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Couples and the Male Birth Control Pill: A Future Alternative in Contraceptive Selection

WILLIAM MARSIGLIO AND ELIZABETH G. MENAGHAN

Contraceptive decision making is likely to become more complex when male oral contraceptives are marketed and as sex-role preferences become more egalitarian. A mailed survey of 47 married couples selected from a newspaper "Birth Listing" column in Columbus, Ohio was used to contrast spouses' views, to assess levels of actual and perceived consensus among partners, and to identify predictors of greater stated likelihood of male pill usage. Modest support was found for the hypothesis that more egalitarian sex-role preferences are positively related to a greater belief in contraception as a shared responsibility, wives: $r = .35$, $p < .01$, husbands: $r = .21$, $p < .10$. No support was found, however, for the hypothesis that beliefs in shared contraceptive responsibility would lead to greater acceptance of a male pill. Wives were also more accurate, $r = .57$, $p < .001$, than husbands, $r = .21$, $p < .08$, in perceiving their spouse's attitudes toward male pill adoption. Results suggest that researchers need to focus on the process by which contraceptive usage is negotiated and renegotiated among married couples.

Contraceptive decision making among married couples is affected by a number of interrelated factors. At a structural level, the contraceptive industry effectively curtails the decision-making process by determining the available options from which couples may choose (Luker, 1975; Marsiglio, 1985). Since the most effective reversible contraceptives are presently designed for women, a biased negotiation and bargaining context may be established a priori for husbands and wives, particularly for couples attempting to delay pregnancy. Each spouse's assumption as to who is or should be responsible for contraception, as well as each spouse's perceptions of his or her partner's preferences and views regarding contraceptive responsibility, also

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may affect how a method is chosen. Spouses' sex-role preferences are likely to play an important role in shaping these individual perceptions.

A unique permutation of couples' contraceptive decision making is considered here by examining spouses' sex-role preferences, perceptions regarding contraceptive responsibility, and their hypothetical intentions concerning the adoption of a *male* birth control pill. Couple data are used to compare and contrast spouses' views and intentions as well as consider levels of actual and perceived consensus within married couples; data from each spouse are used to explore predictors of greater likelihood of male pill adoption.

Contraceptive Alternatives and Decision Making

Prior to the late 1950s and early 1960s, since modern forms of female birth control (e.g., pill, sterilization, and modern I.U.D.) were not yet available, men played a more active role in contraception through their use of condoms and the withdrawal method. However, with the introduction of the oral contraceptive pill in 1960 and the I.U.D.s re-entry into the commercial market in 1965, a notable shift occurred in contraceptive responsibility (Westoff & Jones, 1979). These options, which were highly effective and enhanced spontaneity, qualitatively and quantitatively altered the set of alternatives from which couples could make their selection. Similarly, the development and effective marketing of a male oral contraceptive could today provide an impetus, once again, for a dramatic change in how contraceptive decision making is practiced.

Although a male pill is not commercially available, such a method may soon be a realistic option for couples: Current biomedical contraceptive research has led to some predictions that a male pill can be developed and marketed within the next 10-20 years (see Benditt, 1980; Djessari, 1980, 1981; Nieschalg, Wickings, & Breuer, 1981; Schearer, 1978; Stokes, 1980).

Some researchers have already examined males' beliefs and attitudes concerning the use of potential male chemical contraceptives. The World Health Organization's cross-cultural field survey (1980) and clinical study (1982) provide evidence that a considerable proportion of males are willing to use male hormonal contraceptives. Similarly, Gough (1979) reports, in his study of 151 males living in the San Francisco Bay Area, that 74% responded *yes* (55.6%) or *probably yes* (18.5%) to the question: "Would you use a contraceptive pill for males

if one were available?" Another U.S. study (Jaccard, Hand, Ku, Richardson, & Abella, 1981), examining the effects of contraceptive attribute dimensions on males' stated willingness to use a male oral contraceptive, together with the work of Spillane and Ryser (1975) and Balswick (1972), lends additional support to this view. Males' apparent willingness to use a male pill should be interpreted cautiously, however, given the hypothetical nature of the innovation and the commonly observed discrepancy between beliefs, attitudes, and intentions with respect to subsequent behaviors (Fishbein & Azjen, 1980).

Sex-Role Preferences and Contraceptive Decision Making

Societal changes in sex roles may facilitate increased male involvement in contraceptive responsibility even before new male contraceptives are marketed. It is well documented that U.S. preferences concerning a sex-role based division of labor are shifting from traditional to more egalitarian in nature (Bayer, 1975; Duncan & Duncan, 1978; Iglehart, 1979; Mason, Arber, & Czajka, 1976; Parelius, 1975; Scanzoni, 1976; Thornton & Freedman, 1979). A trend toward more equal sharing and joint decision making among men and women has accompanied this shift in sex-role preferences.[1] More explicit negotiating strategies are likely to be utilized by couples as they increase their level of joint decision making (Scanzoni, 1977).

Contraceptive decisions may be made either through overt exchanges between partners or through some form of tacit understanding which exists between them. The latter frequently occurs subliminally in that one partner acts in a particular way "knowing" that his or her partner will respond accordingly. A case in point is the husband who assumes that his wife will take responsibility for contraception since this is her "role," and thus never raises the subject for discussion. Similar is the wife who "knows" that her husband would never want to use condoms and so chooses a female method of contraception.

[1]We utilize Scanzoni and Szinovacz's (1980) description of sex roles as "*preferences* for desired goals or interests." Preferences for the numerous kinds of tastes, utilities, goals, interests, rewards, and costs associated with different aspects of the roles of husband, wife, father, and mother vary among individuals; consequently, sex-role preferences can be treated as variables ranging on a continuum from traditional to egalitarian (see also Scanzoni & Fox, 1980).

Much contraceptive decision making probably occurs in this manner, and the correctness of one's assumptions about the spouse's family size and contraceptive preferences are therefore never verified. This general lack of knowledge and communication may partly explain why, although Americans are "sold" on family planning, they nevertheless have high numbers of mistimed or unwanted pregnancies (Downs, 1977). The use of couple data in the present study enables us to consider whether spouses have certain misperceptions, for example, about how willing the husband may be to assume contraceptive responsibility himself.

The recognition of particular issues as problematic or nonproblematic, important or unimportant, is one of the important aspects of decision making which sex-role preferences affect. For example, if women hold traditional sex-role beliefs, they may be likely to assume automatically that contraception is their responsibility (Luker, 1975). Traditional males may also have a stronger tendency to view contraception as the female's responsibility and be ambivalent, at best, toward the use of male methods. If this is the case, then little, if any, discussion or negotiation is likely to transpire, since the issue appears to have been settled a priori. Men and women with egalitarian sex roles, therefore, should be more likely than their traditional counterparts to consider contraception a joint responsibility and to discuss their contraceptive preferences more explicitly. Men with more modern sex-role preferences might welcome an opportunity to assume direct contraceptive responsibility by using a male pill whereas women holding similar sex-role views may be more likely to advocate its use.

Earlier studies of the association between sex-role preferences and attitudes toward contraception are inconclusive. Weinstein and Goebel (1979), using a nonrandom sample, found that men who held less stereotypic beliefs about contraceptive responsibilities had a more positive attitude toward male contraceptive use. Benson (1981), however, found that men with less traditional sex-role attitudes were no less likely than males with traditional attitudes to believe that women should be responsibile for contraception. Males' sex-role attitudes have also been found to be poor predictors of contraceptive behavior in a study of college men (Fox, 1977).

Given the contraceptive industry, however, men have limited opportunities to participate as actively as women in either choosing between various methods or assuming direct contraceptive responsibility. Spouses' expectations regarding contraceptive responsibility, therefore, may be affected by the fact that the more effective and con-

venient contraceptives are currently female oriented. A viable male pill would provide men with more practical opportunities to participate actively in the selection process for a given method and to be more directly involved with contraception. The availability of a male pill might also encourage women to attempt to persuade their husbands to assume more contraceptive responsibility.

Method

Sample

Data for this study were drawn from a mailed survey of married couples in the Columbus, Ohio area during the autumn of 1982.[2] A major sampling concern was to obtain a representative list of fertile, married couples who were likely contraceptors. Couples who had given birth 4 to 15 months earlier were selected as the target sample. All hospital births are routinely listed in area newspapers, and the *Columbus Dispatch* newspaper "Birth Listing" column was used to generate the sample. This sampling design included only married couples who were also parents. The design may therefore underrepresent egalitarian couples by excluding voluntarily childless couples (Bram, 1978; Cooper, Cumber, & Hartner, 1978; Veevers, 1973). In addition, it reduces the chances for selecting couples who prefer having fewer children and/or younger, more educated couples in the process of delaying pregnancy. It excludes entirely couples electing to have home births.

The sampling procedure consisted of an initial and follow-up mailing. An extensive 10-page questionnaire and an addressed, stamped envelope were initially sent to both the husband and wife of the 200 selected couples under separate cover. Respondents were asked to complete their questionnaires independently and were encouraged not to discuss their answers with their spouses until each had completed and returned a questionnaire. A follow-up letter was mailed to all respondents 9 days after the initial mailing.

These procedures elicited 102 total responses (25.5%), 49 husbands (24.5%), and 53 wives (26.5%), for a total of 47 completed couples (23.5%). The analyses for this report are based on the data from the 47

[2]We concentrated on members of a committed couple, married couples in this case, because we assumed that women involved in multiple sexual relationships will be less likely to relegate birth control responsibilities to their sexual partners, especially when an imperceptible and novel method is involved. Thus, couples with some degree of commitment are more likely to make use of it, particularly when it is first marketed.

couples. Although relatively low, this 23.5% response rate is within the anticipated range of rates found for comparable survey designs (Goyder, 1982; Heberlein & Baumgartner, 1978). Several factors contribute to the relatively low response rate. First, questionnaires were mailed to couples who had recently had a child. Such couples are customarily bombarded with an assortment of baby-related mail during this period, and the demands on their time are more pressing than usual. Under the circumstances, many spouses might not have welcomed a relatively complex, 10-page questionnaire. The sample was also drawn from a predominantly urban area, and Goyder (1982) has presented evidence suggesting that return rates are considerably lower among urban populations than in rural or mixed settings.

The final sample tended to be highly educated: 55% of the husbands and 34% of the wives were college graduates. All but one of the respondents were white. The mean age was 30.5 years for husbands and 28.9 for wives, with husbands' ages ranging from 21 to 44 and wives' ages ranging from 21 to 37. The couples had been married an average of 6.3 years, with 49% married less than 6 years, 32% married 6 to 10 years, and 19% married 11 to 15 years. Family size was fairly small: 40% had only one child, 43% of the couples had two children, 13% had three children, and 4% had four children. Although 43% (n = 20) of the wives and 38% (n = 18) of the husbands expected to have additional children, approximately one third of the respondents did not want any more children, and the remainder were unsure about future childbearing.

Over 90% of the couples were current users of some form of contraception. The most popular current method was female oral contraceptives (25.5%), followed by condoms (19%), sterilization of one partner (13%),[3] diaphragm, foam, or jelly (13%), and rhythm or abstinence (8.5%). Although restricted in generalizability, this sample may approximate those people who would represent the target market for a male pill.

Measurement of Variables

Seven key variables, measured separately for each spouse, are considered in these analyses: likelihood of using a male contraceptive pill, perception of spouse's attitude toward male pill usage, the likelihood

[3]If the respondent or his or her spouse were sterilized, they were asked to respond as they would have if they had not been sterilized. Analyses reveal no differences in findings if these couples (n = 6) had been excluded.

of initiating a discussion of male pill usage, locus of responsibility for contraception in principle, responsibility for the couple's current contraceptive selection, attitudes toward male chemical contraception, and sex-role preferences.

The major dependent variable, likelihood of using a male pill, was assessed by a Likert-type item with four response categories (see Table 1): "How likely is it that you and your spouse would use a male pill if it were as safe and effective as the female pill?" Spouses' perception of their partner's attitude toward a male pill was explored by asking respondents: "How favorable do you feel your spouse's attitude would be toward adopting a male birth control pill as a method of birth control for your marriage?" The likelihood of raising the issue of adopting a male pill was measured with the question: "If you learned that a male pill were commercially available, how likely is it that you would seriously raise the issue of possibly adopting it as a method of birth control?"

Locus of contraceptive responsibility was assessed in two ways. The first question pertained to spouses' general perceptions of contraceptive responsibility. Partners were asked to indicate how strongly they agreed or disagreed with the statement, "As a matter of principle, the wife should be the spouse primarily concerned with birth control." The second question was more behaviorally grounded and asked how the decision to use their current form of birth control had been made. This item had five response categories ranging from *wife's decision exclusively* to *husband's decision exclusively.* Since only one respondent indicated that the husband was primarily responsible for the decision, and no one stated that the husband was exclusively responsible for it, scoring was collapsed into three categories (shared, wife's decision primarily, and wife's decision exclusively).

The degree to which the chemical nature of a male pill would inhibit a spouse's personal selection of a male pill was assessed by asking, "Would the chemical nature of a male pill inhibit your *personal* selection of a male pill as a form of birth control for you and your spouse? If so, to what extent?"

Scanzoni and Szinovacz's (1980) sex-role preference indices (SRPI) pertaining to the roles of husband and wife were combined into a general index to measure husbands' and wives' sex-role preferences.[4] A

[4]The second item measuring the role of the husband appeared in Scanzoni and Szinovacz (1980) as "If his wife works, she should share equally in household chores such as cooking, cleaning and washing." It was assumed that "she" should have read "he." The item was consequently changed for this study.

SRPI score was calculated for each husband and wife by summing their responses over the 10 items. Each item was scored 1-4, and the overall index had a possible range of 10-40. Items were coded so that lower scores reflect more traditional preferences and higher scores more egalitarian preferences. Cronbach's reliability coefficient for these items was .78 and .74 for the wife and husband subsamples, respectively.

Except for the SRPI, each variable noted above was assessed with a single question. Although this approach does not permit extensive variability of scores for any single variable, it enabled us to obtain some information about a range of theoretically relevant concepts.

Results

Descriptive Analyses: Husband and Wife Responses

Sex differences. Responses for pairs of husbands and wives are displayed in Table 1. Mean differences by sex are evaluated with a paired t test. These respondents were fairly egalitarian, but wives' scores were more egalitarian than their husband's, $t(46) = -4.37$, $p < .01$.

Both husbands and wives tended to report that the decision to use their current form of birth control involved about equal input from husband and wife, but they disagreed about where the locus of responsibility *should* lie: 36% of wives, but only 11% of husbands, strongly disagreed with the statement that "as a matter of principle, the wife should be the spouse primarily concerned about birth control."

Overall, attitudes towards a male pill were favorable. Husbands considered use somewhat more likely than their wives, and they perceived their wives as more favorably disposed toward such a pill than their wives perceived their husbands to be. Men and women both seemed concerned about the chemical nature of the hypothetical male pill, with about 7% of husbands and 17% of wives stating that its chemical nature would inhibit their personal selection of a male pill to a very limited extent or not at all.

Degree of consensus within couples. Sex differences exist even when individual couples are relatively similar to one another in attitudes and responses. Pearsonian correlations between husband-wife responses on the seven items are also shown in Table 1. Significant positive correlation were found for sex-role preferences, reported likelihood of raising

Table 1

Husbands' and Wives' Responses: Basic Statistics and Correlations

Variable	Husbands	Wives	t[a]	r[b]	r_1[c]
Egalitarianism of sex-role preferences (Summary scale, 10 items)					
M	28.06	30.44	-4.37***	.51***	.37
SD	3.62	3.92			
Decision making re current contraceptive method					
1 = Wife alone	8.7[d]	19.6			
2 = Wife mostly	32.6	15.2			
3 = Shared	58.7	65.2			
M	2.51	2.44	0.60	.50***	.49
SD	0.66	0.81			
Locus of contraceptive responsibility in wife					
1 = Strongly agree	0.0	2.1			
2 = Agree somewhat	19.6	10.6			
3 = Disagree somewhat	69.6	51.1			
4 = Strongly disagree	10.9	36.2			
M	2.91	3.26	-2.97***	.13	.04
SD	0.55	0.65			
Likelihood of male pill use					
1 = Very unlikely	17.0	27.7			
2 = Somewhat unlikely	12.8	12.8			
3 = Somewhat likely	38.3	36.2			
4 = Very likely	31.9	23.4			
M	2.85	2.55	1.73+	.43**	.40
SD	1.06	1.14			
Perception of spouse's attitude					
1 = Very unfavorable	6.4	14.9			
2 = Somewhat unfavorable	2.1	21.3			
3 = Somewhat favorable	48.9	48.9			
4 = Very favorable	42.6	14.9			
M	3.28	2.64	4.08***	.23+	.08
SD	0.80	0.92			
Inhibitions concerning chemical contraception					
1 = Extremely large extent	26.1	23.9			
2 = Somewhat	30.4	17.4			
3 = Moderate	30.4	32.6			
4 = Limited extent	6.5	8.7			
5 = Very limited extent	2.2	4.3			
6 = Not at all	4.3	13.0			
M	2.40	2.84			
SD	1.27	1.57	-1.51	.04	.02
Likelihood of initiating discussion re male pill use					
1 = Very unlikely	17.0	17.0			
2 = Somewhat unlikely	19.1	8.5			
3 = Somewhat likely	27.7	34.0			
4 = Very likely	36.2	40.4			
M	2.83	2.98	-1.02	.59***	.58
SD	1.11	1.09			

[a]Paired t test, $df = 46$, two-tailed probability level.
[b]Pearson product-moment correlation coefficient, probability level, one-tailed test.
[c]Intraclass correlation coefficient.
[d]Percentage of responses at each scale point.
$^{+}p < .10$. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

the issue of possible male pill use with their spouse, who made the decision regarding current contraceptive method, and in how likely they would be to adopt a male pill.

Since high positive correlations can occur even when there are pervasive differences in group means and/or variances, some authors have advocated the use of a coefficient of agreement which would reflect the degree of similarity or dissimilarity in means, variances, and relative ranking in a single measure (Robinson, 1957; Thompson & Walker, 1982). As Robinson has shown, in the case of agreement between just two observers, the appropriate coefficient of agreement (A) is a linear function of an intraclass correlation coefficient (R_1). As is evident from its equation,[5] the intraclass coefficient is equal to the Pearson correlation coefficient when group means and variances are equal but is reduced by differences either between group means or group variances or both. Values of the intraclass correlation coefficient are shown in the final column of Table 1. Correcting for the differences between group means reduces the association for sex-role preferences but only slightly affects the estimated similarity between spouses for those variables with similar group means.

It is clear that husbands and wives are *not* similar or consensual on two critical questions. They do not agree about the proper locus for contraceptive responsibility, and they do not agree about how much the chemical nature of a male pill would inhibit adoption.

Consensus, perceived consensus, and accuracy of perceptions. We have noted that husbands and wives were relatively similar in their reported likelihood of adopting the male pill. They also assume that their spouse's attitudes are similar to their own: Husbands who thought pill adoption was likely thought their wives would have favorable attitudes, $r = .59, p < .001$; and conversely, wives' perceptions of their husband's attitude toward male pill usage were correlated, $r = .47$, $p < .001$, with their own stated likelihood of using a male pill. Thus, each partner perceived a marital consensus of attitude toward this contraceptive innovation. The complete intercorrelation matrices for husbands and wives are shown in Table 2.

[5]The intraclass correlation coefficient is equivalent to:

$$\frac{r[(S_1^2 + S_2^2) - (S_1 - S_2)^2] - 1/2(M_1 - M_2)^2}{(S_1^2 + S_2^2) \pm 1/2(M_1 - M_2)}$$

where r is the Pearson correlation coefficient, S_1 is the standard deviation for the first group, S_2 is the standard deviation for the second group, M_1 is the mean of the first group and M_2 is the mean of the second group. Robinson defines his coefficient of agreement as $(r_1 + 1)/2$, to range between 0 and 1.

Table 2

Intercorrelations Among Husbands' and Wives' Responses

	V1[a]	V2	V3	V4	V5	V6	V7
V1	—	.46***	.78***	.02	.01	.40**	.17
V2	.59***	—	.45**	-.14	.02	.22	.26*
V3	.72***	.35**	—	.15	-.02	.21	.13
V4	.03	-.21	.09	—	.09	.21	-.14
V5	.09	-.14	.08	.37**	—	.09	.35**
V6	-.05	-.08	-.06	.13	.02	—	-.21
V7	.27*	.20	.08	.12	.21	.07	—

Note. Husbands' responses are below the diagonal; wives' responses are above the diagonal.

[a]V1 = Likelihood of male pill use (high = very likely).
V2 = Perception of spouse's attitude (high = favorable).
V3 = Likelihood of initiating discussion regarding male pill use (high = very likely).
V4 = Decision making regarding current contraceptive method (high = shared).
V5 = Locus of contraceptive responsibility in wife (high = degree).
V6 = Inhibitions concerning chemical contraception (high = few).
V7 = Egalitarianism of sex-role preferences (high = egalitarian).
*$p < .05$. **$p < .01$. ***$p < .001$, one-tailed test..

It is possible to assess how accurately each spouse estimated his or her partner's response. In other words, husbands' perceptions of how favorably their wives would view male pill usage can be compared with their wife's own forecast of the likelihood of pill usage, and vice versa. Here the findings diverge, with wives apparently more accurate perceivers than husbands of their spouse's attitudes. Wives' reported perceptions of their husband's attitude correlated .57, $p < .001$, with their husband's actual responses about likely pill use, but husbands' perceptions about their wife's attitude were correlated only .21, $p < .08$, with their wife's actual responses about the likelihood of usage.

Since the questions are not fully parallel (each respondent reports the other's perceived *attitude,* but their own estimate of *likelihood of use*), this difference may reflect more than differing accuracy. If wives favor male usage but assume (a) that their husbands would not want to use such a method, and (b) that they would not be able to persuade their husbands to do so, then they might think the likelihood of pill usage is low even though their own attitude is favorable. Thus, husbands may be accurately perceiving their wife's *attitudes,* but those attitudes are not adequately captured when their wives predict the likelihood of male pill usage.

In contrast, since the husband would be the one actually using the

pill, he may be less likely to think its use likely unless his own attitudes are favorable. Thus, there would be a stronger association between husbands' own favorableness toward pill usage and their stated likelihood of use, and if wives accurately perceive their husband's attitudes, there will be a stronger correlation between their perceptions and husbands' reports.[6]

Multivariate Analyses: Model of Male Pill Adoption

We argued that more egalitarian sex-role preferences should be associated with a greater belief in shared contraceptive responsibility and that such a belief should in turn influence the likelihood of adopting a male contraceptive pill. Support was found for the first hypothesis of this model, as individuals with more egalitarian sex-role preferences were more likely to feel that contraceptive responsibility should be shared; this relationship was somewhat stronger for women, $r = .35$, $p < .01$, than for men, $r = .21$, $p < .10$.

Three multiple regression equations were then computed to test the hypothesis that more egalitarian sex-role preferences and a greater belief in contraception as a shared responsibility would be positively related to likelihood of male pill use. Contrary to our expectations, beliefs in shared contraceptive responsibility were not associated with greater likelihood of male pill usage for husbands or wives, as evidenced by the first equation of Table 3. More egalitarian sex roles were directly linked to greater male pill usage, although the regression coefficient for wives fell short of statistical significance.

Since a negative attitude toward systemic chemical contraception should reduce the likelihood of male or female oral contraceptive use, we added this variable to the model in equation 2. With inhibitions regarding chemical contraceptives statistically controlled, more egalitarian sex-role preferences were significantly related to likelihood of male pill usage for both husbands and wives, but beliefs in shared contraceptive responsibility still remained essentially unrelated to the likelihood of male pill usage. The control variable was strongly associated with likelihood of male pill usage for wives but not for husbands.

[6]Some indirect support for these scenarios is evident in the husbands' and wives' responses to two other hypothetical questions about what would happen if you and your spouse had different, strong preferences regarding the adoption of a male pill. Each respondent was asked how likely they were to (a) seriously reconsider their own position and allow their spouse to satisfy his or her preference, or (b) insist on satisfying their own preference. As one would predict from the perspective of traditional sex-role stereotypes, wives were significantly more likely than husbands to report they would reconsider, $t(46) = -3.88$, $p < .001$, one-tailed test, and significantly less likely to insist on their own preference, $t(45) = 1.72$, $p < .05$, one-tailed test.

The final equation (3) also includes the perceived attitude of one's spouse. For both husbands and wives, perceiving that one's spouse would favor this innovation strongly increases the likelihood of its adoption. One's own sex-role preferences and one's beliefs about shared contraceptive responsibility play little direct role in predicting pill usage. Wives', but not husbands', concerns about the chemical nature of a male pill continue to influence the likelihood of use.

Table 3

Sex Role Preferences, Contraceptive Responsibility, and Adopting a Male Pill: Regression Equations

		Wives' model			Husbands' model		
Eq.	Independent variables	*b*	Beta	Sr^2	*b*	Beta	Sr^2
1	Sex-role preferences	.056	.193	.033	.078*	.266*	.067*
	Shared contraceptive responsibility	-.088	-.056	.003	.064	.033	.001
	Intercept	1.124			0.474		
	R^2			.033			.076
2	Sex-role preferences	.094*	.324*	.086*	.079*	.270*	.069*
	Shared contraceptive responsibility	-.230	-.145	.018	.066	.034	.001
	Fewer inhibitions re chemical nature	.377***	.479***	.213***	-.058	-.068	.005
	Intercept	-0.560			0.547		
	R^2			.245			.080
3	Sex-role preferences	.058+	.199+	.029+	.038	.129	.015
	Shared contraceptive responsibility	-.156	-.099	.008	.282	.146	.020
	Fewer inhibitions re chemical nature	.265***	.376***	.119***	-.114	-.017	.000
	Perception of spouse as favorable	.413**	.334***	.093**	.773***	.581***	.310***
	Intercept	-.569			-1.529		
	R^2			.338			.390

Note. All probability levels are based on one-tailed tests of the *t* statistic associated with the regression coefficient.

$^+p < .10$. $^*p < .05$. $^{**}p < .01$. $^{***}p < .001$.

Discussion

In an exploratory study of as few as 47 married couples, one must draw conclusions only tentatively about such complex issues as dyadic consensus, accuracy, and influence and interpret multivariate analyses cautiously. Our results at least suggest, however, that more egalitarian sex-role preferences may translate into greater male participation in contraceptive usage, if an effective and reasonably safe, male form of coitus-independent contraception is marketed. Wives appeared to connect their general egalitarian sex-role beliefs with their beliefs about sharing contraceptive responsibility more readily than did husbands.[7] Somewhat surprisingly, we found no support for the notion that spouses' views of contraception as being ideally a shared responsibility would mediate the influence of sex-role preferences on likelihood of male pill use. These data also suggest that wives' inhibitions about the chemical nature of such a pill may loom as a potential barrier to its adoption.

It is possible that even though wives were asked to indicate their personal views, their responses may to some extent reflect their perceptions of their husbands' orientation, particularly since wives cannot unilaterally decide to adopt a male pill. Our comparison of husband and wife responses indicates, however, that spouses may not accurately perceive their partner's beliefs or intentions, and that wives perceive their spouse's intentions more accurately than do husbands. Such misperceptions may take on greater significance as contraceptive decision making becomes more complicated and potentially problematic with the introduction of a male pill.

Family planning literature seldom addresses issues salient to the selection of a contraceptive method. This shortcoming will become more dissatisfying as the selection process takes on new forms in response to innovative technology. Researchers, therefore, should exert a more concerted effort toward understanding the various implicit and explicit aspects of this decision-making process. Although our research considers spouses' personal views and their perceptions of their partner's beliefs, it does not consider whether similarity within couples indicates that a husband and wife have achieved consensus or if they simply had similar views from the outset. The introduction of male oral contraceptives is likely to complicate the process by which couples negotiate and renegotiate contraceptive usage and will require researchers to examine this process more closely. Research that

[7]It is likely that the weak role of this variable is partly attributable to the low variance of the single-item measure.

focuses specifically on identifying and unraveling the consensus-building processes underlying contraceptive decision making could provide a major contribution in this area.

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