Getting Them In: An Exploratory Mixed-Methods Study with Implications Towards Marketing Marriage and Family Therapy

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ABSTRACT

The purpose of this sequential exploratory mixed methods study was to develop and test a theory of planned behavior questionnaire that includes both direct and belief-based measures for seeking professional help from a MFT for participants and their spouses during times of relationship distress. To complete this goal, three focus groups ($N = 24$) were conducted to elicit the salient behavioral, normative, and control beliefs associated with seeking professional help from a MFT for participants and their spouses during times of relationship distress. The data was member checked and then analyzed using thematic analysis.

Next, two quantitative measures were constructed, one using the salient beliefs elicited during the focus groups and the second using general questions that assessed participants' overall attitude, perceived norm, and perceived behavioral control. Both measures were placed online pilot tested ($N = 102$) using Qualtrics panels. The results suggest that the measures were accurate predictors of behavioral intention. The main stage then used both measures to assess the predictive ability of the elicited beliefs.

The results also suggest that the beliefs accurately predicted participants' behavioral intentions for seeking professional help from a MFT for them and their spouses during times of relationship distress. The results also indicate that an intervention could be used to encourage troubled individuals, couples, and families to seek professional help from a MFT when experiencing relational issues.

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Introduction

Marriage and family therapists (MFTs) are uniquely trained to assess and treat these issues from a relational vantage point that connects these issues with couple and family functioning, dynamics, and interaction patterns (Becvar & Becvar, 2012). MFT's educational background and specialized supervision involves three times more family therapy coursework and 16 times more supervised relational clinical experience than any other mental health profession (MHP; Crane et al., 2010) positioning them as specialists for relational problems with their treatment modalities often being the most successful (Crane & Payne, 2011a; Johnson, 2002; Sprenkle, 2002).

Clinical work with couples and families can be challenging as the issues negatively affecting them can often also be seen in 'healthy' families (Walsh, 2012b). Thus, couple and family treatment is a complex task that includes assessing the presenting problem as well as how specifically this problem is impacting the couple and/or family and working with them to create meaningful change (Walsh, 2012a). Addressing problems in a relational manner provides a more systematic and comprehensive overview that can allow clinicians confront problematic family processes that are at the root of the presenting problem often leading to a more in-depth treatment. Indeed, Moore and Crane (2014) examined administrative data from Cigna from 2001–2006 (N = 3,315) to evaluate cost effectiveness for treating relational problems and found that MFTs were eight times less likely to experience recidivism for couple relational issues using a relational modality than the next mental health professional. MFTs can also address problems that have typically been associated with intrapsychic functioning—such as depression—but in a relational manner in order to process these issues in the context of intimate couple and/or familial relationships, and in doing so, utilize support from a client's spouse and/or family during the treatment process.

Moreover, according to Northey (2004, November/December-b), MFTs conduct almost three-times as many couple and family sessions than social workers, who conducted the second most such sessions; one-third of the presenting problems MFTs face are couple-and-family-related, as compared to less than 20%, for social workers and counselors combined. Additionally, Northey (2002) randomly sampled 292 AAMFT currently practicing clinical members and found that 40% primarily practice couple and family treatment with three of the top five presenting problems stated being relational—marital/couple discord, parent-adolescent conflict, and child behavior problems. The field of MFT has also garnered significant empirical support in addressing relational issues using treatment models that target problematic emotional and systemic processes (Crane & Payne, 2011a; Johnson, 2002; Sprenkle, 2002). Thus, MFTs' educational and clinical training background arguably renders them the most competent clinician to treat relational issues as well as make them more likely to work from a relational standpoint than other mental health professional (MHP).

However, despite these qualifications, 81% of all private practice MHPs engages in couples' therapy while only 12% are in a profession—such as MFT—that requires educational courses and supervision for couples' therapy (Doherty, 2002). This presents a problem as the vast majority of relational treatment is being conducted by MHPs that are not trained to address relational issues which could result in negative outcomes for the couples and families in their care. Furthermore, the general public remains largely unaware of the profession of MFTs as well as what they do (Fall, Levitov, Jennings, & Eberts, 2000; Tse, Wantz, & Firmin, 2010). In fact, the general public perceives MFTs as unintelligent, ineffective, and unaffordable (Zaipen, 2005, July/August), which does not properly reflect their qualifications and ability to conduct conjoint therapy. This poor perception is also reflected in a 1995 Consumers Report where couples

therapy was the only form of therapy to receive low ratings of client satisfaction (Consumer Reports, 1995, November).

It would appear that MFT, especially couple therapy, has an image problem. Gottman (1999) touches on this issue in his finding that most separations and divorces occurred during the first year of marital therapy and stated, perhaps tongue in cheek, that "marital therapy appears to be a reliable vehicle towards divorce!" (p. 5). This image problem can have a deleterious effect on professional help seeking behaviors for troubled couples as marital problems are the number one reason people seek therapy (Veroff, Kulka, & Douvan, 1981, as cited in Gottman, 1999). With such a poor perception of MFT, one question to ask is "where do couples seek professional help for relational issues?"

Where Do People Seek Professional Help for Relational Issues?

Murstein and Fontaine (1993) conducted a study designed to evaluate the public's knowledge of MHPs and used a random sampling procedure in a Connecticut town to recruit participants ($N = 90$). They concluded that 47% of the reasons given for consulting MHPs could be categorized as relational and that most participants preferred seeking professional help from a physician instead of a MHP. Mickus, Colenda, and Hogan (Mickus, Colenda, & Hogan, 2000) examined 1358 randomly selected Michigan participants' preferences for mental health providers via phone. Their findings supported Murstein and Fontaine in that the general public first sought professional help from physicians for mental health concerns. Mickus, Colenda, and Hogan surmised that this could be due to either the familiarity that people–older adults in the case of this study–have with their physician or the stigma associated with seeking help from MHPs.

In a study conducted by Psychology Today and PacificCare Behavioral Health (2004) that assessed the general public's views and attitudes towards mental health via an online and

telephone survey from a nationally representative sample (N = 2,230), most adults seeking therapy often make their choice based upon physician and insurance recommendations, instead of therapists' background factors (e.g., their style) suggesting that people experiencing relational issues may have little say in where they go to seek professional help. Yet "style" can be referred to as a MHPs' stance towards treatment and is arguably what sets MFTs apart from other MHPs. For instance, a 1998 study found 59% of 1000 randomly selected participants disagreeing with the statement that other MHPs could do marriage and family therapy (Northey, 2004, November/December-a).

Physicians as first responders to mental health issues could be problematic if the presenting problem is rooted in couple and family dynamics as medical professionals and non-MFT trained MHPs often lack the training to treat relational problems. In fact, Doss, Simpson, and Christensen (2004) conducted a study with married couples seeking therapy (N=147) and found that the two most cited reasons for couples seeking therapy were problematic communication and lack of emotional affection, both of which MFTs are specifically trained to intervene in. The authors also found that couples often do not agree on what the presenting problem is for seeking therapy, which raises the question, "How much help could a MHP that isn't trained in MFT provide in defining a couple's presenting problem if they are not trained to assess couple dynamics?" Indeed, Doherty (2002, November/December) describes this phenomena as similar to "…having your broken leg set by a doctor who skipped orthopedics in medical school" (p. 26).

Furthermore, studies also show that physicians often do not recognize individual general mental health issues and fail to provide quality professional help when they do (Rost, Smith, Matthews, & Guise, 1992; Tiemens, Ormel, & Simon, 1996). As aptly put by Mickus, Colenda,

and Hogan (2000), “unfortunately, primary care physicians do not detect mental disorders in a high percentage of their patients […] and may not have the time or inclination to effectively manage patients with psychiatric disorders” (p. 202). If physicians struggle with recognizing mental disorders, a characterization of problematic individual behaviors, it is difficult to expect that they would accurately recognize problematic couple and family dynamics and effectively intervene.

Statement of the Problem

Couples that seek marital treatment often wait six years with relational problems before doing so (Gottman, 1999) and, with this confusion, these couples may choose a MHP not trained to address relational dynamics in couple and family systems. Clearly, there is a need for these couples and families to connect with a specialist—such as a MFT—for relational issues as ineffective professional help from a unqualified MHP can contribute to negative attitudes, stereotypes, and perceptions towards MFT (Vogel, Wade, & Hackler, 2007a). With such problematic patterns and dynamics unaddressed, couples and families can leave treatment feeling defeated, and experience negative outcomes (e.g., separation, divorce, hospitalization, residential treatment, etc.; Doherty, 2002; Gottman, 1999). These negative associations can further impact the public image and profession of MFTs as the general public is often confused about which MHP to seek professional help from (Jorm, 2000, 2012). . Such a negative association could jeopardize the perceived legitimacy and effectiveness of MFT, and the general public may be less likely to seek MFT in lieu of alternative, often less effective modes of treatment (e.g., medications, life-coaching, etc.; Whitaker, 2005, 2010) and this poses a particular problem for MFTs.

There has been a significant amount of research on assessing the general public's beliefs and attitudes towards general mental health and methods to reduce stigma (Angermeyer & Dietrich, 2006; Burns & Rapee, 2006; Chandra, 2012; Diefenbach & West, 2007; Feldman & Crandall, 2007; Jorm, 2000, 2012; Jorm et al., 2006). However, literature exploring beliefs and attitudes towards MFT in specific, as well as methods and interventions to combat poor perception, is scarce. Thus, there is a need to establish a framework that can assess attitudes and beliefs towards MFT with implications in creating effective, tailored interventions targeting inaccurate perceptions and beliefs towards MFT. Professional help from MFTs often involves targeted interventions and dialogue requiring specialized training, and were this to be delineated to the general public, perception towards Professional help from an MFT for relational issues might increase.

The Need for an Intervention

With a variety of therapeutic services being offered by a myriad of MHPs (Fall et al., 2000), MFTs need to differentiate themselves from other MHPs by highlighting their expertise with relational problems and effectively promote such expertise to the general public. As Kilgore (1979) put it, "private practice begins with the public delineation of one's services" (p. 87), a statement that remains ever true and relevant today. The field of public health, having faced similar perception issues as MFT, has been successful in addressing perception and attitude issues by using mass media campaigns to alter the general public's health-related behaviors (Randolph & Viswanath, 2004). A meta-analysis of anti-smoking campaigns conducted by Farrelly, Niderdeppe, and Yarsevich (2003) found that aggressive, targeted, and well-funded media campaigns can have an effect on youth smoking habits, whose results are supported by another meta-analyses (Parcell, Kwon, Miron, & Bryant, 2007).

Media campaigns have reduced related mental health issues—such as gun violence (Slovak, Carlson, & Helm, 2007), truancy (Hunt & Eisenberg, 2010), and teen pregnancy (Miller, Benson, & Galbraith, 2001)—on a societal level and have potential in delineating MFT to the general public as a valid response to some relational issues as well as societal level issues. For instance, marital discord and conflict have been shown to negatively impact immune, endocrine, cardiovascular functioning, emotional health, and sleep quality, resulting in acute and chronic pain, high blood pressure, increased risk of heart attack, and poor health habits (For a review see Kiecolt-Glasser & Newton, 2001; Robles & Kiecolt-Glaser, 2003). Similar connections can also be found for families suffering from relational problems. In fact, "research consistently suggests that families characterized by certain qualities [cold, unsupportive, and neglectful] have damaging outcomes for mental and physical health" (Repetti, Taylor, & Seeman, 2002, p. 330).

MFT—as a distinct treatment modality— can reduce health-related costs after treatment (Christenson, Crane, Hafen, Hamilton, & Bruce, 2011; Crane & Christenson, 2012), and has even been shown to be the more cost-effective form of psychotherapy when compared to individual treatment (Crane & Payne, 2011b). Thus, introducing and promoting MFT as an effective treatment option to the general public is not just a business endeavor—such as marketing—but rather a step at addressing larger public health needs—such as decreased long-term health care costs—by confronting public perception issues.

This study attempts to explore three areas, (a) the general public's beliefs towards seeking professional help from MFTs, (b) the impact of these beliefs on the general public's intentions to seek professional help for relational issues, and (c) the implications of a tailored intervention designed to change problematic beliefs (Randolph & Viswanath, 2004; Tse et al., 2010; Wakefield, Loken, & Hornik, 2010). This study could provide insight into the specific

beliefs towards seeking professional help with relational issues and possible intervention methods to target negative beliefs.

Literature Review

Would you seek help from a plumber for car problems? Would you seek treatment from an attorney for cardiac problems? The logical answers to these questions suggest the use of specific expertise to solve complex problems. Expertise generally involves a deeper understanding of the problem by professionals with higher quality training, knowledge, and experience that focuses on more effective interventions and/or techniques. As Friedmann (2007) stated:

> Our culture demands specialists. No longer are parents content to take their children to the doctor—they must see the pediatrician. And when there's a complication, perhaps with the little darling's heart, they don't just go to the cardiologist. Instead, they see a pediatric cardiologist, hopefully one that has expertise in the particular condition in question. (p. 17)

However, specialists need to promote their specialty if they are to attract the attention of the general public to their craft, and MFT is no exception. Historically, this has been done through marketing methods (Friedmann, 2007). As the majority of marketing techniques are designed to promote businesses and increase the consumption of services, any intervention used to promote MFT should be considered marketing. Yet despite its necessity, marketing brings discomfort to many MHPs in general. MHPs connect with their clients most often by establishing a strong therapeutic relationship through displays of genuineness, empathy, and understanding as well as the creation of a non-judgmental atmosphere. Thus, a marketing approach—which possesses elements of persuasion and influence—can often conflict with MHPs' values and business practices. As Gibson (1984), a psychiatrist, suggested:

> Most health professionals are suspicious if not disdainful of marketing. They equate marketing with commercialism and high pressure selling…The physician fears any type of involvement in marketing will be interpreted to mean that he is motivated by money rather than service to patients. (p. 846)

Gottlieb (2012) also echoed this sentiment: "Psychotherapy is perhaps one of the few commercial business that doesn't see itself as one, that views financial gain as unseemly when connected to the delicate work of emotional insight" (para. 4).

Although this appears to be changing as there has been a rise of importance in business and promotion within the MHP. Some graduate counseling programs are even adding marketing courses to their curriculum (Gottlieb, 2012). Marketing is becoming more of an important component within the MHP as it has been shown to be effective in promoting services to the general public. Indeed, advertising campaigns have been designed to impact perceptions of depression in men (Rochlen & Hoyer, 2005), prescription medication (Mintzes, 2012), as well as to target youth mental health practices (Andreasen, 2004). Such campaigns have been shown to be effective when promoting mental health services, especially concerning pharmaceutical medication use (Antonuccio, Burns, & Danton, 2002; Hagen, Wong-Wylie, & Piji-Zieber, 2010). As pharmaceutical companies have made the most effort with marketing campaigns, they have also experienced the most success (Greene & Kesselheim, 2010; Whitaker, 2010).

It would appear that the general public has embraced the marketing strategies and interventions used by pharmaceutical companies. It can even be argued that their marketing interventions have been successful to the extent of altering the general public's perception of mental health, and by extension, their professional help-seeking behavior by seeing physicians first, often for medication (Mojtabai, 2007; Psychology Today & PacifiCare Behavorial Health,

2004). Due to the overwhelming marketing success experienced by pharmaceutical companies, reviewing the impact of their interventions can provide insight into how other MHPs—such as MFT—can proceed to promote their specializations.

Pharmaceutical Companies use of Interventions

Pharmaceutical companies engage more in marketing than any other MHP, with over $4 billion spent on direct to consumer marketing in 2008, and the trend is on the rise (Greene & Kesselheim, 2010). Whitaker (2010) highlights the success of their marketing in his comment, "In 2007, we spent $25 billion on antidepressants and antipsychotics, and to put that figure in perspective, that was more than the gross domestic product of Cameroon, a nation of 18 million people" (p. 3). It's hard to argue with the financial success that pharmaceutical companies have achieved using their marketing strategies and interventions. It is important to note that pharmaceutical marketing has extended beyond financial gain by impacting larger societal beliefs towards mental health. Indeed, in a leaked document from In-Vivo Communications, a medical communications company, a three-year plan was outlined to make Irritable Bowel Syndrome a common disease in the eyes of the general public in order to boost the sales of a new pharmaceutical drug (Moynihan, Iona, & David, 2002). These educational programs are designed as a part of pharmaceutical marketing strategies to change the public's opinion about illnesses in order to connect people to their medical treatments. This has had a negative impact on the MHP as psychotherapy by itself, and in conjunction with medications, has decreased whereas the sole use of medications has increased (Nordal, 2010). Similarly, more than eight in 10 adults have received prescription medication as a mental health treatment with half using medication alone, one in three using a combination of psychotherapy and medication, and fewer

than one in five receiving psychotherapy alone (Psychology Today & PacifiCare Behavorial Health, 2004).

One can certainly argue the ethical merits of marketing medications in this form; however, this is not a referendum on pharmaceutical medication. Rather this point illustrates the success of these marketing strategies as an intervention, and how medications have become the dominant form of mental health treatment in America today. The financial investment that pharmaceutical companies have made into marketing their services and products has played a large role in their success (Moynihan et al., 2002; Whitaker, 2010).

Although, one must point out that any successful treatment incorporates more than positive financial gain but also resolution of the presenting problem that will result in higher life quality. When examining medications in this manner, some inconsistencies arise. Whitaker (2010) illustrates these inconsistencies by highlighting that, from 1996 to 2007, the number of children disabled by a mental illness on Supplemental Security Income (SSI) more than doubled while children affected for other reasons (such as cancer, retardation, etc.) declined from 728,110 to 559,448. Kirsch, Scoboria, and Moore (2002) further review medication effectiveness in a meta-analysis using the Freedom of Information Act and accessed 38 published and unpublished randomly controlled trials (RCTs; $N = 6,944$) from the U.S. Federal Drug Administration (FDA) used in the approval of six antidepressants (fluoxetine, paroxetine, sertraline, venlafaxine, nefazodone, and citalopram). They found that at the end of the modal duration (six weeks), the placebo replicated 82% of antidepressant response in participants. In a subsequent meta-analysis conducted by Kirsch et al. (2008), including 47 RCTs obtained from the FDA for four antidepressants (fluoxetine, paroxetine, nefazodone, and venlafaxine) with mean change scores available in order to examine if depression severity correlated with drug effectiveness, they

found that these antidepressants only significantly affected severely depressed participants. Whitaker's (2010) summary supports these findings with medications showing little long-term effectiveness and often contributing to the disorders they were designed to treat. Indeed, since pharmaceutical medications have become the predominant treatment for mental health problems, the number of mentally sick and disabled persons has increased.

It would seem that though psychiatric medications—while the most marketed, promoted, and used treatment—might not be the most effective option. Pharmaceutical companies' marketing efforts were able to establish a persuasive narrative for the public that medications are indeed the most effective treatment option, and unfortunately, often at the expense of non-medical treatments such as psychotherapy (Lacasse, 2005). One could argue that a franchise with questionable effectiveness has dominated the mental health field and treatment protocols by engaging in successful—although perhaps inappropriate—marketing techniques (Antonuccio et al., 2002).

The Need to Explore Beliefs towards Professional Help-Seeking from an MFT

Though research concerning public perception of MFT is scarce, Tse and colleagues (2010) conducted a study that examined college students' (N=261) attitude towards MFT and found that, while the students thought MFTs were intelligent, competent, and trustworthy, they rated MFTs as the second least effective in helping their clients. A more problematic finding from this study is that 92% of the students reported having knowledge of MFT, but the knowledge they displayed did not represent MFT. This is disconcerting as inaccurate beliefs can affect their treatment seeking behavior for relational issues. Tse and colleagues concluded that,

> If marriage and family counseling/therapy is to be a nationally recognized mental health profession as well as a 'household name,' efforts to educate and promote the availability

and qualifications of MFCs or MFTs should occur on multiple levels, and through educational resources and media outlets. (p. 273)

Other mental health fields—such as counseling—have attempted to explore the perception and attitudes held towards their field. Kaplan, Vogel, Gentile, and Wade (2012) conducted a study using 290 college students to measure the impact of a video intervention designed to increase positive perceptions of counseling. Their results showed that after three viewings to the video, perceptions of seeking counseling had significantly positively increased suggesting that using direct methods of advertising is possible with the mental health field. However, the intervention video was seven minutes long and was comprised of compiled segments from a reality television show in which a woman was receiving treatment. While this intervention showed some effectiveness, a seven-minute long video is hardly a practical intervention that can be used for the general public.

In another study, Vogel et al. (2007a) examined the relationship of public and self-stigma on the willingness to seek counseling using college students (N=680) recruited from a psychology course. In this study, stigma was defined as "a mark or flaw resulting from a personal or physical characteristic that is viewed as socially unacceptable" (p. 40). Using a cross-sectional design, Vogel and colleagues structural equation model (SEM) was a good fit for their data, Satorra-Bentler scaled $X^2(51, N = 676) = 86.09$, $p < .001$, $CFI = .99$, $IFI = .99$ $SRMR = .03$, $RMSEA = .03$ (90% CI: .02 to .04). The results showed that perceived public stigma, self-stigma, and attitudes accounted for 34% of the variance in willingness to seek counseling. These results show the need to address stigma that people experience in the help seeking process. However, Vogel and colleagues' results do not present specific stigmatizing beliefs that can be reduced by targeted interventions.

The Problem with Stigma

This is not just an issue with Vogel et al. (2007), the majority of research that examines the public's perception of mental health focus on a generalized concept of stigma (Jorm, 2000, 2012; Jorm et al., 2006; Vogel, Wade, Wester, Larson, & Hackler, 2007b; Vogel & Wester, 2003; Vogel, Wester, & Larson, 2007c; Yap, Reavley, & Jorm, 2013). While stigma has been shown to impact help-seeking, the definition of stigma is often very inclusive of any negative attribute that is associated with mental health treatment. This can cause confusion as the very definition of stigma can encompass different experiences and explanations. Indeed, Link and Phelan (2014) describe this issue in their statement,

> In the literature on stigma, the term has been used to describe what seem to be quite different concepts. It has been used to refer to the "mark" or "label" that is used as a social designation, to the linking of the label to negative stereotypes, or to the propensity to exclude or otherwise discriminate against the designated person. (p. 78)

With such a broad definition stigma is difficult to operationalize for specific interventions. Thus, there is a need to utilize a theoretical model that has the potential to examine specific perceptions and attitudes towards mental health treatment seeking in order to tailor an intervention accordingly.

Theory of Planned Behavior

The current study aims to explore attitudes and beliefs towards seeking treatment for relational issues in order to increase the social acceptability of this behavior as appropriate. A careful examination of scholarly literature for belief-based behavior change interventions revealed Fishbein and Ajzen's (2010) theory of planned behavior could be used to explore attitudes towards health related behaviors (e.g., contraceptive use, testicular exams, and

abstinence for adolescents). The theory of planned behavior can be utilized for any specified behavior and is considered a viable starting point for designing interventions (i.e., media campaigns). The theory of planned behavior is a conceptual framework of how attitude influences behavior and uses an exploratory mixed-methodology (Creswell & Plano-Clark, 2011)—a qualitative formative research stage that results in a constructed measure for a quantitative stage—in order to uncover the specific characteristics of attitude that has the strongest influence on one's decision to either perform or not to perform the specified behavior (Fishbein & Ajzen, 2010).

Theory of Planned Behavior in the current study. The current study utilizes Fishbein and Ajzen's (2010) theory of planned behavior in two ways, (a) as a conceptual model that hypothesizes how attitude, perceived norm, and perceived behavioral control influence a person's decision to seek professional help from a MFT for them and their spouse during times of relationship distress, and (b) a methodological framework in order to correctly operationalize attitude into specific beliefs that negatively impact treatment seeking behaviors that can then be targeted using a tailored intervention. As far as I have been able to determine, the theory of planned behavior has not been used for MFT and a more thorough understanding of the theory will be provided. Therefore, this section has been organized to provide two areas of explanation: (a) a general overview of the theory of planned behavior followed by an in-depth explanation of its theoretical constructs, (b) a review of relevant theory of planned behavior literature to provide a contrast of what has been done to promote professional help-seeking in the mental health field to what needs to be done to engage in promotion of MFT.

General overview of the Theory of Planned Behavior. Fishbein and Ajzen's (2010) theory of planned behavior conceptualizes that all human behavior follows—often

spontaneously—from information or beliefs people hold towards any specified behavior, which can be predicted by behavioral intention (i.e., one's readiness to perform the behavior which is the single best predictor of behavior). The theory of planned behavior has three levels of explanation starting with behavioral intention, the lowest level of explanation, which states that people perform a specific behavior because they intend to. Intentions have shown to successfully predict actual behavior as Armitage and Conner (2001) conducted a meta-analysis on 185 empirical studies involving the theory of planned behavior and found 48 studies with a mean correlation of .47 between behavioral intentions and a variety of behaviors (e.g., smoking cessation, condom use, drug use, etc.) showing the robustness of the theory of planned behavior as a conceptual model.

Determinates of the Theory of Planned Behaivor. The next level of explanation provides more understanding with the use of three constructs that are the determinants of behavioral intention: (a) attitude, or the favorability that one holds toward performing the behavior, (b) perceived norm, or to what degree the behavior is acceptable or permissible by a groups of people and/or society, and (c) perceived behavioral control, or the extent that people think they are able to perform the behavior. The importance of each determinate—attitude, perceived norms, and perceived behavioral control—are weighted differently depending on the behavior and the population of interest. For example, someone with a lower SES background may hold a positive attitude towards buying a car, experience pressure from friends and family to buy a car, but lack financial resources to actually buy a car. Thus, their financial resources (perceived control) may not allow for them to perform the behavior while someone with a higher SES background will be less likely to experience these perceived control barriers. However, the importance of perceived control could change if the behavior changes. Revisiting the previous

example, if the car was a Ford Taurus and someone is experiencing pressure from family and friends (perceived norms), and believes they can afford the car (perceived control), but doesn't hold think the Ford Taurus is a good model (attitude) then they may not intend to buy the car. Thus, the way each determinate contributes to behavior intention varies depending on the behavior and population of interest.

Beliefs. At the core of each of the three determinants (attitude, perceived norms, and perceived behavioral control) are specific beliefs—the next and most specific level of explanation—towards the specified behavior that are ""the subjective probability that an object has a certain attribute" (Fishbein & Ajzen, 2010, p.96). Beliefs provide the most information concerning behavior and offers insight into the cognitive processes that people engage in when considering to either perform or not to perform behaviors. Each determinate—attitude, perceived norm, and perceived behavioral control—is comprised of specific beliefs—behavioral beliefs, normative beliefs, and control beliefs respectively—that provide the cognitive basis for a person's intention to either perform or not to perform the specified behavior (Fishbein & Ajzen, 2010). According to Fishbein and Ajzen, beliefs are formed automatically from a myriad of sources (e.g., personal experience, television, novels, newspapers, social interaction, the Internet), and are where "we gain most of the concrete information unique to a given behavior" (p. 23). These beliefs can be irrational, prejudicial, and inaccurate, but once formed, create the conceptual framework for attitudes, perceived norms, and perceived behavioral control, which then influences behavioral intentions.

Thus, beliefs are where the field of MFT can intervene. If the specific behavioral, normative, and control beliefs that predict behavioral intentions to seek professional help from MFTs for relational issues can be identified, then an intervention can be designed to target them.

These belief-based interventions would be akin to using a rifle instead of 'shotgun' approaches that cover a large area of problematic perceptions that are involved with stigma interventions and allow for the profession of MFT to delineate their specialty in relation to other MHPs.

Attitude. Fishbein and Ajzen (2010) defined attitude as "a latent disposition or tendency to respond with some degree of favorableness or unfavorableness to a psychological object" (p. 76) referring to the evaluation of an object (personally performing a behavior) and not an affective state of mind. Attitude is measured by two components that work together, (a) behavioral beliefs—the specific outcomes that people believe performing the specified behavior will elicit; e.g., seeking Professional help from an MFT will solve my marriage problems—and (b) outcome evaluations—the corresponding positive or negative judgment for each specified outcome; e.g., solving my marriage problems is good/bad.

Behavioral beliefs influence attitude and the way this process of influence occurs has been called the *expectancy-value model* (EVM). The EVM assumes that people possess preexisting beliefs that are connected to an object/behavior when attitudes are formed. The EVM evaluates the strength of these beliefs, or "the perceived likelihood that the outcome [specific beliefs] will occur" (p. 101), based on the assumption that as the strength of the belief increases, the contribution the outcome evaluation makes to the overall attitude increases. Attitudes are formed automatically as new information is absorbed and new beliefs concerning the behaviors are created. While people can form variety of beliefs—with some that conflict with each other—only the salient beliefs (the beliefs most readily accessible about the behavior) determine the valence of the attitude (Fishbein & Ajzen, 2010).

For MFT, behavioral beliefs can be seen in previously discussed terms of client's expectations and preconceptions of Professional help from an MFT. In a meta-synthesis of 49

qualitative studies concerning clients' experiences with MFT, Chenail and colleagues (2012) constructed a formal grounded theory including clients' preconceptions of therapy, such as resolving past issues, better understanding their spouse/family member, creating closer relationships, making sense of things in their lives, understanding why problems occurred, seeing problems in new light, learning new skills, and coping with stress. Doherty and Simmons (1996) conducted a national study surveying 526 clinical MFTs concerning their practice patterns as well as 492 of the MFTs' clients concerning their satisfaction and progress with treatment. The study showed that marital problems represent 30.1% of presenting problems with most clients (63%) reporting an improved relationship with their spouse.

Perceived norm. It is widely accepted that important others in one's social environment—such as their family, friends, co-workers, and possible religious acquaintances—can significantly impact behavior patterns. Thus, perceived norms—or perceived social pressure from specific people and/or groups—encourage people to either perform or not perform certain behaviors. Fishbein and Ajzen (2010) stated that the "stronger the perceived social pressure, the more likely it is that an intention to perform the behavior will be formed" (p. 130). Furthermore, in the context of the theory of planned behavior, *perceived norms* consist of two differing types of normative pressure—injunctive and descriptive norms—that represent the overall perceived social pressure to engage in the defined behavior.

Injunctive norms. Fishbein and Ajzen (2010) defined injunctive norms as "perceptions concerning what should or ought to be done with respect to performing a given behavior" (p. 131). For this study, this entails the participants' perception of whether others think the participant should or should not seek professional help from an MFT for them and their spouse during times of relationship distress. Injunctive norms are often applied to what other people

and/or groups think should be done concerning a specific behavior. Injunctive norms are measured using two components that work in tandem with each other, (a) injunctive normative beliefs—beliefs about *specific* peoples' and/or groups' thoughts on what should be done concerning the specified behavior (e.g., spouse, parents, siblings, best friend, etc.)—and (b) motivation to comply—or willingness to comply with the specific person and/or group (e.g., I want/do not want to do what my spouse wants me to do). The theory of planned behavior states that a variety of specific peoples' and/or groups' normative prescription is taken into account when an injunctive norm is formed. Thus, only the salient or most readily accessible normative beliefs influence injunctive norms (Fishbein & Ajzen, 2010).

Codd and Cohen (2003) conducted a study that in which the participants ($N = 199$) elicited 934 salient referents categorized by thematic labels—friends, family, significant others, parents, drinking buddies, and teachers., to assess college students' intentions to seek professional help for alcohol abuse. The referents—significant people and/or groups—elicited in Codd and Cohen's study may be similar to referents elicited for Professional help from an MFT. For the current study, potential significant people and/or groups listed could be spouse, parents, children, school officials, and friends. As MFTs often address relational issues in the context of conjoint treatment, the spouse and/or family of a person seeking Professional help from an MFT may exert the highest normative pressure (Fishbein & Ajzen, 2010).

Descriptive norms. Descriptive norms are a recent addition to Fishbein and Ajzen's (2010) theory of planned behavior and are defined as "norms based on perceptions of what other people are doing" (p. 143). For this study, that entails the participants' perception of others seeking professional help from an MFT during times of relationship distress. Such norms assume that peer pressure has a significant impact on how one behaves. Similar to injunctive norms,

descriptive norms represent pressure from people and/or groups, yet unlike injunctive norms, these people and/or groups do not need to be ones that the individual respects or admires, just groups that exert pressure and influence behaviors (Fishbein & Ajzen, 2010). Descriptive norms are measured using two components that work in interaction with one another, (a) descriptive normative beliefs—specific individuals and/or groups (e.g., spouse, parents, siblings, best friend, etc.) —and (b) identification with referent—one's identification with the different specific people and/or groups and assess the notion that the behavior of some referents has greater influence than others (e.g., I want/do not want to be like my parents).

While there has been no exploration on descriptive normative beliefs regarding MFT professional help-seeking, a few parallels can be drawn. Vogel, Wade, Wester, Larson, and Hackler (2007b) conducted a study that tested college students' (N = 780) perception of descriptive norms and their referents' history of mental health treatment. The results showed that 95% of participants who had sought professional help knew someone who had done so as well, suggesting that descriptive norms—perceptions of others' behaviors—are a powerful influence on behaviors. Elek, Miller-Day, and Hecht (2006) examined substance use of 4,030 seventh graders to test the relationship between norms (i.e., injunctive, descriptive, and personal), and found that descriptive norms—defined as "other kids in the school"—had a significant impact on substance use. These studies show the impact of one's perception (or misperception in some cases) of significant others' behaviors on their own behaviors.

Perceived behavioral control. Individuals can hold positive attitudes and perceived norms, and still not be able to perform a behavior due to factors outside their control. According to Fishbein and Ajzen (2010), perceived behavioral control is "the extent to which people believe that they are capable of performing a given behavior, that they have control over its performance"

(p. 154) and stems from a set of control beliefs—factors, circumstances, and situations that aid or impede one's ability to perform the behavior. Perceived behavioral control is measured using two components, (a) control belief strength—the likelihood that certain factors and situations that would either make it easier or more difficult to perform the specified behavior will be present (e.g., my spouse agreeing to seek treatment is/is not important for me in seeking professional help from an MFT)—and (b) power of control factor—the factor's power to either facilitate or become a barrier to performing the behavior(e.g., my spouse agreeing to seek professional help would make it likely/unlikely for me to seek professional help from an MFT).

Control beliefs could parallel structural barriers (such as financial cost, transportation to services, obtaining an appoint, etc.) to mental health treatment reported in other studies (Sareen et al., 2007). Thus, while many individuals, couples, and families may have a positive attitude towards seeking professional help from an MFT and are supported by perceived norms, they may not be able to seek help due to financial hardship, lack of providers in the area, transportation, ability to obtain an appointment, as well as spouse/family agreement to seek professional help. Mojtabai (2005) examined the relationship between cost barriers and contact with MHPs using multiple samples from the National Health Interview Survey conducted between 1997-2002 (N=196,101; Barnes, Adams, & Schiller, 2003). The results showed that during that timeframe, the amount of psychologically distressed participants unable to afford mental health services rose from 15.6% to 20%.

Review of Theory of Planned Behavior Research on Mental Health

While the theory of planned behavior has been effective in explaining and changing health related behaviors, it has rarely been used for mental health help seeking. In one study using 354 college students in a psychology course, Vogel, Wester, Wei, and Boysen (2005) used

the theory of reasoned action—a model similar to theory of planned behavior—to examine the relationship between attitude towards help seeking and intention to seek help for relational issues, drug abuse, and academic issues. Their SEM results showed that the model was a good fit for their data, Satorra-Bentler scaled $X^2(493, N = 354) = 884.52$, $p<.001$, $CFI = .96$, $SRMR = .05$, $RMSEA = .05$ (90% CI: .05, .06)., that the psychological factors tested (i.e., treatment fearfulness ($b = .27$, $p < .001$) and comfort with self-disclosure ($b = .16$, $p < .01$) and attitude towards seeking professional help ($b = .52$, $p < .001$) had direct effects on seeking professional help for relational issues.

Though Vogel and colleagues' (2005) study provided support for using the theory of reasoned action/theory of planned behavior towards mental health treatment, their study was based on an earlier version of the theory of reasoned action/theory of planned behavior that excludes perceived behavioral control and descriptive norms. Vogel and colleagues also didn't include the formative research stage that accompanies theory of reasoned action/theory of planned behavior to elicit salient beliefs towards the defined behavior. Thus, an intervention from their data wouldn't have the benefit of targeting a specific belief in order to create behavior change. Though their model was a good fit for their data, implementing their findings into a specific, tailored intervention could prove to be challenging.

In another study, Hyland, McLaughlin, Boduszek, and Prentice (2012) examined the theory of planned behavior's use in predicting 259 individuals'—that were employed in front-line, at-risk emergency service for the Irish government—intentions to seek psychological help. The authors measured attitudes using three items (α=.69), perceived norm using two items, perceived behavioral control using six items (α=.76)—three to measure perceived internal control (α=.79), and three to measure perceived external control (α=.61)—and behavioral

intentions using three items (α=.77). In a multiple linear regression analysis, the authors found that perceived behavioral control accounted for the most variance (β=.5, p<.01) over perceived norms (β=.29, p<.01) and attitude (β=.18, p<.01). Hyland, McLaughlin, Boduszek, and Prentice's results shows that the theory of planned behavior can be used to explore the process of professional help seeking and design interventions to facilitate one's use of appropriate mental health services.

The issues with Hyland, McLaughlin, Boduszek, and Prentice's (2012) study parallels Vogel and colleagues (2005) with the design and use of formative research. While their results hold great promise for exploring the theory of planned behavior towards mental health, the authors did not utilize the methodology associated with Fishbein and Ajzen's (2010) approach in eliciting specific behavioral, normative, and control beliefs and only used direct measures of the constructs to regress on behavioral intentions. Thus, not having elicited specific beliefs those correlates with the direct measures, the author's limit their results in their application to designing an intervention. The current study includes this methodological procedure in order to address this specific issue.

In another study that examined the use of theory of planned behavior in predicting mental health help seeking among Chinese, Mo and Mak (2009) randomly sampled 941 individuals in Hong Kong between the ages of 18-65. Mo and Mak's CFA model was a great fit for their data, $X^2(128 = 494.9$, $p<.001$, $CFI = .96$, $NNFI = .95$, $RMSEA = .06$, and showed that perceived norm's direct (0.25, p<.01, 95% CI 0.18, 0.33) and belief-based effect (0.36, p<.001, 95% CI 0.30, 0.41) were the most significant predictors in the model which explained 58% of the variance. This data suggests that the theory of planned behavior can be used to explain mental

health help seeking behavior with Chinese participants and further exhibits the robustness of the theory.

Mo and Mak's (2009) CFA model is an excellent example of how the theory of planned behavior can be used to explore behavioral intentions to seek treatment for multicultural populations. However, the same methodological limitations that of Vogel and Colleges (2005) and Hyland, McLaughlin, Boduszek, and Prentice (2009) possessed is also present in that no formative research was conducted to elicit salient behavioral, normative, and control beliefs. Therefore the results of this study are limited to solely highlighting the need for an intervention and do not necessarily provide a specific roadmap in which specific targeted interventions can be designed.

Westerhof, Maessen, de Bruijn, and Smets (2008) used the theory of planned behavior to examine 299 older adults (65 to 75 years of age) intentions to seek preventative and therapeutic help. Their results showed that both intentions to seek preventative help and therapeutic help was low. Using ordinary-least-squares regression, they found that attitude contributed most in the prediction of intentions to seek preventative help ($\beta = .237$, $p < .01$) and intentions to seek therapeutic help ($\beta = .226$, $p < .01$). However, Westerhof and colleagues used Fischer and Farina (1995) Attitude Towards Seeking Professional Psychological Help Scale (ATSPPHS) and added five items that addressed stigma to comprise their theory of planned behavior measure (Mackenzie, Knox, Gekoski, & Macaulay, 2004). The ATSPPHS was subject to principal components analysis using a varimax rotation to show three components existed within the scale. The authors then assigned each component to one of the theory of planned behavior's components; attitude was *psychological openness*, perceived norm was *indifference to stigma*, and perceived behavior control was *help-seeking propensity*. While the ATSPPHS has received

empirical support, adapting its items to fit all three of the theory of planned behavior's components certainly limits the generalizability of the results. The same methodological issue as Vogel and colleges (2005) is reflected in Westerhoff and colleagues: it lacks formative research. Thus, this study does not provide specific strategies to combat low perceptions and intentions to seek professional help.

However, in one study that reflect the theory of planned behavior's methodology, Skogstad, Deane, and Spicer (2005) used the theory of planned behavior to engage in formative research that elicited salient beliefs towards seeking professional help for suicide from New Zealand prisoners ($N = 52$). These beliefs included *talking over problems* and *talking with a psychologist*. Next, an belief-based measure for a cross-sectional study was created using these beliefs (Skogstad, Deane, & Spicer, 2006) and given to 537 New Zealand prison inmates to examine their help-seeking intentions. Their results suggested that inmates were slightly likely to seek professional help. In a hierarchical regression model, specific (belief-based) norm ($\beta = .38$, $p < .001$) and general (direct) attitude ($\beta = .30$, $p < .001$) made the strongest contributions. Due to having engaged in formative research, Skogstand, Deane, and Spicer were able to suggest educational strategies focusing on specific perceptions of psychologists and how they can help inmates (e.g., cope with prison, getting through bad times, etc.) as interventions to influence prisoners behavior.

Skogstand, Deane, and Spicer (2005; 2006) used the theory of planned behavior as a methodology to approach a specific population (New Zealand prison inmates) for a specific behavior (intentions to seek help). Using this approach, Skogstand, Deane, and Spicer were able to outline strategies for increasing inmates' help-seeking for suicide and other behaviors. However, while this study utilized the theory of planned behavior as a methodology for

professional help seeking, their results are limited to a population of prison inmates. Fishbein and Ajzen (2010) outline that salient beliefs will vary in differing populations, indicating that Skogstand, Deane, and Spicer's results cannot be generalized to the general public. Furthermore, these results also refer to seeking help from a psychologist, which can often leave out couple and/or family therapy. Thus, for the present study, Skogstand, Deane, and Spicer do not provide compatible salient beliefs.

Significance of Study

The studies reviewed have shown significant contribution to the predictive validity of the theory of planned behavior. However, while the majority of the work that has been conducted focuses on outlining the need for an intervention to enhance the general publics' intention to seek help from an MHP, these studies cannot provide any specific intervention designs capable of meeting this challenge. Thus, there is a need to expand and provide specific beliefs that can be targeted using tailored interventions. As many large-scale media campaigns require significant resources (such as time, money, etc.), this next step will shed light into how, specifically, these interventions should be designed in order to increase their effectiveness. The field of MFT, being a specialized mental health profession, could benefit from use of such theoretical direction.

Thus, the aims of this study are three fold; (a) to expand the use of the theory of planned behavior in mental health help seeking research by adhering to its methodological framework with the inclusion of the formative research stage, (b) to explore which specific salient behavioral, normative, and control beliefs are associated with seeking treatment from an MFT, and (c) to present possible intervention ideas associated with specific beliefs that are shown to be correlated with negative behavioral intentions of seeking professional help from an MFT. As beliefs are powerful suppositions of behavioral intentions, targeting them with tailored

interventions can connect struggling individuals, couples, and families with MFTs for their relational issues. As these interventions can resemble marketing—an effective tool in promoting brands, products, and services to the general public—they can also be used for the field of MFT to promote their unique education and training background that constitutes them as effective relational specialists separate from other MHPs. MFT treatments and protocols have been empirically tested and found effective for a variety of issues, and there is a need to inform the public to connect their interpersonal and relational issues to MFT treatments. This study—while capturing the general public's beliefs towards seeking professional help from an MFT—can serve as a first step to potentially establishing the field of MFT as separate from that of other MHPs. As Friedmann (2007) suggested,

> By clearly defining your services, you eliminate much of the public confusion regarding your practice. There are dozens of different types of therapists out there, but when someone calls Dr. Phil McGraw, they know exactly what they're in for. He's captured the direct –some would say confrontational –counseling niche, through some brilliant marketing. (p. 30)

Methodology

Design

This mixed methods study will explore married individuals' beliefs towards seeking professional help from an MFT and explain which beliefs are the strongest contributors to their intentions to seek professional help from an MFT using Fishbein and Ajzen's (2010) theory of planned behavior and its associated methodology. This exploratory mixed methods design (Creswell & Plano-Clark, 2011) adheres to the theory of planned behavior specific methodological process in which qualitative and quantitative data are collected sequentially. The first stage of this study consisted of three focus groups that qualitatively explored specific salient behavioral, normative, and control beliefs that married participants associated with the seeking professional help from an MFT during times of relationship distress. A quantitative measure was then constructed using these beliefs and was given to two larger samples in stages two and three. The purpose of this mixed-methods exploratory study is to develop and test a theory of planned behavior (Fishbein and Ajzen, 2010) questionnaire that includes both direct and belief-based measures for seeking professional help from an MFT during times of relationship distress. In order to ensure that the defined behavior would be viably considered, an inclusion criterion of at least 18 years of age and married was set for participation in all the stages. Though current first marriage ages are somewhat later—28.2 for men and 26.1for women (U.S. Census Bureau, 2010)—the current inclusion criteria was set at 18 as an attempt to include married couples of lower than average age as their beliefs could provide additional information. This project received Virginia Tech IRB approval (Appendix A).

The Theory of Planned Behavior as a Methodological Framework

As the theory of planned behavior possess a methodological framework that parallels a sequential exploratory mixed methods design (Creswell & Plano-Clark, 2011), a brief

explanation of how these procedures are to be followed. Thus, this section seeks to explore Fishbein and Ajzen's (2010) set procedures for a theory of planned behavior study. First, the theory of planned behavior requires a behavioral definition in order to maintain a consistent conception of the behavior throughout the study. Therefore, the behavior of interest must be specifically defined as observable events with regard to four elements: action, target, context, and time (Fishbein & Ajzen, 2010). For the current study, the defined behavior is: s*eeking professional help (action) from a marriage and family therapist (target) for my spouse and me (context) during times of high relationship distress (time)*. This behavior must be defined across these four elements throughout both direct and belief-based measures, as any change constitutes a different behavior.

Stage one: Formative research. The first stage in the theory of planned behavior is primarily a qualitative stage—dubbed *formative research* by Fishbein and Ajzen (2010)—in which 25 participants from the population of interest is interviewed to elicit the salient behavioral, normative, and control beliefs towards the defined behavior. Fishbein and Ajzen formulated the following specific questions to elicit salient beliefs for attitudes, perceived norms, and perceived behavioral control: (a) "What are the advantages and disadvantages of seeking professional help from a MFT for you and your spouse during times of relationship distress?" for behavioral beliefs, (b) "What individuals or groups would approve or disapprove of you seeking professional help from a MFT for you and your spouse during times of relationship distress?" for injunctive normative beliefs, (c) "What individuals or groups are most likely or least likely to seek professional help from an MFT for them and their spouse during times of relationship distress?" for descriptive norms, and (d) "What factors and/or circumstances would make it easier or more difficult for you to seek professional help from an MFT for you and your spouse

during times of relationship distress?" for control beliefs. The responses can then be content or thematically analyzed in order to construct a list of modal salient behavioral, normative, and control beliefs. These salient beliefs can then be used to create the *belief-based measures*—which will be explained shortly—that will be used to specify which component (attitude, perceived norms, and perceived behavioral control) predicts behavioral intentions.

During this stage a quantitative survey that includes demographic questions, preliminary direct measures—which will be explained shortly—for each construct, as well as a preliminary measure for behavioral intentions. This is done to test the items for internal consistency as well as the prevalence of the specified behavior in the population of interest. Item wording may need adjusting to find a fit for the population of interest.

Direct measures. Each component of the theory of planned behavior—attitude, perceived norms, and perceived behavioral control—can be assessed in two ways, with direct or belief-based measures. *Direct measures* are designed to measure the global component (such as attitude) and do not involve specific beliefs. This involves asking participants directly about the specified behavior (e.g., *Doing Y behavior is good/bad, pleasant/unpleasant, beneficial/harmful, etc.* for measuring attitude) as well as their intentions in performing the behavior. These measures are theorized to directly assess each construct and provide an overall score of attitude, perceived norm, and perceived behavioral control. This approach has several benefits; first it allows the chance to assess the prevalence of the behavior in the population. If the majority of the sample is actually engaging in the behavior (i.e., seeking professional help from an MFT during relationship distress) than there is no need to intervene. Second, it allows the opportunity to assess if people actually intend on engaging in the behavior (i.e., I intend to seek professional help from an MFT during relationship distress). This information can preliminarily show if an

intervention directed at changing currently held behavioral intentions are needed or to find methods to aid people in acting on the intentions they currently have. Finally, direct measures allows for the piloting of the survey questions. This can uncover problems with item wording, scale formatting, and reliability and these issues can usually be solved by testing the scale cohesiveness using Cronbach alpha, or other relevant statistical analyses (Fishbein & Ajzen, 2010).

The direct measures that assess attitude are based on the seven-point semantic differential scale created by Osgood, Suci, and Tannenbaum (1957; as cited in Fishbein & Ajzen, 2010) that uses adjectives (e.g., good-bad, pleasant-unpleasant, favorable-unfavorable, etc.) to evaluate the phenomena of interest. There are two aspects to attitude that can be measured using different adjectives, (a) instrumental—whether the behavior can achieve something (e.g., useful/worthless, good/bad, etc.)—and (b) experiential—or the feelings associated with performing the behavior (e.g., pleasant/unpleasant, enjoyable/unenjoyable, etc.). These aspects can often be used to explain differing attitudes towards behavior. For example, while some couples may believe that seeking professional help from a MFT would be beneficial and overall good, the experience may be unenjoyable and unpleasant. Thus, when constructing a direct measure of attitude, it is important to employ both instrumental and experiential adjectives for the defined behavior (Fisbein & Ajzen, 2010).

Perceived norms and perceived behavioral control face similar issues. As stated earlier, perceived norms are comprised of both injunctive and descriptive norms. The direct measure of perceived norms should contain both injunctive and descriptive items (such as *People who are important to me approve/disapprove of me performing behavior x* for injunctive norms, and *People who are important to me perform behavior x* for descriptive norms). Direct measures for

perceived behavioral control should also be comprised of two types of items, (a) capacity items—the belief that one is capable of performing the behavior as well as the perceived ease or difficulty of performing the behavior (e.g., *I can easily perform behavior x if I wanted to-strongly agree/strongly disagree*)—and (b) autonomy items—or the degree of control over performing the behavior (e.g., *I am in complete control over whether perform behavior x-strongly agree/strongly disagree*). Including both items should improve the reliability of the scale (Fishbein & Ajzen, 2010).

Scoring direct measures. The direct measures for attitude, perceived norms, and perceived behavioral control are scored using a seven-point unipolar scale (1 to 7). Each item should utilize bipolar adjectives (e.g., good/bad, likely/unlikely, etc.) in their wording and direct measure should be tested for internal consistency. The mean is then calculated for each construct's subset. This total score represents one's direct measurement score for attitude, perceived norms, and perceived behavioral control (Fishbein & Ajzen, 2010).

Belief-based measures. *Belief-based measures* are created from the specific belief elicited in the formative research stage. These specific beliefs are used to belief-based measure attitude, perceived norms, and perceived behavioral control. Unlike the direct measures, the belief-based measures—or belief-based measures—involve only the specific beliefs that are associated with the specified behavior that were elicited during the qualitative stage. While the beliefs can be conflicting, irrational, or biased, they are measured using two items for each component to incorporate the valence of each belief (i.e., while two beliefs are related to the behavior, one is negative and one is positive). For each belief, one item measures the participants' belief strength (i.e., how strongly they hold that belief), and the outcome of that question is weighted (multiplied) by the outcome of another item that measures the participants'

corresponding evaluation (i.e., whether that belief is good or bad overall).These multiplied items—also called *item pairs*—represent the overall contribution that each belief makes to attitudes (behavioral belief strength weighted by outcome evaluation), perceived norms (injunctive belief strength weighted by motivation to comply), and perceived behavioral control (control belief strength weighted by power of control factor; Fishbein & Ajzen, 2010).

Scoring belief-based measures. The belief-based measures should be scored on seven-point scales. Motivation to comply, behavioral belief strength, identification with referent, and control belief strength will be scored using a unipolar (+1 to +7) scale. This is reflects the inherent position of neutrality—because the fact that a participant does not agree with a referent, behavioral or control belief, does not constitute their disagreement with them. Therefore, placing a negative value on their response may over or under contribute to the overall scores of the constructs. However, a belief can contribute positively for one person (such as the belief that seeking professional help from a MFT will lead to staying together with one's spouse) but negatively for another (such as the reverse, the belief that seeking professional help from a MFT will not lead to staying together with one's spouse). This is commonly referred to the *valence* of the beliefs, or the overall negative or positive contribution the belief has to the prediction of behavioral intentions. In order to capture the valence of each belief, outcome evaluations, injunctive belief strength, descriptive belief strength, and power of control factor are scored using bipolar scales (-3 to +3). Thus, when each belief is weighted by it's valence, it will aid in it's ability to contribute to the subscales' ability to predict behavioral intentions (Fishbein & Ajzen, 2010).

This method of scoring can be complex, therefore, to help conceptualize this scoring method, consider *resolving past issues* as if it were a behavioral belief that was elicited during

the formative research stage. This belief would then be measured in two ways: (a) belief strength, and (b) outcome evaluation. The unipolar behavior belief strength item would have seven points (1 to 7) and resemble, "My seeking professional help from a MFT for my spouse and I during times of relationship distress would result in resolving past issues is—likely/unlikely" with *likely* scoring a 7 and *unlikely* scoring a 1. The bipolar outcome evaluation item would have seven points (-3 to +3) and resemble, "My spouse and I resolving past issues is—good/bad" with *good* scoring +3 and *bad* scoring -3. These two items—behavioral belief strength and outcome evaluation—form an item pair of the behavioral belief *resolving past issues* and are multiplied to obtain the participant's score for that specific behavioral belief. All of the behavioral belief item-pairs are then summed to produce the total belief-based attitude score. A similar process is then used for the item pairs of injunctive normative beliefs—injunctive belief strength (-3 to +3) times motivation to comply (1 to 7)—, descriptive normative beliefs—descriptive belief strength (-3 to +3) times identification with referent (1 to 7)—, and control beliefs—control belief strength (1 to 7) times power of control factor (-3 to +3) to compute the scores for each construct on the belief-based measure (Fishbein & Ajzen, 2010).

Using both direct and belief-based measures. Both direct and belief-based measures are assessing the same constructs and should positively correlate with each other even though they each hold different suppositions about the constructs. While direct measures can be tested for reliability, this is not recommended for belief-based measures. Thus, in the context of the theory of planned behavior, both measures should be used so that the belief-based measures can be correlated with the direct measures and show convergent validity as well as provide specific beliefs that can then be targeted for intervention (Fishbein & Ajzen, 2010).

Stage two: Main study. The belief-based measures created from the list of salient behavioral, normative, and control beliefs, will be combined with the direct measures of all constructs and distributed to a larger group of participants. The belief-based measures will assess the strengths of the elicited behavioral, normative, and control beliefs as well as evaluations of the behavioral outcomes, motivation to comply with referents, identification with referents, and power of control factors. This also allows the opportunity to validate stage one's results concerning the prevalence of the specified behavior. This stage also validates that attitude, perceived norms, and perceived behavioral control are related to the specific beliefs that were elicited during the formative research stage. To assess this, the relationship between the belief-based and direct measures of each construct is examined through correlational analyses. A positive correlation indicates that both measures are assessing the same constructs. After convergent validity has been established, a regression analysis is conducted with behavioral, normative, and control belief indices predicting behavioral intention. Whichever construct carries the most weight in predicating intentions would be the most effective to target in order to change intentions. Correlating the item-pair score totals with behavioral intentions would discriminate between specific beliefs would be the most effective to target. These methods would assist in designing an intervention in order to change or create new behavioral intentions towards the specified behavior (Fishbein & Ajzen, 2010).

Research Questions

The rationale for this study is to test the application of Fishbein and Ajzen's (2010) theory of planned behavior to the field of MFT. To achieve this objective, this study was conceptualized and conducted under three central research questions:

Qualitative research question: What beliefs do married participants associate with seeking professional help from an MFT during times of relationship distress?

Quantitative research question: Do the theory of planned behavior measures (direct and belief-based) account for a significant amount of variance of their behavioral intentions to seek professional help from an MFT for them and their spouse during times of relationship distress?

Mixed methods research question: Are the married participants' qualitative beliefs (belief-based measures) towards seeking professional help from an MFT for them in their spouse during times in relationship distress in stage one generalizable to the sample of the population of married participants in stages two and three?

To answer these questions, this study is divided into three stages, (a) the formative research stage, (b) the pilot stage, and (c) the main study stage. Each stage is guided by specific research sub-questions and hypotheses.

Research questions for stage one: The formative research stage:

Q1: How would married participants qualitatively define 'relationship distress' using their own language?

Q2: What are married participants' salient behavioral, normative, and control beliefs towards the defined behavior (seeking professional help from a marriage and family therapist for them and their spouse during times of high relationship distress)?

Research questions for stage two: The pilot stage:

Q3: Do each of the subscales in the direct measure show strong internal consistency during the pilot stage?

Hypothesis One: All subscales in the direct measure will show strong internal consistency.

Q4: Is there a relationship between the belief-based and direct measures of the theory of planned behavior's constructs during the pilot stage?

Hypothesis Two: Based upon Fishbein and Ajzen's (2010) theory of planned behavior, there will be a significant positive correlation between the belief-based measures and the direct measures of the theory of planned behavior's constructs.

Q5: Can the direct measures (attitude towards the behavior, perceived norms, and perceived behavioral control; IVs) significantly predict participants' behavioral intention (DV) in stage two?

Hypothesis Three: The direct measures will predict participants' behavioral intentions in stage two.

Q6: Can the belief-based measures (behavioral, normative, and control beliefs; IVs) significantly predict participants' behavioral intention (DV) in stage two?

Hypothesis Four: The belief-based measures will predict participants' behavioral intentions in stage two.

Research questions for stage three: The main study stage:

Q7: Have the participants sought professional help from an MFT for them and their spouse during times of relationship distress in the past?

Hypothesis Five: The participants will have not sought professional help from an MFT for them and their spouse during times of relationship distress in the past.

Q8: Do the participants intend to seek professional help from an MFT for them and their spouse during times of relationship distress?

Hypothesis Six: The participants do not intend to seek professional help from an MFT for them and their spouse during times of relationship distress.

Q9: Is there a relationship between the stage three belief-based and direct measures of the theory of planned behavior's constructs?

Hypothesis Seven: Based upon Fishbein and Ajzen's (2010) theory of planned behavior, there will be a significant positive correlation between the stage three belief-based measures and the direct measures of the theory of planned behavior's constructs.

Q10: Do the direct measures (i.e., attitude towards the behavior, perceived norms, and perceived behavioral control; IVs) predict participants' behavioral intentions (DV) controlling for demographic variables (i.e., age, gender, income, education, and mental health treatment history) in stage three?

Hypothesis Eight: The direct measures will predict participants' behavioral intentions when controlling for demographic variables in stage three.

Q11: Do the belief-based measures (i.e., behavioral, normative, and control beliefs; IVs) predict participants' behavioral intentions (DV) controlling for demographic variables (i.e., age, gender, income, education, and mental health treatment history) in stage three?

Hypothesis Nine: The belief-based measures will predict participants' behavioral intentions when controlling for demographic variables in stage three.

Q12: Which independent variable of the belief-based measure—among attitude, perceived norms, and perceived behavioral control—is the largest contributor in predicting participants' behavioral intention in stage three?

Hypothesis 10: Based upon Fishbein and Ajzen's (2010) theory of planned behavior, attitude towards the behavior will be most efficient in predicting participants' behavioral intention in stage three.

Q13: Which qualitative beliefs of the largest contributing belief-based predictor (i.e., behavioral, normative, and control beliefs) show a strong correlation ($|r| \geq .5$; Cohen, 1988) with behavioral intentions in the stage three quantitative measure?

As this research question is exploratory in nature, there are no specific hypotheses associated with this question.

Stage One

The first stage serves to answer research questions one and two and uses qualitative focus groups (Han, Hsu, & Sheu, 2010; Yunhi & Heesup, 2010) instead of individual interviews to fulfill Fishbein and Ajzen's (2010) theory of planned behavior formative research stage. Three focus groups that involved group discussion concerning the salient behavioral, normative, and control beliefs towards the defined behavior were conducted. Thus, the aims of this stage are three fold; (a) define 'relationship distress' using participants' language, (b) obtaining a modal set of participants' behavioral, normative, and control beliefs towards the defined behavior and using member checking—a measure of participate validation—to ensure the credibility of the

thematic categories created from the list of behavioral, normative, and control beliefs, and, finally, (c) operationalizing these modal beliefs into a quantitative measure for stages two and three.

Sample. The participants for this stage were recruited for three focus groups. A combination recruitment strategy that involved both flyers (Appendix B) in local establishments (such as libraries, churches, coffee shops, gas stations, yogurt shops, etc.) and an invitation email sent over the graduate student list serv of Virginia Tech (Appendix C) were used to recruit participants for the first two focus groups. The participants for the final focus group were recruited using only flyers posted in the local community. All focus groups were conducted in the conference room at the Family Therapy Center of Virginia Tech and lasted 90 minutes. Food and beverages were provided in each focus group meeting.

All participants received $30 cash as compensation for their time spent in the focus group. A total of 24 participants were recruited for stage one—eight participants in each group—and consisted of 13 females and 11 males. Of the 24 participants, 19 identified as Caucasian and five identified as Asian/Pacific Islander. Although, several of the participants who identified as Caucasian, qualified their ethical and racial background during discussion as belonging to Middle Eastern countries (such as Egypt, India, Saudi Arabia, among others). The ages of the participants were from 25 to 74 (M=36.85, SD=12.39) with 29 being the mode. The majority of the focus group members were students (11), followed by employed for wages (7), a homemaker (2), retired (1), self-employed (1), out of work and looking for work (1), and other (1). The majority of focus group participants were educated with a master's degree (11), followed by bachelor's degree (5), doctorate degree (4), some college credit-no degree (2), and trade/technical/vocational training (1). The focus group participants appear to be split on mental

health treatment history with 54.2% having not received any mental health treatment and 45.8% having received some form of mental health treatment.

Measures. A demographic questionnaire, which included direct assessment scales of the theory of planned behavior constructs (Fishbein & Ajzen, 2010), was also given to all focus group participants (Appendix D). This questionnaire assessed the focus group participants' age, gender, ethnicity, education, annual household income, religious affiliation, marital status, professional or employment status, and mental health treatment history. These questions allowed the researchers to assess the diversity of the participants in all discussion groups. This measure also asked if the participants were willing to participate in member checking defined as participating "online in a later brief (ten minutes or less) stage of this research project".

Procedure. At the beginning of each focus group, the moderator provided each participant with a consent form (Appendix E) and engaged the group in discussion over the purpose of the consent form as well as the rules of participation (e.g., *respect*, and *one person talks at a time*, etc.). Each participant was informed of their right to terminate participation at any time as well as the nature of confidentiality and was encouraged to use a pseudonym during the discussion. A focus group question guide (Appendix F) was developed using Fishbein and Ajzen's (2010) formative research questions designed to elicit (a) the advantages/disadvantages (behavioral beliefs), (b) the individuals and groups that either would or would not support (normative beliefs), and (c) the factors and/or circumstances that make it either easier or more difficult (control beliefs) to seek professional help from a marriage and family therapist for them and their spouse during times of relationship distress. A note-taker was involved with all focus groups to document the groups' discussion of the specific questions that led to the elicitation of specific salient behavioral, normative, and control beliefs. The moderator and note-taker

participated in Virginia Tech's IRB training prior to the focus group meetings. As the focus group was designed according to Fishbein and Ajzen's (2010) theory of planned behavior, the note-taker documented verbatim many of the answers the participants listed to the formative research questions. When the pace of the discussion increased, the note-taker documented the responses that focus group participants gave to one another concerning specific answers to the formative research questions. The names of the participants were removed from the notes and the researcher assigned the participants pseudonyms to protect their confidentiality. These notes were used as the focus group data. Several audio recording devices were used in all group discussion as a secondary measure and were digitally stored on a password-protected computer. The consent forms were also stored in a secure manner—via a locked safe—to ensure the confidentiality of the participants. Member checking was used as a participant validation measure (Koch, 2006).

Analysis. The focus group data were analyzed using theoretical thematic analysis (Braun & Clarke, 2006, 2012). First, in order to answer research question one, the researcher actively reviewed the responses concerning the participants' definition of relationship distress by repeatedly reading over the responses given in each focus group and grouped units of text that discussed relationship distress in a similar way together. This analysis yielded a definition of relationship distress that was used during stage three and answered research question one.

Next, in order to answer research question two, the researcher developed a coding scheme—adopting the three domains of the Fishbein and Ajzen's (2010) theory of planned behavior as themes—by immersing himself in the data and actively reading the documents three times. After repeatedly reading through the data, the researcher noted initial codes that emerged using the online qualitative analysis software Dedoose. Units of text that were addressing the

same concepts were grouped together into analytic categories and provisionally defined. For example, the researcher grouped codes such as *mom* and *dad* into an analytic category of *parents*. During this stage, codes were constantly being recoded, uncoded, and reorganized into categories and sub-categories that matched the participants' rich responses and the constructs they were discussing. Next, the researcher then organized the categories under the three larger overarching themes of the theory of planned behavior's three constructs—behavioral, normative, and control beliefs (e.g., *time* and *financial cost* were grouped under *control beliefs*).

In order to establish credibility, the researcher trained another coder to use the coding scheme via a training document containing 10% of the codes. Using percentage agreement, (Hesieh & Shannon, 2005; Multon, 2010) the coders were able to reach—by resolving differences through discussion—a .90 agreement. The result was a thematic tree (Appendix G) of the focus group data. Thus, the analysis yielded 75 categories that were then grouped under the three key themes provided by Fishbein and Ajzen (2010; i.e., 23 behavioral beliefs, 35 normative—23 injunctive and 12 descriptive— beliefs, and 17 control beliefs). While all of the descriptive norm beliefs were also injunctive norm beliefs, according to Fishbein and Ajzen, each will be operationalized in a different manner in order to capture both aspects of normative pressure.

In order to obtain participant validation, the thematic tree was sent to the focus group members via a follow up email (Appendix H) to review and included a web link to a Qualtrics online survey (Appendix I) for anonymous feedback. As this transaction took place online, a deadline of three days was set for the focus group members. One focus group member requested to be contacted via phone for the member check. Multiple attempts were made to contact this

participant with no success. Out of the 24 focus group participants, eight provided feedback on the thematic tree.

The feedback provided largely reflected accurate analysis (i.e., *I believe we covered advantages and disadvantages for seeking treatment well* and *Yes, I cannot think of anything else to add*), however, one focus group member pointed that the discussion around cultural factors was not represented by the themes with their statement, *"What about cultural factors/cultural perspective of both those seeking treatment and the counselors as well? You left that out entirely."* The researcher then re-reviewed the data that denoted culture and found that culture was discussed in relation to perceived norms, such as cultural members (i.e., other East Asians, or religious figureheads). The category 'Cultural Background' was operationalized as 'Members from my own culture' to incorporate this feedback.

After conducting the member check, the themes were subjected to Fishbein and Ajzen's (2010) selection criteria and were chosen based on the frequency of their emission (i.e., the sum number of times each belief in the thematic category was stated by participants) until 75% of all responses are accounted for. Thus, this procedure generated the final thematic tree (Appendix J) reduced the amount of categories from 75 to 39, 12 behavioral beliefs, 11 injunctive normative beliefs, six descriptive normative beliefs, and 10 control beliefs. The researcher made an a-priori decision to separate three injunctive and descriptive normative beliefs—i.e., (a.) *person/couple's age group (i.e., older couples and younger couples),* (b.) *person/couple's education level (i.e., highly educated and poorly educated)*, and (c.) *person/couple's wealth level (i.e., being rich or poor)* — into two separate beliefs each—i.e., *older people*, *younger people*, *highly educated people*, *poorly educated people*, *wealthy people*, and *poor people*) in order to better capture the normative pressure experienced by participants. Indeed, as a wealthy person can exert a strong

normative pressure on a participant, that does not mean that a poor person could not. Thus, the beliefs being separated better captured the impact of the referent (e.g., wealthy people) and not the description (i.e., wealth, education, and age). The same procedure was used with the control belief *financial cost of therapy (out of pocket, insurance, etc.)* in which two beliefs were created—*cost of therapy* and *Insurance coverage (part or all of treatment)*—as each refers to a different form of financial commitment from the participant. The researcher also made an a-priori decision to include one control belief that did not meet the cut off criteria (*childcare issues*) as it could represent a significant barrier in seeking professional help from a MFT for couples with young children. These procedures yielded a new total of 50 beliefs, 12 behavioral beliefs, 26 normative—14 injunctive and 12 descriptive—beliefs, and 12 control beliefs.

Finally, both coders reread the participants' responses (initial codes) and categorized them into the three key themes to ensure goodness of fit. The beliefs were then operationalized and used in the construction of an online survey in Qualtrics. After this step, the coders determined that the three key themes adequately reflected the participants' responses.

Stage Two

Stage two is a pilot stage that serves to answer research questions three through six by testing the newly constructed belief-based measures from the salient beliefs elicited from the focus group as well as the direct measures of each theory of planned behavior construct. Thus, the aims of stage two are three fold, (a) to test the reliability of direct measures, (b) the test the convergent validity of the belief-based measures, and (c) to test the direct measures ability to predict behavioral intentions.

Sample. To observe a medium effect size of .15 and at a probability of .05, using three predictors (i.e., attitude towards the behavior, perceived norm, and perceived behavioral control)

and seventy-seven participants would be needed to conduct a regression analysis with an anticipated power of .80 (G*Power, see Faul, Erdfelder, Buchner, & Lang, 2009). Qualtrics online survey panel (http://www.qualtrics.com) was used to recruit a nationally representative sample and yielded 105 participants with the selection criteria being married and 18 years old. While no internet-based survey can achieve a sample that perfectly represents a national population, Qualtrics panels repeatedly sends survey links to randomized subsets of a representative population until the desired number of participants is reached. Thus, for the inclusion criteria for this study, Qualtrics panels repeatedly sent invitations to married individuals who are at least 18 years old until the desired number was reached. Three participants did not complete a large portion of the survey, yielding 102 qualifying participants. At the time of the survey, 51.5% of the participants were female and 48.5% of the participants were male. The ages of this sample ranged from 27 to 76 (M=51.33, SD=11.44) with 60 being the mode. At the time of the survey, the majority of the participants possessed a bachelor's degree (23.7%), followed by a master's degree (20.6), some college education (16.5%), high school degree or equivalent (11.3%), associate's degree (9.3%), a bachelor's degree with some graduate education (8.2%), a vocational/technical degree (6.2%), a professional degree (MD, JD, etc.; 3.1%), and middle school graduation (1%). The majority of the participants have never received mental health treatment (79.4%).

Measures. The belief-based measures of attitude, perceived norm, and perceived behavioral control were created from the behavioral, normative, and control beliefs elicited during stage one. The direct measures of attitude, perceived norms, perceived behavioral control, as well as behavioral intention and past behavior were created from sample items provided by Fishbein and Ajzen (2010). Items were also included to assess demographic variables (e.g., age,

gender, etc.). All items were combined to create the stage two survey used during this stage and placed online via Qualtrics (http://www.qualtrics.com; Appendix K) and used a variety of responses (e.g., *Extremely unlikely/Extremely likely, Strongly agree/Strongly disagree,* etc.) in a Likert-type format.

The survey questions were presented in matrix format that allowed measuring multiple variables using one question. The aim of this action was to minimize the time required by participants to take the survey. Thus, while there were 136 variables, they were assessed using 43 questions. While online surveys in theory of planned behavior studies have been used before (Lee, 2009; Pavlou & Fygenson, 2006), at the time of this study, no prior research could be found that used online matrix formatted theory of planned behavior items. Each subscale—six total—and their corresponding items were then placed in separate 'blocks' within the online survey. Each block and their corresponding items, except for the demographic questions, were randomized for every participant.

Direct Measures. The direct measure of attitude was measured by one question (i.e., *My seeking professional help from a marriage and family therapist for my spouse and me during times of relationship distress would be:*) assessing six sets of bipolar adjectives (i.e., *Bad-Good, Harmful-Beneficial, Unpleasant-Pleasant, Negative-Positive, Detrimental-Constructive, Painful-Enjoyable*) in a matrix format. Four of the items were instrumental and measured the cognitive evaluations associated with the behavior while two were experiential items and measured the affective evaluations associated with the behavior. Perceived norm was measured using seven items; three were injunctive items (e.g., *Most people who are important to me think I should seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress. – Disagree/Agree*) and measured participants' perception of what others

think they should do concerning the defined behavior. The other four items were descriptive (e.g., *Most people who are important to me would seek professional help from a marriage and family therapist for themselves and their spouse during times of relationship distress. – Disagree/Agree*) and measured participants' perception of others engagement in the defined behavior. Perceived behavioral control was measured using six items; four capacity items (e.g., *My seeking professional help from a marriage and family therapist for my spouse and I during times of relationship distress would be – Very easy/Very difficult*) and two autonomy items (e.g., *Whether or not I seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress is completely up to me – Strongly disagree/Strongly Agree*). All direct measures were scored using unipolar scoring with the mean of each subscale Internal consistency for the direct attitude (α=.91), perceived norm (α=.91), and perceived behavioral control (α=.88) sub-scales for this stage were very high.

Four items were created to assess participants' intention to perform the behavior (i.e., *I intend to seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress – True/False*) and two items were created to assess participants' past behavior (i.e., *I have previously sought professional help from a marriage and family therapist for me and my spouse during times of relationship distress – True/False*). Both subscales of behavioral intention (α=.93) and past behavior (α=.89) for this stage showed very high internal consistency. Items were also created to assess demographic factors (e.g., age, gender, etc.).

Belief-based measures. All belief-based measures used a matrix answer format in which several items could be listed in a Likert-type format under one question to minimize the time required to complete the survey. As the belief-based measures consist of elicited beliefs,

reliability was not assessed using Cronbach alpha. The beliefs included relate to both positive and negative aspects of performing the behavior. Since it is possible that participants can hold two conflicting beliefs at the same time, internal consistency using Cronbach alpha could be an inappropriate analysis

(Fishbein and Ajzen, 2010). Thus, the recommended method for assessing the belief-based scales is correlation analyses with the direct scales.

Belief-based attitude (behavioral beliefs) consisted of 12 beliefs and were measured by two items, behavioral belief strength and outcome evaluation for a total of 24 items. Behavioral belief strength was measured using two questions. The first question (i.e., *My seeking professional help from a marriage and family therapist for my spouse and I during times of relationship distress would:*) listed 11 of the 12 operationalized behavioral beliefs in matrix format and measured the likelihood (i.e., *extremely unlikely-extremely likely*) that the defined behavior will result in the stated belief. The second question was designed to assess one behavioral belief—we can solve our own problems—that did not fit with the other beliefs. Thus, a new question (i.e., *I would not consider seeking professional help from a marriage and family therapist for me and my spouse during times of relationship distress as I believe we can solve problems on our own – strongly disagree/strongly agree*) was created. All behavioral belief strength items were scored in a bipolar fashion (-3 to +3). Outcome evaluation was measured using one question with all 12 operationalized behavioral beliefs listed in matrix format and measured evaluations of each behavioral beliefs outcomes. All outcome evaluation items were scored in a unipolar fashion (1 to 7). Each behavioral belief's score on behavioral belief strength and outcome evaluation was multiplied and then summed to form a total attitude score.

Belief-based measures of perceived norms (normative beliefs) were measured by injunctive and descriptive norms. There were 14 injunctive normative beliefs and 12 descriptive normative beliefs that were included in the survey. All of the normative beliefs listed for descriptive norms were also included in injunctive norms as during the focus group discussion, every group listed for descriptive norm was also listed for injunctive norms. Fishbein and Ajzen (2010) highlight that this is not uncommon as injunctive and descriptive norms can coexist and be congruent or incongruent. Two items measured each aspect of normative pressure, injunctive norm belief strength and motivation to comply for injunctive norms, and descriptive norm belief strength and identification with referent for descriptive norms that comprised a total of 52 items. Injunctive norm belief strength was scored using a bipolar scale (-3 to +3) and assessed by two questions using one statement. The first question evaluated for 11 beliefs. The second question evaluated for three beliefs but consisted of beliefs that may not pertain to the participant (i.e., parents, members from my own culture, and siblings). Indeed, some participants may not have siblings, or consider themselves as connected to a cultural group. Thus, for this question, an additional selection category (*not applicable*) was added in order for participants to distinguish which beliefs do not pertain to them. The other beliefs did not have a "*not applicable"* option as participants should have experience with those groups. For example, even if a person is not religious (i.e., atheist) it is reasonable to assume that they have had experience with religious people and, therefore, have an opinion towards that group. Motivation to comply was scored using a unipolar format (1 to 7) and assessed in a similar fashion to belief strength, with one question having "*not Applicable"* to assess for the three beliefs that may not pertain to the participant. The scores on both belief strength and motivation to comply were multiplied for each injunctive normative belief. The scores were then summed to produce an overall injunctive norm

score. Descriptive norms followed the same procedure as injunctive norms with belief strength and identification with referent being multiplied for each descriptive normative belief. The scores were then summed to create an overall descriptive norm score. Both injunctive and descriptive norm score totals were then summed to create an overall score for the belief-based normative measure.

The belief-based measure for perceived control (control beliefs) consisted of 13 control beliefs, 10 were included via the cut-off inclusion and three were included via a priori decision by the researcher. The belief-based control measure was assessed using two items, power of control factor and control belief strength for a total of 26 items. Power of control factor was scored using a bipolar format and consisted of three questions to evaluate all beliefs. Control belief strength was scored using a unipolar format and consisted of one question for all beliefs. Scores were totaled by multiplying power of control factor with control belief strength for each control belief. Then all item-pair scores were summed to arrive at a total belief-based perceived control score.

Procedure. Both belief-based and direct measures were constructed in an online Qualtrics Survey. The scoring was set for each question within the survey. Qualtrics panel services were used to recruit eligible participants for this study. Qualtrics recruited and compensated all participants. The survey was sent out to Qualtrics participants to take. To ensure that every participant met the selection criteria, only the participants that selected "*Married*" and "*Separated*"—since separated is still married—and input an age at least 18 years of age were included in the survey. All others were screened out. All subscale blocks, except for were presented in random order for every participant. The results were then downloaded into SPSS for statistical analyses. The average score was taken for each belief-based subscale. This was done

by dividing the total score for each belief-based scale by the number of item-pairs (beliefs) that were used to compute each total score. The average time it took participants to complete the survey was 19 minutes.

Analysis. To answer research questions three and four, Pearson's product-moment bivariate correlation analysis was utilized to provide reliability between the direct and belief-based scales and Cronbach alpha will measure the internal consistency of the direct scales. This will provide convergent validity for the belief-based scales. All 102 qualifying cases were included in the bivariate and Cronbach alpha analyses. To answer research questions five and six, multiple regression was used to test two models of prediction; (a) the three direct measures (i.e., attitude, perceived norm, and perceived behavioral control) predicting behavioral intention, and (b) the three belief-based measures (i.e., behavioral, normative, and control beliefs) predicting behavioral intention. Outliers that were assessed using Mahalanobis' distance will be deleted by an a priori decision made by the researcher.

Stage Three

Stage three serves to answer research questions seven through eleven by testing the complete piloted measure for use in predicting behavioral intentions. Thus, the aims of this stage are three fold, (a) to establish convergent validity between the direct and belief-based measures, (b) to examine which direct and belief-based measure—attitude, perceived norm, and perceived behavioral control—accounts for the most variance in predicting behavioral intentions, and (c) to examine which beliefs account for the most variance in the significant predictors.

Sample. To observe a medium effect size of .15 and at a probability of .05, using six demographic predictors (i.e., age, gender, income, education, race, and mental health treatment history) and three main predictors (i.e., attitude towards the behavior, perceived norm, and

perceived behavioral control), at least 119 participants would be needed to conduct a hierarchical regression analysis with an anticipated power of .95 (G*Power, see Faul et.al, 2009). Qualtrics online survey panel was used to recruit a nationally representative sample and yielded 266 participants with the selection criteria being at least 18 years of age and married. Twenty-eight did not complete the survey yielding 238 total responses. At the time of the survey, 58.8% of the participants were female and 41.2% of the participants were male. The ages of this sample ranged from 22 to 83 (M=50.45, SD=11.9) with 55 being the mode. At the time of the survey, the majority of the participants Non-Hispanic White (84%) followed by Black or African-American (6.7%), Latino or Hispanic (2.1%), Asian (2.1%), Other (2.1%), Hispanic White (1.7%), Native American or Alaskan Native (.8%), and Native Hawaiian or Other Pacific Islander (.4%). The majority of the participants possessed a bachelor's degree (22.7%), followed by high school degree or equivalent (16.4%), some college education (16%), a master's degree (11.8%), associate's degree (8.8%), vocational/technical degree (8.4%), a bachelor's degree with some graduate education (8%), a doctoral degree (3.4%), middle school graduation (2.5%), and a professional degree (MD, JD, etc.; 2.1%). The majority of the participants have never received mental health treatment (75.6%).

Measures. The stage two survey was edited within Qualtrics to create the stage three survey (Appendix L). The direct and belief-based measures from stage two were edited for three reasons, (a) in an effort to reduce the amount of time participants spent taking the survey, (b) to better represent the theoretical constructs, and (c) to better represent the focus group responses. For instance, the last behavioral belief—*we can solve our own problems*—in the belief-based attitude measure was re-operationalized in order to be placed within the matrix question with the other behavioral beliefs. This lessened the sub-scale by one question. Other subscales were

reworded and reorganized based on theoretical reasons. For example, one set of adjectives were added to the direct attitude scale (i.e., *worthless-valuable*) as the researcher believed it added to the evaluative nature of the question. As the direct attitude scale was in matrix format, the addition of this adjective set did not add significant time to take the survey.

Next, the direct norm items were edited as one item (i.e., *Most people like me will seek treatment from a marriage and family therapist for them and their spouse during times of relationship distress.*) was dropped to as it closely resembled another item (i.e., *How many people similar to you seek professional help from a marriage and family therapist for them and their spouse during times of high relationship distress?*). Items that possessed grammatical mistakes were also reworded. Thus, the seven items—three injunctive and four descriptive—that comprised the direct normative sub-scale during stage two were edited and reworded to comprise a new six item—three injunctive and three descriptive— direct norm sub-scale for stage three.

The researcher also evaluated the injunctive and descriptive normative beliefs that comprised the belief-based norm scale. The normative belief *members from my own culture* was edited as the term 'culture' could be interpreted in a multitude of ways by participants. Thus, the researcher re-operationalized the belief to *members from my own culture (race, ethnicity, nationality, religion, etc.)* in order to provide a more inclusive definition for the participants. This definition was also a better representation of the focus group responses. The response '*not applicable*' was removed as it is assumed that all participants are a part of a form of culture—national, ethnic, racial, and/or religious—and should be measured as such. This belief was edited in both injunctive and descriptive norm items.

The direct control scale was reviewed and multiple items were edited. One item (i.e., *It is mostly up to me whether or not I seek professional help from a marriage and family therapist for*

my spouse and I during times of relationship distress.) was deleted because it was similar to another item (i.e., *Whether or not I seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress is completely up to me*.) on the sub-scale. The other items were edited for wording as well as to represent the two aspects of control—autonomy and capacity—discussed previously. Thus, six items—four capacity and two autonomy items—were edited to a new six-item direct control scale comprised of three capacity and three autonomy items. This was done in order to better represent both aspects of perceived control.

The belief-based control scale was also reviewed and edited by the researcher. The power of control questions were found to pose a biasing issue. Two questions were worded in a manner that could skew the participants' conception of the stated beliefs. One question (i.e., *The following things would make it likely for me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.*) was used to evaluate five beliefs and worded in a manner that could provoke initial positive evaluations. The other question (i.e., *The following things would make it more difficult for me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.*) measured three beliefs and worded in a manner that could provoke initial negative evaluations. The third question measured five factors associated with the therapist and could be combined with the other two to create a more comprehensive matrix formatted question. Thus, the three power of control questions were combined under one question (i.e., *Consider the following factors and circumstances. Please rate how each of them would make it easier or more difficult for you to seek professional help from a marriage and family therapist for you and your*

spouse during times of relationship distress.) that evaluated all 13 listed control beliefs. The past behavior and behavioral intention items were not edited from stages two to three.

Internal consistency for the direct attitude (α=.95), perceived norm (α=.90), and perceived behavioral control (α=.83) sub-scales for this stage were very high. Behavioral intention for this stage initially did not show high internal consistency (α=.54). However, one item (i.e., *I will seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.*) correlated poorly with the other items and was deleted, leaving three items that showed high internal consistency (α=.89). Past behavior also showed high internal consistency for this stage (α=.87). The stage three survey also included all demographic items from stage two with the addition of a item that assessed ethnicity.

Procedure. This stage used the procedures from stage two. The new belief-based and direct measures were constructed in a new online Qualtrics Survey. The scoring was set for each question within the survey. Qualtrics panel services were used to recruit eligible participants for this study. Qualtrics recruited and compensated all participants. The survey was then sent out to Qualtrics participants via email. To ensure that every participant met the selection criteria, only the participants that selected "*Married*" and "*Separated*"—since separated is still considered being married—and input an age at least 18 years of age were included in the survey. All others were screened out. Similar to stage two, the survey questions were grouped by subscale and each group, except for the demographic questions, were randomized for each participant. The results were then downloaded into SPSS for statistical analyses.

Analysis. To answer research questions seven and eight, the mean of both, the past behavior and behavioral intentions sub scales will be computed. A descriptive analysis will be conducted that evaluates the mean of the past behavior and behavioral intentions scores. This

will indicate if the sample has or is intending to engage in the defined behavior. To answer research question nine, a Pearson's product-moment bivariate correlation analysis was used to examine the relationship between the direct and belief-based scales. All 238 qualifying cases were included in the Pearson's correlation and Cronbach alpha analyses. To answer research questions 10 through 12, two hierarchical multiple regression analysis with five demographic variables (i.e., age, gender, income, education, and mental health treatment history) entered into the first block of independent variables. The first model will include the direct measures (i.e., direct attitude, direct norm, and direct perceived behavioral control) into the second block of independent variables. The second model will include the belief-based predictor variables (i.e., behavioral, normative, and control beliefs) instead of the direct measures entered into the second block of independent variables. Behavioral intention will included as the dependent variable in both models. 'Race' will not be included in the data analysis as the sample is significantly skewed with the overwhelming majority being White Non-Hispanic (n = 200). To answer research question 13, a Pearson's product-moment bivariate correlation was used to examine the relationship between the specific behavioral beliefs and behavioral intentions as outlined by Fishbein and Ajzen (2010). All 238 cases were included in the Pearson's correlational analysis.

Qualitative Findings

Stage One

To address the overall qualitative research question, "*What beliefs do married participants associate with seeking professional help from an MFT during times of relationship distress?"*, three-eight participant focus groups were conducted elicit the salient behavioral, normative, and control beliefs associated with seeking professional help from a MFT for them and their spouse during times of relationship distress. Indeed, the discussions in the focus groups identified several key behavioral, normative, and control beliefs that were associated with seeking professional help from a MFT. The beliefs are presented under the area of the theoretical domain of Fisbein and Ajzen's (2010) theory of planned behavior (i.e., behavioral, normative, and control beliefs).

Relationship distress. To answer the first research question, "*How would married participants qualitatively define 'relationship distress' using their own language?",* the researcher asked the focus group participants questions designed to generate a definition of 'relationship distress'. The respondents' descriptions were consistent but draw from a variety of experiences. Many respondents cited the negative emotions that often arise out of spousal conflict such as "sadness", "tense", "lonely", "crying", "complacency" and "stressed out" while others cited the interactional aspects such as "arguing", "lack of communication", "stalemate", "can't agree" and "considering divorce". Thus, the researcher, using these descriptors, defined relationship distress as *periods of intense conflict, arguing, and fighting between you and your spouse marked by high stress and, possibly, leading to separation and/or divorce*. This definition was used in stages two and three.

Theme one: behavioral beliefs. The first theme is associated with the cluster of behavioral beliefs, or beliefs of specific outcomes associated with seeking professional help from

a MFT. This cluster of beliefs—categories of respondents' rich statements—that answered the second research question, "*What are married participants' salient behavioral, normative, and control beliefs towards seeking professional help from an MFT during times of relationship distress?",* represents perceived consequences of MFT help-seeking and is designed to qualitatively reflect the first construct—attitude—of Fishbein and Ajzen's (2010) theory of planned behavior. These beliefs—presented in Table 1—are briefly discussed and explored using data excerpts from the respondents.

Table 1

Inductively Developed Behavioral Beliefs

Belief
Help us obtain a neutral, professional opinion
Lead to me/us experiencing social stigma (e.g., shameful feelings, feeling judged, disapproval from others, etc.)
Lead to a better understanding of the problem we are experiencing
Mean that we (my spouse and I) can't solve our own problems without seeking professional help
Make things worse between my spouse and me
Mean that our problems are more serious than I/we originally thought
Therapy may not work or be unproductive
Make me/us feel uncomfortable
Result in us staying together
Help us learn new relationship strategies and skills
Result in me and/or my spouse receiving a diagnosis and/or medication
Solve our problems

Help us obtain a neutral, professional opinion was a belief that was consistently discussed by the participants in all three focus groups. This belief referred to a couple's limited ability to solve their problems when in conflict and/or disagreement as well as the importance of neutrality in providing solutions. While often described as "objective" and a "non-biased perspective", respondents highlighted the importance of this opinion being from a professional. This was reflected in the group construction of how a neutral, professional opinion would be helpful for couples in relationship distress. One respondent highlighted how a neutral party can be used to create a truce in couple conflict: "If you [we] don't agree, let's agree to listen to this guy." Another woman spoke of how a therapist, as providing a neutral, professional opinion could aid troubled couples:

> Because [the therapist] has an impartial perspective and when it's just the two of you together you are kind of locked into your own point of view and you might not be hearing each other but having someone else who's outside the situation can help you I guess kind of reach of compromise or see where the other person's point of view is valid and how you need to listen to that.

Lead to me/us experiencing social stigma (e.g., shameful feelings, feeling judged, disapproval from others, etc.) was consistently discussed throughout all three focus groups and the discussion highlighted how stigma exists on multiple levels. One respondent discussed how even the therapist's marriage quality can be stigmatized:

> No matter the case, the awkwardness that I was describing is that I think everyone in the room feels judged and that's the problem sometimes. The marriage counselor, if they are married, happily married, then they're perceived as then you have no problem with your marriage.

Respondents also discussed how shameful it can make them feel to reach out for professional help for problems they perceived that they should be able to solve without help. One respondent highlighted how seeking professional help would challenge her sense of self:

> The feeling of shame because you cannot overcome it by yourself and for me personally, I'm extroverted and I'm a very strong person. To ask help, it's really-especially ask advice from somebody in my marriage, where you not its-it will hurt my ego.

Lead to a better understanding of the problem we are experiencing was another belief reported in all focus groups. Participants consistently referred to couples not understanding one another's conceptualization of the problem they were facing. This lack of understanding was constructed as a major barrier to acknowledging the need for professional help. On respondent discussed how a lack of understanding can cause more problems for couples in her statement,

> ...just getting both people on the same side as to whether it's beneficial, like I think it's common that the husband doesn't think they need it, or they don't agree in it, don't believe in it or whatever, and the wife wants to and so that causes more friction...

Mean that we (my spouse and I) can't solve our own problems without seeking professional help was also discussed by the participants. This often took the form "We can solve our own problems without therapy" in the group discussions. As one respondent stated, "Between couple, I think they should keep their problems more [to themselves]-unless it's really a serious problem that you cannot forgive it-something really big..." When these participants did refer to therapy, they often discussed it in terms of major issues and problems as highlighted this respondent:

> … I look at more of it like a last resort, like oh if they are going to therapy they must be having some major problems. Somebody must have cheated or something major has happened and I think in our own relationship with my husband and I, we probably, there probably have been times we would have benefited just like a communication issue. So I hear all that and understand all that, but I picture it more like something really bad has happened and you know maybe we're thinking about divorce or something.

Make things worse between my spouse and me was another topic that was discussed in the focus groups. The participants voiced concerns that seeking professional help could increase the conflict or make things worse between them and their spouse. The participants described that

even discussing the possibility of seeking professional help could cause conflict. As one respondent put it,

> You can actually add more fuel to the fire in case you don't tell your spouse before meeting a counselor, I mean if…she would be like, my wife would be like, 'Why the hell do you want to see a counselor?

Another respondent described that bringing another person into the couples' business can create more problems:

> Whenever you involve a third party, it's not good for marriage. I mean, strangers, or even family like your mom or his mom, when they get into a problem, the problem gets enlarged. But when you are only keeping problems together, it will somehow, it will be figured out.

Mean that our problems are more serious than I/we originally thought is another issue that participants voiced. Many participants commented on not really understanding how serious and deep the problem existed between them and their spouse until either they discussed seeking professional help or actually sought professional help. One respondent recounted his experience of finding out how deep these issues were when he sought professional help during his first marriage:

> I'm on my second marriage, my first marriage we actually went through marriage counseling and what happened with ours is, um, obviously went to seek treatment and similar to what ___ said, there was issues that I was unaware of that didn't come up until we went to marriage counseling and that was what really got us into the divorce. I went to seek treatment thinking it was going to resolve, at least I did, and then we went to, you know...and was just kind of like "whoa!?", I wasn't expecting that and I left with a negative attitude about the whole thing.

Other participants highlighted that seeking professional help may not only negatively impact the relationship but also cause them significant distress. One respondent discussed how seeking professional help affected her sister,

> I have not gone to counseling for myself yet but my sister recently did go through divorce and then when, she was in an abusive marriage so it was a little bit different, but when

> she had started going to counseling, she had been fine and then when she started going to counseling and talking through everything, she actually started having nightmares.

Therapy may not work or be unproductive was another topic that many participants discussed but in different ways. For instance, one respondent highlighted how one spouse could take a stance that would jeopardize the treatment process, "I think if one of the spouses thought they were smarter and knew better than any therapist, it [the therapy] would not be productive." Other participants discussed how therapy outcomes could be reflective if the couple should stay together or not. This was highlighted by one respondent who stated, “You go there, because I guess you're hoping to solve a problem, you might learn that, maybe it's-for the two of you-it's not solvable. Maybe you realize that this is the end...you know?” While this was discussed in multiple ways, the participants framed this as a fear of MFT help-seeking.

Make me/us feel uncomfortable was a significant concern that participants discussed. Many participants discussed how the topics that would arise in therapy could make them feel uncomfortable with the process as reflected by one respondent’s statement,

> Another aspect is if you go in and you're uncomfortable talking about certain topics that may be sensitive or that you think is private like sex or sexuality, or maybe money or something like that. And you have to discuss it with basically a stranger. I think you're going to feel awkward or perhaps judged.

Other participants discussed the discomfort with reliving embarrassing and painful memories and experiences during the therapy. These experiences were discussed in both negative and positive terms with the possibility of resolving and/or processing negative emotions as positive but the challenge of facing those experiences with a therapist as negative. One respondent discussed her recent experience with counseling and processing her husband’s infidelity with the therapist,

> ...reliving like uh, a hard circumstances, like something, like uh, infidelity, um that's something people probably seek counseling on if they're trying to work on their marriage. Well obviously, the person that it happened to, that's going to be...I mean, I'll- it's

> happening to me right now...so I know that every time I go it's good because I get to talk about it but it's hard at the same time...It's kind of bittersweet.

Result in us staying together was another belief that participants discussed in a variety of ways throughout all the focus groups. Some participants discussed the need to stay together for children. This was reflected in one respondent's statement of "In some situations, maybe they just want to stay together for the kids...but you're still being committed to each other there." Other participants discussed how seeking professional help shows that each person has a deep desire to stay together with each other in her statement,

> If the couple were intending to go for therapy, this is a positive thing that they want their life together to continue, because if one of them decided that they don't want to continue anymore, the therapy would do nothing. So that's something positive, they have the intention that they want to solve the problem so they have the intention that they want to keep being together.

Although the reasons the focus group participants listed for staying together varied, the concept of staying together was present throughout multiple responses as a preferred therapeutic outcome.

Help us learn new relationship strategies and skills was a concept that participants discussed reflecting the need for couples to learn new ways of handling issues between one another. One respondent stated that "learning new strategies for dealing with stuff" would be an advantage of MFT help-seeking. New strategies and skills were also referred to by participants as viewing others and issues in a different way. One respondent discussed how professional help can help people reduce their reactivity to issues and aid in their ability to see those issues from another point of view, "Instead of letting their tempter take control of them, start thinking about options; different ways of looking at certain perspectives on things." Other participants discussed how therapy could teach communication skills as reflected in this respondent's statement, "…a lot of people don't know how to talk to each other...you go to some kind of counseling or therapy, one of the things they teach you to do is basically learn how to talk to each other."

Result in me and/or my spouse receiving a diagnosis and/or medication often referred to the fear of being diagnosed and having to take medication. However, some participants discussed being diagnosed as more of a nascence rather than a fear. One respondent referred to being diagnosed as an unwanted necessity for insurance coverage in his statement,

> ...If we didn't want to pay out of pocket, in a lot of cases, in order to get your insurance to pay for it you have to be diagnosed with some kind of life transition disorder or something like that. So you then carry on this transitional delay or whatever and the stigma associated with that. Well we can go get diagnosed with something we don't agree with or go pay exorbitant amount out of pocket.

Other participants discussed the fear of the medication process and how it can take time to find the right medication for their issue. One respondent captured this in her statement,

> If you've got a tumor, you cut it out. That's different than taking something for a chemical imbalance where it's like you may have to try several different kinds of medication to find the right one because they all work in different ways and things could get worse before they get better. I mean there is medication out there for depression that actually causes people to kill themselves you know that's a scary thing to have to consider.

While the statements towards receiving a diagnosis and medication were mixed, the category reflects this outcome in a neutral way.

Solve our problems referred to a preferred outcome for MFT help-seeking with many participants wanting to fix a problem between them and their spouse. This was often discussed in terms of couples communication issues and problems where spouses do not agree. One respondent discussed this concept in her statement,

> I think mine is along the same lines as ____ because I think just needing the tools to know how to get to where you're wanting to go. Like my husband and I, we are really good communicators and we agree on which areas are weak parts of our marriage but we don't necessarily know how to fix them or like where to go from there. So I think going to counseling would be good to have an outsider's view on if it's really a problem or if it's just us thinking it is and how do we fix it.

Theme two: normative beliefs.

This is a cluster of beliefs—categories of respondents' rich statements—that represent normative beliefs, or specific individuals and/or groups that would either support or disapprove of seeking professional help from a MFT. These beliefs represent both injunctive norms—specific groups or individuals' perceptions of seeking professional help from a MFT—and descriptive norms—perceptions of others' professional help seeking from a MFT aspects of normative pressure—and are presented in Table 2.

While some of these beliefs were constructed through group discussion, most were taken directly from participant quotes. For instance, many participants stated "my mom" or "my dad" as individuals who assert significant social pressure concerning whether they should or shouldn't seek professional help from a MFT. Both of these responses were combined under the theme of "parents." As this process occurred several times for very similar response (i.e., siblings, friends, etc.) only the groups that were co-constructed during group discussion and require additional explanation will be discussed (i.e., Religious people, members from my own culture, and media).

Religious people (church goers, priests, pastors, etc.) were consistently discussed by the focus group participants. While often stated as "religious people" or "clergy", some statements referred to specific religious people such as priests or pastors. One respondent stated "If you are going to church and you're a religious person, the first person whom you would think like a therapist would be your pastor" highlighting that for religious people, often a religious figure, such as a pastor, would be the first person that they would see for any issue they were experiencing. Religious people were referred to both as a positive and negative influence on seeking professional help. One respondent stated "Religious groups, a lot of religions would frown upon [seeking therapy]" while a respondent from a different focus group stated the

Table 2

Inductively Developed Normative Beliefs

Belief
*Religious people (church goers, priests, pastors, etc.)
*My parents (mom, dad, step-parents, etc.)
*Your friends
*Members from my own culture (race, ethnicity, nationality, religion, etc.)
Your spouse
*My siblings (brothers, sisters, step-siblings, etc.)
*Younger people
*Older people
Media (such as the internet, magazines, TV, yellow pages, etc.)
*Well educated people
*Poorly educated people
*People/Couples who have received therapy in the past
*Wealthy people
*Poor people

** denotes beliefs that were elicited for both injunctive and descriptive norms*

opposite, "From my religion, they would be more likely to go to family counseling." Thus, religious people encompassed a wide range of individuals that were associated with religion.

Members from my own culture (race, ethnicity, nationality, religion, etc.) referred to multiple responses from participants that consistently described groups of people that defined themselves using specific criteria. Many respondents referred to members of a specific race (e.g.,

"Asian" and "Chinese") and nationality (e.g., "American") as highlighted by this respondent form East Asian,

> In my society, if something might go wrong, we just solve the problem by ourselves, and when I take a road side perspective, somehow I thought that, I might be wrong but, and I'm not trying to be a racist, but here like Chinese, or East Asian, I don't have data, but India, and Japanese, some of my colleagues. Well, family business is not public, it'sfamily. And somehow in Western society, I think they are more open-minded, so they seek out help to get another perspective. So we have a very different culture and perspective...Based on my knowledge, I don't hear often in my society people seek help for family therapy.

However, other participants, with their comments, highlighted that the term 'culture' varies. One respondent, in response to another who was discussing religion, highlighted that the discussion appears to refer to culture instead of religion by his statement,

> I'm not quite sure about the word 'religious'. Because for myself, as a Muslim and in my country, I think it is not related to religion even if the religion is giving steps like going to family [first], it is not saying don't seek help from specialized people that are qualified to help you. But it is cultural issue that people feel it is not ok for them to seek this kind of service. So I don't think it is a religious issue but it is a cultural thing.

This statement suggested that while many individuals incorrectly attribute a person's intentions to seek treatment to their religion instead of their culture. However, many respondents often referred to the impact that their culture has on their belief of seeking professional help. One Russian woman stated,

> I'm from Russia, and for me, I mean, I'm an Orthodox. From an Orthodox perspective it's not very popular. For example, my family, my parents, they don't actually care, but they don't believe in that. But it's a little bit different here in the USA.

Another respondent, a man from India, agreed with her in his statement.

> I actually quite agree with what she said. I'm from India and a huge part of any marital discord or distress is actually seeking help from family and older, wiser people who have gone through that. So it's much more of a thing here that people be like, 'Oh you should go meet a therapist.' but that's not really, it's kind of catching up now, but that's not really a thing back in India.

Thus, qualifiers were added to this belief to encompass a variety of definitions that respected the wide range of responses obtained from the focus group participants.

Media (such as the internet, magazines, TV, yellow pages, etc.) were another group that the participants consistently discussed and referred to when looking for information concerning therapy. Many participants discussed how media often portray therapists as being too rigid and professional, creating an image of someone who cannot connect to their clients. One respondent stated during a discussion about professionalism that the "…movie portrayed therapist is always the one hiding behind their clip-board saying 'I see'." Others commented on how they search the internet to see what other people think about certain therapists. One respondent commented on how she turns to popular publications for information,

> As far as people I would talk to, I think I might read literature about it, say written by an authority, like a psychologist, I might read *Psychology Today* just about the issues we are having and see what they recommend.

Other participants discussed turning to advertisements or the *Yellow Pages* to obtain information on finding a therapist. While the responses could be viewed as stating several different ways of relying on media, all the responses captured the participants turning to media for answers and reflect media as a specific source of information regarding therapy.

Theme three: control beliefs.

This is a cluster of control beliefs associated with one's perceived capability to seek professional help from a MFT and are presented in Table 3. While some of these beliefs were constructed through group discussion, most were taken directly from participant quotes. For instance, many participants stated concepts such as financial cost, insurance help, location of therapy, and spousal agreement. Thus, only the beliefs that were co-constructed during group

Table 3

Inductively Developed Control Beliefs

Belief
Therapist's competency level (such as the ability to understand you, your spouse, and your culture; success rates; effectiveness; etc.)
My spouse agreeing to seek professional help
Financial cost of therapy
Therapist’s personal background (such as his/her personality, gender, marital status, age, etc.)
Having a good fit between us (my spouse and I) and the therapist
Knowledge about therapy
The location of the therapist’s office
The therapist’s credentials (such as educational background, licenses, etc.)
The therapist’s reputation
The therapy being confidential
Time commitment
Insurance coverage (part or all of treatment)

discussion will be discussed (i.e., therapist’s competency level, therapist’s personal background, and having a good fit between us—my spouse and me—and the therapist).

Therapist’s competency level (such as the ability to understand you, your spouse, and your culture; success rates; effectiveness; etc.) was an important factor for the focus group participants. While this may not appear to fall under the umbrella of perceived behavior control, the focus group participants discussed how important the therapist’s competency as a factor to their decision in seeking professional help for them and their spouse during relationship distress. For instance, one respondent captured how important it is to her that a therapist understands her

culture, “If I go to a therapist, I would go to someone who would understand my culture. I wouldn't go to someone who wouldn't because it would be useless.”

Another respondent discussed how the therapist’s competency would affect their decision to seek professional help,

> I think maybe the competency of the person who was doing the therapy. If you think they're incompetent or inadequate then you're not going to think that you are going to benefit very much and might prevent you from going.

Other participants stated the importance of the therapist being able to understand them and the problem that they are experiencing. During a discussion, two respondents, in essence, describe how a professional stance can be perceived as rigid,

> First respondent: The counselor shouldn't be very professional...Ok, you know that it's your profession, but your attitude should not be professional with the person you are trying to heal, you shouldn't be so professional.
>
> Second respondent: Not too formal..
>
> First respondent: Yeah, not formal. Be more friendly.

Other participants discussed how therapists can often be careless and offer advice that would result in the couple divorcing or the breakup of a family. One respondent stated, “A bad therapist, or maybe not clever enough, maybe, like a source of troubles. Maybe increase the troubles by his bad advices, or careless advices.” Thus, this belief was qualified to further explain possible characteristics of the therapist’s competency level. Although distantly related to one’s personal power in choosing to seek professional help, it represents significant concerns of the focus group participants and characterizes an important aspect in MFT help-seeking.

Therapist’s personal background (such as his/her personality, gender, marital status, age, etc.) refers to the personal aspects of the therapist that the focus group participants voiced interest in. Participants consistently discussed the age, gender, and marital status of the therapist as being factors that would affect their decision to engage in MFT help-seeking. One respondent

discussed how the therapist should be “a patient listener” while in another focus group, two respondents were discussing the role gender plays in therapy,

> Fist respondent: Finding a therapist that you're both comfortable with. Where, as a guy, you don't feel—the majority, I don't know the statistics, but the majority of family counselors have been female that I've been exposed too—so it's kind of you know...
>
> Second respondent: Kinda feel ganged up on?
>
> First respondent: Yeah. But it's a challenge...because then you have two women..[inaudible, everyone laughing]

Many participants discussed how the marital status of the therapist could impact their decision to seek professional help. One respondent discussed how a MFT may not understand the same level of conflict that a husband and wife may go through if they themselves are not married,

> Specifically for marriage and family counselors, one of the setbacks is that they—sometimes people don't feel that they don't understand their issues if they're not married. Even if their training as a marriage and family counselor or something like that, even though they've been trained in that field, some people don't give them respect or credence or whatever if they're not actually married they don't think they've been in the same situations or know how to deal with the same conflicts and stuff like that.

Many participants discussed how important these personal factors were to MFT help-seeking and, therefore, this category was best defined with qualifiers to exemplify the multitude of aspects discussed by the participants.

Having a good fit between us (my spouse and me) and the therapist refers to the nature of the connection between the couple and the therapist. Many focus group participants discussed this in terms of a therapist over-identifying with one spouse and not connecting with the other. One respondent highlighted the need for a good fit in his statement,

> You want an unbiased professional, you don't want someone who is going to always side with the husband, or side with the wife because she's a victim. You want someone who’s going to see things objectively and fairly so you can figure out where the problem is.

While this may seem similar to the earlier belief of *a neutral, professional opinion*, the respondent discussed this in terms of over-identifying with one spouse over the other which, as

other participants discussed, can lead to feeling ‘ganged up on’. Another respondent discussed the nature of a therapist-couple fit in terms of jealousy with her statement, “I wouldn't go in for therapy with a therapist who is a woman who I feel jealous of.” In this dialogue, the respondent framed this discussion in terms of couple’s therapy with another woman who may be in a better life situation in front of her husband. This was important enough in one focus group that it lead to the discussion of using two therapists, one for each spouse, to solve marital problems. Another respondent framed this discussion in terms of how therapists approach problems, “The counselor shouldn't be method driven, like you have this disease this method will solve this problem. You're categorizing your people into this method, this method, and this method. Every individual is different and it's a mental problem...”

Quantitative Results

Stage Two

Reliability and convergent validity of direct and belief-based measures. To test hypothesis one, *all subscales in the direct measure will show strong internal consistency,* a reliability analysis was conducted to assess the internal consistency of each direct measure. The Cronbach alpha for each subscale is presented in Table 5. To test hypothesis two, *based upon Fishbein and Ajzen's (2010) theory of planned behavior, there will be a significant positive correlation between the belief-based measures and the direct measures of the theory of planned behavior's constructs*, a Pearson's product-moment correlation was run to assess the relationship between the direct and belief-based measures of attitude, perceived norm, and perceived behavioral control. There was a strong positive correlation between the direct and belief-based measures of attitude, $r = .67$, $p < .001$, and perceived norms, $r = .50$, $p < .001$. There was a moderate positive correlation between the direct and belief-based measures of perceived behavioral control, $r = .39$, $p < .001$. These results represent convergent validity between the direct and belief-based scales and indicate we accept hypotheses one and two.

Multiple regression with stage two direct measures. To test hypotheses three, *the direct measures will predict participants' behavioral intentions in stage two*, a multiple linear regression was employed to determine if the direct measures could significantly predict participants' intentions to seek professional help from a MFT during times of relationship distress. The descriptive statistics and correlations of all included continuous variables are presented in Table 4. There was an independence of residuals, as assessed by the Durbin-Watson statistic of 2.25. An examination of the correlations revealed that no independent variables were highly correlated with the exception of direct attitude and direct norm. However, as the

collinearity statistics (i.e. Tolerance and VIF) were within acceptable limits, the assumption of multicollinearity was not violated (Field, 2013). One multivariate outlier was found using Mahalanobis' distance (11.40). This outlier exceeded the critical value (11.34) and was excluded from the analysis leaving 101 cases.

Table 4

Descriptive Statistics, Reliability, and Correlations for All Continuous Variables included in the Stage Two Multiple Regression Model of Direct Measures

Variables	DA	DN	DC	BI
Direct Attitude (DA)	1			
Direct Norm (DN)	.53*	1		
Direct Control (DC)	.45*	.45*	1	
Behavioral Intention (BI)	.57*	.77*	.52*	1
Means	5.06	4.06	4.70	4.13
Standard Deviations	1.07	1.39	1.32	1.74
Range	2 to 7	1 to 7	1 to 7	1 to 7
Possible Range	1 to 7	1 to 7	1 to 7	1 to 7
Cronbach's Alpha	.91	.91	.88	.89
No. of items	6	7	6	4

Note. $N = 101$. $*p < .001$.

Residual and scatter plots indicated that the assumptions of normality, linearity, homoscedasticity were all satisfied (Field, 2013). For this model, these variables statistically significantly predicted participants' behavioral intentions ($R^2 = .64$, $F(3,97) = 58.10$, $p < .001$, adjusted $R^2 = .63$). In this model, direct norm ($\beta = .39$) was the strongest predictor followed by direct attitude ($\beta = .18$) and direct control ($\beta = .17$). Each of these predictors has a positive relationship with behavioral intention. Thus, the greater ones direct norm, attitude, and control,

the higher one's intentions to seek professional help from a MFT. Regression coefficients and standard errors can be found in Table 5. The results suggest we accept hypothesis three.

Table 5

Multiple Regression Model of Stage Two Direct Measures

	B	*SE*	*β*	*t*
Intercept	-1.41	.53	-	-2.65
Direct Attitude	.29	.13	.18*	2.31
Direct Norm	.74	.10	.59**	7.76
Direct Control	.23	.09	.17*	2.42

Note. $N = 101$. *$p < .05$; **$p < .01$.

Multiple regression with stage two belief-based measures. To test hypothesis four, *the belief-based measures will predict participants' behavioral intentions in stage two*, a multiple linear regression was employed to determine if the belief-based measures could significantly predict participants' intentions to seek professional help from a MFT during times of relationship distress. The descriptive statistics and correlations of all included continuous variables are presented in Table 6. There was an independence of residuals, as assessed by the Durbin-Watson statistic of 2.23. Three extreme multivariate outliers were found using Mahalanobis' distance (12.14 – 22.92) that exceeded the critical value (11.34) and were excluded from the analysis leaving 99 cases in the analysis. The assumptions of linearity, independence of errors, homoscedasticity, multicollinarity were met. For this model, two out of the three variables statistically significantly predicted participants' behavioral intentions ($R^2 = .28$, $F(3,95) = 12.29$, $p < .001$., adjusted $R^2 = .26$). In this model, belief-based norm ($\beta = .39$) was the strongest predictor followed by belief based attitude ($\beta = .20$). The predictor variables have a positive relationship with behavioral intention indicating that the more positive behavioral and normative

beliefs one has towards seeking professional help from an MFT, the higher their intentions to engage in the behavior. Regression coefficients and standard errors can be found in Table 7. The results suggest we accept hypothesis four.

Table 6

Descriptive Statistics, Reliability, and Correlations for All Continuous Variables included in the Stage Two Multiple Regression Model of Belief-based measures

Variables	IA	IN	IC	BI
Belief-based Attitude (IA)	1			
Belief-based Norm (IN)	.47*	1		
Belief-based Control (IC)	.57*	.33*	1	
Behavioral Intention (BI)	.40*	.49*	.18*	1
Means	3.67	1.84	7.66	4.11
Standard Deviations	3.41	3.49	4.42	1.70
Range	-4.83 to 11.92	-5.15 to 10.83	-3.85 to 17.77	1 to 7
Possible Range	-21 to 21	-21 to 21	-21 to 21	1 to 7
No. of items	12	26	13	4

Note. $N = 99$. *$p < .001$. Means and standard deviations for belief-based measures were averaged.

Table 7

Multiple Regression Model of Stage Two Belief-based measures

	B	*SE*	*β*	*t*
Intercept	3.56	.30	-	12.00
Belief-based Attitude	.14	.06	.20*	2.39
Belief-based Norm	.19	.05	.39**	3.99
Belief-based Control	-.040	.041	-.10	-.97

Note. $N = 99$. *$p < .05$. **$p < .01$.

Stage Three

Past behavior and intention to engage in professional help-seeking from a MFT. To test hypothesis five*, the participants will have not sought professional help from an MFT for them and their spouse during times of relationship distress in the past*, and hypothesis six, *the participants do not intend to seek professional help from an MFT for them and their spouse during times of relationship distress,* the computed scores of past behavior and behavioral intention were examined using descriptive statistics. For past behavior, the participants were likely to have not sought professional help from a MFT for them and their spouse during times of relationship distress ($M = 2.33$, $SD = 1.78$). These results indicate that we accept hypothesis five and that the prevalence of the behavior in the study sample is low. For behavioral intentions, the participants were neutral in their intentions to seek professional help form a MFT for them and their spouse during times of relationship distress ($M = 3.70$, $SD = 1.77$). These results indicate that we reject hypothesis six and that participants possess neutral behavioral intentions.

Stage three convergent validity. To test hypothesis seven, *Based upon Fishbein and Ajzen's (2010) theory of planned behavior, there will be a significant positive correlation between the stage three belief-based measures and the direct measures of the theory of planned behavior's constructs,* a Pearson's product-moment correlation was run to assess the relationship between the belief-based and direct measures in stage three. The direct and belief-based measures of attitude were found to be strongly correlated with each other, $r = .77$, $p < .001$, as well as the direct and belief-based measures of perceived norms, $r = .51$, $p < .001$. The direct and belief-based measures of perceived behavioral control showed a significant moderate relationship, $r = .33$, $p < .001$. These results represent convergent validity between the direct and belief-based scales and indicate that we accept hypothesis seven.

Hierarchical multiple regression with stage three direct measures. To test hypothesis eight, *the direct measures will predict participants' behavioral intentions when controlling for demographic variables in stage three*, a two stage hierarchical multiple regression was employed to investigate the ability of the direct measures to predict behavioral intentions after controlling for demographic variables (i.e., age, gender, income, education, and mental health treatment history). Preliminary analyses were conducted to ensure that no assumptions were violated. The descriptive statistics and correlations of the primary independent and dependent variables for this analysis are presented in Table 8.

Table 8

Descriptive Statistics, Reliability, and Correlations for Primary Variables included in the Stage Three Hierarchical Multiple Regression Model of Direct Measures

Variables	DA	DN	DC	BI
Direct Attitude (DA)	1			
Direct Norm (DN)	.45*	1		
Direct Control (DC)	.46*	.37*	1	
Behavioral Intention (BI)	.61*	.63*	.41*	1
Means	4.87	3.98	4.59	3.70
Standard Deviations	1.33	1.34	1.01	1.77
Range	1 to 7	1 to 7	1 to 6.5	1 to 7
Possible Range	1 to 7	1 to 7	1 to 7	1 to 7
Cronbach's Alpha	.95	.90	.83	.89
No. of items	7	6	6	3

Note. $N = 237$. *$p < .001$.

There was an independence of residuals, as assessed by the Durbin-Watson statistic of 2.16. An examination of the correlations revealed that direct attitude and direct norm as well as

direct attitude and direct control were moderately correlated. However, as the collinearity statistics (i.e. Tolerance and VIF) were within acceptable limits, the assumption of multicollinearity was not violated (Field, 2013). One multivariate outlier was found using Mahalanobis' distance (15.64). This outlier exceeded the critical value (15.51; Field, 2013) and was excluded from the analysis leaving 237 cases.

In the first model of the hierarchical multiple regression, five predictors were entered: age, gender, income, education, and mental health treatment history. This model was statistically significant $F(5,231) = 6.78$, $p < .001$ and accounted for 12.8% of the variance. After entry of the direct measure variables in model two, two out of the three variables (i.e., direct attitude and direct norm) were significant predictors of behavioral intentions and explained an additional 42.7% of the variance and this change in the R^2 was significant, $F(8,228) = 35.58$, $p < .001$. In the fina model, both direct attitude ($\beta = .38$) and direct norm ($\beta = .38$) were the strongest predictors and have a positive relationship with behavioral intention. Thus, as the other variables remain constant, the more positive ones attitude and perceived social pressure towards seeking professional help from a MFT, the higher their intention to engage in that behavior. Age was also a significant predictor ($\beta = -.14$) but has a negative relationship with behavior intention. Thus, as the other variables remain constant, the older one is, the less they intend to seek professional help from a MFT. Regression coefficients and standard errors for the full hierarchical model can be found in Table 9. The results suggest we accept hypothesis eight.

Hierarchical multiple regression with stage three belief-based measures. To test hypothesis nine, *the belief-based measures will predict participants' behavioral intentions when controlling for demographic variables in stage three,* and hypothesis ten, *based upon Fishbein and Ajzen's (2010) theory of planned behavior, attitude towards the*

Table 9

Hierarchical Multiple Regression Model of Stage Three Direct Measures

	R	***R²***	***ΔR²***	***B***	***SE***	***β***	***t***
Stage One	.36	.13***					
Gender				.12	.23	.03	.51
Age				-.03	.01	-.2**	-3.2
Income				.07	.04	.12	1.63
Mental Health Treatment History				.79	.26	.19**	3.10
Education				.08	.06	.10	1.34
Stage Two	.75	.56***	.43***				
Gender				-.07	.17	-.02	-.41
Age				-.02	.01	-.14**	-3.11
Income				-.004	.03	-.01	-.13
Mental Health Treatment History				.19	.19	.05	1.007
Education				.04	.04	.05	.93
Direct Attitude				.50	.07	.38***	7.05
Direct Norm				.50	.07	.38***	7.21
Direct Control				.15	.09	.09	1.77

Note. $N = 237$. *$p < .05$. **$p < .01$. ***$p < .001$.

behavior will be most efficient in predicting participants' behavioral intention in stage three, a two stage hierarchical multiple regression was employed to investigate the ability of the direct measures to predict behavioral intentions after controlling for demographic variables (i.e., age, gender, income, education, and mental health treatment history). Preliminary analyses were

conducted to ensure that no assumptions were violated. The descriptive statistics and correlations of the primary independent and dependent variables for this analysis are presented in Table 10.

Table 10

Descriptive Statistics, Reliability, and Correlations for Primary Variables included in the Stage Three Hierarchical Multiple Regression Model of Belief-based measures

Variables	IA	IN	IC	BI
Belief-based Attitude (DA)	1			
Belief-based Norm (DN)	.55*	1		
Belief-based Control (DC)	.42*	.26*	1	
Behavioral Intention (BI)	.59*	.49*	.27*	1
Means	2.48	1.20	7.63	3.69
Standard Deviations	3.68	3.53	6.12	1.75
Range	-9.33 to 11.17	-8.38 to 12.31	-12.46 to 21	1 to 7
Possible Range	-21 to 21	-21 to 21	-21 to 21	1 to 7
No. of items	12	24	13	3

Note. $N = 234$. *$p < .001$.

There was an independence of residuals, as assessed by the Durbin-Watson statistic of 1.80. An examination of the correlations revealed that belief-based attitude and belief-based norm were strongly correlated. However, as the collinearity statistics (i.e. Tolerance and VIF) were within acceptable limits, the assumption of multicollinearity was not violated (Field, 2013). Four extreme multivariate outliers were found using Mahalanobis' distance (16.24 to 24.73). These outliers exceeded the critical value (15.51; Field, 2013) and were excluded from the analysis leaving 234 cases.

In the first model of the hierarchical multiple regression, five predictors were entered: age, gender, income, education, and mental health treatment history. This model was statistically significant $F(5,226) = 5.49$, $p < .001$ and accounted for 10.8% of the variance. After entry of the belief-based measure variables in model two, two out of the three variables (i.e., belief-based attitude and belief-based norm) were significant predictors of behavioral intentions and explained an additional 44.2% of the variance and this change in the R^2 was significant, $F(8,223) = 22.12$, $p < .001$. Belief-based attitude ($\beta = .43$) was the strongest predictor followed by belief-based norm ($\beta = .22$) with both variables having a positive relationship with behavioral intention. Thus, when controlling for the other variables, when one holds positive behavioral and normative beliefs towards seeking professional help from a MFT, the higher their intention to engage in that behavior. Age ($\beta = -.18$) was also a significant predictor but had a negative relationship with behavioral intention. Thus, controlling for the other variables, the older one is, the less their intentions to seek professional help from a MFT. Regression coefficients and standard errors for the full hierarchical model can be found in Table 11. The results suggest we accept hypotheses nine and ten.

Strongest contributing behavioral belief. To answer research question 13, *"Which qualitative beliefs of the largest contributing belief-based predictor (i.e., behavioral, normative, and control beliefs) show a strong correlation ($|r| \geq .5$; Cohen, 1988) with behavioral intentions in the stage three quantitative measure?",* a Pearson's product-moment correlation was conducted to assess the relationship between the behavioral beliefs and behavioral intentions. The correlations are presented in Table 12. Two beliefs show strong significant positive correlations with behavioral intentions; *To obtain a neutral, professional opinion* ($r = .54$, $p < .001$) and *A better understanding of the problem* ($r = .52$, $p < .001$).

Table 11

Hierarchical Multiple Regression Model of Stage Three Belief-based measures

	R	R^2	ΔR^2	B	SE	β	t
Stage One	.33	.11**					
Gender				.11	.23	.03	.49
Age				-.03	.01	-.20*	-3.07
Income				.05	.04	.09	1.28
Mental Health Treatment History				.70	.26	.17*	2.70
Education				.08	.06	.11	1.48
Stage Two	.67	.44**	.33**				
Gender				.04	.19	.01	.19
Age				-.03	.01	-.18**	-3.52
Income				.01	.03	.01	.19
Mental Health Treatment History				.38	.21	.09	1.80
Education				.06	.05	.07	1.24
Belief-based Attitude				.21	.03	.43**	6.64
Belief-based Norm				.11	.03	.22**	3.53
Belief-based Control				.01	.02	.03	.52

Note. $N = 234$. *$p < .01$. **$p < .001$.

Table 12

Pearson's Product-Moment Correlation between Behavioral Beliefs and Behavioral Intention in Stage Three

Behavioral Beliefs	*Correlation with Behavioral Intention*
Therapy may make things worse	.18**
Therapy may be unproductive	.19**
Therapy will make me/us feel uncomfortable	.19**
Receive a diagnosis and/or medication	.36***
To solve the problem/issue	.46***
We will experience social stigma (shameful feelings, feeling judged, disapproval from others, etc.)	.17**
The problem is more serious than we originally thought	.13*
A better understanding of the problem	.52***
To stay together	.30***
To learn new skills and/or strategies	.48***
To obtain a neutral, professional opinion	.54***
We can't solve our problems without therapy	.25***

Note. $N = 238$. *$p < .05$. **$p < .01$. *** $p < .001$.

Discussion

Summary of findings

The summary of this study's qualitative, quantitative, and mixed methods findings will be presented according to their respective central research questions. Findings that converge and diverge from the studies previously reviewed will be discussed and grouped by hypotheses. Implications and limitations will be discussed in subsequent sections.

Qualitative research question. The findings from stage one are a response to the qualitative research question, *"What beliefs do married participants associate with seeking professional help from an MFT during times of relationship distress?"* and were largely similar to the findings from previous studies that explored beliefs associated with MFT. The behavioral beliefs *To obtain a neutral, professional opinion* and *We will experience social stigma* were the two most referenced in the first stage. These findings appear similar to Chenail et al. (2012) findings of client's positive experiences with an MFT—such as *supportive, unbiased,* and *nonjudgemental*—reflect these elicited beliefs as these therapist qualities do not characterize a stigmatizing experience in MFT. Thus, the convergence of these beliefs from the present study as well as from Chenail and colleagues indicate their importance to the MFT help-seeking process.

Some behavioral beliefs, or specific outcomes associated with professional help seeking form a MFT, such as *received a diagnosis and/or mediation,* diverged from Chenail and colleagues (2012) and are likely due to how the behavior is defined. The current study evaluates the beliefs that are important to the MFT help-seeking process while Chenail and colleagues meta-synthesis evaluated clients' experiences with a MFT. Many MFTs choose to work collaboratively with their clients using a non-medical model approach. Thus, while these beliefs

are important when 'going in' for professional help, their actual experiences with non-medical modalities may change how they view professional help from an MFT.

The normative beliefs also converged with previously reviewed studies, Codd and Cohen's (2003) found *friends, family, parents,* and *significant other* as important injunctive referents in their study. While their study was defined as seeking professional psychological services, these referents were largely the same for the current study. It would appear that when it comes to seeking professional help, these referents are important support systems that people turn to when struggling with a personal or relational issue. However, the current study does diverge in many of the referents. While Codd and Cohen evaluated injunctive norms, the current study evaluates both injunctive norms—specific groups or individuals' perceptions of seeking professional help from a MFT—and descriptive norms—perceptions of others' professional help seeking from a MFT—which capture two different aspects of normative pressure. The current study elicited referents such as *wealthy people, poor people, highly educated people, lowly educated people, religious people,* and *people who have sought therapy in the past.* All of which served as both injunctive and descriptive normative beliefs. This can capture both what others think we should do as well as what we think others are doing. Vogel et al.'s (2007b) descriptive norm findings mirror the current study's as people who seek professional help often know of others who have provided support for *people who have sought therapy in the past*.

The control beliefs—beliefs associated with one's perceived capability to seek professional help from a MFT—found in the current study also converge with previously reviewed studies. Sareen et al.'s (2007) finding of *financial cost* was found in the current study. This mirrors Mojtabai's (2005) findings that financial cost is becoming more of a structural factor in obtaining professional help. *Knowledge about therapy* also mirrors concerns originally

voiced by Jorm et al. (2006)—dubbed 'mental health literacy'—that the general public knows very little about how and where to obtain appropriate mental health services. The current study's findings of control beliefs provide additional support to some structural level beliefs. Some beliefs, such as *having a good fit between us and the therapist* and *my spouse agreeing to seek professional help* diverged from these studies suggesting that the defined behavior, referring to seeking treatment as a couple, elicits additional concerns of how one's spouse agrees or reacts to treatment. This reflects the unique character of couple's therapy and provides new knowledge of the factors that can become barriers to MFT professional help-seeking.

Quantitative research question. The results from stages two and three answered the quantitative research question, "*Do the theory of planned behavior measures (direct and belief-based) account for a significant amount of variance of married participants' behavioral intention to seek professional help from an MFT for them and their partner during times of relationship distress?*"

Reliability and validity of measures. Stages two and three tested a measure developed from the qualitative findings in stage one. As the theory of planned behavior relies on valid reliable measures, hypotheses one and two were designed to test the reliability of the direct measures and convergent validity of the newly created belief-based measure in stage two. Hypotheses seven was designed to test the convergent validity of the stage three belief-based measures. All three hypotheses were accepted and the direct and belief-based measures from stages two and three were created according to the theory of planned behavior methodology outlined by Fishbein and Ajzen's (2010) and provides additional support for the theory of planned behavior being used with professional help-seeking behaviors while providing new information regarding its application specific to MFT help-seeking.

The current study also extends previously conducted studies (Table 13) by adhering to theory of planned behavior methodology that also correlated the direct and belief-based measures to show convergent validity. Fishbein and Ajzen highly recommend this procedure as it ensures that the qualitative beliefs in the belief-based measures are valid assessments of the theoretical constructs. The current study shows this validity indicating that the qualitative beliefs can be assumed to be associated with the theory of planned behavior constructs. Indeed, the consistent reliability and significant positive correlations between the direct and belief-based measures from stage two to three suggest that the behavioral definition was adequately and consistently defined in all four areas (Action, Target, Context, and Time) consistently throughout the study. Thus, grounded in theory and previous research, the direct and belief-based measures from the current study are valid theory of planned behavior measures.

Past behavior and behavioral intentions. The current study is the only one, out of the studies reviewed, to measure past behavior (Table 13), which should be used in all theory of planned behavior research to measure previous engagement with the behavior of interest. The current study shows that participants largely have not engaged in the defined behavior indicating that an intervention would be appropriate. If the behavior is frequently occurring, there would be no reason to intervene. While there are concerns over the public's knowledge about and access to mental health treatment today (Jorm, 2000; Jorm et al., 2006), evidence suggesting that help-seeking behaviors are not occurring is needed to justify the resources required to create an intervention. Also, measures of past behavior can be used to highlight if interventions are successful as newly changed intentions will not correlate well with past behavior. Thus, we accepted hypothesis five suggesting that MFT help-seeking behaviors are appropriate to target for interventions.

The scores from behavioral intentions were more positive than originally thought with participants being neutral to slightly likely to engage in MFT professional help-seeking leading to the rejection of hypothesis six. These scores were consistent across both stages two and three and mirrored the internal consistency of scores from other studies (Table 13). Furthermore, these scores on behavioral intentions reflect a possibility of utilizing an intervention designed to increase intentions.

Predicting behavioral intentions using direct measures. The results from the stage two and three regression analyses with the direct measures as the independent variable mirror the previously reviewed studies that have utilized Fishbein and Ajzen's (2010) theory of planned behavior to examine professional help-seeking behaviors (Table 14). For both stage two and three, direct attitude and norm consistently predicted behavioral intentions. However, perceived behavioral control only predicted behavioral intention in stage two. This led to the acceptance of hypotheses three and eight concerning the direct measures' predictive ability. The results from the main stage mirror those from Skogstad et al. (2006) and Westerhof et al. (2008) with attitude contributing most to the models predictive ability.

The contribution of the direct measures differed from stages two and three with perceived norms being the biggest contributor in stage two and attitude in stage three. There could be many reasons for this change. First, the hierarchical regression in stage three controlled for demographic variables and mental health treatment history that were not controlled for in stage two. Thus, the regression model in stage three could have revealed the unique variance explained by each component. Next, the sample size in stage three was more than double the sample size in stage two. This sample increase could have provided a chance to find the significance of attitude. Third, the direct measures were edited between stages two and three with one attitude item being

Table 13.

Comparison of Direct and Belief-based measures between Previously Reviewed theory of planned behavior Studies for Mental Health Help-Seeking Behaviors and the Current Study

	Correlation of Direct and Belief-based Attitude Measures Correlation	*Direct and Belief-based Perceived Norm Measures Correlation*	*Direct and Belief-based Perceived Behavioral Control Measures Correlation*	*Cronbach Alpha for Direct Attitude Measures*	*Cronbach Alpha for Direct Perceived Norm Measures*	*Cronbach Alpha for Direct Perceived Control Measures*	*Cronbach Alpha for Behavioral Intention Measures*	*Cronbach Alpha for Past Behavior Measures*
Current Study – Stage Two (Direct *N* = 101; Belief-based *N* = 99)	**.67*** **	**.50*** **	**.39*** **	**.91**	**.91**	**.88**	**.93**	**.89**
Current Study – Stage Three (Direct *N* = 237; Belief-based *N* = 234)	**.77*** **	**.51*** **	**.33*** **	**.95**	**.90**	**.83**	**.89**	**.87**
Hyland et al. (2012; *N* = 259)	-	-	-	**.69**	**X**	**.76**	**.77**	-
Skogstad et al. (2005; 2006; Direct N = 353; Indirect N = 328)	**.42** **	**X**	**X**	**.75**	**.72**	**.64**	**.82**	-
Westerhof et al. (2008; *N*= 167)	-	-	-	.76	.66	.63	.84	-

Note. *$p < .05$. **$p < .01$. ***$p < .001$. *X* = non-reporting of the results although the measure was used. **bold** = scales that were constructed according to theory of planned behavior. - = measures were not included in the study, for correlational analyses, this indicates that belief-based measures were not used.

Table 14.

Comparison of Regression Results from Previously Reviewed theory of planned behavior Studies for Mental Health Help-Seeking Behaviors and the Current Study

	Regression Coefficients							
	Direct Attitude	*Direct Norm*	*Direct Control*	*Belief-based Attitude*	*Belief-based Norm*	*Belief-based Control*	*Direct Model Adjusted R^2*	*Belief-based Model Adjusted R^2*
Current Study – Stage Two (Direct N = 101; Belief-based N = 99)	.178*	.589**	.171*	.270*	.394**	-.103	.63	.26
Current Study – Stage Three (Direct N = 237; Belief-based N = 234)	.378***	.384***	.085	.433***	.215**	.030	**.56**	**.44**
Hyland et al. (2012; N = 259)	.18***	.29***	.50***	-	-	-	.50	-
Skogstad et al. (2005; 2006; Direct N = 353; Indirect N = 328)	.38***	.19***	.26***	.28***	.46***	.07	.44	.43
Westerhof et al. (2008; N= 167)	.226**	.023	.170*	-	-	-	.07	-

Note. *p < .05. **p < .01. ***p < .001. Numbers in bold denote hierarchical regression analyses

added and one perceived norm item being deleted. Among the direct items remaining, perceived norm and perceived behavioral control measures were edited. These changes could have increased the contribution that attitude made in the regression analysis. However, while the

direct control measures were edited, they were only significant in stage two. It is always possible, of course, for the difference to be due to randomness.

Mixed methods research question. The results from the belief-based regression analyses answer the research question, "*Are married participants' qualitative beliefs (belief-based measures) towards seeking professional help from an MFT for them and their spouse during times of relationship distress in stage one generalizable to a sample of a population of married participants in stages two and three?*"

Predicting behavioral intentions using belief-based measures. The results from the stage two and three regression analyses with the belief-based measures as independent variables mirrored Skogstad et al. (2006) findings with both belief-based attitude and norm measures predicting behavioral intentions leading us to accept hypotheses four and nine. Behavioral beliefs—belief-based attitude—were the biggest contributor in predicting behavioral intentions in stage three. These findings indicate that one's intentions to engage in MFT help-seeking behavior can be predicted by their qualitative behavioral and normative beliefs.

As with the direct measures, the contribution of the belief-based measures differed from stages two to three with belief-based norm being the largest contributor during stage two and belief-based attitude during stage three. Again, the sample size increase could have revealed the unique variance of each component, thus changing their level of contribution to the model. However, there were some changes to the belief-based measures between stages two and three with one behavioral belief item reworded to fit with the other behavioral beliefs. These changes could have better captured participants' attitude towards seeking professional help from a marriage and family therapist and increased its predictive ability for stage three. Belief-based normative beliefs were also changed which could have provided a more realistic representation

of their contribution in predicting behavioral intentions. While belief-based control was also edited, the component was not significant in predicting behavioral intentions throughout the study.

Most effective beliefs. Attitude was found to be the most efficient predictor in the stage three regression analyses leading us to accept hypothesis ten. These finding mirrors the studies reviewed as well as Fishbein and Ajzen's (2010) discussion of the theory of planned behavior components. For the current study, this indicates that attitude is the most influential construct for participants' behavioral intentions to seek professional help from a MFT. These results suggest that interventions designed to influence specific behavioral beliefs will have an effect on behavioral intentions. Of the beliefs included in the belief-based attitude measure, *to obtain a neutral, professional opinion, a better understanding of the problem*, *to learn new skills and/or strategies,* and *to solve the problem/issue* were found to moderately to strongly significantly positively correlate with behavioral intentions. An intervention that targets these beliefs should impact intentions to seek professional help from a MFT.

Furthermore, the direct and belief-based normative measures were also significant contributors in the regression models ability to predict behavioral intentions. Along with injunctive beliefs, this study included descriptive normative beliefs, which capture a different aspect of normative pressure, providing a more complete picture of how social pressure can influence their intentions to seek professional help from an MFT. As explained further shortly, these beliefs (Table 15) could also be targeted for intervention.

Implications

The rationale for this study was to develop and test a theory of planned behavior (Fishbein & Ajzen, 2010) questionnaire that included both direct and belief-based measures. The

results suggest that the theory of planned behavior holds potential for assessing qualitative beliefs, developing specific measures, and testing these measures in order to explore professional help seeking for MFT. This study, building on previous research using the theory of planned behavior on help-seeking behaviors, shows that

Table 15

Pearson's Product-Moment Correlation between Injunctive/Descriptive Normative Beliefs and Behavioral Intention in Stage Three

Normative Beliefs	*Correlation between injunctive belief and behavioral intention*	*Correlation between descriptive belief and behavioral intention*
Religious people	.27***	.17*
Friends	.39***	.33***
Spouse	.32***	-
Younger people	.31***	.20**
Older people	.33***	.20**
Media	.24***	-
Well-educated people	.43***	.35***
Poorly-educated people	.17**	.14*
People who have received therapy in the past	.43***	.37***
Wealthy people	.33***	.31***
Poor people	.27***	.14*
Members from my own culture	.35***	.36***
Parents	.47***	.43***
Siblings	.43***	.48***

Note. *$p < .05$. **$p < .01$. *** $p < .001$. – denotes belief not included as descriptive norm

attitude and perceived norm predict participants' behavioral intention to seek professional help from a MFT. Furthermore, the use of mixed methods to elicit qualitative salient beliefs, using those beliefs to develop a quantitative measure, and then testing that measure with a larger sample provides a more comprehensive view of how those beliefs influence behavior. Thus, while many of the studies involving the theory of planned behavior use Fischer and Farina (1995) ATSPPHS (Hyland et al., 2012; Mo & Mak, 2009; Skogstad et al., 2005, 2006; Vogel et al., 2005; Westerhof et al., 2008), this study uses both direct and belief-based measures which provides more insight into designing and using interventions to change, or create new, behavioral intentions.

This study expands the theory of planned behavior research by evaluating its applicability to MFT, a mental health specialty. The salient beliefs qualitatively elicited and quantitatively tested and validated are specific to a couple's context for conjoint therapy. Mental health help-seeking behaviors are often explored in a personal context with the actual behavior relying solely on the individual. MFT often includes both spouses in the treatment context. Therefore, this study explores the beliefs associated with conjoint help-seeking. This study also expands MFT research by providing empirical evidence that attitudes and perceived norms predict intentions to seek professional help from an MFT, providing a foundation in which interventions—such as marketing advertisements, brochures, web pages, etc.—could be constructed to change these intentions. These interventions can be used on a micro level—such as increasing business to a single MFT's private practice—or on a macro level—increasing public recognition and awareness to professional organizations such as the AAMFT—to create behavioral change. While using these methods on a macro level could connect troubled individuals, couples, and families to treatment options offered from their local MFTs as well as generate interest in the

general public to join the profession of MFT. While further research is needed, the results from the current study can be combined with other theories to generate theoretically based interventions to effectively change behavioral intentions.

Enhancing the understanding of stigma. This study could enhance the manner in which stigma is understood and evaluated as it is consistently associated with people who do not seek professional help for psychological or interpersonal problems (Corrigan, 2004). As previously discussed, stigma has often been characterized as a generalized concept that is inclusive of any negative attribute associated with mental health treatment. Thus, the beliefs elicited during this study are concrete examples in the attitudes that the general public associates with professional help seeking for conjoint couple treatment. Stigma can be discussed, conceptualized, and studied from multiple perspectives, however, this study presents specific ways in which stigma can be combated. Indeed, Vogel, Wade, and Hackler (2007a) explained the importance of this with their statement, "…it is important to develop models that account for the reasons why people do not seek services when experiencing a psychological or interpersonal problem to develop ways to reach out to those in need" (p.40). The beliefs from this study provide insight into specific avenues for public outreach to combat stigma.

For example, the belief *to obtain a neutral, professional opinion* represents the importance of a non-judgmental stance on behalf of the clinician. While this may appear as commonsensical knowledge that every clinician knows, it is important to note that the current study found this as the most influential belief when associated with intentions to seek professional help from a MFT. This could represent the importance of an unbiased and neutral stance in the context of conjoint couple treatment.

Other beliefs that also contributed to the prediction of intentions to seek professional help from a MFT were *a better understanding of the problem*, *to learn new skills and strategies*, and *to solve the problem/issue*. These findings may represent the notion that individuals affected by psychological and interpersonal problems are more interested in understanding the issue that they are experiencing in order to learn new ways in coping or solving the problem. These findings expand upon Kaplan, Vogel, Gentile, and Wade's (2012) study, which found that a video intervention increased positive perceptions of seeking counseling, by presenting the specific beliefs that the video intervention may have addressed.

Indeed, the video, which consisted of segments cut from a reality TV show that was seven minutes in length, addressed the beliefs *a better understanding of the problem* and *to learn new skills and strategies* by the therapist discussing what treatment would look like and how the interventions would be used. In addition, the main character stated "I like talking to the doctor 'cause he's an unbiased party and doesn't make me feel crazy…[He is] just trying to help me help myself to not be so negative and that there is a different way to look at situations" (Kaplan, Vogel, Gentile, & Wade, 2012, p. 422) which addresses the importance that the belief *to obtain a neutral, professional opinion* plays in the professional help-seeking process. These findings can provide direction for stigma research as these beliefs can be addressed using more cost effective and time saving interventions.

Elaboration Likelihood Model. For example, social persuasion theories, such as Petty and Cacioppo's (1996) Elaboration Likelihood Model, could be used to construct tailored interventions. In short, the elaboration likelihood model is a dual-route processing theory that postulates that attitude change occurs in two routes: a central route and a peripheral route. The central route is an extensive method of processing information (such as a message) in an effortful

manner that critically examines the merits of the issue under consideration. The peripheral route is a method of processing information (such as a message) that requires less cognitive effort and relies on cues such as communicator credibility. Attitudes that are formed through the central route are stronger, more resistant to counterarguments, and more persistent through time while attitudes formed through the peripheral route are weaker, short-lived, and subject to change through counterarguments. These two routes exist on an 'elaboration continuum' that assesses how motivated and capable people process information concerning a topic or issue. The arguments inherent in the message can encourage people to operate in the central route, thus, being responsible for the message's effectiveness (Fishbein & Ajzen, 2010; Petty & Wegener, 1999).

It is important to note that while the theory of planned behavior incorporates the word 'planned' it doesn't necessarily mean that behavior is deliberate. Indeed, the beliefs that people hold towards any number of behaviors can be inaccurate, biased, and ill informed. Nevertheless, these beliefs still inform their intentions to engage in behavior and, therefore, responsible for well, thought out responses as well as snap judgments. Thus, the elaboration likelihood model is a viable method that can inform the manner in which messages are framed, encouraging people to evaluate information through the central processing route which can change their beliefs, resulting in a change in behavior.

Elaboration Likelihood Model examples. For example, a MFT in private practice could use the elaboration likelihood model to construct a marketing message (e.g., television commercial, brochure, online advertisement, flyer, etc.) using the primary beliefs found in the current study—*to obtain a neutral, professional opinion, a better understanding of the problem, to learn new skills and/or strategies,* and *to solve the problem/issue*—to market his/her practice

specifically to troubled couples. First, the MFT would need to make the message personally relevant to couples to ensure that they process his message within the central route. To accomplish this, the MFT could explain possible 'red flags' that indicate a couple's relationship is in trouble—such as arguing, conflict, problematic communication, emotional distance, etc.—and explain how toxic relationships can have negative implications such as increased stress, chances of separation and divorce, increased health risks (Kiecolt-Glasser & Newton, 2001; Robles & Kiecolt-Glaser, 2003). This may increase the relevance of the message.

Next, specific details of what the MFT can offer troubled couples can be presented and, to ensure that couples are evaluating the message in the central route, the primary beliefs stated earlier could be targeted within that message. Therefore, the MFT could explain how he/she is trained to *provide neutral, professional opinions* designed to generate *a better understanding of the problem* and provide *new skills and/or strategies* that could *solve the problem and/or issue* the couple is facing. Thus, by framing the MFT's clinical training, expertise, credentials, and outcomes presented in the message by using the elicited beliefs, troubled couples may be more likely to process the message using the central route and connect their relational issues with the MFT.

This strategy can also be employed for those who take a broader, more cost effective approach to promoting their practice. For example, a MFT could create brochures, pamphlets, and/or flyers that address the beliefs previously discussed and strategically place these advertisements inside physicians' offices, hospital waiting rooms, or any other establishment where troubled couples and families could access them. This low cost strategy could connect troubled couples and families with a MFT that is specially trained to address the interactional, emotional, and/or cognitive issues that they are experiencing.

These results are not limited to those in private practice. Mental health agencies and clinics that often utilize MFTs to address relational issues that are prevalent in local communities could also benefit from these techniques. For example, if an agency or a clinic employed a licensed MFT, engaging in public outreach to address these specific beliefs may be useful in connecting with troubled individuals, couples, and families. Public service announcements on local television and radio stations, newspaper advertisements could be useful as well as personal representation at local events such as football games, community fairs and events. This could connect local troubled individuals, couples, and families to seek professional help from a MFT whose specialized training.

Future research. Future research is needed to validate these findings. Repeating this design would ensure that the salient beliefs are valid and, therefore, viable to be used in an intervention. Although the beliefs that were elicited during this study could be used in many different ways, it is important that formative research always be conducted to ensure the beliefs exist within the specific population that is being targeted with marketing interventions. Revisiting the mental health agency and/or clinic example, the beliefs in the current study may not have an effect if the agency and/or clinic primarily served a Native American population on a Oklahoma reservation. Thus, in order to justify the resources that are used to create interventions, the beliefs that would be used for a intervention designed for Native Americans should be explored and examined.

Furthermore, future studies could also examine the possibility of interaction effects between perceived behavioral control and attitude. It is possible that one's attitude is moderated by their perceived control over intending to seek professional help from an MFT. For example, if Bob is experiencing high conflict with his wife and perceives MFT treatment as too expensive to

engage in, he is more likely to have negative evaluation of MFT treatment. Thus, while perceived behavioral control may not directly impact Bob's intention to seek professional help from an MFT, if it is low, then it may suppress his attitude towards his intentions to seek professional help from an MFT.

Next, future studies should examine how the theory of planned behavior could be applied to generate interest in MFT graduate training programs. For example, a theory of planned behavior designed study could elicit salient beliefs towards clinical work with couples and families from a specific population, such as college students who are interested in the MHP, and examine which component (i.e., attitude, perceived norm, and perceived behavioral control). Next, MFT graduate programs could design a specific intervention based on these beliefs—such as a short promotional videos, in-class talks, examples of clinical sessions, etc.—that could increase the competiveness of MFT among the other MHP graduate programs and increase the perception of MFT as a specialty that requires intensive training.

Finally, future studies should examine the effectiveness of an intervention based on salient beliefs elicited during a formative research stage. Such studies could generate specific models of promotion that practicing MFTs could use in order to compete in the current mental health market, thus, increasing the brand of MFT to the general public by generating greater public awareness of the benefits of MFT treatment.

Limitations

Sample. The most notable limitation of this study is the predominately white sample in all three stages making the generalizability of the findings to minority populations problematic. The age of the sample posed another issue with the mean age for stages two and three over 50. However, as Fishbein and Ajzen (2010) have discussed, the beliefs elicited during the qualitative

stage should only be tested with the same population. Thus, the current findings can also be viewed in a positive light as the focus groups were predominately white with a mean age of 36. For future studies, minority populations should be chosen for the elicitation process and then quantitatively examined within a larger sample. This could yield potentially important insight that could aid MFTs in addressing the specific barriers that minority populations experience when seeking conjoint couple treatment.

Perceived behavioral control. Another limitation refers to the possibility that the direct and belief-based measures of perceived behavioral have been conceptualized with inappropriate beliefs. Examining the findings of other theory of planned behavior studies that investigated help-seeking intentions (Table 14) suggests that this could be an issue. For the current study, perceived behavioral control only significantly contributed in the regression models during the direct regression analyses in stage two. The use of matrix formatting in the online survey could have also impacted the perceived behavioral control measures. Another explanation may be that the construct dos not contribute to predicting behavioral intentions for MFT help seeking. Furthermore, perceived behavioral control may, instead, moderate attitude's prediction of behavioral intention, thus, future research is needed to examine this possible relationship.

Online survey and question format. The survey being posted online could also have be a limitation. While Internet access is prevalent throughout the U.S., online surveys may prevent lower SES individuals from participating potentially skewing these results away from beliefs that could contribute to a more effective intervention. The survey items were also presented in matrix format which could have impacted the findings.

Another possible limitation could have been the randomization method for the question blocks. This could have affected participants' attitudes towards professional help-seeking form

an MFT and, in turn, could have affected their behavioral intention score for those where behavioral intention items were randomized in the middle or at the end of the survey possibly inflating the intention scores. Future studies should assess behavioral intentions at the beginning of the survey in order to provide a more accurate assessment of intentions.

Conclusion

Attitude and perception are crucially important to every profession, including MFT. Compared to other MHPs, MFT is a relatively young field that is quickly gaining in popularity due to being effective in assessing and intervening in problematic couple and family problems. However, the general public is still largely unaware of the differences between the MHPs, which can lead to seeking professional help for couple and family problems from inappropriate sources. In order to continue to grow as a profession, as well as in numbers, the field of MFT needs to engage in promotion. While more research is needed, this study provides a conceptual framework that can aid in this endeavor.

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Appendix A
IRB Approval Letter

VirginiaTech

Office of Research Compliance
Institutational Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE: April 21, 2014

TO: Scott W Johnson, Jason Paul Austin

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: Getting Them In - Jason's Dissertation

IRB NUMBER: **14-368**

Effective April 21, 2014, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 6,7**
Protocol Approval Date:	**April 21, 2014**
Protocol Expiration Date:	**April 20, 2015**
Continuing Review Due Date*:	**April 6, 2015**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Date*	OSP Number	Sponsor	Grant Comparison Conducted?

* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this IRB protocol is to cover any other grant proposals, please contact the IRB office (irbadmin@vt.edu) immediately.

Appendix B
Focus Group Flyer

Volunteers Needed for Research Study

We need participants for a research study concerning married adults' perceptions, beliefs, and attitudes about seeking treatment from a marriage and family therapist for them and their spouse.

Description of participation: Your participation will take about 90 minutes in one of two focus groups and does not require the presence of your spouse. We will ask you to take a paper survey and participate in a group discussion. Participants will be compensated with $ 30 cash. Food and beverages will be provided. Please choose a date from the listed focus groups (below) and reserve by emailing or calling Jason Austin. The focus groups will take place at the Family Therapy Center of Virginia Tech (840 University City Blvd.).

Focus Group One: Saturday, May 3^{rd} from 1:00 to 2:30PM
Focus Group One: Saturday, May 10^{th} from 1:00 to 2:30PM
Focus Group Two: Saturday, May 17^{th} from 1:00 to 2:30PM

To participate: You must be married and at least 18 years of age.

To learn more or to reserve a date, contact the co-investigator of the study, Jason Austin, at 318-366-1458 or jpaustin@vt.edu

This research has been reviewed and approved by the Virginia Tech Institutional Review Board. You'll have the freedom to withdraw from the focus group at any time without being penalized in any way. We anticipate minimal risk to you from participating in this focus group.

Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy	Jason Austin jpaustin@vt.edu Perception of Marriage and Family Therapy

Appendix C
Virginia Tech Graduate Student ListServ Email Posting

Participants are sought for a focus group concerning married adults' perceptions, beliefs, and attitudes about seeking treatment from a marriage and family therapist for them and their spouse. If you are married and at least 18 years of age, we sincerely invite you to participate. Your participation in this focus group will be confidential from everyone outside the group. The first focus group will be held on Saturday 5/3/2014 from 1:00pm to 2:30pm and a second focus group on Saturday 5/10/2014 from 1:00pm to 2:30pm. The focus group will be held at the Family Therapy Center of Virginia Tech. Food and beverages will be provided and to compensate you for your time, all participants will receive $30 cash. This research study has received VT IRB approval. If you are interested in participating, please contact Jason Austin (jpaustin@vt.edu) for a reservation in one of the listed focus groups.

Appendix D
Focus Group Demographics Questionnaire

Section One: Demographic Information

Instructions: Please mark the description that best describes you.

Gender

- ☐ Male
- ☐ Female

Age:_____

Ethnicity

- ☐ White
- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ Native American or American Indian
- ☐ Asian/Pacific Islander
- ☐ Other_____

Professional or Employment Status

- ☐ Employed for wages
- ☐ Self-employed
- ☐ Out of work and looking for work
- ☐ Out of work and not currently looking for work
- ☐ A homemaker
- ☐ A student
- ☐ Military
- ☐ Retired
- ☐ Unable to work

Education

- ☐ No schooling completed
- ☐ Elementary school to 8th grade
- ☐ Some high school, no diploma
- ☐ High school graduate, diploma or the equivalent (e.g., GED)
- ☐ Some college credit, no degree
- ☐ Trade/technical/vocational training
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional degree
- ☐ Doctorate degree

Marital Status

- ☐ Single, never married
- ☐ Married
- ☐ Domestic spouseship
- ☐ Widowed
- ☐ Divorced
- ☐ Separated

Religious Affiliation

- ☐ Christian/non-denominational
- ☐ Christian/Protestant
- ☐ Christian/Catholic
- ☐ LDS/Mormon
- ☐ Jewish
- ☐ Muslim
- ☐ Hindu
- ☐ Buddhist
- ☐ Atheist
- ☐ Other_____
- ☐ No preference
- ☐ Prefer not to say

Household Income

- ☐ Less than 10,000
- ☐ 10,000 – 19,999
- ☐ 20,000 – 29,999
- ☐ 30,000 – 39,999
- ☐ 40,000 – 49,999
- ☐ 50,000 – 59,999
- ☐ 60,000 – 69,999
- ☐ 70,000 – 79,999
- ☐ 80,000 – 89,999
- ☐ 90,000 – 99,999
- ☐ 100,000 – 109,999
- ☐ 110,000 – 119,999
- ☐ 120,000 – 129,999
- ☐ More than 130,000

Mental Health Treatment History

Have you ever sought treatment for yourself and/or your spouse from any mental health professional during times of high relationship/personal distress?

- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Social Worker
- ☐ Professional Counselor
- ☐ Clergy
- ☐ Psychiatric Nurse
- ☐ Marriage and Family Therapist
- ☐ Life Coach
- ☐ Other [Please Specify]_____
- ☐ I have never sought or received mental health treatment

Section Two: Survey Questions

Instructions: Many places in this survey make use of rating scales with seven places, you are to circle the number that best describes your opinion. For example, if you were asked to rate "Exercising" on such a scale, the seven places should be interpreted as follows:

Exercising is:

bad : 1 : 2 : 3 : 4 : 5 : 6 : 7 : good

Extremely Quite Slightly Neither Slightly Quite Extremely

If you think exercising is ***extremely good*** than you would circle the ***number*** 7.

Exercising is:

bad : 1 : 2 : 3 : 4 : 5 : 6 : 7 : good

Extremely Quite Slightly Neither Slightly Quite Extremely

For this question, if you think exercising is ***quite beneficial***, then you would circle the ***number*** 2.

Exercising is:

Beneficial: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Harmful

Extremely Quite Slightly Neither Slightly Quite Extremely

For this question, if you think exercising is ***neither pleasant nor unpleasant***, then you would circle the ***number*** 4.

Exercising is:

Pleasant: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Unpleasant

Extremely Quite Slightly Neither Slightly Quite Extremely

In marking your ratings, please remember the following points:

- Be sure to answer all items –do not omit any item.
- Never circle more than one number on a single scale.

Please answer each of the following questions by circling the number that best describes your opinion. Some of the questions may appear to be similar, but they do address somewhat different issues. Please read each question carefully before answering.

Part One

1. Seeking treatment from a marriage and family therapist for a person and their spouse during times of high relationship distress is

Bad: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Good
Beneficial: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Harmful
Pleasant: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Unpleasant
Positive: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Negative
Constructive: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Detrimental

2. My seeking treatment from a marriage and family therapist for me and my spouse during times of high relationship distress would be

Bad: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Good
Beneficial: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Harmful
Pleasant: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Unpleasant
Positive: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Negative
Constructive: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Detrimental

Part Two

1. Most people who are important to me think
   I should: 1 : 2 : 3 : 4 : 5 : 6 : 7 : I should not

seek treatment from a marriage and family therapist for me and my spouse during times of high relationship distress.

2. Most people whom I respect and admire would
support: 1 : 2 : 3 : 4 : 5 : 6 : 7 : oppose

me seeking treatment from a marriage and family therapist for me and my spouse during times of high relationship distress.

3. When it comes to seeking treatment from a marriage and family therapist for me and my spouse during times of high relationship distress
I want to do: 1 : 2 : 3 : 4 : 5 : 6 : 7 : I don't want to do

what people whom I respect and admire think I should do.

4. Most people like me will seek treatment from a marriage and family therapist for them and their spouse during times of high relationship distress.

Unlikely: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Likely

5. I am confident that I can seek treatment from a marriage and family therapist for me and my spouse during times of high relationship distress.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

Part Three

1. I feel I would be capable of convincing my spouse to seek treatment from a marriage and family therapist for us during times of high relationship distress.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

2. My seeking treatment from a marriage and family therapist for me and my spouse during times of high relationship distress is completely up to me.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

3. If I really wanted to, I could seek treatment from a marriage and family therapist for us during times of high relationship distress.

Likely: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Unlikely

4. For me to seek treatment from a marriage and family therapist for us during times of high relationship distress is under my control.

Not at all: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Completely

Part Four
Note: Please answer both questions even if they appear similar to questions you've already answered

1. I intend to seek treatment from a marriage and family therapist for me and my spouse during times of high relationship distress.

   Unlikely: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Likely

2. In the past, how often have you sought treatment from a marriage and family therapist for you and your spouse during times of high relationship distress?

   Never: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Always

Would you be willing to participate in a later brief stage of this research project for a possibility to win a $25 Amazon gift card?

☐ Yes [If so, please list an email address and phone number in order to contact you _____]

☐ No

Appendix E
Focus Group Informed Consent

Project Title: An Exploratory Mixed-Methods Study: Predicting Intentions of Seeking MFT Treatment for Relational Issues

IRB#: 14-368

Investigators: Jason Austin, M.A. & Scott Johnson, Ph.D.

Purpose
The purpose of the focus group meeting is to explore the perceptions, attitudes, and beliefs of the general public about seeking treatment for you and your spouse from a marriage and family therapist.

Procedures
You will take part in a 90 minute focus group discussion with other members of the community. The focus group discussion will be audio taped and a note taker will be present to take notes. Your name will not be associated with either the transcript of the discussion, or any document summarizing the information obtained from this discussion.

Risks
We don't anticipate any risks to you beyond those you would experience in any discussion of marriage and family therapy issues and/or relationship issues with your peers. However, it is possible that certain focus group questions may raise issues and/or experiences that you may find potentially uncomfortable. Remember, you do not have to answer any question you do not want to answer, and you may stop your participation in the focus group at any time.

Benefits
This focus group evaluation will provide insight into the perceptions, beliefs, and attitudes associated with seeking treatment from a marriage and family therapist. This could provide relevant information about the barriers that couples experience when seeking treatment for relationship issues. You will have the opportunity to share your perspectives, and perhaps even shape future studies by calling attention to issues that you believe are important about the marriage and family therapy treatment seeking process. The focus group data will help the researchers to better understand these perceptions, beliefs, and attitudes associated with the marriage and family therapy treatment seeking process.

Confidentiality
The audiotape of the focus group sessions will be retained for a period of three years on a password protected computer system. Your comments will be treated with complete confidentiality. Your name will not appear on the transcript, and it will not be associated with any report or discussion related to the focus group data. You are free to withdraw from this evaluation at any time without penalty. You may also choose not to respond to any question without being penalized. If you are concerned with confidentiality, you may give a pseudonym during the focus group in order to protect your identity.

This project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, and by the Department of Human Development.

April 21, 2014	April 20, 2015
IRB Approval Date	IRB Approval Expiration Date

Your Responsibilities

I voluntarily agree to participate in this study. I understand that my responsibilities include participating in a 90 minute focus group. I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

_____	_____
Subject Signature	Date

Should I have any questions about this project or its conduct, I may contact:

Jason Austin, M.A. Phone: 318-366-1458 E-mail: jpaustin@vt.edu
(Faculty oversight contact information will be given upon request)
Or

David M. Moore Phone: 231-4991 E-mail: moored@vt.edu
Chair, IRB
Office of Research Compliance
Research & Graduate Studies

Appendix F
Focus Group Question Guide

Welcome group participants:

Hand out Informed Consent Forms, folded cards, and markers. Encourage participants to create a 'pseudonym' to which they can be referred to during the discussion interactions.

Purpose:

The purpose of the focus group meeting is to explore the perceptions, attitudes, and beliefs of the general public about seeking treatment for you and your spouse from a marriage and family therapist.

What will be done with the focus group information?

I am tape recording the focus group and will also have a note-taker present to take content and process notes that focus on the discussion occurring. Pseudonyms will be created for any documents resulting from the notes or recordings. The recordings will be held for a period of three years and used only for research purposes.

How the focus group will work:

A focus group is basically a group discussion. We will meet for about 90 minutes. I'll ask a series of questions. For each, you will have the opportunity to respond, to react to, elaborate on, agree with, or disagree with other's responses. There's no one right answer, so we won't be trying to come to any consensus. Basically, we'd like to hear all opinions.

Ground Rules

- Respect
- One person talks at a time
- Confidentiality (no names will be associated with anything you say)
- It's OK to choose not to answer a questions
- It's OK to disagree
- No right or wrong answers

Introductions:

Share some information about myself and then invite group participants to introduce themselves using their pseudonyms.

Questions:

Part 1: Intro Questions

1. Write down the words that come to mind when you think of marriage and family therapy?

   a. Ask each participant to share a few of the words. Then read them back to the group before you proceed.
2. How do you differentiate marriage and family therapy from other mental health professions?

Part 2: Behavioral Definition

1. What does it look like when couples' relationships are in trouble?

What would you call these times of 'relationship distress'?

Note: After they state these times, use them in the future questions instead of 'relationship distress'.

Part 1: Behavioral Beliefs

1. What do you see as the ***advantages*** of your seeking treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress']*****?**

2. What do you see as the ***disadvantages*** of your seeking treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress']?***

3. What else comes to mind when you think about the advantages or disadvantages of seeking treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress']?***

Part 2: Normative Beliefs
When it comes to you seeking treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress'],*** there might be individuals or groups who would think you should or should not seek this kind of help. .

1. What individuals or groups who would ***approve*** or think you ***should*** seek treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress']?***

   1a. After list, ask "Why?"

2. What individuals or groups who would ***disapprove*** or think you ***should not*** seek treatment from a marriage and family therapist for you and your spouse during times of high *[**insert group generated term for 'relationship distress'**]*?

    2a. After list, ask "Why?"

3. What other people or groups you might want to talk to if you were trying to decide whether or not to seek treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress'].***

4. Sometimes, when we are not sure what to do, we look to see what others are doing. Who are some individuals or groups that are ***most likely*** to seek treatment from a marriage and family therapist for them and their spouse during times of high ***[insert group generated term for 'relationship distress']***.

5. Who are some individuals or groups that are ***least likely*** to seeking treatment from a marriage and family therapist for them and their spouse during times of high ***[insert group generated term for 'relationship distress'].***

Part 3: Control Beliefs

1. What factors or circumstances that would make it ***easy*** for you to seek treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress'].***

2. What factors or circumstances that would make it ***difficult*** for you to seek treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress'].***

3. What else comes to mind when you think about factors or circumstances around seeking treatment from a marriage and family therapist for you and your spouse during times of high ***[insert group generated term for 'relationship distress'].***

Backup Questions

1. If you are experiencing relationship distress, what is one thing that mental health professionals can do to encourage you to seeking treatment?

2. What specifically can MFTs do to encourage you to seek treatment from them?

Appendix G
Focus Group Thematic Tree for Member Checking

Themes from focus groups regarding perception, attitudes, and beliefs towards marital therapy

1. Advantages/Disadvantages of seeking treatment from a marriage and family therapist for you and your spouse/spouse during times of relationship distress:

1.01 Learn new skills
1.02 Problems will go away without treatment
1.03 To improve our relationship
1.04 Staying together
1.05 Difficult to express my feelings
1.06 Feeling like you've failed
1.07 Divorce amicably
1.08 Learning that the marriage is not salvageable
1.09 Confronting communication issues
1.10 Obtaining a neutral, professional opinion
1.11 Fear that therapy may make matters worse
1.12Therapy will make me/us feel uncomfortable
1.13 Increase spouse/spouse's understanding of each another
1.14 I may dislike the therapist's advice
1.15 To solve the problem/issue
1.16 Therapy may not work or will be unproductive
1.17 Receiving a diagnosis and medication
1.18 The problem is more serious than originally believed
1.19 I will experience social stigma (Shameful feelings, feeling judged, disapproval from others, etc.)
1.20 We can solve our own problems without therapy
1.21 Issues coming from my own family history
1.22 Therapist's personal knowledge of our family history
1.23 Better understanding of our problem
1.24 Engaging in treatment for the sake of children

2. Factors and circumstances that would make it ***easy and/or difficult*** to seek treatment from a marriage and family therapist for you and your spouse/spouse during times of relationship distress:

2.01 Financial cost of treatment
2.02 Time
2.03 Physical location of therapy office
2.04 Insurance
2.05 Childcare issues
2.06 Office setting
2.07 Spouse/Spouse and therapist interaction

2.08 Therapist credentials (Licensed, education, etc.)
2.09 Therapist's reputation
2.10 Therapist's competency/effectiveness (ability to understand you, outcomes, etc.)
2.11 Proximity to the therapist
2.12 Therapist's availability
2.13 Confidentiality
2.14 Therapist's personal factors
    2.14.1 Therapist's gender
    2.14.2 Therapist's age
    2.14.3 Therapist's personality
    2.14.4 Therapist's marital status
2.15 The fit between therapist and couple
2.16 Spouse/spouse agreeing to seek treatment
2.17 Knowledge about therapy
2.18 Therapy being private from others (family, friends, etc.)

3. (a) People/Groups who ***approve/disapprove*** of you seeking treatment from a marriage and family therapist for you and your spouse/spouse during times of relationship distress; (b) People/Groups that ***would or would not*** seek treatment ***themselves*** from a marriage and family therapist for them and their spouse/spouse during times of relationship distress:

3.01 Friends
3.02 Couples who have a good relationship
3.03 Spouse/Spouse
3.04 Family
    3.04.1 Parents
    3.04.2 Extended family
    3.04.3 Siblings
    3.04.4 Spouse/Spouse's family
3.05 Religious people (Church goers, priests, pastors, etc.)
3.06 Conservative/Traditional people
3.07 People/couples who have sought therapy in the past
3.08 Couple's age group
    3.08.1 Older people
    3.08.2 Younger people
3.09 Other mental health professionals
3.10 Famous people
3.11 People's open-mindedness/close-mindedness
3.12 People's wealth
    3.12.1 Rich people
    3.12.2 Poor people
3.13 People's educational attainment
    3.13.1 Educated people
    3.13.2 Uneducated people

3.14 People with certain personality traits (e.g., easy going, arrogant, etc.)
3.15 Boss
3.16 Advertisements
3.17 Person/Couple's cultural background
3.18 Supportive network
3.19 Divorced people
3.20 People/couples experiencing a similar issue
3.21 Military personnel
3.22 People with high social status
3.23 Children
3.24 Media (Internet, magazines, TV, yellow-pages, etc.)
3.25 Doctor (family physician, etc.)

Appendix H
Focus Group Follow-up Email

Hi [Name of Participant],

I wanted to thank you again for taking the time to attend my focus group. Since then I have conducted analyses of the responses, and want to invite you to give feedback to my analysis as you indicated interest in such contribution. I anticipate that this should take no longer than 10-15 minutes. Attached, please find a PDF file of the themes that arose from the responses of everyone that participated in all three focus groups. If you are willing, please review them to ensure that they represent what you and the other focus group members contributed during the discussion.

The data is organized by the three main question groups that were asked during the group discussion: (1) Advantages/Disadvantages of seeking treatment from a marriage and family therapist during times of high relationship distress; (2) Feedback for factors and circumstances that would make it easy and/or difficult to seek treatment from a marriage and family therapist for you and your spouse/spouse during times of relationship distress; and (3) (a) People/Groups who approve or disapprove of you seeking treatment from a marriage and family therapist for you and your spouse/spouse during times of high relationship distress; (b) People/Groups that would or would not seek treatment themselves from a marriage and family therapist for them and their spouse/spouse during times of high relationship distress.

The link below will direct you to a secure page, on which you will find three text boxes to leave your feedback on the themes for each question group. If you find the existing themes adequate, please still kindly leave a comment to indicate your feedback as such. I have set the web survey link to close this Thursday at 11:59pm.

Web link: https://virginiatech.qualtrics.com/SE/?SID=SV_b2FCwvR7IzaT7p3

I sincerely appreciate your time and help, and I look forward to receiving your feedback.

Sincerely,

Jason P. Austin, M.A.
Doctoral Candidate
Department of Human Development
College of Liberal Arts and Human Sciences
Virginia Polytechnic Institute and State University

Appendix I
Qualtrics Member Check Online Survey

Thank you for agreeing to review my focus group themes. Below are the text boxes organized by the three main question groups. Please type your feedback into the text boxes.

1. Feedback for ***advantages and/or disadvantages*** for seeking treatment from a marriage and family therapist for you and your spouse/spouse during times of high relationship distress:

Do the themes accurately represent what was discussed in your focus group? If not, please list the advantages and/or disadvantages that are missing from the document.

2. Feedback for factors and circumstances that would make ***it easy and/or difficult*** to seek treatment from a marriage and family therapist for you and your spouse/spouse during times of high relationship distress:

Do the themes accurately represent what was discussed in your focus group? If not, please list the factors and circumstances that are missing from the document.

3. Feedback for **(a)** People/Groups who ***approve or disapprove*** of you seeking treatment from a marriage and family therapist for you and your spouse/spouse during times of high relationship distress; (**b)** People/Groups that ***would or would not*** seek treatment ***themselves*** from a marriage and family therapist for them and their spouse/spouse during times of high relationship distress:

Do the themes accurately represent what was discussed in your focus group? If not, please list the people and/or groups that are missing from the document.

4. Any additional feedback?

Appendix J
Final Thematic Tree

Behavioral Beliefs

Code Number	Belief	Response Frequency
1.01	*Obtaining a neutral, professional opinion*	19
1.02	*I will experience social stigma (Shameful feelings, feeling judged, disapproval from others, etc.)*	17
1.03	*A better understanding of the problem*	13
1.04	*We can solve our own problems without therapy*	13
1.05	*Therapy may make things worse*	12
1.06	*The problem is more serious than originally thought*	11
1.07	*Therapy may not work or will be unproductive*	8
1.08	*Therapy will make me/us feel uncomfortable*	7
1.09	*To stay together*	6
1.10	*To learn new skills*	6
1.11	*To receive a diagnosis and medication*	5
1.12	*To solve the problem/issue*	5
1.13	Increase spouse/spouse's understanding of each other	4
1.14	Therapist's personal knowledge of our family history	4
1.15	Confronting communication issues	4
1.16	Difficult to express my feelings	4
1.17	Engaging in treatment for the sake of children	4
1.18	I may dislike the therapist’s advice	3
1.19	Learning that the marriage is not salvageable	3
1.20	Feeling like you've failed	2
1.21	Divorce amicably	2
1.22	Problems will go away without treatment	1
1.23	Issues coming from my own family history	1
Total Number of Responses	154	
Cut off Response Number	115.5	

Note: The italicized beliefs met the 75% cut-off selection criteria

Control Beliefs

Code Number	Belief	Response Frequency
2.01	*Therapist's competency/effectiveness (ability to understand you and your culture, outcomes, etc.)*	22
2.02	*Spouse/spouse agreeing to seek treatment*	15
2.03	*Financial cost of therapy (Out of pocket, Insurance, etc.)*	15
2.04	*Therapist's Personal Factors (e.g., personality, gender, marital status, and age)*	10
2.05	*The fit between therapist and couple*	8
2.06	*Knowledge about therapy*	7
2.07	*Location of therapy office*	7
2.08	*Therapist's Credentials (licensed, education, etc.)*	5
2.09	*Therapist's Reputation*	5
2.10	*Confidentiality*	5
2.11	**The time for therapy**	4
2.13	Office setting	4
2.14	Therapy being private from others (family, friends, etc.)	4
2.15	Childcare Issues	3
2.16	Therapist's availability	2
2.17	Proximity to the therapist	1
Total Number of Responses	124	
Cut off Response Number	93	

Note: The italicized beliefs met the 75% cut-off selection criteria. The researcher included the bold belief.

Injunctive Normative Beliefs

Code Number	Belief	Response Frequency
3.01	*Religious people (Church goers, priests, pastors, etc.)*	18
3.02	*Parents*	16
3.03	*Friends*	12
3.04	*Person/Couple's cultural background*	11
3.05	*Spouse/Spouse*	10
3.06	*Siblings*	10
3.07	*Person/Couple's age group (e.g., older couples, younger couples)*	9
3.08	*Media (Advertisements, Internet, magazines, TV, yellow-pages, etc.)*	9
3.09	*Person/Couple's education level (e.g., highly educated, low education)*	8
3.10	*People/Couples who have sought therapy in the past*	7
3.11	*Person/Couple's wealth level (e.g., being rich or poor)*	7
3.12	Extended family	4
3.13	Spouse/Spouse's family	4
3.14	Person/Couple's open-mindedness/close-mindedness	4
3.15	Couples who have a good relationship	3
3.16	Children	3
3.17	Conservative/Traditional people	2
3.18	Doctor (family physician, etc.)	2
3.19	Military Personnel	2
3.20	Supportive network	2
3.21	Divorced people	1
3.22	Boss	1
3.23	People/couples experiencing a similar issue	1
Total Number of Responses	146	
Cut off Response Number	109.5	

Note: The italicized beliefs met the 75% cut-off selection criteria

Descriptive Normative Beliefs

Code Number	Belief	Response Frequency
4.01	*Religious people (Church goers, priests, pastors, etc.)*	18
4.02	*Person/Couple's cultural background*	11
4.03	*Person/Couple's age group (e.g., older couples, younger couples)*	9
4.04	*Person/Couple's education level (e.g., highly educated, low education)*	8
4.05	*People/Couples who have sought therapy in the past*	7
4.06	*Person/Couple's wealth level (e.g., being rich or poor)*	7
4.07	The gender of a person	4
4.08	Person/Couple's open-mindedness/close-mindedness	4
4.09	Mental Health Professionals	3
4.10	People with certain personality traits (e.g., easy going, arrogant, etc.)	3
4.11	Famous people	2
4.12	Military Personnel	2
Total Number of Responses	78	
Cut off Response Number	58.5	

Note: The italicized beliefs met the 75% cut-off selection criteria

APPENDIX K
Survey Measure for Stage Two

Instructions: This survey is designed to explore married adults' perceptions, beliefs, and attitudes towards marriage and family therapy. Specifically with your perception of you seeking professional help from a marriage and family therapist for you and your spouse during times of relationship distress. If you are married and at least 18 years of age, you are eligible to participate. Your responses are anonymous and you will have the freedom to withdraw from the study at any time. We anticipate minimal risk to you from participating in this survey. This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech. The completion of the survey signifies your voluntary willingness to participate.

Should you have any questions or concerns about this research, its conduct, research participants' rights, and/or in the event of a research-related injury, please contact:

Jason Austin: jpaustin@vt.edu
David M. Moore, Chair, IRB: 540-231-4991; moored@vt.edu

Thank you for your time and consideration!

To participate in this survey, and confirm that you are married and at least 18 years of age, please click NEXT.

Demographic Questions

1. What is your gender?

- ❍ Female (1)
- ❍ Male (0)

2. What is your current marital status?

- ❍ Single (1)
- ❍ Married (2)
- ❍ Separated (3)
- ❍ Divorced (4)
- ❍ Widowed (5)

3. How old are you?

4. How many children do you have?

5. Please indicate the highest level of education completed.
- ❍ I graduated Middle School (1)
- ❍ I graduated High School or equivalent (e.g., GED) (2)
- ❍ I have some college education (3)
- ❍ I have a Vocational/Technical Degree (4)
- ❍ I have an Associates Degree (5)
- ❍ I have a Bachelor's Degree (6)
- ❍ I have a Bachelor's Degree and some graduate education (7)
- ❍ I have a Master's Degree (8)
- ❍ I have a Doctoral Degree (9)
- ❍ I have a Professional Degree (MD, JD, etc.) (10)
- ❍ Other (11)

6. Which of the following best describes the area you live in?
- ❍ Urban (1)
- ❍ Suburban (2)
- ❍ Rural (3)

7. Please indicate your current yearly household income in U.S. dollars
- ❍ Rather not say (1)
- ❍ Under $10,000 (2)
- ❍ $10,000 - $19,999 (3)
- ❍ $20,000 - $29,999 (4)
- ❍ $30,000 - $39,999 (5)
- ❍ $40,000 - $49,999 (6)
- ❍ $50,000 - $59,999 (7)
- ❍ $60,000 - $69,999 (8)
- ❍ $70,000-$79,999 (9)
- ❍ $80,000-$89,999 (10)
- ❍ $90,000-$99,999 (11)
- ❍ $100,000 - $109,999 (12)
- ❍ Over $110,000 (13)

8. Have you ever received mental health treatment before?
- ❍ No (1)
- ❍ Yes (2)

Instructions: Many places in this survey make use of rating scales with seven places. These scales will often have opposite, bipolar statements (such as agree-disagree, good-bad, etc.) on each end. You are to click the circle between the two bipolar statements that best describes your

opinion on each question. Some of the questions may appear to be similar, but they do address somewhat different issues. Please read each question carefully before answering.

Relationship distress is defined as periods of intense conflict, arguing, and fighting between you and your spouse marked by high stress and, possibly, leading to separation and/or divorce.

Direct Attitude Scale

1. My seeking professional help from a marriage and family therapist for my spouse and I during times of relationship distress would be:

	1	2	3	4	5	6	7	
Bad	❍	❍	❍	❍	❍	❍	❍	Good
Harmful	❍	❍	❍	❍	❍	❍	❍	Beneficial
Unpleasant	❍	❍	❍	❍	❍	❍	❍	Pleasant
Negative	❍	❍	❍	❍	❍	❍	❍	Positive
Detrimental	❍	❍	❍	❍	❍	❍	❍	Constructive
Painful	❍	❍	❍	❍	❍	❍	❍	Enjoyable

Belief-based Attitude Scale

Behavioral Belief Strength

1. My seeking professional help from a marriage and family therapist for my spouse and I during times of relationship distress would:

	1 Very Unlikely	2 Unlikely	3 Somewhat Unlikely	4 Undecided	5 Somewhat Likely	6 Likely	7 Very Likely
1. make things worse	❍	❍	❍	❍	❍	❍	❍
2. be unproductive	❍	❍	❍	❍	❍	❍	❍
3. make me/us feel uncomfortable	❍	❍	❍	❍	❍	❍	❍
4. result in me and/or my spouse receiving a diagnosis and/r medication	❍	❍	❍	❍	❍	❍	❍
5. solve our problems	❍	❍	❍	❍	❍	❍	❍
6. lead to me/us experiencing social stigma (e.g., shameful	❍	❍	❍	❍	❍	❍	❍

feelings, feeling judged, disapproval from others, etc.).							
7. mean that our problems are more serious than I/we originally thought	❍	❍	❍	❍	❍	❍	❍
8. lead to a better understanding of the problem we are experiencing	❍	❍	❍	❍	❍	❍	❍
9. result in us staying together	❍	❍	❍	❍	❍	❍	❍
10. help us learn new relationship strategies and skills	❍	❍	❍	❍	❍	❍	❍
11. help us obtain a neutral, professional opinion	❍	❍	❍	❍	❍	❍	❍

2. I would not consider seeking professional help from a marriage and family therapist for me and my spouse during times of relationship distress as ***I believe we can solve our problems on our own.***

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

Outcome Evaluation

1. Picture each statement below filling in the blank of this sentence:

It is *bad/good* for my spouse and/or I to _____.

	-3 Bad	-2	-1	0	1	2	3 Good
1. obtain a neutral, professional opinion	❍	❍	❍	❍	❍	❍	❍
2. experience social stigma (e.g., shameful feelings, feeling judged, disapproval from others, etc.).	❍	❍	❍	❍	❍	❍	❍
3. gain a better understanding of the problem we are experiencing	❍	❍	❍	❍	❍	❍	❍
4. solve our problems on our own	❍	❍	❍	❍	❍	❍	❍
5. get worse because of therapy	❍	❍	❍	❍	❍	❍	❍
6. discover the problem is more serious that I/we originally thought	❍	❍	❍	❍	❍	❍	❍
7. experience therapy as being unproductive	❍	❍	❍	❍	❍	❍	❍
8. stay together	❍	❍	❍	❍	❍	❍	❍
9. learn new relationship strategies and skills	❍	❍	❍	❍	❍	❍	❍
10. feel uncomfortable during therapy	❍	❍	❍	❍	❍	❍	❍
11. receive a diagnosis and/or medication	❍	❍	❍	❍	❍	❍	❍

12. solve our problems (through therapy)	❍	❍	❍	❍	❍	❍	❍

Direct Norm Scale (7 items)

1. Most people who are important to me think I should seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Disagree	❍	❍	❍	❍	❍	❍	❍	Agree

2. Most people whom I respect and admire would support me seeking professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Disagree	❍	❍	❍	❍	❍	❍	❍	Agree

3. Most people whose opinions I value think it is appropriate for me to seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Disagree	❍	❍	❍	❍	❍	❍	❍	Agree

4. Most people who are important to me would seek professional help from a marriage and family therapist for themselves and their spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Disagree	❍	❍	❍	❍	❍	❍	❍	Agree

5. How many people similar to you seek professional help from a marriage and family therapist for them and their spouse during times of high relationship distress?

	1	2	3	4	5	6	7	
Virtually none	❍	❍	❍	❍	❍	❍	❍	Almost all

6. How many of the people whom you respect and admire seek professional help from a marriage and family therapist for them and their spouse during times of relationship distress?

	1	2	3	4	5	6	7	
Very few	❍	❍	❍	❍	❍	❍	❍	Almost all

7. Most people like me will seek treatment from a marriage and family therapist for them and their spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Unlikely	❍	❍	❍	❍	❍	❍	❍	Likely

Belief-based Normative Scale – Injunctive Norms

Injunctive Norm Belief Strength

1. How likely are the following people/groups to think that I should seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress:

	-3 Unlikely	-2	-1	0	1	2	3 Likely
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. My friends	❍	❍	❍	❍	❍	❍	❍
3. My spouse	❍	❍	❍	❍	❍	❍	❍
4. Younger people	❍	❍	❍	❍	❍	❍	❍
5. Older people	❍	❍	❍	❍	❍	❍	❍
6. Media (such as the Internet, magazines, TV, Yellow Pages, etc.)	❍	❍	❍	❍	❍	❍	❍
7. Well educated people	❍	❍	❍	❍	❍	❍	❍
8. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
9. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
10. Wealthy people	❍	❍	❍	❍	❍	❍	❍
11. Poor people	❍	❍	❍	❍	❍	❍	❍

2. How likely are the following people/groups to think that I should seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress:

	-3 Unlikely	-2	-1	0	1	2	3 Likely	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. Members from my own culture	❍	❍	❍	❍	❍	❍	❍	❍
3. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

Motivation to Comply

1. When it comes to seeking professional help for relationship distress, I want to do what the following people/groups think(s) I should do.

	1 Disagree	2	3	4	5	6	7 Agree	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. Members from my own culture	❍	❍	❍	❍	❍	❍	❍	❍
3. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

2. When it comes to seeking professional help for relationship distress, I want to do what the following people/groups think(s) I should do.

	1 Disagree	2	3	4	5	6	7 Agree
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. My friends	❍	❍	❍	❍	❍	❍	❍
3. My spouse	❍	❍	❍	❍	❍	❍	❍
4. Younger people	❍	❍	❍	❍	❍	❍	❍
5. Older people	❍	❍	❍	❍	❍	❍	❍
6. Media (such as the Internet, magazines, TV, Yellow Pages, etc.)	❍	❍	❍	❍	❍	❍	❍
7. Well educated people	❍	❍	❍	❍	❍	❍	❍
8. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
9. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
10. Wealthy people	❍	❍	❍	❍	❍	❍	❍
11. Poor people	❍	❍	❍	❍	❍	❍	❍

Belief-based Normative Scale – Descriptive Norms

Descriptive Norm Belief Strength

1. How likely would it be for the following people/groups to seek professional help from a marriage and family therapist if they or their spouse had relationship distress:

	-3 Unlikely	-2	-1	0	1	2	3 Likely
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. Younger people	❍	❍	❍	❍	❍	❍	❍
3. Older people	❍	❍	❍	❍	❍	❍	❍
4. Well educated people	❍	❍	❍	❍	❍	❍	❍
5. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
6. Wealthy people	❍	❍	❍	❍	❍	❍	❍
7. Poor people	❍	❍	❍	❍	❍	❍	❍
8. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
9. My friends	❍	❍	❍	❍	❍	❍	❍

2. How likely would it be for the following people/groups to seek professional help from a marriage and family therapist if they or their spouse had relationship distress:

	-3 Unlikely	-2	-1	0	1	2	3 Likely	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. Members from my own culture	❍	❍	❍	❍	❍	❍	❍	❍
3. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

Identification with Referent

1. When it comes to seeking professional help for relationship distress, how much do you want to be like the following people/groups?

	1 Not at all	2	3	4	5	6	7 Very much
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. Younger people	❍	❍	❍	❍	❍	❍	❍
3. Older people	❍	❍	❍	❍	❍	❍	❍
4. Well educated people	❍	❍	❍	❍	❍	❍	❍
5. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
6. Wealthy people	❍	❍	❍	❍	❍	❍	❍
7. Poor people	❍	❍	❍	❍	❍	❍	❍
8. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
9. My friends	❍	❍	❍	❍	❍	❍	❍

2. When it comes to seeking professional help for relationship distress, how much do you want to be like the following people/groups?

	-3 Not at all	-2	-1	0	1	2	3 Very much	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. Members from my own culture	❍	❍	❍	❍	❍	❍	❍	❍
3. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

Direct Perceived Behavioral Control Scale

1. My seeking professional help from a marriage and family therapist for my spouse and I during times of relationship distress would be...

	1	2	3	4	5	6	7	
Very difficult	❍	❍	❍	❍	❍	❍	❍	Very easy

2. I am confident that I can seek professional help from a marriage and family therapist for my spouse and myself during times of relationship distress.

	1	2	3	4	5	6	7	
Completely disagree	❍	❍	❍	❍	❍	❍	❍	Completely agree

3. If I wanted to, I could easily seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

4. Whether or not I seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress is completely up to me.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

5. For me to seek professional help from a marriage and family therapist for my spouse and I during times of relationship distress is under my control

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

6. It is mostly up to me whether or not I seek professional help from a marriage and family therapist for my spouse and I during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

Belief-based Perceived Behavioral Control Scale

Power of Control Factor

1. The following traits about the therapist will make it more likely for me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	-3 Not at all	-2	-1	0	1	2	3 Very much
1. Therapist's competency level (such as the ability to understand you, your spouse, and your culture; success rates; effectiveness; etc.)	❍	❍	❍	❍	❍	❍	❍
2. Therapist's personal factors (such as his/her personality, gender, marital status, age, etc.)	❍	❍	❍	❍	❍	❍	❍
3. Therapist's credentials (such as educational background, licenses, etc.)	❍	❍	❍	❍	❍	❍	❍
4. Therapist's reputation	❍	❍	❍	❍	❍	❍	❍
5. Therapist's office location	❍	❍	❍	❍	❍	❍	❍

2. The following things would make it likely for me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	-3 Not at all	-2	-1	0	1	2	3 Very much
1. Spouse agreeing to seek professional help	❍	❍	❍	❍	❍	❍	❍
2. Knowing about therapy	❍	❍	❍	❍	❍	❍	❍
3. Having a good fit between us (my spouse and I) and the therapist	❍	❍	❍	❍	❍	❍	❍
4. The therapy being confidential	❍	❍	❍	❍	❍	❍	❍
5. Insurance coverage (Part or all of treatment)	❍	❍	❍	❍	❍	❍	❍

3. The following things would make it more difficult for me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	-3 Not at all	-2	-1	0	1	2	3 Very much
1. Cost of therapy	❍	❍	❍	❍	❍	❍	❍
2. Time commitment	❍	❍	❍	❍	❍	❍	❍
3. Childcare Issues	❍	❍	❍	❍	❍	❍	❍

Control Belief Strength

1. How important do you find the following factors when considering seeking professional help from a marriage and family therapist for you and your spouse during times of relationship distress?

	1 Not at all	2	3	4	5	6	7 Very much
1. Spouse agreeing to seeking professional help	❍	❍	❍	❍	❍	❍	❍
2. Your knowledge about therapy	❍	❍	❍	❍	❍	❍	❍
3. Having a good fit between us (my spouse and I) and the therapist	❍	❍	❍	❍	❍	❍	❍
4. Therapist's credentials (such as educational background, licenses, etc.)	❍	❍	❍	❍	❍	❍	❍
5. The therapy being confidential	❍	❍	❍	❍	❍	❍	❍
6. Therapist's competency level (such as the ability to understand you, your spouse, and your culture; success rates; effectiveness; etc.)	❍	❍	❍	❍	❍	❍	❍
7. Financial Cost	❍	❍	❍	❍	❍	❍	❍
8. Therapist's reputation	❍	❍	❍	❍	❍	❍	❍
9. Time commitment	❍	❍	❍	❍	❍	❍	❍
10. Childcare Issues	❍	❍	❍	❍	❍	❍	❍
11. Therapist's personal factors (such as his/her	❍	❍	❍	❍	❍	❍	❍

personality, gender, marital status, age, etc.)							
12. Therapist's office location	❍	❍	❍	❍	❍	❍	❍
13. Insurance coverage (Part or all of treatment)	❍	❍	❍	❍	❍	❍	❍

Direct Behavioral Intention Scale

1. I intend to seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
False	❍	❍	❍	❍	❍	❍	❍	True

2. I will seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Unlikely	❍	❍	❍	❍	❍	❍	❍	Likely

3. I am willing to seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
False	❍	❍	❍	❍	❍	❍	❍	True

4. I plan to seek professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Disagree	❍	❍	❍	❍	❍	❍	❍	Agree

Direct Past Behavior Scale

1. In the past, how often have you sought professional help from a marriage and family therapist for you and your spouse during times of relationship distress?

	1	2	3	4	5	6	7	
Never	❍	❍	❍	❍	❍	❍	❍	Almost always

2. I have previously sought professional help from a marriage and family therapist for me and my spouse during times of relationship distress.

	1	2	3	4	5	6	7	
False	❍	❍	❍	❍	❍	❍	❍	True

APPENDIX L
Survey Measure for Stage Three

Instructions: This survey is designed to explore married adults' perceptions, beliefs, and attitudes towards marriage and family therapy. Specifically with your perception of you seeking professional help from a marriage and family therapist for you and your spouse during times of relationship distress. If you are married and at least 18 years of age, you are eligible to participate. Your responses are anonymous and you will have the freedom to withdraw from the study at any time. We anticipate minimal risk to you from participating in this survey. This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech. The completion of the survey signifies your voluntary willingness to participate.

Should you have any questions or concerns about this research, its conduct, research participants' rights, and/or in the event of a research-related injury, please contact:

Jason Austin: jpaustin@vt.edu
David M. Moore, Chair, IRB: 540-231-4991; moored@vt.edu

Thank you for your time and consideration!

To participate in this survey, and confirm that you are married and at least 18 years of age, please click NEXT.

1. What is your gender?
- ❍ Female (1)
- ❍ Male (0)

2. What is your current marital status?
- ❍ Single (1)
- ❍ Married (2)
- ❍ Separated (3)
- ❍ Divorced (4)
- ❍ Widowed (5)

3. How old are you?

4. How many children do you have?

5. Which of the following best represents your racial or ethnic background?

- ❍ Non-Hispanic White (0)
- ❍ Black or African American (1)
- ❍ Latino or Hispanic (2)
- ❍ Asian (3)
- ❍ Hispanic White (4)
- ❍ Native Hawaiian or Other Pacific Islander (9)
- ❍ Middle Eastern or Arab American (5)
- ❍ Native American or Alaskan Native (6)
- ❍ Other (7)

6. Please indicate the highest level of education completed.

- ❍ I graduated middle school (1)
- ❍ I graduated high school or the equivalent (e.g., GED) (2)
- ❍ I have some college education (3)
- ❍ I have a Vocational/Technical Degree (4)
- ❍ I have an Associate Degree (5)
- ❍ I have a Bachelor's Degree (6)
- ❍ I have a Bachelor's Degree and some graduate education (7)
- ❍ I have a Master's Degree (8)
- ❍ I have a Doctoral Degree (9)
- ❍ I have a Professional Degree (MD, JD, etc.) (10)
- ❍ Other (11)

7. Which of the following best describes the area you live in?

- ❍ Urban (1)
- ❍ Suburban (2)
- ❍ Rural (3)

8. Please indicate your current annual household income in U.S. dollars

- ❍ Rather not say (1)
- ❍ Under $10,000 (2)
- ❍ $10,000 - $19,999 (3)
- ❍ $20,000 - $29,999 (4)
- ❍ $30,000 - $39,999 (5)
- ❍ $40,000 - $49,999 (6)
- ❍ $50,000 - $59,999 (7)
- ❍ $60,000 - $69,999 (8)
- ❍ $70,000-$79,999 (9)
- ❍ $80,000-$89,999 (10)
- ❍ $90,000-$99,999 (11)
- ❍ $100,000 - $109,999 (12)
- ❍ Over $110,000 (13)

9. Have you ever received mental health treatment before?

- ❍ No (1)
- ❍ Yes (2)

Instructions: Many places in this survey make use of rating scales with seven points. These scales will often have opposite, bipolar statements (such as agree-disagree, good-bad, etc.) on each end. The seven points on the scale should be interpreted as, for instance:

Bad:	1	:	2	:	3	:	4	:	5	:	6	:	7	:Good
	Extremely		Quite		Slightly		Neither		Slightly		Quite		Extremely	

Please click the circle between the two bipolar statements that best describes your opinion on each question. Some of the questions may appear similar, but they do address somewhat different issues. Please read each question carefully before answering.

Relationship distress is defined as periods of intense conflict, arguing, and fighting between you and your spouse marked by high stress and, possibly, leading to separation and/or divorce.

Relationship Distress Scale

1. How much relationship distress have you and your spouse experienced in the past six months?

	1	2	3	4	5	6	7	
None at all	❍	❍	❍	❍	❍	❍	❍	All the time

Direct Attitude Scale

1. My seeking professional help from a marriage and family therapist for my spouse and me during times of relationship distress would be:

	1	2	3	4	5	6	7	
Bad	❍	❍	❍	❍	❍	❍	❍	Good
Harmful	❍	❍	❍	❍	❍	❍	❍	Beneficial
Unpleasant	❍	❍	❍	❍	❍	❍	❍	Pleasant
Negative	❍	❍	❍	❍	❍	❍	❍	Positive
Detrimental	❍	❍	❍	❍	❍	❍	❍	Constructive
Painful	❍	❍	❍	❍	❍	❍	❍	Enjoyable
Worthless	❍	❍	❍	❍	❍	❍	❍	Valuable

Belief-based Attitude Scale

Behavioral Belief Strength

1. My seeking professional help from a marriage and family therapist for my spouse and me during times of relationship distress would...

	1 Extremely unlikely	2	3	4	5	6	7 Extremely likely
1. make things worse between my spouse and me	❍	❍	❍	❍	❍	❍	❍
2. be unproductive	❍	❍	❍	❍	❍	❍	❍
3. make me/us feel uncomfortable	❍	❍	❍	❍	❍	❍	❍
4. result in me and/or my spouse receiving a diagnosis and/or medication	❍	❍	❍	❍	❍	❍	❍
5. solve our problems	❍	❍	❍	❍	❍	❍	❍
6. lead to me/us experiencing social stigma (e.g., shameful feelings, feeling judged, disapproval from others, etc.).	❍	❍	❍	❍	❍	❍	❍
7. mean that our problems are more serious than I/we originally thought	❍	❍	❍	❍	❍	❍	❍
8. lead to a better	❍	❍	❍	❍	❍	❍	❍

understanding of the problem we are experiencing							
9. result in us staying together	❍	❍	❍	❍	❍	❍	❍
10. help us learn new relationship strategies and skills	❍	❍	❍	❍	❍	❍	❍
11. help us obtain a neutral, professional opinion	❍	❍	❍	❍	❍	❍	❍
12. mean that we (my spouse and I) can't solve our own problems without seeking professional help	❍	❍	❍	❍	❍	❍	❍

Outcome Evaluation

2. Picture each statement below filling in the blank of this sentence: It is bad/good for my spouse and/or I to _____.

	-3 Bad	-2	-1	0	1	2	3 Good
1. obtain a neutral, professional opinion	❍	❍	❍	❍	❍	❍	❍
2. experience social stigma (e.g., shameful feelings, feeling judged, disapproval from others, etc.).	❍	❍	❍	❍	❍	❍	❍
3. gain a better understanding of the problem we are experiencing	❍	❍	❍	❍	❍	❍	❍
4. discover that we (my spouse and I) can't solve our own problems without seeking professional help	❍	❍	❍	❍	❍	❍	❍
5. get worse because of therapy	❍	❍	❍	❍	❍	❍	❍
6. discover the problem is more	❍	❍	❍	❍	❍	❍	❍

serious that I/we originally thought							
7. experience therapy as being unproductive	❍	❍	❍	❍	❍	❍	❍
8. stay together	❍	❍	❍	❍	❍	❍	❍
9. learn new relationship strategies and skills	❍	❍	❍	❍	❍	❍	❍
10. feel uncomfortable during therapy	❍	❍	❍	❍	❍	❍	❍
11. receive a diagnosis and/or medication	❍	❍	❍	❍	❍	❍	❍
12. solve our problems	❍	❍	❍	❍	❍	❍	❍

Direct Norm Scale

1. Most people who are important to me think I should seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

2. Most people whom I respect and admire would support me seeking professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

3. Most people whose opinions I value think it is appropriate for me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

4. Most people who are important to me will seek professional help from a marriage and family therapist for them and their spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

5. How many of the people whom you respect and admire will seek professional help from a marriage and family therapist for them and their spouse during times of relationship distress?

	1	2	3	4	5	6	7	
Virtually none	❍	❍	❍	❍	❍	❍	❍	Almost all

6. Most people similar to me will seek treatment from a marriage and family therapist for them and their spouse during times of relationship distress.

	1	2	3	4	5	6	7	
Extremely unlikely	❍	❍	❍	❍	❍	❍	❍	Extremely likely

Belief-based Norm Scale

Injunctive Normative Scale

Injunctive Norm Belief Strength

1. How likely are the following people/groups to think or believe that you should seek professional help from a marriage and family therapist for you and your spouse during times of relationship distress:

	-3 Extremely unlikely	-2	-1	0	1	2	3 Extremely likely
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. Your friends	❍	❍	❍	❍	❍	❍	❍
3. Your spouse	❍	❍	❍	❍	❍	❍	❍
4. Younger people	❍	❍	❍	❍	❍	❍	❍
5. Older people	❍	❍	❍	❍	❍	❍	❍
6. Media (such as the Internet, magazines, TV, Yellow Pages, etc.)	❍	❍	❍	❍	❍	❍	❍
7. Well educated people	❍	❍	❍	❍	❍	❍	❍
8. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
9. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
10. Wealthy people	❍	❍	❍	❍	❍	❍	❍
11. Poor people	❍	❍	❍	❍	❍	❍	❍
12. Members from my own culture (race,	❍	❍	❍	❍	❍	❍	❍

ethnicity, nationality, religion, etc.)							

2. How likely are the following people/groups to think or believe that you should seek professional help from a marriage and family therapist for you and your spouse during times of relationship distress:

	-3 Extremely unlikely	-2	-1	0	1	2	3 Extremely likely	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

Motivation to Comply

1. When it comes to seeking professional help for relationship distress, I want to do what the following people/groups think I should do.

	1 Strongly disagree	2	3	4	5	6	7 Strongly agree	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

2. When it comes to seeking professional help for relationship distress, I want to do what the following people/groups think I should do.

	1 Strongly disagree	2	3	4	5	6	7 Strongly agree
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. Your friends	❍	❍	❍	❍	❍	❍	❍

3. Your spouse	❍	❍	❍	❍	❍	❍	❍
4. Younger people	❍	❍	❍	❍	❍	❍	❍
5. Older people	❍	❍	❍	❍	❍	❍	❍
6. Media (such as the Internet, magazines, TV, Yellow Pages, etc.)	❍	❍	❍	❍	❍	❍	❍
7. Well educated people	❍	❍	❍	❍	❍	❍	❍
8. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
9. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
10. Wealthy people	❍	❍	❍	❍	❍	❍	❍
11. Poor people	❍	❍	❍	❍	❍	❍	❍
12. Members from my own culture (race, ethnicity, nationality, religion, etc.)	❍	❍	❍	❍	❍	❍	❍

Belief-based Descriptive Norm Scale

Descriptive Belief Strength

1. How likely would it be for the following people/groups to seek professional help from a marriage and family therapist for them and their spouse if they are experiencing relationship distress?

	-3 Extremely unlikely	-2	-1	0	1	2	3 Extremely likely
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. Younger people	❍	❍	❍	❍	❍	❍	❍
3. Older people	❍	❍	❍	❍	❍	❍	❍
4. Well educated people	❍	❍	❍	❍	❍	❍	❍

5. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
6. Wealthy people	❍	❍	❍	❍	❍	❍	❍
7. Poor people	❍	❍	❍	❍	❍	❍	❍
8. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
9. My friends	❍	❍	❍	❍	❍	❍	❍
10. Members from my own culture (race, ethnicity, nationality, religion, etc.)	❍	❍	❍	❍	❍	❍	❍

2. How likely would it be for the following people/groups to seek professional help from a marriage and family therapist for them and their spouse if they are experiencing relationship distress?

	-3 Extremely unlikely	-2	-1	0	1	2	3 Extremely likely	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

Identification with Referent

1. When it comes to seeking professional help for relationship distress, how much do you want to be like the following people/groups?

	1 Not at all	2	3	4	5	6	7 Very much
1. Religious people (church goers, priests, pastors, etc.)	❍	❍	❍	❍	❍	❍	❍
2. Younger	❍	❍	❍	❍	❍	❍	❍

people							
3. Older people	❍	❍	❍	❍	❍	❍	❍
4. Well educated people	❍	❍	❍	❍	❍	❍	❍
5. Poorly educated people	❍	❍	❍	❍	❍	❍	❍
6. Wealthy people	❍	❍	❍	❍	❍	❍	❍
7. Poor people	❍	❍	❍	❍	❍	❍	❍
8. People and/or couples who have received therapy in the past	❍	❍	❍	❍	❍	❍	❍
9. My friends	❍	❍	❍	❍	❍	❍	❍
10. Members from my own culture (race, ethnicity, nationality, religion, etc.)	❍	❍	❍	❍	❍	❍	❍

2. When it comes to seeking professional help for relationship distress, how much do you want to be like the following people/groups?

	1 Strongly disagree	2	3	4	5	6	7 Strongly agree	9999 Not Applicable
1. My parents (mom, dad, step-parents, etc.)	❍	❍	❍	❍	❍	❍	❍	❍
2. My siblings (brothers, sisters, step-siblings, etc.)	❍	❍	❍	❍	❍	❍	❍	❍

Direct Control Scale

1. For me to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress would be...

	1	2	3	4	5	6	7	
Very difficult	❍	❍	❍	❍	❍	❍	❍	Very easy

2. To what extent do you see yourself as capable in seeking professional help from a marriage and family therapist for you and your spouse during times of relationship distress?

	1	2	3	4	5	6	7	
Very incapable	❍	❍	❍	❍	❍	❍	❍	Very capable

3. If I wanted to, I could easily seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

4. Whether or not I seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress is completely up to me.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

5. I feel in complete control over whether I seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Completely false	❍	❍	❍	❍	❍	❍	❍	Completely true

6. The number of events outside my control which could prevent me from seeking professional help from a marriage and family therapist for my spouse and me during times of relationship distress are...

	1	2	3	4	5	6	7	
Very few	❍	❍	❍	❍	❍	❍	❍	Numerous

Belief-based Control Scale

Power of Control Factor

1. Consider the following factors and circumstances. Please rate how each of them would make it easier or more difficult for you to seek professional help from a marriage and family therapist for you and your spouse during times of relationship distress.

	-3 Much more difficult	-2	-1	0	1	2	3 Much easier
1. The therapist's competency level (such as the ability to understand you, your spouse, and your culture; success rates; effectiveness; etc.)	❍	❍	❍	❍	❍	❍	❍
2. The therapist's personal background (such as his/her personality, gender, marital status, age, etc.)	❍	❍	❍	❍	❍	❍	❍
3. The therapist's credentials (such as educational background, licenses, etc.)	❍	❍	❍	❍	❍	❍	❍
4. The therapist's reputation	❍	❍	❍	❍	❍	❍	❍
5. The location of the therapist's office	❍	❍	❍	❍	❍	❍	❍
6. My spouse agreeing to seek professional help	❍	❍	❍	❍	❍	❍	❍
7. Knowledge about therapy	❍	❍	❍	❍	❍	❍	❍
8. Having a good fit between us (my spouse and I) and the therapist	❍	❍	❍	❍	❍	❍	❍
9. The therapy being confidential	❍	❍	❍	❍	❍	❍	❍
10. Insurance coverage (part or all of treatment)	❍	❍	❍	❍	❍	❍	❍
11. Cost of therapy	❍	❍	❍	❍	❍	❍	❍

12. Time commitment	❍	❍	❍	❍	❍	❍	❍
13. Childcare Issues	❍	❍	❍	❍	❍	❍	❍

2. Would the following factors concern you if you were considering seeking professional help from a marriage and family therapist for you and your spouse during times of relationship distress?

	1 Not at all	2	3	4	5	6	7 Very much
1. The therapist's competency level (such as the ability to understand you, your spouse, and your culture; success rates; effectiveness; etc.)	❍	❍	❍	❍	❍	❍	❍
2. The therapist's personal background (such as his/her personality, gender, marital status, age, etc.)	❍	❍	❍	❍	❍	❍	❍
3. The therapist's credentials (such as educational background, licenses, etc.)	❍	❍	❍	❍	❍	❍	❍
4. The therapist's reputation	❍	❍	❍	❍	❍	❍	❍
5. The location of the therapist's office	❍	❍	❍	❍	❍	❍	❍
6. My spouse agreeing to seek professional help	❍	❍	❍	❍	❍	❍	❍
7. Knowledge about therapy	❍	❍	❍	❍	❍	❍	❍
8. Having a good fit between us (my spouse and I) and the therapist	❍	❍	❍	❍	❍	❍	❍
9. The therapy being confidential	❍	❍	❍	❍	❍	❍	❍
10. Insurance	❍	❍	❍	❍	❍	❍	❍

coverage (part or all of treatment)							
11. Cost of therapy	❍	❍	❍	❍	❍	❍	❍
12. Time commitment	❍	❍	❍	❍	❍	❍	❍
13. Childcare Issues	❍	❍	❍	❍	❍	❍	❍

Behavioral Intention Scale

1. I intend to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Extremely unlikely	❍	❍	❍	❍	❍	❍	❍	Extremely likely

2. I will seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Extremely unlikely	❍	❍	❍	❍	❍	❍	❍	Extremely likely

3. I am willing to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Completely false	❍	❍	❍	❍	❍	❍	❍	Completely true

4. I plan to seek professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Strongly disagree	❍	❍	❍	❍	❍	❍	❍	Strongly agree

Past Behavior Scale

1. In the past, how often have you sought professional help from a marriage and family therapist for you and your spouse during times of relationship distress?

	1	2	3	4	5	6	7	
Virtually never	❍	❍	❍	❍	❍	❍	❍	Almost always

2. I have previously sought professional help from a marriage and family therapist for my spouse and me during times of relationship distress.

	1	2	3	4	5	6	7	
Completely false	❍	❍	❍	❍	❍	❍	❍	Completely true

Qualitative Questions

1. How can you tell the difference between marriage and family therapists and other mental health professionals (such as psychologists, psychiatrists, social workers, counselors, etc.)? Please type your response in the text box below.

2. Marriage and family therapists receive specialized training that focuses on relationship issues. What can marriage and family therapists do to encourage you to seek their services for relationship issues over other mental health professionals (such as psychologists, psychiatrists, social workers, counselors, etc.)? Please type your response in the text box below.