Positive correlations have also been noted between sexual assertiveness and body satisfaction and comfort (Schooler, Ward, Merriweather, & Caruthers, 2005), which indirectly contribute to positive sexual experiences. As far as social coercion is concerned, most researchers agree that sexual assertiveness is a protective factor (Parrot, 1990; Bohmer & Parrot, 1993; Ullman, 1998; Fisher, Cullen, & Turner, 2000). In fact, a negative association has been reported between sexual assertiveness and experiences of abuse and sexual and verbal coercion (Morokoff, *et al*., 1997; MacGreene & Navarro, 1998; Testa & Dermen, 1999; Rickert, Neal, Wiemann, & Berenson, 2000; Livingston, Testa, & VanZile-Tamsen, 2007; Sierra, Ortega, Santos, & Gutiérrez, 2007; Stoner, Norris, George, Morrison, Zawacki, Davis, *et al*., 2008), even in married couples (Apt & Hurlbert, 1993). Finally, lack of sexual assertiveness is also a risk factor for HIV, sexually transmitted infections (STIs), and unwanted pregnancies (Somlai, Kelly, McAuliffe, Gudmundson, Murphy, Sikkema, *et al*., 1998). Likewise, sexual assertiveness is a significant predictor of condom use in adolescent and young adult samples (Catania, Coates, Kegeles, Fullilove, Peterson, Marin, Siegel, & Hulley, 1992; Wingood & DiClemente, 1998; Ehrhardt, Exner, Hoffman, Silberman, Leu, Miller, *et al*., 2002; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Crowell, 2004; Auslander, Perfect, Succop, & Rosenthal, 2007), of intention to use microbicides for HIV and STI prevention (Mosack, Weeks, Sylla, & Abbott, 2005), and of the absence of sexual risk behaviors (Rickert, *et al*., 2000; Zamboni, Crawford, & Williams, 2000; Thompson, Geher, Stevens, Stem, & Lintz, 2001; Noar, Morokoff, & Redding, 2002).

Because sexual assertiveness is a very important component of human sexuality, reliable and valid tests are necessary, given that the interpretations of studies and interventions could be based on the scores (Padilla, Gómez, Hidalgo, & Muñiz, 2006, 2007). In the Spanish context, the only test to measure sexual assertiveness with some psychometric evidence is the Hurlbert Index of Sexual Assertiveness (Sierra, *et al*., 2008), the measure of sexual assertiveness most frequently used (Santos-Iglesias & Sierra, 2010).

The Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991) has 25 items and provides a unidimensional measure of sexual assertiveness in couples. Studies of the English version have reported adequate psychometric properties, with internal consistency reliability values ranging from .84 to .92 (Hurlbert, 1991; Apt & Hurlbert, 1993; Schooler, *et al*., 2005)

and a test-retest reliability of .85 over a 4-wk. interval (Pierce & Hurlbert, 1999). Nevertheless, none of these studies have replicated the unidimensional factor structure. With regard to construct validity, a correlation of .82 was found with the Gambrill-Richey Assertion Inventory (Hurlbert, 1991). A psychometric assessment of the Spanish version (Sierra, *et al*., 2008) showed a single factor with an internal consistency reliability estimate of .90 and significant positive correlations with measures of erotophilia and self-esteem. However, this study was only based on adult female participants, half of whom were Salvadorian. Since there may be cultural as well as gender-based differences in sexual assertiveness, the reliability and validity of the Spanish version need to be assessed with a Spanish sample of men and women.

The present instrumental study (Montero & León, 2007) was carried out to analyze the psychometric properties of the Hurlbert Index of Sexual Assertiveness in a nonrepresentative Spanish sample. In conducting this study, the recommendations made by Hambleton, Merenda, and Spielberger (2005) and Carretero-Dios and Pérez (2007) were followed. The psychometric properties of the items in the scale were analyzed and the factor structure of the scale was examined through exploratory factor analysis and later confirmed through confirmatory factor analysis. After confirming the final structure of the scale in the Spanish population, internal consistency reliability and convergent validity indicators were analyzed. To assess convergent validity, correlations of scores on the Hurlbert Index of Sexual Assertiveness with those on the Questionnaire on Assertion in Couples (Carrasco, 1998), the abbreviated Spanish version of the Dyadic Adjustment Scale (Santos-Iglesias, Vallejo-Medina, & Sierra, 2009), and the Social Skills Scale (Gismero, 2002) were calculated; all these tests measure different constructs (assertion in couples, dyadic adjustment, and social skills) related to sexual assertiveness.

The following hypotheses about the relations between scores on the Hurlbert Index of Sexual Assertiveness and the various measures were developed: (1) Since Apt and Hurlbert (1993) argued that women who experience abuse and male dominance in their marriages show lower assertiveness, scores on the Hurlbert Index of Sexual Assertiveness were hypothesized to correlate positively with the Assertion subscale of the Questionnaire on Assertion in Couples and negatively with the subscales Aggression, Submission, and Passive aggression. (2) Sexual assertiveness was hypothesized to correlate positively with marital satisfaction (Hurlbert, 1991), and marital adjustment was hypothesized to correlate with assertive interactions in couples (Epstein, 1981; Smolen, Spiegel, Bakker-Rabdan, Bakker, & Martin, 1985). A positive correlation was expected between scores on the Hurlbert Index of Sexual Assertiveness and the abbre-

viated Spanish version of the Dyadic Adjustment Scale. (3) Since sexual assertiveness is related to communication skills and other social skills that are useful to negotiate safe sexual behaviors (Hammond & Oei, 1982; Quina, Harlow, Morokoff, Burkholder, & Deiter, 2000; Salazar, DiClemente, Wingood, Crosby, Harrington, Davies, *et al.*, 2004), Hurlbert Index of Sexual Assertiveness scores were hypothesized to correlate positively with those of the Social Skills Scale.

Method

Participants

The sample was recruited from the general population through a convenience sampling procedure and consisted of 400 men and 453 women ($N = 853$) who had been involved in stable sexually active heterosexual relationships for at least 6 mo. at the time of the study. Ages of participants ranged from 18 to 71 years ($M = 30.8$; $SD = 9.6$); men's mean age was 32.1 yr. ($SD = 10.0$; range 18–71) and women's mean age was 29.7 yr. ($SD = 9.0$; range 18–65). A total of 65.7% of the participants had a university education (64.4% men, 68.8% women), 24.7% had secondary school (27.2% men, 22.7% women), and 9.6% had primary school education (8.2% men, 7.2% women). Due to the sampling procedure and participants' distribution across different educational levels, the sample is not representative of the Spanish population.

For the statistical analysis, the sample was randomly divided into two subsamples. The first subsample consisted of 300 participants (137 men, 163 women) selected through a random sampling procedure without replacement using SPSS software. This sample size is considered "good" for an exploratory factor analysis (Tabachnick & Fidell, 2001). The other subsample consisted of 490 participants (232 men, 258 women) and was used for the confirmatory factor analysis. The data of 63 participants (7.38%) could not be used in the factor analyses because their responses were incomplete. These 63 participants did not show statistically significant differences in age (Mann-Whitney $U = 20{,}461.5$, $p = .4$), sex ($U = .008$, $p = .8$), or education ($U = .8$, $p = .2$).

Measures

Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991).—The version used was the corrected Spanish translation by Sierra, *et al*. (2008). This version, which was previously used with Salvadoran women, was sent to four Spanish experts in human sexuality, who were asked to analyze the meaning of the items in the Spanish context. After making the changes suggested by the experts, the result was administered to 28 participants (13 university students, 15 nonstudents) who assessed the meaning of the items again and suggested new changes. The resulting version was used

in the present study. The 25-item scale uses a 5-point response format with anchors of 0: Never and 4: Always, so scores could range from 0 to 100. High scores indicate high sexual assertiveness. The psychometric properties of the scale have been described above.

Questionnaire on Assertion in Couples (Carrasco, 1998).—This questionnaire is a 40-item scale that uses a 5-point response format with anchors of 1: Very rarely and 5: Very often. Higher scores reflect higher assertion. The Questionnaire on Assertion in Couples provides scores on four different subscales: Assertion, direct expression of feelings and opinions without forcing others' agreement by means of punishment or punishment threat; Aggression, coercive expression of feelings and opinions using coercive tactics to obtain others' agreement; Submission, lack of direct expression of feelings and opinions or automatic subjugation to others' opinions and preferences; and Passive aggression, lack of direct expression of preferences and opinions, while coercing indirectly by means of punishment or punishment threat. The author of the questionnaire reported internal consistency values between $\alpha = .75$ and .90 (in the present study, McDonald's omega values ranged from .86 to .78) and adequate convergent validity, with statistically significant positive correlations with scores on the Dyadic Adjustment Scale ranging from .33 to .46 (Carrasco, 1998).

Dyadic adjustment.—The abbreviated version of the Dyadic Adjustment Scale (Santos-Iglesias, Vallejo-Medina, *et al*., 2009), which has 13 items that provide a global score on dyadic adjustment as well as specific scores on three: subscales Consensus, Satisfaction, and Cohesion. The scale also uses a Likert-type response format with six response options (with anchors of 0: Always disagree and 5: Always agree) and five response options (with anchors of 0: Never and 4: Every day). Higher scores indicate greater adjustment. The authors reported adequate internal consistency reliability, with a value of .83 for the global scale, and values of .73, .70, and .63 for the three subscales, as listed above, respectively (Santos-Iglesias, Vallejo-Medina, *et al*., 2009). In the present study, estimates of McDonald's omega were .92 for the global scale and .71, .72, and .62, respectively, for the three subscales.

Social Skills Scale (Gismero, 2002).—This scale has 33 items and uses a 5-point Likert response format with anchors of 1: I don't identify at all and 5: I strongly agree and would feel or act this way in most cases. High scores indicate greater assertiveness and social skills. Internal consistency reliability was $\alpha = .88$; in the present study, McDonald's omega was .91. Convergent validity was indicated by significant correlations with scores on assertive self-descriptions (from .48 to .50) and scores on neuroticism (−.40) and extraversion (.52; Gismero, 2002).

Procedure

Participants were recruited through convenience sampling from the general population. A quota convenience sampling method was used to obtain the same number of men and women, distributed across different ages and education. The only requirement for participating was involvement in a stable heterosexual relation with sexual activity for at least 6 mo. at the time of the study. This sampling method does not allow generalizing results to the Spanish population.

Testing was conducted individually, except in university classrooms, where it was performed collectively, by eight well-trained researchers who recruited participants in different settings (university classrooms, public libraries, social centers, and public places). The purpose of the study was explained briefly to all participants; after obtaining verbal informed consent, each participant was given a booklet with the questionnaires in the same order as described above and a response sheet. Anonymity and confidentiality were guaranteed, as well as the exclusive use of the tests for research purposes. Since participants were recruited from the general population, no institutional review board was required.

Results

Item Analysis and Exploratory Factor Analysis

The item analysis was carried out with SPSS Statistics, Version 17.0, software and showed all response options were chosen for all of the items. In every case, the means obtained were above the theoretical midpoint of the response scale (which was 2, with anchors of 0: Never and 4: Always). Standard deviations were greater than 1.00 for all items except 1, 2, 10, 11, 14, 19, 23, and 25, for which they were slightly below 1.00. Skewness and kurtosis values ranged between −2.3 (Item 19) and −0.2 (Item 20) for skewness, and between 0.03 (Item 18) and 5.1 (Item 19) for kurtosis, so there were no extreme problems with skew and kurtosis (Kline, 2005). Corrected item-total correlations were above .30 (Nunnally & Bernstein, 1995), except for Items 15 (r_{it} = .28), 20 (r_{it} = .01), and 22 (r_{it} = .27). Eliminating some of these items increased internal consistency reliability for Items 20 and 22, although the increase was not statistically significant. The low item-total correlation of Item 20 ("Pleasing my partner is more important than my pleasure"/"*Dar placer a mi pareja es más importante que mi propio placer*"), the inconsistency of the content of Item 22 ("I enjoy masturbating myself to orgasm"/"*Disfruto masturbándome hasta llegar al orgasmo*") with the construct of sexual assertiveness led to eliminating these two items from later analyses.

The exploratory factor analysis was carried out with Factor 7.02 software (Lorenzo-Seva & Ferrando, 2006) after eliminating Items 20 and 22.

The coefficient of multivariate normality showed the nonnormal distribution of the data ($Z = 37.56$, $p < .001$). Thus, an unweighted least squares procedure was used to extract the factors. Promin, an oblique rotation procedure (Lorenzo-Seva, 1999), was used, given that a correlation between the possible factors was expected. The Kaiser-Meyer-Olkin measure of sampling adequacy (KMO = .87) and Bartlett's test of sphericity ($\chi^2 = 1{,}971.90$, $p < .001$) showed the adequacy of the data for this type of analysis (Catena, Ramos, & Trujillo, 2003; Carretero-Dios & Pérez, 2007).

The analysis yielded a two-factor structure, Initiation and No shyness/Refusal. Initiation is related to the beginning of sexual contact and the expression of sexual desires and fantasies to one's partner, and No shyness/Refusal means the difficulty starting and maintaining conversations on sexual issues and an inability to reject undesired sexual contact. The correlation between both factors was .64 ($p < .001$). Except Items 8 and 15, all factors loaded above .30 on either of the two factors (see Table 1). Items 8 and 15 were therefore eliminated from the scale. Items 12 and 23 loaded on the factor No shyness/Refusal, although their content was more typical of the factor Initiation. Moreover, the difference in the loadings of these items on both factors was lower than .15. Thus, they were retained in the analysis and tested in various models with confirmatory factor analysis.

Confirmatory Factor Analysis

AMOS 7.0 software was used to perform a confirmatory factor analysis. Three different models were compared: (a) a one-factor model, justified by the high correlation between both factors and the results obtained in earlier studies (Sierra, *et al*., 2008); (b) a two-factor model from the exploratory factor analysis; and (c) a two-factor model in which Items 12 and 23 were eliminated, since their content did not fit that of the factor No shyness/Refusal and their loadings on the factor Initiation were lower than .30. These models were compared using the generalized least squares procedure. To assess the fitness of the proposed models, a joint assessment of a group of indexes was used (Tanaka, 1993; Kline, 2005). Given that the value of χ^2 is highly influenced by sample size, the χ^2/df ratio was analyzed (Kline, 2005). Moreover, following the recommendations of Jöreskog and Sörbom (1993), the Goodness of Fit Index and Adjusted Goodness of Fit Index were used as absolute indicators of adjustment, since no comparison was made with the independence model (Kline, 2005), and the Root Mean Square Error of Approximation as the best overall fit index (Marsh, Balla, & Hau, 1996). Good fit is shown by values below 3 in the χ^2/df ratio, above .90 in the Goodness of Fit Index and Adjusted Goodness of Fit Index (Hu & Bentler, 1999; Kline, 2005), and below .05 in the Root Mean Square Error of Approximation (Browne & Cudeck, 1993). Table 2 shows the fit indexes of the three models compared. The two-factor model in

TABLE 1

FACTOR LOADINGS, COMMUNALITIES (H^2), PERCENT OF VARIANCE, AND EIGENVALUE OF EACH FACTOR

Item	English	Spanish Translation	Initiation	No shyness/ Refusal	H^2
1 (R)	I feel uncomfortable talking during sex.	Me siento incómodo/a al hablar durante mis relaciones sexuales.	.30	**.37**	.38
2 (R)	I feel that I am shy when it comes to sex.	Creo que soy tímido/a en el ámbito sexual.	.32	**.36**	.39
3	I approach my partner for sex when I desire it.	Le propongo sexo a mi pareja cuando lo deseo.	**.66**	−.05	.39
4	I think I am open with my partner about sexual needs.	Creo que soy abierto/a con mi pareja acerca de mis necesidades sexuales.	**.59**	.11	.45
5	I enjoy sharing my sexual fantasies with my partner.	Disfruto compartiendo mis fantasías sexuales con mi pareja.	**.55**	−.13	.23
6 (R)	I feel uncomfortable talking to my friends about sex.	Me siento incómodo/a hablando de sexo con mis amigos/as.	−.10	**.56**	.25
7	I communicate my sexual desires to my partner.	Le comunico mis deseos sexuales a mi pareja.	**.59**	.15	.49
8 (R)	It is difficult for me to touch myself during sex.	Me resulta difícil tocarme durante mis relaciones sexuales.	.23	**.29**	.22
9 (R)	It is hard for me to say no even when I do not want sex.	Me resulta difícil decir que no, incluso cuando no deseo tener relaciones sexuales.	−.10	**.54**	.23
10 (R)	I am reluctant to describe myself as a sexual person.	Soy reacio/a a describirme como una persona sexualmente activa.	.03	**.55**	.32
11 (R)	I feel uncomfortable telling my partner what feels good.	Me siento incómodo/a al decirle a mi pareja lo que me gusta.	.08	**.61**	.44
12	I speak up for my sexual feelings.	Expreso mis sensaciones sexuales.	**.24**	.37	.30
13 (R)	I am reluctant to insist that my partner satisfy me.	Soy reacio/a insistirle a mi pareja para que me satisfaga sexualmente.	.001	**.43**	.19
14 (R)	I find myself having sex when I do not really want it.	Suelo tener relaciones sexuales cuando realmente no quiero.	−.05	**.47**	.19
15	When a technique does not feel good, I tell my partner.	Cuando no me gusta una práctica sexual, se lo digo a mi pareja.	**.06**	.27	.10

(continued on next page)

Note.—(R): the scores of these items are reversed. Content coherence is indicated with loadings in bold. The reversal of the scores of the factor No shyness/Refusal implies that higher scores show an absence of sexual shyness, that is, greater sexual assertiveness.

TABLE 1 (CONT'D)

FACTOR LOADINGS, COMMUNALITIES (H^2), PERCENT OF VARIANCE, AND EIGENVALUE OF EACH FACTOR

Item	English	Spanish Translation	Initiation	No shyness/ Refusal	H^2
16	I feel comfortable giving sexual praise to my partner.	Me siento cómodo/a diciendo piropos sexuales a mi pareja.	**.64**	–.20	.28
17	It is easy for me to discuss sex with my partner.	Me resulta fácil hablar de sexo con mi pareja.	**.45**	.06	.24
18	I feel comfortable in initiating sex with my partner.	Me siento cómodo/a tomando la iniciativa en las relaciones sexuales con mi pareja.	**.65**	–.19	.29
19 (R)	I find myself doing sexual things that I do not like.	Tiendo a realizar actividades sexuales que no me gustan.	–.09	**.52**	.22
21	I feel comfortable telling my partner how to touch me.	Me siento cómodo/a indicándole a mi pareja cómo tocarme.	**.46**	.01	.22
23	If something feels good, I insist on doing it again.	Si algo me gusta, insisto en volver a hacerlo.	**.27**	.30	.26
24 (R)	It is hard for me to be honest about my sexual feelings.	Me resulta difícil ser sincero/a acerca de mis sensaciones sexuales.	.16	**.39**	.27
25 (R)	I try to avoid discussing the subject of sex.	Trato de evitar hablar de sexo.	.06	**.60**	.41
	% variance		28.17	7.65	
	eigenvalue		6.48	1.76	

Note.—(R): the scores of these items are reversed. Content coherence is indicated with loadings in bold. The reversal of the scores of the factor No shyness/Refusal implies that higher scores show an absence of sexual shyness, that is, greater sexual assertiveness.

TABLE 2
Fit Idexes of the Confirmatory Models Compared

Model	χ^2	*df*	χ^2/df	GFI	AGFI	RMSEA
1 factor	488.9*	189	2.58	.905	.884	.057
2 factors of the exploratory factor analysis	460.9*	188	2.45	.910	.890	.054
2 factors eliminating Items 12 and 23	320.3*	149	2.14	.931	.912	.048

*$p < .001$.

which Items 12 and 23 were eliminated showed the best fit, as its χ^2/df ratio was lowest and was the only one with values above .90 in the Adjusted Goodness of Fit Index and below .05 in the Root Mean Square Error of Approximation (Browne & Cudeck, 1993). Modification indexes suggested relations between Items 7 and 17, and 9 and 14. Such relations were included in the model given their theoretical consistency (Batista Foguet & Coenders, 2000). Thus, Items 7 and 17 correspond to the same factor (Initiation) and refer to the beginning of sexual communication with one's partner. Items 9 and 14 correspond to the factor No shyness/Refusal and are both related to the inability to reject unwanted sexual contact, as stated by Morokoff, *et al*. (1997). Therefore, 19 items, which clustered into two factors (see Fig. 1), were included in the Spanish version of the Hurlbert Index of Sexual Assertiveness.

Before analyzing the reliability and validity of the Spanish version of the Hurlbert Index of Sexual Assertiveness (19 items clustered into two factors), it was considered that the underlying structure might be showing a methodological artifact rather than the true structure of the scale. As demonstrated in studies with other tests, such as the Hurlbert Index of Sexual Fantasies or the Index of Sexual Satisfaction (Marsh, 1996; Desvarieux, Salamanca, Ortega, & Sierra, 2005; Santos-Iglesias, Sierra, García, Martínez, Sánchez, & Tapia, 2009), this artifact consists of separating the positive and negative items of a unidimensional scale into two different factors (Carmines & Zeller, 1979; Marsh, 1996; Morales, 2000). A hierarchical multiple regression analysis of the various criteria (scores on the Social Skills Scale, the abbreviated version of the Dyadic Adjustment Scale, and the subscales of the Questionnaire on Assertion in Couples) was performed. It showed that when the second factor is introduced as a predictor in the model, the change of prediction is significant, except in the Aggression subscale of the Questionnaire on Assertion in Couples, as shown by the *F* change (see Table 3). This result implies that both factors form different constructs.

Internal Consistency Reliability and Convergent Validity

Internal consistency reliability (McDonald's omega) of the global scale was .87, whereas McDonald's omega of both subscales was .83. Con-

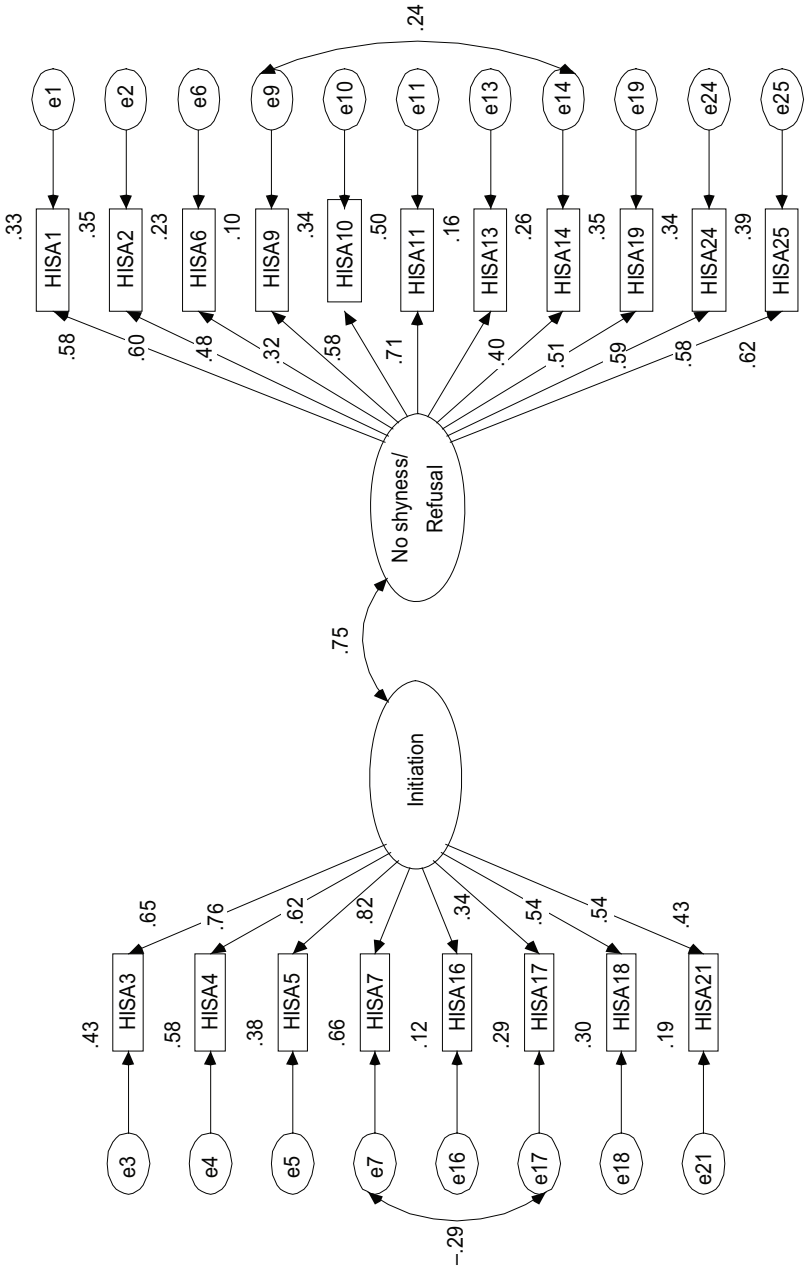

FIG. 1. Two-factor structure of the Hurlbert Index of Sexual Assertiveness

TABLE 3
Summary of Hierarchical Multiple Regression Models

Criterion/Predictor	R^2	β	r_p	Semi-partial *r*	R^2	*F*
ASPA Assertion						
1. No shyness/Refusal	.13	.25	.23	.21	.13	119.66*
2. Initiation	.17	.21	.19	.18	.04	31.66*
ASPA Aggression						
1. No shyness/Refusal	.09	−.27	−.23	−.23	.09	75.99*
2. Initiation	.09	−.05	−.04	−.04	.002	1.82
ASPA Submission						
1. No shyness/Refusal	.22	−.39	−.35	−.33	.22	219.74*
2. Initiation	.23	−.14	−.14	−.12	.01	15.42*
ASPA Passive aggression						
1. No shyness/Refusal	.07	−.18	−.16	−.15	.07	61.38*
2. Initiation	.09	−.16	−.15	−.14	.02	17.81*
EAD-13						
1. No shyness/Refusal	.09	.20	.18	.17	.09	75.73*
2. Initiation	.11	.18	.17	.16	.02	21.95*
EHS						
1. No shyness/Refusal	.18	.31	.29	.26	.18	172.02*
2. Initiation	.22	.22	.21	.19	.04	35.15*

Note.—ASPA: Questionaire on Assertion in Couples; EAD-13: Spanish abbreviated version of the Dyadic Adjustment Scale; EHS: Social Skills Scale. *$p < .001$.

vergent validity indicators confirmed the three hypotheses. Indeed, statistically significant positive correlations were found with all the subscales of the Questionnaire on Assertion in Couples, the abbreviated version of the Dyadic Adjustment Scale, and the Social Skills Scale, except with the subscales Aggression, Submission, and Passive aggression of the Questionnaire on Assertion in Couples, which showed negative correlations (see Table 4).

TABLE 4
Pearson Correlations Between Both Factors of Hurlbert Index of Sexual Assertiveness and Subscales of the Questionnaire on Assertion in Couples, Dyadic Adjustment Scale, and Social Skills Scale

Subscale	Initiation	No shyness/Refusal
Questionnaire on Assertion in Couples		
Assertion	.34*	.36*
Aggression	−.19*	−.30*
Submission	−.34*	−.47*
Passive aggression	−.26*	−.27*
Dyadic Adjustment Scale		
Consensus	.22*	.22*
Satisfaction	.28*	.33*
Cohesion	.23*	.18*
Social Skills Scale	.39*	.43*

*$p < .001$.

Discussion

Sexual assertiveness, as an essential component of people's sexual health (Sierra, *et al*., 2008), has many implications for human sexuality. Therefore, it is important to have appropriate scales to assess this construct. Although there are many measures of sexual assertiveness available in English, no psychometrically adequate scale is available in Spanish. This study has been carried out to assess the internal consistency reliability and construct validity of a Spanish version of the Hurlbert Index of Sexual Assertiveness, the most frequently used sexual assertiveness test (Santos-Iglesias & Sierra, 2010).

First of all, it is important to note that sampling procedure and sample distribution across education do not guarantee a representative sample, and therefore results cannot be generalized to the Spanish population. Nevertheless, results show appropriate psychometric properties of the items. Response means were above the theoretical midpoint of the scale, probably due to the use of nonclinical instead of clinical samples, because the former show higher scores on sexual assertiveness (Pierce & Hurlbert, 1999). In this item analysis, two items (20 and 22) were eliminated from the scale due to problems with item-total correlations and content coherence. It should be noted that these two items also showed the same problems in earlier studies (Sierra, *et al*., 2008).

Results of the exploratory and confirmatory factor analyses show a structure formed by 19 items clustered into two correlated factors, after eliminating six items of the scale. The factor Initiation refers to the ability to initiate sexual activity pointed out by Morokoff, *et al*. (1997) and the use of behavioral skills to obtain and provide satisfaction in sexual relations (Dunn, *et al*., 1979). The factor No shyness/Refusal refers both to the difficulty starting and maintaining conversations on sexual issues and the inability to reject undesired sexual contact (Morokoff, *et al*., 1997). This two-factor structure is not consistent with the proposal by Sierra, *et al*. (2008) or the original proposal by Hurlbert (1991). However, Hurlbert did not study the dimensionality of the scale. In a later study, Greene and Faulkner (2005) found a structure composed of three highly correlated factors (Initiation, Refusal, and Sexual assertive talk). Although the exact distribution of the items is not known, since it was not a strictly psychometric study, there might be correspondence between the factors Initiation (in Greene and Faulkner and the present study) and between the factors Refusal and Sexual assertive talk, found by Greene and Faulkner, and No shyness/Refusal in this study.

One of the problems raised by this factor structure is that the high correlation observed between both factors may suggest overlap between them and therefore the existence of one single factor. The two-factor structure has been maintained for several reasons. The first one is theoretical,

given that the contents included in both factors reflect different components of sexual assertiveness such as the beginning of sexual activity, the rejection of unwanted sexual contact (Morokoff, *et al*., 1997), or the use of behavioral skills to obtain satisfaction in sexual relations (Dunn, *et al*., 1979), given that sexual satisfaction has often been found to be related to the expression of sexual desires (Hurlbert, 1991; Hurlbert, Apt, & Rabehl, 1993; Haavio-Mannila & Kontula, 1997; Hurlbert, *et al*., 2005; Ménard & Offman, 2009). Secondly, the two-factor structure was found using an exploratory factor analysis and confirmed through a confirmatory factor analysis, unlike the one-factor structure, which provides evidence of better fit of the two-factor model to the data. Thirdly, the results of the multiple hierarchical multiple regression model show that after introducing one of the factors as a predictor over one criterion, the second factor is still able to significantly contribute to the percentage of variance explained by the first factor. This suggests the existence of two different factors. Finally, previous studies performed with sexual assertiveness (Greene & Faulkner, 2005) and other constructs (e.g., social anxiety or gelotophobia) have shown that highly correlated dimensions can form isolated factors (Carretero-Dios, Ruch, Agudelo, Platt, & Proyer, 2010).

Finally, results showed an internal consistency reliability of .87 in the global scale. This is slightly lower than the reliability found in earlier studies (Hurlbert, 1991; Schooler, *et al*., 2005; Sierra, *et al*., 2008). Yet, in the present study, the final version of the Hurlbert Index of Sexual Assertiveness was formed by a lower number of items. The reliability of its two factors was .83, a very adequate value that guarantees that they can be used separately. Likewise, the convergent validity tests confirmed the hypotheses, since positive correlations were found with social skills (Hammond & Oei, 1982; Quina, *et al*., 2000; Salazar, *et al*., 2004), marital adjustment (Epstein, 1981; Smolen, *et al*., 1985; Hurlbert, 1991), and assertion in couples, and negative correlations were found with the subscales Aggression, Submission, and Passive aggression of the Questionnaire on Assertion in Couples (Apt & Hurlbert, 1993).

In short, this 19-item abbreviated version of the Hurlbert Index of Sexual Assertiveness shows a consistent internal structure with adequate indicators of internal consistency reliability and convergent validity. However, this scale should be the subject of further research to verify the stability of its factor structure and the possible invariance of the scale between sexes. It is also highly important to analyze other forms of validity, such as discriminant or predictive validity, and other forms of reliability, such as test-retest reliability. Once again, it should be noted that these results must be interpreted with caution because of the nonrepresentative sample and cannot be generalized to the Spanish population.

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