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Examining Relationship/Family Planning Factors and Sexual Relationship Power Among Immigrant Latino Couples in the United States

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Abstract

The ability to influence partners' actions within an intimate relationship (sexual relationship power [SRP]) is a key concept in achieving optimum family planning (FP) among U.S. Latinos. The purpose of this study was to examine the associations between relationship/FP factors and SRP. The actor-partner interdependence model was used to analyze data for 40 couples. Both men's and women's sexual communications were positively associated with SRP, only women's relationship satisfaction was positively associated with SRP, women's general communication was negatively associated with men's SRP, and men's contraception attitudes were negatively associated with SRP. Couples interventions are needed, which account for SRP and gender differences. These findings provide direction for developing targeted interventions to achieve better FP for Latino couples.

Abstract

La habilidad para influir, en una relación íntima, sobre las acciones de la pareja (Poder en la Relación Sexual [PRS]) es un concepto clave para lograr una óptima planificación familiar (PF) entre los Latinos en EEUU. El propósito de este estudio fue examinar la asociación entre los factores de la relación/PF y PRS. Para analizar los datos de 40 parejas se utilizó el Modelo de Interdependencia Actor-Pareja. Se estableció asociación: positiva entre la comunicación sexual de

mujeres y hombres y el PRS; asociación positiva solo entre la satisfacción de la relación de las mujeres y el PRS; asociación negativa entre la comunicación general de las mujeres y el PRS de los hombres; y asociación negativa entre las actitudes de anticoncepción de los hombres con el PRS. Se necesitan intervenciones para parejas que consideren el PRS y las diferencias de género. Los resultados de este estudio guiarán el desarrollo de intervenciones específicas para lograr una mejor PF en las parejas Latinas.

Keywords

Latinos; couples; family planning; pregnancy; contraception; prenatal care

One in six Americans in the United States is Latino (U.S. Census Bureau, 2010). The increase in Latino population was 1.5 times higher than the nation's overall population growth in the last 10 years (Passel, Cohn, & Lopez, 2011). Moreover, the Latino population is estimated to increase from 16% of the U.S. population in 2010 to nearly 30% by 2050 (U.S. Census Bureau, 2010). An increase in unintended pregnancies (UPs) accompanies the population growth rate (Finer & Henshaw, 2006). UP is defined as a pregnancy that is considered either mistimed or unwanted at the time of conception by women (Santelli et al., 2003). Women with UP are more likely to delay prenatal care (Cheng, Schwarz, Douglas, & Horon, 2009), and as a result, the pregnancy may be inadequately managed, pre-disposing both the mother and infant to poorer health outcomes (Evers, de Valk, & Visser, 2004). In addition, UP disrupts optimum birth spacing, which may further predispose the mother and infant to negative effects such as higher maternal complications during pregnancy and at delivery, neonatal morbidity, and long-term psychosocial development (Conde-Agudelo, Rosas-Bermudez, & Kafury-Goeta, 2007; David, 2006; Evers et al., 2004).

UPs could be reduced by effective family planning (FP), according to the World Health Organization (WHO; 2014). FP refers to the ability of individuals and couples, through their own intent, to determine their desired number of children and the spacing and timing of their births. Despite the WHO definition of FP as a couple's process, FP interventions have been directed primarily at women through the provision of contraceptives (Kirby, 2008) or building women's contraceptive negotiation skills (Choi, Wojcicki, & Valencia-Garcia, 2004). Several interventions targeted at women only for increasing contraceptive use have been unsuccessful (Kerns, Westhoff, Morroni, & Murphy, 2003). Sexually transmitted infection (STI)/HIV prevention intervention initiatives, however, have been successfully implemented with couples (El-Bassel et al., 2003; Harvey et al., 2009; Kraft et al., 2007). One of the important elements in these interventions is communication. Considering these findings in tandem, FP interventions could benefit from focusing on couples' communication about FP method use.

One factor that hinders couples from achieving optimum FP is power inequality. It is more difficult for women to negotiate safer sex, and there are only a few empirical methods that can be used to measure the power inequality that exists between men and women. Taking these two important concepts into account, sexual relationship power (SRP) has been operationalized (Pulerwitz, Gortmaker, & DeJong, 2000). One definition of SRP is the

ability to influence a partner's action within an intimate relationship (Ragsdale, Gore-Felton, Koopman, & Seal, 2009). Investigators have shown that SRP is associated with less risky sexual behaviors and use of effective FP methods (Matsuda, McGrath, & Jallo, 2012). The studies to prevent HIV, along with other STIs, were included in the integrative literature review of SRP by Matsuda, McGrath, et al. (2012). Effective FP methods for the most part are defined therefore as consistent male condom use. To our knowledge, however, there have not been other studies in which investigators examined how SRP is associated with relationship and FP factors from a dyadic perspective. Therefore, the actor-partner interdependence model (APIM) was used as a framework to analyze the current study data. This statistical method is regarded as the best way to examine the dyad relationship because it accounts for interdependence between and within the dyad (Kenny, Kashy, & Cook, 2006).

Purpose of the Study

The purpose of this study was to examine the associations between relationship/FP factors and SRP. Relationship factors include communication (in general and sexual), relationship satisfaction, relationship commitment, and sexual decision making. FP factors include attitudes and perceptions toward contraception.

Theoretical Model

The study's theoretical model (Figure 1) was developed to guide our conceptualization of heterosexual couples' SRP in relation to relationship/FP factors. The APIM is a statistical model but has been used as a theoretical framework in other studies (Kenny et al., 2006; Kim, Reed, Hayward, Kang, & Koenig, 2011). We used the APIM and other theories to conceptualize the relationships between variables of interest for this study. The basis of the theoretical model is two existing theories: the theory of gender and power and the social exchange theory. Connell (1987) reported that the theory of gender and power was developed to explain gender inequality that exists because of societal gender roles. Thus, societal gender roles may preclude women from making healthy sexual choices including the use of appropriate contraceptives and making better FP decisions (Wingood & DiClemente, 1998). In the social exchange theory, relationship power through decision-making dominance is defined as how much a partner controls his or her partner and how much he or she can make decisions against his or her partner's wishes (Emerson, 1981). Relationship power increases when one partner becomes more dependent on the other, when a partner comes with more resources into the relationship, or as more alternatives to the relationship exist (a person with more alternatives to the relationship possesses characteristics desired by others, e.g., being physically attractive). This partner, therefore, would have more power in the relationship. A power dynamic exists between men and women who are in an intimate relationship, and men's and women's relationship/FP factors may be associated with their own as well as their partners' SRP. Thus, our theoretical model takes into account such interdependence between partners.

Variables deemed critical to the study were selected from literature on HIV/STI prevention, relationships, and SRP. Harvey, Beckman, et al.'s (2006) conceptual model of condom use intention takes into account as one of the greatest barriers to women's condom use—their

lack of condom negotiating skill and power. Three variables in our study—sexual decision making, relationship commitment, and contraception attitudes and perception—were selected based on this model. The concept of relationship quality has been used in research with the development of the dyadic adjustment scale (Spanier, 1976). Power structure within couples has been shown to influence relationship quality (Zukoski, Harvey, Oakley, & Branch, 2011). SRP has not been examined, however, in terms of relationship satisfaction. We believe that learning about the association of these two variables could inform strategies to improve couples' relationships. Two types of communications—general communication and sexual communication—were examined in this study because of the positive associations between open communication and shared contraceptive decision making found in previous studies (Blanc, 2001; Mbweza, Norr, & McElmurry, 2008).

Method

Participants and Procedures

This was a cross-sectional descriptive study. A convenience sample of 40 heterosexual immigrant Latino couples was recruited for study participation. All the female partners were in their second or third trimester of pregnancy. Recruitment occurred at prenatal care clinics and through personal referrals. The inclusion criteria were the following: (a) both partners were 18 years of age or older, (b) both partners emigrated from Latin American countries, and (c) couples were married or living together. The potential female participants were identified through clinician referral and approached by the researcher. A bilingual male Latino research assistant (RA) joined in recruitment and data collection to increase the male participants' comfort. The RA also emigrated from Latin America and possessed a similar demographic background to the study participants. One hundred thirty women were approached during the recruitment period. Some women were followed up by phone with their permission so they could speak with their partners about study participation. This process of follow-up was necessary because many women did not come with their partners to their prenatal care appointments.

Screening questions were asked in a private setting prior to consent to ensure eligibility, and the study visit appointments were made after both partners agreed to participate. Eligible participants signed the consent form and were asked to complete paper and pencil questionnaires. The first author (YM) and the male RA ensured that all the participants completed the questionnaires in a separate space to protect their confidentiality. All participants were given a choice of completing the study questionnaires in English or Spanish; all participants completed the questionnaires in Spanish. Total time required for participation was approximately one hour.

Institutional review board approval was obtained from the university and the recruitment sites prior to data collection. Also prior to data collection, we used Hauck, Gilliss, Donner, and Gortner's (1991) approach to estimating of the power, based on computing an effective sample size—that is, the equivalent sample size for independent observations. In our case, the effective sample size is 70 independent observations, which provides 80% power for identifying at 5% significance a moderate multiple R^2 of at least 13%, indicating that linear mixed models would be sufficiently powered to identify moderate effect sizes.

Measures

Seven measures were used in this study to quantify the association between SRP and relationship/FP factors. The concepts used for the analyses were the following: SRP, sexual communication, general communication, relationship satisfaction, relationship commitment, sexual decision making, and FP attitudes and perceptions. The details of the measures, including validity and reliability, are listed in Table 1. Because Spanish measures were needed for men and women, appropriate modification as well as translation and back-translation of the measures that did not exist in Spanish have been done. Details are described in the following sections.

Modification of the Sexual Relationship Power Scale for Men.—Even though the scale was originally developed for women, authors of several studies have administered the SRP Scale to men after appropriate modifications (Matsuda, McGrath, et al., 2012). We similarly modified the scale for this study: The wording was changed (to refer to appropriate pronouns, “he” is changed to “she” at appropriate places), and the survey was given to 10 Latino men comparable to study participants’ demographics such that the authors ensured an accurate understanding of the modified scale and face validity.

Translation of English Measures.—The Dyadic Sexual Communication Scale (measure of sexual communication) and Communication with Partner (measure of general communication) were translated and back-translated using the American Academy of Orthopaedic Surgeons’ Institute for Work and Health Guidelines for translating research measures (Beaton, Bombardier, Francis, & Ferraz, 1998). Two bilingual translators whose native language was Spanish translated the English measures into Spanish. A bilingual moderator whose native language was also Spanish compared translations and synthesized the documents into one. Then, two bilingual translators whose native language was English back-translated the synthesized document into English. Another moderator whose native language was English compared the back-translated documents to the original document to ensure the accuracy of the translation. At the end, the translated documents were administered to 10 people who are similar in demographic characteristics to the target population of the study. These individuals were interviewed to determine what they believed the questions meant to ensure their appropriateness for use with this study’s target population. We determined that the translated measures were adequately capturing the same meaning in English and Spanish with cultural nuances incorporated.

Bilingual Measures.—SRP Scale and the measure for relationship satisfaction are both available in English and Spanish (described in Table 1). Three measures (relationship commitment, sexual decision making, and contraceptive attitudes and perceptions) were developed by Harvey’s (2009) research team for use in HIV/STI prevention research among the U.S. immigrant Latino population. They were originally created in English and Spanish. The team gave us permission to use the scales. Their construct validity was examined by performing confirmatory factor analysis. Model fit was assessed with standardized root mean square residual (SRMR) and comparative fit index (CFI). Three measures (relationship commitment, sexual decision-making, and contraceptive attitudes and perceptions) met the

criteria of SRMR less than 0.08 indicating close fit and a CFI greater than 0.9 indicating adequate fit (Harvey, Beckman, et al., 2006).

Analysis

Descriptive statistics were first generated for the demographic variables. Then the APIM framework was used to examine associations between SRP and individual relationship/FP factors. The APIM (Kenny et al., 2006; Rayens & Svarvarsdottir, 2003) was created and has been used to study associations for various dyadic data. In our study, the APIM was used to account for two kinds of relationships: men's or women's independent variable effects on their own dependent variable (referred to as actor effects), and men's or women's independent variable effect on each other's dependent variable (referred to as partner effects; see Figure 2).

The APIMs were computed using linear mixed models with fixed effects corresponding to actor and partner effects. Tests were also conducted to compare actor and partner effects between men and women using an adjusted fixed effects model. Values of β for these actor and partner effects reported in the results are estimated changes in mean SRP for changes of one estimated standard deviation for the associated predictor rather than unit changes in these predictors to be more comparable across predictors. For our analyses, models used the compound symmetry covariance structure with heterogeneous variances. Analyses were conducted using SAS Version 9.3.

Results

Demographics

Forty couples (80 individuals) completed questionnaires (refer to Table 2 for the participants' demographic characteristics). The mean age of women was 26.5 years ($SD = 4.8$), and the mean age of men was 28.2 years ($SD = 5.7$). The mean time since immigration to the United States was 67 years ($SD = 4.3$) for women and 7.8 years ($SD = 5.0$) for men. The mean gestational age of the fetus was 28.5 weeks ($SD = 7.8$) at the time of consent and study participation. Many of the participants had children from previous relationships. Forty-three percent of women and 28% of men said that they have children from previous relationships.

Almost half of the sample was of Mexican descent ($n = 19$; 47.5% and $n = 17$; 42.5% for women and men, respectively). Other participants were from various Central American countries. Most of the participants had completed between 1 and 12 years of education: 21 women (52.5%) and 15 men (37.5%) completed 1st through 6th grade; 18 women (45%) and 19 men (47.5%) completed 7th through 12th grade. Questionnaires were read to the male participants by the male RA and to the female participants by the first author (YM), as needed.

Twenty-eight couples (70%) were unmarried but living together. They referred to their relationship status as *acompañado* or *juntado*. This is generally a Latino phenomenon where a man and a woman decide to stay together and live together without commitment. Twelve

of the couples (30%) were either married through the judicial system or the church. The mean length of the current relationship was 4.8 years ($SD = 4.3$) and ranged from 3 months to 20 years.

Actor–Partner Interdependence Model

The individual effects of the following six independent variables on the dependent variable, SRP, were examined: sexual and general communication, relationship satisfaction, relationship commitment, sexual decision making, and contraception attitudes and perception. Figure 3 Panels A to D show the results of the APIM analyses. On Figure 3, Panel A, men's and women's higher rating of sexual communication was associated with higher scores on their own SRP (men: $\beta = .172$, $p = .008$; women: $\beta = .144$, $p = .004$). Thus, significant actor effects were shown. The men's actor effect was not significantly different from the women's actor effect, however ($\beta = .003$, $p = .702$). For general communication on Figure 3, Panel B, higher scores on women's general communication scale were associated with lower SRP for men $\beta = -.151$, $p = .049$). The women's partner effect was therefore statistically significant. On Figure 3, Panel C, relationship satisfaction was significant among women; higher relationship satisfaction was associated with higher SRP ($\beta = .192$, $p < .001$). Only the women's actor effect was significant for relationship satisfaction. On Figure 3, Panel D, contraception attitudes and perception was only significant for men. Higher scores on men's FP attitude and perception was associated with lower SRP ($\beta = -.321$, $p < .001$); higher contraception attitudes scores, meaning more barriers from using FP methods, therefore corresponded to lower SRP. No significant effects on SRP were found for relationship commitment and sexual decision-making models.

Discussion

We identified men's and women's actor/partner effects on SRP as well as similarities and differences in these actor/partner effects. We found how men's relationship/FP factors are associated with their SRP as well as how these variables are associated with their partners' SRP. Women's relationship/FP factors were examined in the same manner as the men's. Thus, we were able to examine differences and similarities in how each independent factor is associated with men's and women's SRP. We estimated changes in mean SRP under changes of size one estimated SD for each predictor. Whether positive or negative the estimated changes, they were greater ($.144$) among the statistically significant associations.

Sexual communication was the only relationship/FP variable with both men's and women's actor effects being positive: If men and women rate couples' sexual communication as being more open, they also perceived that they had higher SRP. Sexual communication was not specific to talking about FP method use. Several other investigators, however, have reported that higher SRP was associated with consistent FP method use (consistent condom use; Campbell et al., 2009; Matsuda, McGrath, et al., 2012; Powwattana, 2009; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002). Thus, having open sexual communication may be associated with consistent FP method use, yet we need more research to discover the distinct nuances of couples' sexual communication as well as if and how FP method use is

part of such communication. Our study findings support the existing body of literature about SRP.

For women, higher general communication scores (as a partner effect) were significantly associated with men's low SRP. Thus, men's SRP tended to be lower when women are less hesitant to communicate and ask for things from their partner. Flores, Tschann, Marin, and Pantoja (2004) found that more acculturated couples expressed their feelings directly to each other during conflict as compared to less acculturated couples. Although Flores et al. (2004) do not address power as a study variable, a power dynamic shift because of acculturation may be occurring.

We did not measure acculturation in the study reported here because two of us who work closely with the Latino population in the geographic location where the study was conducted deemed participants as being similarly acculturated. We determined that it would be more appropriate to use acculturation scores if we were working with Latinos across generations (i.e., first vs. second generation Latinos). Every Latino or Latina adjusts to life in the United States, however; he or she is influenced by the values and thought process that promoted by the U.S. media and culture. It has also been shown that as Latinas have more children, they become less supportive of male-centered decision making (Agnew, 1999). As reported earlier, some research findings explain why women may become significantly more powerful than men. How women with high general communication scores and men with low SRP scores work out their contraception use is unknown, however, and may be a theme for further research. For women, the actor effect for relationship satisfaction was significantly associated with SRP, which means the more satisfied women are with their intimate relationship, the higher they are likely to perceive their SRP to be. Zukoski et al. (2011) also noted that only women perceived that relationship power was about general communication and positive relationship qualities. Our results partially support the finding of Zukoski et al.

Contraception attitudes and perception was negatively associated with SRP only among men, which means that when men perceive higher barriers toward contraception use, they rate SRP to be lower. Harvey (2009) created the contraception attitudes and perception questionnaire that contains various aspects of one's attitude and perception toward contraception (denial, knowledge, ambivalence, norms, partner, side effects, hassle, and cost). Thus, demystifying and answering men's concerns about contraception may decrease contraception barriers and increase their SRP. Such an increase in SRP can be positive because correct knowledge and ownership may empower them to choose appropriate FP methods for themselves and their partners. Conversely, the negative relationship between contraception attitudes and perception and SRP means that men in our study, who had lower contraception attitudes and perception scores, were more likely to have higher SRP scores. These findings are consistent with the literature: Men with lower education/socioeconomic status and those from rural areas tend to act paternalistic; men with more education and formal employment tend to hold a more egalitarian view toward contraception decision making and its use (Mbweza et al., 2008; Speizer, Whittle, & Carter, 2005). Although demographic factors are not modifiable, contraception attitudes and perception can be. Our study findings and men's characteristics, as well as perception toward contraception, are

similar. It is important, therefore, for researchers and clinicians to make efforts to decrease barriers toward contraception attitudes and perception barriers for men.

Relationship commitment was not a significant variable for this study. Thirty percent of the couples were married, and 70% were unmarried and living together. There are contextual factors regarding relationships that were not examined. For example, this study was conducted at “new destination” areas, where the Latino population is increasing but bilingual resources are still limited. The lack of accessible resources may therefore affect a couple’s relationship and willingness to be committed and remain in the relationship. Sexual decision making was also not a significant variable for this study; however, it has been documented as important in the HIV/STI prevention literature (Harvey et al., 2009; Harvey, Beckman, et al., 2006; Harvey, Henderson, & Casillas, 2006). Sexual decision making may be a moderator rather than a variable that is affecting SRP directly. We know that sexual decision making cannot be a mediator because there is no significant relationship between SRP and sexual decision making. As noted earlier, however, sexual decision making has been documented as a key variable for contraceptive use. There is not enough power for this study to address the effects of multiple variables in combination. Larger samples are needed to conduct multiple variable APIM analyses of SRP.

Given that the significant factors associated with SRP are different among men and women, further research is needed focusing on interventions to promote sexual communication to increase SRP. In addition, differences in men’s and women’s results within a couple can be incorporated into interventions to target gender-specific barriers/facilitators toward effective FP method use. Furthermore, given the cultural- and personality-laden complexity of the topic, qualitative methods would augment researchers’ understanding about how to best intervene with Latino couples. To facilitate clinical implementation of our findings, it would be beneficial to investigate ways that clinicians might encourage couples’ sexual communication to promote FP method use during the clinic visits. These strategies would be an innovative way to take advantage of the rapport between clinicians and prenatal care patients and their partners.

Nursing Implications

Gender differences in significant factors associated with SRP need to be taken into account during postpartum contraception counseling and education. First of all, our results showed that men’s degree of contraception barriers negatively predicted SRP. Educating men about contraception, therefore, may empower men to be more active participants in FP. Health care providers (HCPs) can encourage women to bring their partners to prenatal care visits. The prenatal care environment must be more welcoming to men increasing their involvement and active participation in the pregnancy in preparation of fatherhood. If we can increase men’s involvement in prenatal care, male partners might become more active participants in the postpartum contraception.

Policy changes to encourage partners’ involvement within the clinical setting should also be considered (Jooste & Amukugo, 2012). During the clinic visit, HCPs can facilitate conversation with women and couples (i.e., listening to fears or past failures of contraceptive methods, asking about the intention of last pregnancies), assess the relationship and power

dynamic, and ask the couple how they are planning their postpartum contraception to provide correct information and select contraceptive methods that are the most appropriate for the couple (Matsuda, Masho, & McGrath, 2012). Such conversation becomes an appropriate segue to interconceptional care (time after last delivery, before the next pregnancy) that is important for every woman, but these discussions may never occur for various complex reasons (Hogan et al., 2012).

Pregnant women repeatedly come to the clinic for their prenatal care visits, providing a wonderful opportunity for providers to establish trust and rapport with the patients. The prenatal care period, therefore, is the best time frame to approach women/couples about postpartum contraception. It may not seem imminent to deal with postpartum contraception while being pregnant; in a worst case scenario, however, a pregnant woman may not come to see HCPs until she is pregnant again. Keeping this in mind, it is important to address postpartum contraception during this time to prevent recurring UPs. More efforts are needed to increase couples' involvement in contraception choices.

Limitations

Even though there are strengths in this study design, there are limitations that must be acknowledged. First, this is a descriptive study. Descriptive studies illustrate associations between variables and do not allow investigators to establish causality. Findings from this descriptive study may, however, inform a research trajectory for developing individualized targeted interventions to support FP communication in couples, in the context of SRP.

Second, acculturation was not measured in this study. However, the mean number of years in the United States is less than 10 years, which is defined as newly immigrated Latinos and has been used in other studies as a crude measure of acculturation (Winett, Harvey, Branch, Torres, & Hudson, 2011). In addition, all the participants chose to complete the survey in Spanish, which indicates a degree of cultural similarities within the study sample.

Third, this study used a convenience sample. The people who chose not to participate may hold different characteristics than those who participated in the study. The majority of those who did not qualify for the study reported they were single (without a partner). Although conception most often includes a partner, many women did not have partners when seen in the prenatal care clinic. There may have been traumatic reasons that caused the separation for these mothers, potentially from extreme power dynamics with their past partners (fathers of the babies). Moreover, their pregnancy and raising the child is well known to be more difficult because of the lack of social and emotional support from the partners (Christensen, Stuart, Perry, & Le, 2011; Diaz, Le, Cooper, & Muñoz, 2007). Future study can focus on examining SRP factors for single pregnant women to help with this presumably high-risk population. Finally, our sample was collected from a single geographical location limiting generalizability of the findings.

In addition, some of the study measures have particularly lower reliability (men's and women's relationship satisfaction [.67, .68], men's and women's relationship commitment [.67, .62], and women's contraception attitudes and perception [.65]). Cronbach's alpha should be higher than .7 (Tavakol & Dennick, 2011), and alpha less than .6 is not acceptable

(Lynn, 2013). When reliabilities are low, the measures are not consistent or dependable measuring the concept they are supposed to measure (Trochim & Donnelly, 2008). Therefore, low reliabilities may be one of the reasons that there were no significant association between SRP and relationship commitment/men's relationship satisfaction/women's contraception attitudes and perception. The reasons for lower Cronbach's alpha include fewer number of items in the measure, poor interrelatedness, or heterogeneous constructs (lower reliabilities are a result of measuring more than one constructs; Lynn, 2013). To perform factor analysis of the measures, the authors need to increase the sample size. Further study could focus on factor analysis and evaluation of psychometric properties for the measures with low reliabilities.

Finally, we used the Communication with Partner Scale, a subscale of the Couple's Pre-Counseling Inventory to measure general communication scale. We acknowledge that when using only selected scales from established measures the psychometric properties are altered.

Conclusion

Several important factors associated with SRP among Latino couples were discovered during this investigation. Examining couples as units for FP studies and interventions must continue to be emphasized not only because of the potential effectiveness of these types of interventions but also because couples influence each other. In addition, there is a need for creating culturally tailored couples interventions that address the similarities and differences of men's and women's characteristics as demonstrated in this study.

Latino immigrants in the United States are facing many difficulties in their transition to making a living and adjusting to an unfamiliar environment. During this time of transition, reproductive matters may be secondary to them. Reproductive matters, however, are a concern that needs to be addressed because having children and raising them requires more adjustment and responsibility. Latinos also may face more difficulty raising children in the United States because they may need to work harder to understand school systems and other organizations where language and/or cultural differences may exist. The family is the smallest unit of human organization for children, and it begins with the couple's desire to be together in support of growing children. Efforts to promote couples' FP method use must be a priority in promoting healthy Latino families in the United States.

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Figure 1. Theoretical model on dyad relationship/family planning (FP) factors and sexual relationship power (SRP).

Figure 2.

Actor-partner interdependence model. Actor Effect = effect of independent variable on their dependent variable; Partner Effect = effect of independent variable on partners' dependent variable.

a) APIM for Sexual Communication (SC) and Sexual Relationship Power (SRP)

b) APIM for General Communication (GC) and SRP

c) APIM for Relationship Satisfaction (RS) and SRP

d) APIM for Contraception Attitudes & Perception (CA&P) and SRP

Figure 3.

Results of the actor-partner interdependence model (APIM) analyses on relationship/family planning factors and sexual relationship power. Estimated changes in mean SRP for changes of one estimated standard deviation for the associated predictor. ** $p < .001$. * $p < .05$.

TABLE 1.

Measures Used in the Study

Concept Measuring and Interpretation	Name of the Scale and No. of Items	Rating	What the Scale Is Measuring	Score Range	Validity	Reliability	Cronbach's Alpha
Sexual relation ship power (SRP), higher scores represent higher SRP	SRP Scale (Pulerwitz et al., 2000); 23 items with 2 subscales: 15 (Relationship Control Scale [RCS]); 8 (Decision Making Dominance Scale [DMDS])	RCS: a 4-point rating scale of 1 = <i>strongly disagree</i> ; 2 = <i>strongly disagree</i> ; 3 = <i>both of you equally</i> , and 4 = <i>you</i> DMDS: a 3-point rating scale of 1 = <i>your partner</i> , 2 = <i>both of you equally</i> , and 3 = <i>you</i>	RCS: how the partner reacts to various daily and sex-related behaviors DMDS: who has more say about various activities/dealings that couples encounter	1–4, compute using formulas developed by Pulerwitz et al. (2000)	Good reported validity: face validity with minority women and construct validity significant with consistent condom use	Cronbach's $\alpha = .85$ (English); .89 (Spanish)	Men: .82; women: .81
Sexual communication, higher score corresponds to higher quality and more openness toward sexual communication	Dyadic Sexual Communication Scale (DSCS; Catania, 1998); 13 items	A 6-point Likert scale ranging from 1 = <i>disagree strongly</i> to 6 = <i>agree strongly</i>	Respondents' perceptions of their sexual communication process with their partners (quality of sexual communication)	13–78	Construct validity: a single factor was obtained from factor analysis; consistent condom use was associated with high DSCS score among minority adolescent girls. Used in high-risk STI/HIV population	Cronbach's $\alpha = .87$ (high risk STI/HIV population and young adults)	Men: .70; women: .74
General communication, higher score indicates better communication between couples	Communication with Partner Scale (Stuart & Jacobson, 1987); 13 items	A 5-point Likert scale ranging from 1 = <i>almost never</i> to 5 = <i>almost always</i>	Respondents' communication styles and how they perceive general communication with their partners on frequency (quantity) and quality of communication in general	13–65	Criterion-related validity was established using the measure of the same dimension as the CPCI and had correlations between 0.77 and 0.96.	This scale is a component of the CPCI. Only the Cronbach's alpha of the CPCI is available, .91.	Men: .72; women: .83
Relationship satisfaction, higher scores indicate higher relationship quality	Dyadic Adjustment Scale 7-Item Short Form (DAS-7; Spanier, 1976)	A 6-point Likert scale: 0 = <i>always disagree</i> to 5 = <i>always agree</i> & 0 = <i>never</i> to 5 = <i>more often</i> ; last question: a 7-point Likert scale (overall relationship satisfaction) 0 = <i>extremely unhappy</i> to 6 = <i>perfect</i>	Degree of relationship satisfaction: 3 questions are about value agreement, 3 questions are about frequency of activities together, 1 question is about overall happiness with the current relationship	0–36	Concurrent validity: >0.9 (correlation between DAS in English and in Spanish). Good construct validity: FACES II and on DAS (correlations were between 0.26 and 0.46; Youngblut, Brooten, & Menzies, 2006)	Cronbach's alpha: 0.67–.93	Men: .67; women: .68
Relationship commitment, higher scores indicating more commitment to the relationship	Relationship Commitment Scale (Harvey, 2009); 8 items	A 9-point Likert scale: 0 = <i>do not agree at all</i> to 8 = <i>agree completely</i>	How much each person is committed to the existing relationship with his or her current partner	0–128	Construct validity: significant correlation with perceived vulnerability ($r = -0.2, p < .05$) and with condom use decision making ($r = 0.13, p < .05$)	.77 (S. M. Harvey, personal communication, April 24, 2011)	Men: .67; women: .62
Sexual decision making, higher score indicates more active involvement with sexual decision making	Sexual Decision-Making Scale (Harvey, 2009); 6 items	A 5-point Likert scale from 1 = <i>not at all</i> to 5 = <i>a great deal</i>	Subjects' participation/involvement in sexual decision making with their partner	12–60	Construct validity: significant increase in sexual decision making among those who were in a couple intervention study, $F = 27.15, p = .001$	.82 (S. M. Harvey, personal communication, April 24, 2011)	Men: .9; women: .89

Concept Measuring and Interpretation	Name of the Scale and No. of Items	Rating	What the Scale Is Measuring	Score Range	Validity	Reliability	Cronbach's Alpha
Attitude toward contraception, higher score indicates more barriers toward contraception use	Contraception Attitudes and Perception Scale (CA&P; Harvey, 2009); 21 item	A 5-point Likert scale from 1 = <i>do not agree at all</i> to 5 = <i>completely agree</i>	Measure different aspects of contraception, including denial/knowledge/ambivalence, norms, partner, side effects, hassle, and cost	21–105	Construct validity: exploratory factor analysis yielded on seven factors, accounting for 37% of the variance in scores	.76 (S. M. Harvey, personal communication, April 24, 2011)	Men: .86; women: .65

Note. CPCI = Couple's Pre-Counseling Inventory; STI = sexually transmitted infection; FACES = Family Adaptability and Cohesion Evaluation Scale.

TABLE 2.

Participant Demographics

Individual Characteristics	Women (<i>n</i> = 40)	Men (<i>n</i> = 40)
Age, years <i>M</i> (<i>SD</i>)	26.5 (4.8)	28.2 (5.7)
Gestational age of the fetus, weeks <i>M</i> (<i>SD</i>)	28.5 (7.8)	N/A
Time in the United States, years <i>M</i> (<i>SD</i>)	6.7 (4.3)	7.8 (5.0)
Existence of children from previous relationship, <i>n</i> (%)	17.0 (43.0)	11.0 (28.0)
Country of origin, <i>n</i> (%)		
Mexico	19.0 (47.5)	17.0 (42.5)
El Salvador	11.0 (27.5)	9.0 (22.5)
Honduras	11.0 (27.5)	7.0 (17.5)
Guatemala	5.0 (12.5)	6.0 (15.0)
Other Central American countries	N/A	1.0 (2.5)
Education, <i>n</i> (%)		
No formal education	N/A	2.0 (5.0)
1st–6th grade	21.0 (52.5)	15.0 (37.5)
7th–12th grade	18.0 (45.0)	19.0 (47.5)
College or more	1.0 (2.5)	4.0 (10.0)
Couple characteristics		
Relationship status, <i>n</i> (%)		
Living together (<i>acompañado</i> or <i>juntado</i>)	28.0 (70.0)	
Married	12.0 (30.0)	
Length of relationship, years <i>M</i> (<i>SD</i>)	4.8 (4.3)	