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Who's Asking the Important Questions? Sexual Topics Discussed among Young Pregnant Couples

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Abstract

Purpose—The aim was to examine gender differences in sexual risk communication among young couples and factors influencing communication.

Methods—Sample consisted of 296 young pregnant couples. We assessed individual, interpersonal, and community factors on sexual risk communication. The Actor-Partner Independence Model was used to assess actor and partner effects on sexual risk communication.

Results—For actor effects, being female, older, not being Hispanic, and higher condom use self-efficacy was associated with sexual risk communication. The significant partner effect was avoidant romantic attachment. Gender interactions were significant for high risk behaviors and family functioning. High risk behaviors and family functioning were associated with sexual risk communication for females but not for males.

Conclusion—The study emphasizes the need to promote sexual risk communication among young high risk couples, particularly for males. Family support could serve as a catalyst for sexual risk communication and other sexual protective behaviors among young couples.

Keywords

HIV; Gender; Couples; Young Adult; sexual behavior; Communication

Sexual risk communication can serve as a self-protective health behavior in the context of a romantic sexual relationship (Whitaker et al., 1999). Sexual risk communication can be defined as the verbal exchange of content related to sexual behavior, the possibility of adverse sexual outcomes (e.g., sexually transmitted infection) and sexually-related

protection topics (e.g., condom use, HIV testing). Earlier couples-related sexual communication research focused on topics such as sexual satisfaction (Byers & Demmons, 1999) and marital satisfaction (Cupach & Comstock, 1990). However, as younger generations were increasingly affected by the HIV epidemic, more recent studies have focused on examining the relationship between safer sexual communication and sexual protective behaviors (Noar et al., 2006). Engaging in sexual risk communication is thought to be helpful in young romantic relationships as it allows the partners to learn about each other's prior sexual behavior and levels of sexual risk which could increase the probability of safer sex behaviors (Whitaker et al., 1999). Communicating with a sexual partner (i.e., discussion between young partners of topics such as condom use, partner's sexual history, pregnancy prevention, protecting self from STIs, and protecting self from HIV) is associated with increased condom use (Catania, 1989; Sales et al., 2012; Whitaker et al., 1999), increased confidence in communicating with future partners about their sexual history, and reduced number of sexual partners (Catania, 1989).

Though young couples stand to benefit from engaging in sexual risk communication, they are often faced with relationship challenges that may overshadow communicating. This may be especially true for young pregnant couples. Young pregnant couples can experience low relationship functioning, high conflict and distress, and high sexual risk behaviors (Kershaw et al., 2012). Recent evidence has shown that low relationship functioning is associated with poor sexual risk communication among young pregnant couples (Kershaw et al., 2012).

Furthermore, engaging in sexual risk communication among young pregnant couples is important because pregnant couples' HIV/STI risk is high. A systematic review of pregnant and mothering young women showed that they were five times less likely to use condoms than those not pregnant (Meade & Ickovics, 2005), and approximately 28% test positive for chlamydia, trichomoniasis, and/or gonorrhea (Meade & Ickovics, 2005). These findings highlight the sexual risk among young pregnant couples and the need for ongoing sexual risk communication to protect the health of the couple and the unborn child. However, these findings also suggest that pregnancy may create a false sense of protection from HIV/STIs, and therefore, less emphasis is placed on sexual risk communication.

Explaining Sexual Communication in Young Couples

The current paper will examine sexual risk communication as it occurs in young romantic couples who are pregnant. The decision that young couples make to engage in sexual risk communication and sexual protective behaviors is one of interdependence. A sexual protective behavior such as condom use is an "interdependent behavior", which means that condom use is a couple decision (Zukoski et al., 2009). As with condom use, the decision to engage in sexual risk communication requires compliance from both parties. Sexual risk communication may be initiated by either member of the couple, but there must be a joint decision to continue the conversation. For this study, we examine the notion of interdependent behavior of sexual risk communication among young pregnant couples. Employing an interdependence methodological approach will allow us to observe the influence that both members of a couple has on one another and on themselves.

Gender and Sexual Communication

Whether to engage in sexual communication with a partner is further compounded by gender socialization roles and what is viewed as “acceptable” communication for males and females. Males and females communicate differently, and when there is not a common sexual communication language between the two, it may be difficult for both males and females to effectively discuss sexual risk behaviors (Metts & Spitzberg, 1996). This difference may be partially due to the way in which males and females are socialized to discuss sex.

According to the sexual script theory, males are socialized to be more forthcoming about their sexual needs and typically are the initiators of sexual intimacy (Widman et al., 2006). In general, males are noted as having a more dominant language style, are seen as expert problem-solvers, and subject matters initiated by females are often not the focal point of conversations (Henley & Kramarae, 1991). This difference suggests the need to consider gender as an important distinguisher in the effectiveness and content of sexual risk communication in heterosexual couples. In particular, the lack of consideration given to female initiated communication may be reflective in actual sexual behaviors. In a study assessing assertive communication and safer sex behavior, females’ attitudes about AIDS-related talk did not predict safer sex behavior (Feeney et al., 1999), suggesting that female-initiated communication may be less indicative of sexual outcomes than male-initiated.

The less assertive communication style exerted by females may be due to the socialization and expectation that females are to be demure and less sexually assertive (Widman et al., 2006). Within the context of heterosexual relationships, females are expected to be passive and to allow the man to “take charge” (Quina et al., 2000). Otherwise, females risk being stereotyped as sexually aggressive for discussing safe sex behaviors and for engaging in safe sex preparedness, such as carrying condoms (Fasula et al., 2007). These gender differences reflect the “sexual double standard” that is often reinforced during adolescence. For instance, mothers are more likely to purchase condoms for their sons, but discourage their daughters from discussing condom use with partners and from carrying condoms (Fasula et al., 2007). These gendered constraints perpetuate male sexuality dominance in romantic relationships, which in turn impact sexual risk communication and sexual decision-making (Lear, 1995).

Despite evidence suggesting the role of gender expectations in males and females’ discussion of sex-related topics, little is known about how these gender differences in sexual communication exist in young couples. Our goal for this study is to examine the gender differences in sexual risk communication topics discussed among young couples, and the degree to which these differences explain the effect of other social factors on couple-level sexual risk communication.

Theoretical Framework

Sexuality among young couples is undoubtedly a complex social and behavioral construction, and is influenced by psychological and environmental factors. From the ecological perspective, the person and environment are not distinct from one another but

they interact to result in particular behaviors (Corcoran, 2000). Adolescent sexual risk and protective factors often fall within systems of the ecological framework (DiClemente et al., 2005). Considering the multiple factors that predict behavior, we will examine the individual, interpersonal, and community level factors that might impact sexual risk communication. The individual level includes both psychological (e.g., depression, stress) and sexual risk behaviors that might impact sexual risk communication. Individual high risk behaviors such as intravenous drug use, multiple sexual partners, commercial sex work, and men having sex with men have all been associated with increased transmission of HIV/AIDS and other STIs. Although these high risk behaviors have been well-documented in the literature, whether engaging in high risk behaviors leads individuals to engage in more sexual risk communication has not been assessed among adolescent and young adult couples.

Interpersonal level factors include couple and family relationships and functioning. Strong couple relational bonds and family support may result in lower risk behaviors for young couples, such as increased sexual risk communication and condom use (Feeney et al., 1999; Kershaw et al., 2007). Community level factors have also been associated with sexual risk. For example, adolescents who perceive a higher level of social support engage in less sexual risk taking than those with lower perceived social support (St. Lawrence et al., 1994). Researchers have employed the social capital construct to assess its impact on health disparities, including HIV and STI risks (Cene et al., 2011; Holtgrave & Crosby, 2003). Social capital is highly predictive of certain STIs; the more social capital the lower the STIs and AIDS rates (Holtgrave & Crosby, 2003).

Current Study

The majority of previous research that has been conducted has focused primarily on the impact of individual, interpersonal, and community level factors on sexual risk behaviors. While useful in the larger attempt to identify behavioral correlates, this approach does not elucidate the role of multiple levels of individual and social influence on sexual risk communication. The current study aims to consider the ways in which factors nested within these systems of individual, interpersonal, and community interaction may impact the likelihood of sexual risk communication among adolescent couples. To our knowledge, no other study has examined the predictors of sexual risk communication using this framework in the context of adolescent couples, particularly young pregnant couples. Considering the dearth of research on predictors of partner sexual risk communication for adolescent males and females, and to discern which predictors may be responsible for gender differences in sexual risk communication, we propose the following research aims:

1. To examine gender differences in sexual risk communication; and
2. To examine association between multiple individual, interpersonal, and community level factors and sexual risk communication.

METHOD

Study Sample and Procedures

We used the Parenting and Relationship Transition & Risk Study (PARTNRS) baseline data to conduct this study. The study sample consists of 296 expectant young couples. Sample characteristics are found in Table 2.

Between July 2007 and February 2011, couples were recruited from obstetrics and gynecology clinics and an ultrasound clinic in four university-affiliated hospitals in southern Connecticut. Young females were referred to the study by their healthcare provider or recruited by research staff. Prospective participants were screened by the research staff. If eligible, research staff explained the study details and answered any questions from the prospective participant(s). If their baby's father was absent during the screening, the research staff obtained permission to contact their partner to provide information about the study. Research staff also encouraged the young females to talk to their partner about the study and provided informational materials to share with their partner.

The study eligibility criteria included: (a) pregnant or partner is pregnant in the second or third trimester at time of baseline interview; (b) females age 14–21 and males age greater than or equal to 14 at time of the interview; (c) both partners report being in a romantic relationship with each other; (d) both partners report being the biological parents of the unborn baby; (e) both partners agree to participate in the study and (f) both partners are able to speak English or Spanish. Because of the longitudinal study design, we used an initial run-in period as part of eligibility criteria where participants were considered ineligible if they could not be contacted after the initial screening and before their estimated due date.

Each participant provided written informed consent and completed a structured interview using the audio computer-assisted self-interview at the baseline appointment. The couples' interview occurred at the same time but was completed separately. All of the study procedures were approved by the Yale University Human Investigation Committee and by the Institutional Review Board at study clinics. The participants received \$25 for their participation.

Measures

The dependent variable, sexual risk communication, consisted of five items. Example items were: "I ask my partners about their past sexual partners" and "I ask my partners about their STD history." Participants indicated their responses using a 5-point Likert scale ranging from *never* = 1, *rarely* = 2, *sometimes* = 3, *often* = 4, and *very often* = 5. This scale was developed by the PARTNRS research team to measure partner communication about sexual issues such as condoms, past sexual partners, STI history, HIV testing, and AIDS concern. The Cronbach alpha reliability estimate for sexual risk communication was 0.86.

Individual level variables—The individual factors include depression, stress/anxiety, condom use self-efficacy, and high risk behaviors. For each *depression* symptom, the participant indicated how often they felt or behaved in the specified way, ranging from 0 (less than 1 day a week) to 3 (most of the time, 5–7 days a week). Depression was measured

using 15 of the 20-items in the Center of Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977). We did not include the 5 somatic depression items because they have been shown to relate to common symptoms of pregnancy. This abbreviated scale has been used and validated in pregnant populations (Milan et al., 2004; Westdahl et al., 2007). For the *stress/anxiety* measure the participants were asked to indicate how often in the past month they had experienced stressful feelings and thoughts, on a 5-point scale ranging from 0 = *Never* to 4 = *Very often*. The *condom use self-efficacy* items focused on whether the respondent felt confident in how to actually use a condom, how often and how assertive they are about using condoms, and whether they believe drugs or alcohol affect their condom use. The response items ranged from 1 = *Strongly Agree* to 5 = *Strongly Disagree*. To measure *high risk behaviors*, a composite was created using reported sexual risk behaviors such as, had sex with a man who also had sex with men, intravenous drug use, commercial sex work, multiple sexual partners, and history of STI. Table 1 provides more details about the measures used to assess the individual, interpersonal, and community level factors. The table includes a list of the scales used and the reliability estimates.

Interpersonal level variables—The interpersonal factors measured include relationship power, romantic attachment, family functioning and family, and peer support of romantic relationship. *Relationship power* consisted of a single item: “In general, who do you think has more power in your relationship?” (Pulerwitz et al., 2000). Responses ranged from: 1 = *Your partner*, 2 = *Both of you equally*, and 3 = *You*. The *romantic attachment* scale measures two romantic attachment types, attachment avoidance and anxiety. Participants responded to statements about their relationship on a 7-point Likert scale, ranging from 1 = *Disagree strongly* to 7 = *Agree strongly*. The *family functioning* required participants to indicate how accurate the statements were in describing their family on a 7-point scale, ranging from 1 = *Never* to 7 = *Always*. *Family and peer support of relationship* was assessed the reactions and attitudes of the participants’ family and friends regarding their romantic relationship. The participants responded using a 7-point Likert scale, which ranged from 1 = *Disagree strongly* to 7 = *Agree strongly*.

Community level variables—In assessing *social support* participants indicated how often others were available to them for companionship, assistance, and other forms of support. The responses ranged from 0 = *None of the time* to 4 = *All of the time*. *Social capital* was assessed by asking participants to indicate their level of comfort and attachment in their neighborhood using a 5-point scale ranging from 1 = *Strongly disagree* to 5 = *Strongly agree*.

Data Analysis

Frequencies and means were conducted to describe the study sample. To assess differences between the related items of communication by gender we conducted a General Linear Model with two within-subjects variables: type of communication and gender. This approach takes into account the correlated nature of the types of communication and the correlation among male and female partners. To examine the influence of individual predictors on sexual risk communication, we used multi-level modeling to assess the Actor-Partner Interdependence model using SPSS version 18. The Actor-Partner Interdependence

Model incorporates responses from both members of a dyad into a single analysis using multilevel modeling. Multilevel modeling treats members of a dyad as nested scores within the same group (Kenny et al., 2006). A detailed description on how to conduct the Actor-Partner Independence Model analyses using multilevel modeling programs has been previously outlined (Kenny et al., 2006) and served as the guide for our analysis plan. Actor effects refer to whether a person's score on the predictor variable influences the person's own outcome (e.g., a woman's relationship power relates to her own communication). Partner effects refer to whether a partner's score on the predictor variable influences the person's outcome (e.g., the male partner's relationship power influences the woman's communication).

To assess whether any of the actor and partner associations differed between males and females, a set of interactions between gender and all predictor variables were entered one at a time in the final model. Significant interactions were added to the final model. The actor and partner effects presented in the model are unstandardized regression coefficients (and their standard errors).

RESULTS

Forty-nine percent of male participants were African American, whereas the females were largely comprised of African Americans (39.5%) and Hispanics (39.5%). The average age for males and females were 21.3 ($SD = 4.06$) and 18.7 ($SD = 1.63$), respectively. More females reported that they were currently attending school (39.5%) compared to their male counterparts (26.7%). Both males and females reported completing approximately 12 years of school at the time of the interview. The reported length of time in the couple partnership was over 2 years. Sample characteristics are shown in Table 2. Other sample characteristics not shown in the table are the frequency of high risk behaviors (i.e., men who have sex with men, intravenous drug use, commercial sex work, multiple sexual partners, and history of STI). We assessed high risk behavior by summing all risks experienced by each participant, such that the risk score ranged from 0 to 5, with higher scores indicating more risk. We found that 62.7% had no high risk behaviors, 27.9% had at least 1 high risk behavior, and 9.4% had at least 2 or more high risk behaviors.

The mean of sexual risk communication topics indicated that females communicated more about sexual topics compared to males. In the GLM analyses, a significant gender effect was found, $F(1, 290) = 12.32, p = .001$. The overall mean across sexual communication topics was 2.84 for males and 3.14 for females. The main effect of gender was qualified by a significant sex risk communication interaction. The interaction effect (gender x sexual risk communication) was significant at $F(4, 287) = 5.66, p = .001$, indicating that the profiles of communication topics differed by gender. Simple effects were conducted to show the nature of these differences. Figure 1 presents the mean differences for males and females. For females, the most common sexual communication topic was past sexual partners, followed by HIV testing, followed by STI history, and talking about condoms was the lowest. However for males, the highest area of sexual risk communication was HIV testing, followed by condoms, and past sexual partners was the lowest. There were no differences in communication on condom use between males and females, but there were marked

differences on discussions of past sexual partners and STI history. The mean difference for past sexual partners and STI history was 0.52 and 0.32, respectively, indicating greater communication among females compared to males. Smaller mean differences were found for concerns about AIDS (0.34) and HIV testing (0.26), where female communication was higher compared to males.

Next, we examined predictors of sexual risk communication by employing dyadic analyses using multilevel modeling. The actor-partner bivariate associations are shown in Table 3. Several covariates and variables representing the three ecological levels were significant. All covariates (regardless of significance) and significant individual, interpersonal, and community level variables were included in the final model. The results from the final model showed that several actor effects were related to increased sexual risk communication, including being female ($B = 0.384$), older ($B = 0.038$), not being Hispanic ($B = -0.265$), and having higher condom use self-efficacy ($B = 0.217$). Only one partner effect was associated with sexual risk communication, which was having a partner with more avoidant romantic attachment ($B = 0.006$). Table 4 shows the results for all of the main effects predictors.

We then tested whether gender modified any of these associations. Two significant interaction effects were found, *high risk behaviors* x *gender*, $t = 2.362$, $p = 0.019$ and *family functioning* x *gender*, $t = 1.949$, $p = 0.052$. Simple effects indicated that there was a significant relationship between having high risk behaviors and increased sexual communication for females ($B = 1.139$, $p = 0.012$) but not for males ($B = -0.350$, $p = 0.459$). Similarly, the relationship between family functioning and increased sexual communication was significant for females ($B = 0.014$, $p = 0.010$) but not for males ($B = -0.001$, $p = 0.940$).

DISCUSSION

Our results highlight gender differences in sexual risk communication. Contrary to research indicating male dominance in sexual communication, females tended to engage more frequently in sexual risk communication than their male counterparts. One explanation for this finding could be that females have greater exposure to reproductive health information (Marcell et al., 2002). Sexually active females may have greater access to sexual risk information, particularly if they have sought out care to obtain contraceptives such as forms of birth control. The female participants in this study were already pregnant and had current access to care where they would potentially receive more frequent reminders of sexual risk behaviors and its affect on the mother and unborn child. Males, on the other hand, are less likely to seek out healthcare for contraceptives. Consequently, males have fewer opportunities to receive sexual risk information, which could explain the lower sexual risk communication among males in this study. Also, males tend to engage in sexual communication as a means of initiating sex or communicating sexual desires (Vannier & O'Sullivan, 2011), and thus, they may be less focused on communication as a protective measure. Yet, another possible reason for more sexual risk communication among females is that as young couples' relationship progresses, there is less concern with maintaining gender scripts around sexual communication and initiation (Vannier & O'Sullivan, 2011). This may

be the case for the couples in our study whose average relationship length was over two years.

Interestingly, the least common sexual risk communication topic among females was condom use. Again, this could be due to the fact that because the females were already pregnant they viewed condom use as less important considering their current reproductive status. In addition, the relationship length for these couples was slightly over two years, wherein the importance of practicing consistent condom use may have diminished over time (Kershaw et al., In Press). Not as surprising was the finding that males most frequently discussed HIV testing. Minority populations have been targeted for increasing HIV testing over the past three decades. For males, the most frequent sexual risk information they may receive is the importance of getting tested to learn one's HIV status (McGlynn et al., 2003; Stein & Nyamathi, 2000). Young males are not required to access the healthcare system to receive HIV testing information and messages; therefore, the sexual risk behavior information they obtain may be far more limited compared to their female counterparts. This could explain why HIV testing is reflected as the most frequently discussed sexual risk communication topic in this male sample. It is possible that males believe that other sexual risk communication topics such as condom use and past sexual partners are less relevant if their sexual partner has a negative HIV status.

As for the various ecological predictors of sexual risk communication, the significant actor effects were not unexpected. Being older (Dancy et al., 2010) and having condom use self-efficacy (Baele et al., 2001) are positively associated with sexual protective behaviors. Despite the aforementioned sexual communication gender norms, being female was also associated with sexual risk communication. In terms of racial background as a predictor, it was interesting to find that Hispanics had lower levels of sexual risk communication. The Hispanic culture could play a significant role in whether sexual risk communication takes place within romantic relationships. Both Hispanic males and females report feeling uncomfortable discussing sexual topics (Marin, 2003). Finally, the partner effects were significant for avoidant romantic attachment. A probable explanation for this finding could be that a partner's expressed detachment could generate feelings of distrust, which could spur their partner's need to inquire about sexual risk behaviors.

The gender interactions further suggested differences between males and females on what influences sexual risk communication. First, the finding that a female's *high risk behaviors* increased her sexual risk communication reemphasizes the notion that females may be more aware of different high risk behaviors. This awareness may lead females to engage in sexual risk communication to assess the risks associated with her partner or to protect her partner if she believed her history poses a risk to him (e.g., STI transmission). Second, the result that family functioning was associated with sexual risk communication for young females and not males was somewhat unexpected. One would likely conclude that parental communication, parental modeling, parental monitoring, and family connectedness would benefit both males and females equally. It is possible that family functioning acts as an empowering agent for females subjected to the societal "sexual double standard", wherein they feel self-assured when engaging in what some would consider unacceptable

communication for young females. Positive family functioning could have long term benefits for females throughout their lifetime sexual experiences.

One of the strengths of this study is that we examined sexual risk communication among young couples. The fact that sexual behaviors among couples are interdependent suggests that couples-based research is important for understanding sexual risk behaviors and sexual protective behaviors. The second strength was that we used the Actor-Partner Interdependence Model as the analytical approach to examining the predictors. Thus, we were able to account for the behaviors nested within couples. A third strength was that our sample consisted on young pregnant couples. It is important to understand which ecological factors promote sexual risk communication during pregnancy, as young mothers and their unborn child are at continued risk for infections. Although the findings from this paper add to the literature, the study is not without limitations. The cross-sectional design prevented us from inferring causal relationships (Newman et al., 2001). The use of self-report measures denotes concern over reliability and validity (Clark et al., 1997). This limitation is mitigated by the fact that the PARTNRS data collection team used audio computer-assisted self-interview to survey sensitive content. The reduction of socially desirable responding and the production of higher reported frequencies of sensitive behaviors among high-risk groups, including adolescents, have been attributed to the use of audio computer-assisted self-interview software (Macalino et al., 2002; Turner et al., 1998).

IMPLICATIONS

As we conclude, this study has shown that gender is a determining factor in the sexual risk communication topics discussed. We also learned that certain predictors are more of a catalyst for communication and that these predictors tend to be gender-specific. Moving forward, there are several implications for future intervention research. First, interventions should focus on improving communication for young couples. Interventions should include gender-specific skills for communicating sexual risk concerns to their partner. Second, interventions should target adolescent males to increase their overall sexual health knowledge and sexual protective skills. Interventions targeted towards males could serve as a mechanism for sexual health education and prevention for adolescent males who generally have less exposure to formal systems of care. Third, parents should be involved in intervention research as parental involvement serves as a risk protective factor for adolescents. The inclusion of parents could help to dissipate traditional gender expectations that inhibit assertive sexual communication and sexual protective behaviors. Parental involvement and support could have long term effects on adolescent sexual protective behaviors beyond the duration of the intervention.

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Figure 1.
Means of Sexual Risk Communication Topics Discussed by Gender

Table 1**Multiple Level Predictors of Sexual Risk Communication**

Variables	Assessment	Items	Range	α
<i>Individual Level</i>				
Depression	Center of Epidemiological Studies-Depression Scale (CES-D), (Radloff, 1977)	15 items	34.0	.82
Stress	Perceived Stress Scale, (Cohen & Williams, 1988)	10 items	40.0	.76
Condom use self-efficacy	Condom Use Self-Efficacy Scale, (Brafford & Beck, 1991)	17 items	2.82	.91
High risk behaviors	Summed variable created specifically for this study.	5 items		--
<i>Interpersonal Level</i>				
Relationship power	Sexual Relationship Power Scale, (Pulerwitz, Gortmake, & DeJong, 2000)	1 item		--
Romantic attachment	Experiences in Close Relationships Inventory, avoidance and anxiety subscales, (Brennan, Clark, & Shaver, 1998)	36 items	106.0 avoidance 95.0 anxiety	.94 avoidance .91 anxiety
Family functioning	Family Functioning Scale, (Tavitian, Lubiner, Green, Grebstein, & Velicer, 1987)	12 items	70.0	.81
Family and peer support of romantic relationships	Network Involvement, (Knobloch & Donovan-Kicken, 2006)	16 items	40.0	.83
<i>Community Level</i>				
Social support	Medical Outcomes Social Support Survey (MOSS Survey), (Sherbourne & Stewart, 1991)	20 items	36.0	.95
Social capital	Perception of Neighborhood Cohesion, (Buckner, 1998)	16 items	28.0	.92

Note. No alpha is reported for relationship power because the measure consisted of one item. No alpha is reported for the high risk behaviors because it is an index.

Table 2

Sample Descriptive of Young Couples

Sample Characteristics		Males (N = 296)	Females (N = 296)	p-value
Race:	N (%)			
Black		144 (48.6)	117 (39.5)	0.001
Latino		108 (36.5)	117 (39.5)	
Other		44 (14.9)	62 (20.9)	
School status:	N (%)			0.001
Yes		79 (26.9)	117 (39.5)	
No		215 (73.1)	179 (60.5)	
Age	M ($\pm$)	21.30 $\pm$ 4.06	18.70 $\pm$ 1.63	0.001
Years of education		11.84 $\pm$ 1.89	11.75 $\pm$ 1.82	0.001
Household income		17,500.00 $\pm$ 21,540.65	12,500.00 $\pm$ 15,529.89	0.014
Age at first sex		14.30 $\pm$ 3.22	15.00 $\pm$ 1.88	0.051 [†]
Length of relationship with MOB/FOB (in months)		27.24 $\pm$ 20.01	26.60 $\pm$ 19.52	0.001
Total number of heterosexual partners ever		12.61 $\pm$ 17.09	5.12 $\pm$ 5.24	0.001

Note. Standard deviation ($\pm$)

Mother/Father of the baby (MOB/FOB)

[†]Marginally significant p-value

Table 3**Actor-Partner Bivariates**

Parameter	Estimate	Standard Error	P-Value
<i>Covariates</i>			
Gender (actor)	.313	.086	.001
Age (actor)	-.005	.014	.697
Age (partner)	.010	.014	.476
Latina (actor)	-.300	.101	.003
Latina (partner)	-.245	.101	.015
White (actor)	-.181	.128	.159
White (partner)	-.171	.127	.181
Age at First Sex (actor)	-.026	.018	.141
Age at First Sex (partner)	-.032	.018	.076
Length of Relationship (actor)	-.003	.003	.200
Income (actor)	.155	.103	.134
Income (partner)	-.233	.102	.023
<i>Individual Level</i>			
Number of Sex Partners (actor)	.002	.004	.534
Number of Sex Partners (partner)	.007	.004	.051
Condom Use Self-Efficacy (actor)	.343	.073	.001
Condom Use Self-Efficacy (partner)	-.114	.075	.127
Depressed (actor)	-.001	.007	.937
Depressed (partner)	.004	.007	.584
Stress (actor)	5.834	.008	.994
Stress (partner)	.001	.008	.929
High Risk Behaviors (actor)	.838	.332	.012
High Risk Behaviors (partner)	.468	.334	.162
<i>Interpersonal Level</i>			
Relationship Power (actor)	.184	.105	.080
Relationship Power (partner)	-.033	.106	.758
Anxiety Attachment (actor)	-.001	.002	.877
Anxiety Attachment (partner)	-.001	.002	.821
Avoidant Attachment (actor)	.001	.003	.778
Avoidant Attachment (partner)	.007	.003	.015
Family Functioning (actor)	.009	.004	.017
Family Functioning (partner)	-.002	.004	.568
Family and Peer Support of Relationship (actor)	-.007	.007	.289
Family and Peer Support of Relationship (Partner)	-.003	.007	.657
<i>Community Level</i>			
Social Support (actor)	.016	.005	.003
Social Support (partner)	-.009	.005	.103
Social Capital (actor)	.007	.008	.353

Parameter	Estimate	Standard Error	P-Value
Social Capital (partner)	.011	.008	.174

Note. The *length of relationship* item is highly correlated for actor/partner and is only represented as actor here.

Table 4

Actor-Partner Main Effects

Parameter	Estimate	Standard Error	P-Value
<i>Covariates</i>			
Gender (actor)	.384	.117	.001
Age (actor)	.038	.017	.027
Age (partner)	-.018	.017	.294
Latina (actor)	-.265	.124	.033
Latina (partner)	-.111	.124	.371
White (actor)	-.251	.154	.103
White (partner)	-.090	.152	.556
Income (actor)	-3.693	2.541	.147
Income (partner)	-1.514	2.518	.548
Length of Relationship (actor)	-.004	.003	.112
Age at First Sex (actor)	-.035	.019	.059
<i>Individual Level</i>			
Number of Sex Partners (partner)	.001	.004	.861
Condom Use Self-Efficacy (actor)	.217	.078	.006
High Risk Behaviors (actor)	.431	.338	.203
<i>Interpersonal Level</i>			
Avoidant Attachment (partner)	.006	.003	.046
Family Functioning (actor)	.007	.004	.080
<i>Community Level</i>			
Social Support (actor)	.006	.006	.344