

**Individual Motivation to Seek Couple Therapy:
An Application of the Health Belief Model**

Lyn Moore O'Connell

Dissertation submitted to the faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

In

Human Development and Family Science

Dr. Megan Dolbin-MacNab, Committee Chair

Dr. Erika Grafsky

Dr. Jenene Case Pease

Dr. Rachel Tambling

March 2, 2018

Blacksburg, VA

Keywords: Couple Therapy; Motivation to Change; Barriers; Distress; Stigma; Health Belief Model

Copyright © - Lyn Moore O'Connell 2018

Individual Motivation to Seek Couple Therapy: An Application of the Health Belief Model

Lyn Moore O'Connell

ABSTRACT

Despite the well-established effectiveness of couple therapy for reducing distress and improving relationship satisfaction (Cohen, 1988; Christensen & Heavey, 1999), less than a fourth of couples seek couple therapy prior to divorce (Albrecht, Bahr, & Goodman, 1983; Wolcott, 1986). Rather, the majority of couples wait over 5 years before seeking therapy (Johnson et al., 2002). Barriers to seeking individual therapy are well established and are associated with decreased rates of therapy attendance and the negative consequences of untreated distress and mental health problems (Corrigan, 2004; Killaspy, Banerjee, King, & Lloyd, 2000; Vogel, Wade & Hackler, 2007). It is unclear as to whether the same barriers exist for individuals who are seeking couple therapy. This study examined the applicability of the Health Belief Model (HBM; Rosenstock, 1966), with the addition of demographic characteristics (gender, income, education, and religion) and contextualizing individual factors (relational distress and perceived stigma), to predict an individual in a committed relationship's ($N = 158$) motivation to seek couple therapy. When controlling for demographic variables and contextualizing factors, the Health Belief Model factors of lower barriers and lower benefits were predictive of higher motivation to seek couple therapy. Throughout all iterations of the model, lower income and lower relational distress were also associated with higher rates of motivation to seek couple therapy. This research indicates that barriers, including high levels of relational distress, impact an individual's motivation to seek couple therapy. Further investigation of the application of the HBM factors to mental health, including research into more systemic measurements of these factors, is needed. Future research should also identify other potentially contextualizing factors,

as the overall model accounted for a relatively small amount of variation in the individual's motivation to seek couple therapy.

Individual Motivation to Seek Couple Therapy: An Application of the Health Belief Model

Lyn Moore O'Connell

GENERAL AUDIENCE ABSTRACT

Couple therapy has been shown to provide relief for relationship distress and individual mental health problems (Cohen, 1988; Christensen & Heavey, 1999). Despite this, the majority of couples choose to either live with relationship distress prior to seeking couple therapy or never seek treatment prior to getting divorced (Albrecht, Bahr, & Goodman, 1983; Gottman & Gottman, 2013; Johnson et al., 2002; Wolcott, 1986). Unfortunately, very little is known about the reasons couples avoid couple therapy; therefore, this research is based on the established barriers found in the literature on why individuals do not seek mental health treatment. Because of the inclusion of an established help-seeking theory, known as the Health Belief Model (HBM; Rosenstock, 1966), the results of this study can more broadly inform individuals, couples, therapists, and policy makers about the reasons individuals may not seek couple therapy. An online survey of 158 couples indicated that higher levels of relationship satisfaction, lower income levels, lower perceived benefits to couple therapy, and lower perceived barriers to accessing treatment were associated with higher motivation to seek couple therapy. Overall, research should continue to examine the application of the Health Belief Model constructs (perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action) to mental health seeking behavior, especially couple and family therapy. Research should also identify other potential constructs, beyond those used in this study (gender, income, education, religion, self-stigma, and relational distress), that impact an individual's motivation to seek couple therapy.

Dedication

This dissertation is dedicated to my loving parents, Ian and Jill Moore, without whom I would not have been able to achieve my dreams. Words cannot express or acknowledge all of your selfless support that helped me get to where I am today. You have taken late night and early morning phone calls, driven thousands of miles, and lost incalculable hours of sleep to support me and my educational pursuits. Thank you, will never be enough. Instead, here is over a hundred pages of writing and years off my life dedicated to you! I love you very much.

This is also dedicated to my loving grandparents, who paved the way but never had the opportunity to see the success of their token American granddaughter. Thank you for raising my adventurous parents!

Acknowledgements

This degree and dissertation would not have been possible without the leadership and guidance of many inspirational strong women in my life.

While I was a freshman in college, a woman visited Franklin & Marshall and presented to a packed classroom about the opportunities of a Marriage & Family therapy degree. With her words, she forever changed the trajectory of my life.

Dr. Kathy Sullivan of Leesburg, VA provided me my first exposure to mental health through a summer time internship in residential care. She will never know just how far her faith and encouragement to pursue mental health has taken me. Thank you, Kathy.

Dr. Rachel Tambling, it is hard to express the impact you have had on me as a professor, a supervisor, a mentor, and a friend. I know the first rule of life is to not to throw up on yourself, thanks to you. But more importantly I know when to be empathetic but direct, guide while listening, and when to push beyond being comfortable. Thank you for serving on my committees for eight long years!

Dr. Megan Dolbin-MacNab, you have been a pillar of support through the past six years and I am so thankful you took a chance on me. I would not be the researcher, clinician, teacher, or person I am today without your guidance. Thank you for never giving up on me and always knowing the path, even when I felt lost. I am honored to be your advisee. Thank you!

Thank you also to my faculty and committee members, Dr. Erika Grafsky and Dr. Jenene Case Pease. Dr. Grafsky, I am so glad you joined the MFT faculty with your passion, advocacy, and ability to give the most needed and sincere advice. Dr. Pease, thank you so much for taking a chance on me late in the process and being willing to put in the work to help me through the final stages.

Lastly, I want to acknowledge the man who helps me become a stronger woman every day. Corey, other than saying yes to you, Virginia Tech was the best decision of my life because it brought you into my life. Thank you for challenging me, supporting me, and loving me though everything. I love you now and always.

Table of Contents

Chapter 1 INTRODUCTION	1
Statement of the Problem.....	1
Barriers to Individual Mental Health Treatment.....	6
Relational Mental Health Treatment.....	8
Help Seeking Behavior	13
Motivation to Change	16
Current Study	17
Chapter 2 REVIEW OF LITERATURE	20
Relational Distress	23
Perceived Stigma	28
Health Belief Model.....	34
Demographic Variables	47
Motivation to Seek Couple Therapy.....	54
The Present Study	58
Chapter 3 METHODOLOGY	62
Design Overview	62
Sample.....	62
Procedures.....	64
Measures	67
Open-Ended Questions	76
Data Analysis	76
Chapter 4 RESULTS	82
Participant Characteristics	82
Preliminary Analysis.....	86
Hierarchical Regression Analysis	91
Open-Ended Questions	94
Chapter 5 DISCUSSION	98
Demographic Factors	99
Contextualizing Factors	101
Health Belief Model.....	105
Personal Experiences	110
Limitations	114
Directions for Future Research	117
Clinical Implications.....	123
Conclusion	126
References	129
Appendix A Virginia Tech Institutional Review Board Approval	151
Appendix B Recruitment Material.....	152
Appendix C Inclusion Criteria	154
Appendix D Demographic Questions	156
Appendix E Self-Stigma Scale.....	161

Appendix F Couples Satisfaction Index (CSI-32)	161
Appendix G Health Belief Model Scales	164
Appendix H Modified R-URICA.....	171
Appendix I Open-Ended Questions	172

List of Figures

1	Conceptual Model.....	61
---	-----------------------	----

List of Tables

1	Sample Demographics	82
2	Education & Employment.....	83
3	Household Income	84
4	Religion & Spirtuality.....	85
5	Scale Scores for Regression Variables	87
6	Correlation Matrix	90
7	Heirarchical Regresion Analysis Summary Results	92
8	Couple Therapy Topics.....	95

Chapter 1

INTRODUCTION

Statement of the Problem

The majority of individuals struggling with individual mental health issues or relational distress do not seek treatment. Of those in need of services, approximately 10% access mental health services and another 5% choose to access religious or community groups, instead of professional mental health services (United States Department of Health & Human Services [DHHS], 1999). Formal and informal barriers are hypothesized to be one potential reason for the underutilization of mental health services. Formal barriers include a lack of transportation, high costs, and excessive time-constraints (Ackerman, Colapinto, Scharf, Weinshel, Winawer, 1991; Baker-Ericzén, Jenkins, & Haine-Schlagel, 2013; Larke, 1985; Weakland & Jordan, 1990). Informal barriers to seeking mental health treatment include the stigma associated with mental illnesses and mental health treatment, lack of awareness of treatment opportunities, and misperceptions about seeking treatment (Corrigan & Matthews, 2003; Vogel, Wade, & Hackler, 2007). These formal and informal barriers have been well established as the primary reasons individuals do not seek treatment for mental health issues (Baker-Ericzén et al., 2013; Corrigan, 2004; Doss, Simpson, & Christensen, 2004, Vogel et al., 2007). However, as these barriers have only been examined in the context of individual mental health services, it is unclear whether individuals in need of couple therapy face the same barriers.

Researchers and practitioners are aware of the gap between the number of couples experiencing relational distress and the number of couples accessing therapy (Morrill et al., 2011). Unfortunately, little has been done by researchers to identify the factors that impact relational treatment seeking behavior or by clinicians to improve access for these struggling

couples. Much of the literature on this topic is dated, as will be seen throughout this research. It is necessary to close this gap, both in treatment and in the literature, as relational distress is negatively effecting not just on the couple relationship but also the children, individuals in the relationship, and the larger community. Relational distress is a risk factor for children in the home developing behavioral problems, mental health disorders, poor school performance, and attachment problems that may follow them into adulthood (Erel & Burman, 1995; Laumakis, Margolin, & John, 1998). Within the couple relationship, relational distress increases each individual's likelihood of developing a mental health disorder such as depression, anxiety, or a substance use disorder (Jacob & Krahn, 1988; Whisman, 2013). Individuals with mental health disorders, especially those with Major Depressive Disorder (MDE; DSM-IV) are 15% more likely to use illicit drugs, engage in risk taking behavior, or attempt suicide ("Suicide and self-inflicted injury," 2015). Mental illness, suicide, and substance use disorders have significant costs to the larger society in productivity, care and treatment, and loss of life (Department of Health and Human Services (DHHS), 1999). Society benefits from a reduction in these life-altering illnesses, therefore, researchers and providers should focus on identifying how to motivate people to seek treatment for relational distress before it has far more significant consequences.

Couple therapy remains an effective but underutilized intervention to reduce relational distress (Johnson et al., 2002). Therefore, research needs to focus on the individual and systemic factors that influence motivation to seek couple therapy. Once barriers of motivation to seek couple therapy are recognized, they can be addressed to improve access to couple therapy, which in turn will reduce the negative consequences on the individual, couple, family, and larger community (Eubanks, Fleming, & Cordova, 2012). The purpose of this study was to identify

what factors impact an individual's motivation to seek couple therapy based on the established constructs in the individual help seeking literature, such as the Health Belief Model constructs (Rosenstock, 1966) and other contextualizing factors such as self-stigma (Vogel et al., 2007).

Historical focus on individual mental health. Individual mental health has long been the focus of treatment and research in the United States and globally. In the late 1990s, improving access to mental health treatment for individuals was a priority of the United States Government and the World Health Organization (WHO). This was due to the negative consequences of not treating mental illnesses on both the individuals impacted and greater society (Global Disease Report, 2003; Department of Health and Human Services (DHHS), 1999). The WHO and United States government initiated a special investigation and comprehensive report on the negative consequences of mental illness. Specifically, the effects of depression, substance abuse disorders, self-inflicted injuries, schizophrenia, bipolar affective disorder, and panic disorders were identified as the leading causes of disability in the United States (Department of Health and Human Services, 1999).

The 1999 DHHS report was eventually updated with a supplement in 2001, which highlighted the need to consider culture, race, and ethnicity as they relate to the treatment of and research on mental health issues. Currently, the initial and supplemental WHO and DHHS reports remain the most comprehensive national reports on mental illness. They continue to inform policy and initiatives regarding mental illness nationally and globally. More recently, an organization known as Mental Health in America (MHA) has started to release annual rankings of mental health and accesses to services for each of the 50 states to call attention to poor performing states and general lack of access to services (MHA, 2017).

While they bring needed attention to the devastating impacts of mental illness on individuals, families, and communities, the WHO and DHHS reports from 1999 and 2003 and the more recent MHA annual reports focus solely on individual patients, individual mental illness diagnoses, and individual treatment options. As such, the current reports on mental illness do not account for the detrimental role that couple and relational distress can play on an individual's mental health; especially publically humiliating marital events (i.e. affairs), which have been associated with dramatic increases in individual mental illness (Cano & O'Leary, 2000). Even more typical relational distress is associated with increased risk of developing a mood disorder, depressive symptomology, or an anxiety disorder in one or both partners (Whisman & Beach, 2012; Whisman, 2013).

By solely focusing on individual diagnoses and treatment, these WHO and DHHS reports also ignore couple therapy as a potentially effective treatment for individual mental health issues or relational distress (Chambless, Miklowitz, & Shoham, 2013). Couple therapy has been shown to improve what are often perceived as individual problems such as a Substance Use Disorder or individual mental health disorder (Doss, Atkins, & Christensen, 2003; Johnson et al., 2001; Sprenkle & Blow, 2004). Additionally, when examining barriers to treatment, these reports also fail to consider the role of the partner on the relationship as a potential barrier or asset to accessing treatment. For this reason, greater understanding of the factors that affect an individual's motivation to seek couple therapy are needed.

No subsequent substantial reports on mental illness in the United States were initiated until President Obama's Executive Order (2012) and then the Obama Mental Health & Substance Use Disorder Parity Task Force report (2016), both of which renewed the government's focus on addressing mental illness and substance use disorders. These reports

were unique in that they referenced the family, and their need for services, however, they only focused on military families. Obama's 2012 executive order, entitled "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," called for a focus on improving access to mental health care not only for individuals but also for the families of service members (Obama, 2012). The release of the 2016 task force report also called to attention the significant effect of mental illness can have on families. The report stated:

Mental illness can be particularly disruptive for families, as family members often serve as caregivers for loved ones with serious mental illness. Substance use disorders frequently rob the happiness, potential and lives of the people who have them and significantly strain family and friends. (Obama Task Force, 2016, p. 5)

As suggested by these reports, it is necessary to broaden the conversation and research beyond individual mental health and treatment focused on the individual. Nonetheless, research on mental health treatment, including barriers to accessing treatment, has remained focused on the individual (Bazargan, Bazargan, & Baker, 1998; Corrigan, 2004; Vogel et al., 2007).

Reports that initiate a conversation about mental health treatment that is broader than just the individual are important (Obama, 2012). However, it is necessary to accelerate a focus on relational distress and barriers to accessing couple therapy. It is especially important to utilize current literature and help-seeking theories to conceptualize and effectively examine the multiple individual and systemic factors that impact an individual's motivation to seek couple therapy. Researchers are aware of this gap in the literature and have encouraged a greater focus on better understanding the help-seeking behavior of couples and families (Doss et al., 2004). It is essential that relational-barriers are identified and established by researchers so that the barriers to seeking couple therapy can be addressed, thereby reducing the negative consequences individuals, couples, and the larger community face when mental health needs go untreated. This research seeks to address the current literature gap by utilizing the theoretical framework

provided by the Health Belief Model (HBM), which predicts individual help-seeking behavior, to identify the factors that impact an individual's motivation to seek couple therapy (Rosenstock, 1966).

Barriers to Individual Mental Health Treatment

Based on the lack of theory-driven research on barriers that impact an individual's motivation to seek couple therapy, it is necessary to utilize the current research on the barriers that individuals face when seeking individual mental health treatment and identify whether or not those barriers are relevant to couple therapy. Couple therapy is a well-established, evidence-based, and an effective treatment for a variety of mental health diagnoses and relational problems (Piper, Ogrodniczuk, Joyce, & Weideman, 2011). Unfortunately, although mental health treatment has been proven to be effective at resolving distress and a wide range of mental health and even physical problems (Baker & Cementon, 2014), individuals still report significant barriers to seeking treatment. These include individual demographic factors as well as formal and informal barriers. To better understand the experience of the individual who needs but does not seek couple therapy, demographic variables along with contextualizing factors such as self-stigma and relationship distress were assessed within the context of the HBM (Rosenstock, 1966). The HBM provided a theoretical underpinning for this research with the addition of established individual constructs that predict help-seeking behavior (i.e. perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action). Individual factors, contextualizing factors, and the HBM constructs were examined to identify what factors impact the individual's motivation to seek couple therapy.

Individual factors. Individual factors, including education, gender, income, and religion, have been identified as influencing an individual's ability to seek treatment (Kirby &

Keon, 2006; Vessy & Howard, 1993; Wesselmann & Graziano, 2015). For example, prior research indicates that highly educated, middle-aged, higher-income earning, Caucasian individuals are more likely to seek mental health treatment than other populations (Vessy & Howard, 1993). This is likely due to these individuals' ability to overcome formal barriers to treatment including high cost, lack of transportation, scheduling conflicts, and a lack of child-care (Bazargan et al., 1998). Informal barriers including lack of knowledge about couple therapy, the impact of stigma, and mismatched expectations may also impact the decision-making process (Corrigan & Penn, 1999). Religious belief may increase stigma about mental health treatment or encourage people to seek help within the church rather than from an outsider (Wesselmann & Graziano, 2015). Although certain individual characteristics such as income and gender may impact someone's motivation to seek mental health treatment, it is likely that these individual factors impact their relationship with other informal or formal barriers. For example, a female in a low-income minority community may be more adversely affected by self-stigma than someone else who does not have as many confounding barriers. This research will control for these demographic variables to identify what factors significantly impact an individual's motivation to seek couple therapy.

Stigma. When considering why someone would or would not consider treatment, especially related to mental illness or relational distress, it is essential to acknowledge the role of stigma. Stigma, which the original Greek denotes as someone who is "stained" and different than society, prevents individuals and couples dealing with mental health issues from acknowledging that they have a problem because they do not want to be associated with "those people" (Corrigan, 2004). There are two types of stigma, both with damaging effects. Individuals may hide their need for therapy or avoid seeking mental health treatment because

they are afraid of the effects of *public stigma* (Corrigan & Matthews, 2003), or society's negative impression of them. *Self-stigma* reflects the negative effect mental illness has on individuals' self-esteem or self-worth because they identify themselves as being part of "the unacceptable" in society (Vogel Wade, & Haake, 2006). Stigma is not experienced the same universally; some populations, such a minority groups, may experience higher levels of self-stigma (Kirby & Keon, 2006). This is due to the compounding effect of stigma on an individual in a minority group who is already perceived as being "other than" the general population based on their minority status. These individuals may be reluctant to identify themselves with any other self-inflicted stigmatizing status, such as having a mental health problem or needing couple therapy (Cooper et al., 2003).

Relational Mental Health Treatment

Couple therapy has been shown to be widely effective at treating not only "individual" issues such as addiction and depression (de Larocque, Wecker, Usubelli, Aubague, & Michaud, 2015; Nelson & Sullivan, 2007; Whisman & Beach, 2012), but also couple issues such as poor communication, sexual displeasure, extra-dyadic relationships, or parenting disagreements (Butterworth & Rodgers, 2008; Lebow, Chambers, Christensen, & Johnson, 2012; Sprenkle, 2003). Unfortunately, societal norms appear to indicate that couple therapy is only for the most severely distressed couples, such as those experiencing violence or trauma (Doss et al., 2004). However, these norms prevent the majority of the population from seeking couple therapy as a possible source of assistance (Doss et al., 2004). Therefore, although couple therapy is effective for a wide range of issues, including reducing relational distress, the persistent problem is that a large number of couples never seek treatment (United States Department of Health and Human Services, 1999), in part due to formal and informal barriers to treatment.

Relational distress. The past decade has seen a significant increases in research on relational or couple distress, identifying it as one of the most frequent reasons people seek couple therapy (Lebow et al., 2012). Relational or couple distress is often used as a catch-all term for high levels of conflict between partners or a lack of agreement within the couple relationship. Relational distress results in impairments in individual and relationship functioning (DSM-V, 1994). Relational distress not only affects relationship success (i.e., whether the relationship is maintained or dissolved), but it has also been linked to an exacerbation of individual mental health issues, including an increase of anxious or depressive symptomology (Cano & O’Leary, 2000), role impairment, poor work performance, and compromised physical health (Whisman & Uebelacker, 2006). Untreated mental health issues in one or both members of the relationship also influences the overall relationship quality and increases the likelihood of relationship dissolution (Butterworth & Rodgers, 2008). Unfortunately relational distress is very common, with 20% of couples reporting marital distress (Bradbury, Fincham, & Beach, 2000), but only 10% of those couples report-seeking treatment (Johnson et al., 2002). Additionally, of those couples that sought treatment, the majority waited six years before going to therapy (Gottman & Gottman, 2013). Untreated relational distress increases the likelihood of divorce (Lebow et al., 2012). Of those couples that divorce, only a quarter reported seeking couple therapy prior to divorcing (Johnson et al., 2002). Thus, the majority of couples experiencing relational distress are not seeking effective treatment prior to divorcing (Center for Disease Control, 2012; Johnson et al., 2002).

Not all couple relationships may be maintained by therapy, as relationship resolution is not always the goal of couple therapy, but it is possible that couple therapy may help repair couple relationships, improve communication, and promote positive outcomes for the individuals

in the relationship and the relationship as a whole (Anker, Owens, Duncan, Sparks, 2010).

Regardless of the outcome of couple therapy, it is necessary to understand why individuals do not seek couple therapy but rather live temporarily or permanently with the negative consequences of relational distress.

Reason for not seeking therapy. Researchers have long questioned why couples do not seek couple therapy. The current research on this topic has often focused on retrospective examinations of divorced couples, has focused on the individual, lacked a theoretical framework or validated scale, and utilized a clinically distressed sample population (Butterworth & Rodgers, 2008; Gottman & Gottman, 1999; Wolcott, 1986). Wolcott (1986) conducted a retrospective examination of couples who had divorced and asked them why they did not seek therapy before divorcing. Wolcott found that 33% of participants reported that their spouse was unwilling, 17% reported that they did not think anything was wrong, and 9% reported that it was a private matter. The most common reason cited was that it was “too late” (Wolcott, 1986). This was again found by an unpublished, but widely cited, study by Gottman and Gottman (1999), which found that most couples experiencing relational distress wait over 6 years before seeking couple therapy. These retrospective examinations of divorced samples provide insight into why couples think they did not seek treatment but does not provide insight into the motivation of a more general couple population. Research that only focuses on distressed couples is skewed towards individuals who were less likely to seek treatment in general, as the literature indicates that more distressed individuals are often less likely to seek treatment (Butterworth & Rodgers, 2008). These studies also requested individuals to think back about why they didn’t seek treatment with someone they divorced, a potentially upsetting and volatile memory, which may lead an individual to indict their partner’s behavior more than their own. Lastly, this research was

focused on the individual rather than on relational help-seeking behavior (Butterworth & Rodgers, 2008; Gottman & Gottman, 1999; Wolcott, 1986).

Another more prominent study surveyed heterosexual married couples who had accessed couple therapy and were clinically distressed (Doss et al., 2003). Participants were asked to complete a not yet validated scale about the steps involved in seeking couple therapy. Doss et al. (2003) asked participants to identify the role of their partner in the initiation of seeking therapy. This is an additional study limited by only including distressed couples. Another key limitation is that these were couples that had successfully sought therapy, which was provided free of charge based on a larger study. Doss et al.'s (2003) research helps inform the steps a couple takes in accessing therapy and makes an important contribution to the dyadic literature, however it does not identify the reasons a couple would not seek therapy, such as barriers and stigma.

Another study examined couples, some of whom had and others who had not sought couple therapy about their intention to seek couple therapy (Bringle & Byers, 1997). This study focused on an individual's locus of control and potential presenting problems for which people might seek therapy. Bringle & Byers (1997) found individuals with prior couple therapy attendance were predisposed towards going to counseling in the future. They also found significant gender differences in regards to what individuals are willing to seek treatment for (Bringle & Byers, 1997). Both men and women agreed that if they wanted a divorce or if there was violence in the relationship, couple therapy would be effective (Bringle & Byers, 1997), however, they didn't see it as beneficial for jealousy, sex, child rearing, housework, money, or conflict with in-laws (Bringle & Byers, 1997).

More recently, Halford and Snyder (2012) found that couple therapy is less effective with couples with higher levels of distress. This was hypothesized to be due to the overwhelming

nature of relational distress. Overly distressed couples may not be able to overcome barriers to seek therapy or do not think it is going to work, so they do not want to put in the effort. For these couples, it appears as if distress is serving as a barrier to accessing treatment. Halford and Snyder (2012) examined the effectiveness of couple therapy but did not examine those individuals who were unable to access or engage in couple therapy. This research reinforces the need for the inclusion of distress as a key construct in understanding an individual's motivation to seek couple therapy along with other barriers.

Relational barriers. The current project is based on the framework provided by the theories and literature of individual help-seeking behavior due to the lack of research on the barriers that impact an individual's motivation to seek couple therapy. Unlike individuals, couples may face unique reasons for not seeking treatment and more systemic barriers to seeking treatment. These may include the need for both partners to be motivated to engage in treatment, the effort required for both individuals to overcome formal barriers such as child-care and fears about discussing topics that are perceived as intimate or private in the relationship (Doss et al., 2003; Weakland & Jordan, 1990). For example, couples may need to talk about infidelity, anger or violence, sexual problems, or something seemingly small like what they argue over, all of which they may perceive to be very private or embarrassing. This indicates that the reasons a couple may need couple therapy (i.e. intimate partner-violence or problems with sexual intimacy) are serving as a barrier to their motivation to seek couple therapy because of the perception that that may be judged or stigmatized for their problem. When it comes to couple therapy, there are individual barriers, couple barriers, and the intersection of the two (Johnson et al., 2002). Within the couple system each individual is impacted by the other's decision-making process (Becvar & Becvar, 1982). Systems theory supports these hypotheses in its articulation of

the interconnectedness of different roles in relationships and families, which include, for example, the scapegoat in the family who is blamed for all conflict and problems (Becvar & Becvar, 1982). In couple relationships, individuals may perceive their partners to be the source of the problem and seek therapy for how to cope with their partners or soft-mandate their partners into individual treatment for what, in both cases, is a relational problem (Moore, Tambling & Anderson, 2013). As highlighted by this discussion, there are many potential barriers to individuals seeking couple therapy. However, these reasons remain hypotheses, as they have not been examined empirically.

To prevent negative or highly conflictual divorces or increases in individual mental health distress, it is important to better understand why couples are not motivated to seek treatment and how to improve access to available treatment. The current project is grounded in the theoretical framework provided by the HBM and utilized validated scales to measure other potentially impactful contextualizing constructs (self-stigma and relational distress) to identify what factors impact an individual's motivation to seek couple therapy (Rosenstock, 1966).

Help Seeking Behavior

Based on the historical focus towards individuals and individual help-seeking behavior many different models of individual help-seeking behavior have been developed. The majority of these models propose hierarchical stages through which the individual moves with increasing likelihood of making a change (Prochaska & DiClemente, 1982; Rosenstock, 1966). These models are used to inform public health campaigns, clinical interventions, and predict individual behavior (Prochaska & DiClemente, 1982; Rosenstock, 1966). Unfortunately, the predictive nature of these models has yet to be applied to the behavior of couples or families. As such, it is unclear whether these models wield the same predictive capability towards couples and families

or whether they measure uniquely individual constructs. For example, considering an individual stage-based help-seeking model, an individual progresses through the stages towards making a successful change. However, in a relationship there are two individuals. Does each individual progress through the stages of change simultaneously? How does each individual's stage progress or lack of progression impact their partner? These individual help-seeking models may be able to help inform how individuals in couple relationships become motivated to seek therapy, nevertheless they may not be able to account for or currently consider relational constructs. Currently these models provide the framework to start considering differences between individual and couple's motivation to seek help.

A recent American Psychological Association [APA] (2013) article encouraged the application of the HBM to the underutilization of mental health care services (Sullivan, Pasch, Cornelius, & Cirigliano, 2004). In response to this call, this study sought to use the HBM to explain why individuals in couple relationships are not motivated to seek couple therapy. Existing literature lacks a clear theoretical framework to conceptualize a predictive model of motivation to seek couple therapy, however this project addressed this need by including the established constructs of the HBM (Rosenstock, 1966).

Health belief model. Based on the countless factors that may influence an individual's decision to seek couple therapy, this research started with an examination of the HBM constructs. The HBM was developed to explain and predict health-seeking behavior, specifically why people did not participate in disease preventing activities even when there were proven benefits (Stretcher & Rosenstock, 1997). The HBM is based on the concept that personal perceptions, which are influenced by interpersonal factors, influence whether or not individuals will engage in strategies available to them to help with a problem.

The HBM initially focused on four major constructs: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers (Rosenstock, 1966). These perceptions or constructs, whether in conjunction with each other or in isolation, are used to explain whether or not a person is likely to engage in healthy behaviors. Perceived susceptibility is an individual's perception of the likelihood that they are susceptible or vulnerable to the negative health effects of a disease or disease occurrence (Rosenstock, 1966). Perceived severity refers to how much the individual thinks the negative condition (i.e., disease or illness) would affect their life emotionally and financially (Rosenstock, 1966). Perceived benefits to action are related to the individual's belief that they can do something to reduce their susceptibility to and the severity of the condition (Rosenstock, 1966). Perceived barriers to action are the individual's belief that action would be difficult, inconvenient, expensive, painful, or upsetting and, therefore, they may not act (Rosenstock, 1966). Later research supported the inclusion of a fifth construct, cues to action (Janz & Becker, 1984). Cues to action are an individual's personal connection to external people, places, or events that increased their readiness towards making a behavior change.

The constructs within the HBM have an additive effect. For example, if an individual perceives themselves as susceptible to a negative outcome and perceives the severity of risk to be high, then they will perceive a problem to be a threat, which increases the likelihood that they will do something about it. Their perceived susceptibility and perceived severity may be influenced by other modifying factors (gender, SES, education, and religion; Kirby & Keon, 2006; Vessy & Howard, 1993; Wesselmann & Graziano, 2015) or may be influenced by cues to action (Janz & Becker, 1984). If an individual knows someone who has recently experienced the same problem, the individual's personal connection to that person means they are more intimately connected, and thereby motivated by the negative consequences that person

experiences. However, just perceiving a threat does not cause changes in behavior. Rather, according to the HBM, the greatest influence on the individual's likelihood to act is their perception of benefits minus perceived barriers (Janz & Becker, 1984).

The HBM assess constructs that are theorized as being impactful to an individual's motivation to seek help. Previously, the HBM has been applied to cervical cancer screening (Austin, Ahmad, McNally, & Stewart, 2002), HIV testing (Rosenstock, Strecher, & Becker, 1994), and health screenings (Aiken et al., 1994). More recently, the HBM has been applied to couples' beliefs about attending premarital therapy (Borowski & Tambling, 2015; Sullivan et al., 2004) and adolescents' beliefs about attending therapy (O'Connor, Martin, Weeks, & Ong, 2014). For example, Borowski and Tambling (2015) used the HBM to identify that susceptibility to divorce, perceived barriers to treatment, especially for younger adults, and the perceived benefits of premarital therapy, were predictive of an individual's decision to seek treatment. Similarly, O'Connor et al., (2014) found that perceived benefits and perceived barriers were direct predictors of help seeking in an adolescent population, but perceived benefits were a moderating variable and appeared more important than barriers in predicting help-seeking behavior. O'Conner and colleague's (2014) study did not find perceived susceptibility to be predictive of help-seeking behavior, unless the individual believed strongly in the benefits of counseling. While the HBM has shown promise with individual help-seeking behavior, it has not yet been applied to motivation to seek couple therapy, despite recent encouragement from the APA for this application (Sullivan et al., 2004).

Motivation to Change

Motivation has long been considered a prerequisite for seeking mental health treatment (Schottenfeld, 1989), however most of the current models of motivation conceptualize it as an

individual construct (Prochaska & DiClemente, 1982). Limited research has focused on motivation to change from a relational perspective (Bradford, 2012; Moore et al., 2013). Moore et al. (2013), found that individuals who were pressured to attend treatment by a partner or family member, but not legally mandated, could have successful outcomes. This suggests that internal motivation may not be a prerequisite for engagement or that motivation can be shared (i.e., the partner is motivated so the other partner becomes motivated). Little is known about what factors may be impacting the individual's motivation to seek help for a relational problem. The majority of research on a couples' motivation to change has ascribed a single stage of motivation to the couple rather than assessing each individual's motivation to change (Bradford, 2012; Bradford, LaCoursiere, & Vail, 2010). The development of an effective measure of a couple's motivation to change has yet to be established empirically. Current research has not clarified whether or not each individual's motivation to change matters in the decision to seek couple therapy or how each individual's motivation to change influences their partner's motivation to change. Based on the lack of clarity about what factors impact an individual's motivation to change and the role of motivation to relational therapy in general, this research will examine what factors may impact an individual's motivation to seek couple therapy.

Current Study

Relational distress significantly impacts the personal well-being of individuals and increases the likelihood of relational dissolution (Morrill et al., 2011), however couple therapy remains to be an established intervention to reduce relational distress (Sprenkle & Blow, 2004; Johnson et al., 2002). Due to the high rates of relational distress and low rates of therapy attendance by couples, it is necessary to focus research on the reasons that individuals in relationships are not seeking couple therapy. Current literature, which is dated, on couple's

decision-making processes in regards to therapy has been retrospective, non-theoretically driven, and focused on a clinically distressed population (Doss et al., 2003; Halford & Snyder, 2012; Wolcott, 1986). In response to this gap in the literature, this study utilized the conceptual framework and constructs provided by a well-established theory, the HBM (Rosenstock, 1966). The HBM model promotes the incorporation of individual factors and other contextualizing factors (i.e. stigma and relational distress), which were identified from other established help-seeking literature to predict why an individual will or will not engage in an effective treatment. This research also focused on recruiting a non-clinically distressed sample. Relational distress was measured and controlled for in this sample. Distress clearly impacts an individual's decision to seek therapy, therefore it was included as a predictive factor (Butterworth & Rodgers, 2008) to better understand why some are motivated to seek couple therapy while others are not. By incorporating a well-established theory (HBM; Rosenstock, 1966), along other individual and contextualizing factors, this research helped identify what factors impact an individual's motivation to seek couple therapy.

As noted previously, this study explored the role of the five major constructs of the HBM (i.e., perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action), contextual factors (perceived stigma and relational distress), and individual factors on an individual's motivation to seek couple therapy. The study was guided by the following research questions:

1. To what extent do demographic characteristics (i.e., gender, SES, education, and religion) predict an individual's motivation to seek couple therapy?

2. To what extent do demographic characteristics (i.e., gender, SES, education, and religion) and contextualizing factors (i.e., relational distress and perceived self- stigma) predict an individual's motivation to seek couple therapy?
3. To what extent do HBM factors (i.e., perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action) predict an individual's motivation to seek couple therapy for relational distress, when controlling for demographic characteristics and contextualizing factors?

Chapter 2

REVIEW OF LITERATURE

Over the past 20 years, the number of marriages ending in divorce has remained relatively constant at approximately 48% to 50% (CDC, 2012; National Center for Family & Marriage Research, 2009). Simultaneously, the number of couples reporting relational distress without seeking couple therapy has also remained relatively stable at 20% of married couples (Bradbury et al., 2000). Half of all divorces occur within the first seven years of marriage and relational satisfaction drops markedly during the first decade of marriage for those who remain married (Bradbury et al., 2000; Lebow et al., 2012). Furthermore, only one third of married individuals report being “very happy” in their marriage and, in a work place study, 65% reported family issues, including couple difficulties, as considerably difficult or extremely difficult (Shumway, Wampler, Dersch, & Arredondo, 2004). The high degree of couple distress reported by the general population is unfortunate, given that couple therapy is a potentially effective intervention for addressing couple distress. (Matusiewicz, Hopwood, Banducci, & Lejuez, 2010; Piper et al., 2011; Sprenkle, 2003; United States Department of Health and Human Services, 1999). One potential reason for the underutilization of services is the barriers individuals and couples face when seeking mental health treatment. Minimal research has explored the factors that may prevent an individual from being motivated to seek couple therapy. Individual-treatment seeking literature suggests distress levels, perceptions of self-stigma, and perceived need or effectiveness of therapy may impact the decision making process (Vogel et al., 2007). However, research on individual-help seeking behavior has not yet been extrapolated to couple therapy or been conducted with couples.

In recent years, marriage and family therapy researchers have worked diligently to expand the breadth of couple and family therapy research, documenting treatment efficacy in reducing the negative influence of mental illness, relationship distress, conflict, or violence, and in improving individual, couple, and family well-being (e.g., Christensen, Atkins, Baucom, & Yi, 2010; Corrigan & Watson, 2002; Gottman & Gottman, 2013; Sprenkle, 2003). Many different relational treatment modalities, such as Emotion Focused Couple Therapy, have shown effectiveness in the alleviation of couple distress (Johnson & Talitman, 1997; Piper et al., 2011; Sprenkle, 2003). Furthermore, meta-analytic studies of couple therapy have shown it to be as effective as other psychological or pharmacological interventions at reducing distress (Shadish & Baldwin, 2003). These studies of couple therapy also indicate that improvements in the relationship that are a result of therapeutic interventions, tend to be maintained for at least 6 months after treatment (Shadish & Baldwin, 2003).

There are many different systemic treatments that have been used with couples, however; no single approach to couple therapy has been shown to be more effective than others (Halford & Snyder, 2012). Due to the existence of multiple effective treatment methods and a lack of funding, specifically for couple therapy research (United States Department of Health and Human Services, 1999), researchers have recently sought to focus on common factors across different approaches, the integration of different approaches, and the modification of therapy based on a live feedback-loop from the clients (Halford & Snyder, 2012). Research that establishes couple therapy as effective is important (Sprenkle, 2003), however, couple therapy is not beneficial to those who are unable to access it. The majority of couples experiencing relational distress continue to suffer from the negative consequences without treatment (Gottman & Gottman, 2013; Sprenkle, 2003). Current research on this topic has often utilized a

retrospective examination of a clinically distressed divorced population to examine why they did not seek treatment before divorcing (Doss et al., 2003; Halford & Snyder, 2012; Wolcott, 1986). These few studies also lacked a clear theoretical framework to analyze the systemic nature of seeking couple therapy and the multiple factors that may impact the individual (Doss et al., 2003; Halford & Snyder, 2012; Wolcott, 1986). No known research utilizes an established theoretical framework to examine the role of individual factors and contextual factors on an individual's motivation to seek couple therapy. Therefore, this research is necessary to identify the barriers these couples face, which, once addressed, can reduce the underutilization of services.

To better understand the reasons individual do not seek couple therapy, it is necessary to start with the constructs established by the individual help-seeking literature. Two factors that significantly impact an individual's decision-making process in regard to mental health therapy and which seem particularly relevant to seeking couple therapy are an individual's experiences of distress (Shadish & Baldwin, 2003) and an individual's experience of self-stigma towards mental health treatment (Vogel et al., 2007). Since relational distress is the main reason an individual may be seeking couple therapy it is important to understand if it also serves as a barrier to accessing this type of help (Lebow et al., 2012). Stigma is also well established as a barrier to seeking individual mental health and substance use treatment, but it is unclear if it plays a role in accessing couple therapy (Vogel et al., 2007).

Current individual help-seeking research indicates that demographic characteristics including gender (Ojeda & Bergstresser, 2008), income (Coker, 2005; West, Kantor, and Jasinski, 1998), educational level (Kirby & Keon, 2006), and religiosity (Wesselmann & Graziano, 2015) also impact an individual's ability or wiliness to seek mental health treatment. These individual variables impact not only the decision to seek therapy, but they also likely

impact an individual's experience of stigma and relational distress. The current individual help-seeking literature indicates that the individual's decision to seek help is not impacted solely by one variable, therefore, it is necessary to utilize an established theoretical model to understand the interconnectedness of variables on an individual's beliefs about seeking help.

The HBM is an established model to explain and predict preventative health behavior based on an individual's beliefs (Rosenstock, 1966). The HBM utilizes five constructs (i.e., perceived ...susceptibility, severity, barriers, benefits, and cues to action) to explain why some individuals do not engage in health interventions that they know to be beneficial (Rosenstock, 1966). The HBM has not yet been applied to an individual's beliefs about seeking couple therapy but it provides the necessary conceptual model to more accurately explore factors that impact help-seeking beliefs. Based on the limitations of prior research, this research focused on a general couple population to explore individual and contextual factors that impact an individual's motivation to seek couple therapy while utilizing the theoretical framework of the HBM (Rosenstock, 1966).

Relational Distress

One key contextual factor that may impact an individual's motivation to seek couple therapy is their experience of distress in their relationship. When considering relational distress and couple therapy in general, it is important that the language used throughout this research is inclusive of both legally married and non-married long-term committed unions of romantic partners and the lesbian, gay, bisexual, transgendered community, whom may have been unable to marry until recently. With this intention, the research focuses on "relational distress" but may also refer to research that has included the term "marital distress." Using these terms synonymously is considered accepted practice in the field (Lebow et al., 2012).

Relational distress (DSM-V) is often used as a catchall term for communication or interactional difficulties within a long-term couple relationship, resulting in impairments in individual or relationship functioning for one or both individuals in the relationship (American Psychological Association, 1994). Relational distress has also been defined as meeting a certain cut-off point on a self-report marital satisfaction scale, such as the Couple Satisfaction Index (Funk & Rogge, 2007) or the Revised Dyadic Adjustment Scale (Busby, Crane, Larson, & Christensen, 1995; Crane, Middleton, & Bean, 2000). Couples scoring below the cut-off score are thought to have significant relationship difficulties in areas such as (a) consensus related to decision-making, values, and affection, (b) satisfaction around relationship stability and conflict, or (c) cohesion in activities and communication (Busby et al., 1995). Relational distress is the most cited reason for ongoing conflict in couple relationships and is commonly cited as a reason that couples eventually seek treatment or divorce (Lebow et al., 2012). Of individuals seeking individual therapy, a large number report marital distress as a negative experience in their lives, whether or not it was the primary reason for seeking therapy (Lin, Goering, Offord, Campbell, & Boyle, 1996). The divorce rate is also considered the salient indicator of the long-term effects of couple distress (Kreider & Fields, 2002), as the research literature indicates that many, if not most, relationships face turmoil that puts them at increased jeopardy of dissolution because of ongoing symptomology (Swindle, Heller, Pescosolido, & Kikuzawa, 2000). Although most couples are likely to experience distress in their relationship or currently are experiencing high levels of distress, they do not access the effective treatment provided by couple therapy (Morrill et al., 2011). The negative consequences of distress not only impact the success of the relationship but also have far reaching negative consequences for individuals in the relationship, children in the family, and the larger community (Butterworth & Rodgers, 2008; Gotlib &

Beach, 1995; Kielcolt-Glaser et al., 1993). It is necessary that research identified the factors that are impacting the individual's motivation to seek couple therapy to reduce these negative consequences.

Negative consequences of relational distress. While 50% of couples relationships with high levels of distress end in dissolution (Bray & Jouriles, 1995; Lebow et al., 2012), divorce is not the only negative consequence of relational distress. Relational distress can significantly affect one's mental health, physical health, and overall wellness (Whisman, 2013; Gotlib & Beach, 1995; McLeod & Uemura, 2012; Kielcolt-Glaser et al., 1987). Relational distress is also a risk factor for one or both partners developing mood disorders (Whisman, 2013), depression (Whisman & Beach, 2012), anxiety disorders (Gotlib & Beach, 1995), alcohol abuse (Leonard & Roberts, 1998), as well as both short and long-term negative health outcomes such as a weakened immune system (Kielcolt-Glaser et al., 1993; Kielcolt-Glaser & Newton, 2001). However, a positive couple relationship has been shown to have significant positive effects on one's life including better health outcomes, improved psychological well-being, and improved mental-health (Halford & Snyder, 2012).

Ongoing relational distress not only impacts individual well-being, but it also increases the likelihood of someone in the relationship developing a substance use disorder, which would negatively impact children and other family members (Anderson, 2014; Butterworth & Rodgers, 2008; Lebow et al., 2012). Although separation or divorce is never easy on children in the home, children who live with exposure to ongoing relational distress have higher rates of negative outcomes in childhood and through adulthood (Whisman, 2013). Relational distress is predictive of behavioral problems, attachment problems, conduct disorders, depression, poor coping skills, and lower academic performance in the children of those couples (Erel & Burman, 1995;

Laumakis, Margolin, & John, 1998). Children in these homes may not experience negative consequences only during childhood as more recent research has identified that the negative effects of relational distress on children continue into their adulthood (Whisman, 2013).

Beyond the family, individual mental illness, negative physical health, and intergenerational increased risk factors caused by relational distress impact the larger community. The World Health Organization (WHO) estimates that, on average, mental illness costs a country between 3% and 4% of their GDP and permanent or temporary disability, as a result of mental health problems, costs a country billions of dollars annually (WHO, 2003). These are considered the direct costs of mental illness on the United States economy; however, it is only a portion of the overall financial burden that mental illness places on the community. Another 193.2 billion dollars worth of indirect costs are also incurred by the United States; these costs include the mean reduction of earning and resulting loss of taxes for those living with mental illness, medical complications that often coincide with mental illness (psychosomatic or otherwise), the cost of homelessness, and the daily cost associated with incarcerating 230,000 individuals with mental illnesses (Insel, 2008). Treating relational distress before it causes negative outcomes for the individual, family, and larger community is essential to promote healthy and happy communities. This research focused on identifying the factors impacting an individual's motivation to seek couple therapy in hopes of increasing the likelihood that individuals will receive treatment for their relational distress. Unfortunately, current efficacy research on couple therapy indicates that the experience of relational distress may serve as a barrier to accessing treatment, as the individual becomes too overwhelmed or hopeless with the feelings of distress (Shadish & Baldwin, 2003).

Relational distress as a barrier to accessing couple therapy. Although relational distress is a commonly cited reason for seeking therapy services, it may also serve as a barrier to accessing help. Current research on individual's help-seeking behavior indicates that individuals experiencing lower degrees of distress are more likely to seek treatment (Connors et al., 2000; Knerr et al., 2009; Moore et al., 2013). This outcome is attributed to the belief that individuals experiencing lower distress are more equipped to seek effective support, without their distress serving as a barrier (Knerr et al., 2009).

Unfortunately, the transitive nature of individual distress in a relationship is unclear. For example, does one partner's experience of distress make it harder for the other partner to seek treatment (Knerr et al., 2009)? Does one partner's experience of distress cause an increase in the other's experience of distress? Distress is understood to be something someone should seek help for, however it appears to be serving as a barrier to accessing treatment for individuals (Connors et al., 2000; Knerr et al., 2009). Research has yet to indicate whether relational distress serves as a barrier to seeking couple therapy.

Current research on couples engaged in therapy supports the hypothesis that distress serves as a barrier to seeking treatment; the majority of couples seeking treatment are less distressed than approximately 80% of couples that do not seek therapy (Shadish & Baldwin, 2003). More distressed couples are often in greater need of therapy, but do not access services because they are overwhelmed by the feelings of distress and conflict in their relationship (Doss, Mitchell, Georgia, Biesen, & Rowe, 2015). Research on the efficacy of current treatment models including behavioral couple therapy (Shadish & Baldwin, 2005) and emotion-focused couple therapy (Anker, Owen, Duncan, & Sparks, 2010), indicate that couples with lower levels of distress may be more likely to seek treatment. This is consistent with research on individual

distress, which indicates that individual distress serves as a barrier for accessing mental health treatment (Connors et al., 2000; Knerr et al., 2009). Due to the lack of research on the impact of distress on an individual's motivation to seek couple therapy, it is necessary to measure distress as a potential barrier. The current literature focused on why couples do not seek treatment has often recruited a clinically distressed sample, however that limited the impact of distress as a potential barrier (Wolcott, 1986). For this reason, this research did not recruit a clinically distressed sample rather attempted to access a more generalized sample. This allowed the impact of distress as a potential barrier to be measured as a variable in the predictive model.

Perceived Stigma

One of the most commonly cited reasons individuals do not seek mental health treatment is their discomfort with the stigma that is directed at those with mental illnesses (Corrigan, 2004; SAMSHA, 2013). Stigma, originally from the Greek meaning the scar left by a hot iron (Merriam-Webster Dictionary, 2017), came to be associated with the often invisible mark or characteristic that is associated with shame or discredit (Merriam-Webster Dictionary, 2017). Stigma is a “perception of being flawed because of a personal or physical characteristic that is regarded as socially unacceptable” (Blaine, 2000; Vogel et al., 2007, p. 325). Goffman's theory of stigma identified three types: those who bear the stigma (stigmatized), the “normal” who do not bear stigma, and the wise who are “normal” but accepted by the stigmatized due to their awareness of their condition (Goffman, 1963). Goffman (1963) believed that the stigma associated with a given condition was part of one's social identity, whether or not the condition was something able to be proven about the person.

Historical models of stigma include two groups of individuals who experience stigma: discredited (already revealed, which affects self and others) and discreditable (yet to be revealed;

Goffman, 1963). Non-therapy attenders would likely want to remain in the discreditable category, meaning they would not want to be revealed to others as needing mental health treatment. In order to keep their problem hidden, they would not access mental health treatment, despite their level of need. Goffman's theory (1963) is relevant to how stigma may impact an individual's motivation to seek mental health therapy, including couple therapy. Individuals in couple relationships with high levels of relational distress but who keep their distress hidden would be in the discreditable category whereas those seeking treatment would move to the discredited group (Goffman, 1963). The desire not to move to the publically known help-seeking category (i.e. discredited) may be a barrier to accessing couple therapy. This hypothesis is based on the current role of stigma on individual help-seeking behavior; however, it is unknown whether stigma operates similarly on individuals in couple relationships. It is possible that, like distress, there is a compounding experience of stigma in a relationship if both partners perceive high levels of stigma towards mental health. It is also unknown whether one individual's lack of stigma may be able to overcome their partner's experience of stigma and help the couple engage in therapy. These questions have not been addressed in the current literature.

Assessment of stigma as a barrier to accessing couple therapy often focuses on treatment for a highly stigmatized problem such as treatment for a substance use disorder (Schonbrun, Strong, Wetle, & Stuart, 2011) or treatment with a population that is more likely to stigmatize mental health in general, such as veterans (Blais, Hoerster, Malte, Hunt, & Jakupcak, 2014). Again, this research focused on a general population in order to identify the role of self-stigma on motivation to seek couple therapy rather than focusing on a stigmatized problem or population.

Public-stigma. Scholars have identified two main types of stigma that are relevant to a person's decision to seek mental health treatment: public and self-stigma (Vogel et al., 2006). Public stigma prevents individuals from seeking treatment because they believe that they will be stereotyped, experience discrimination, or be judged by others for their need for mental health treatment (Corrigan, 2004). Mental health therapy is considered to be a stigmatized treatment since the divide between medical health and mental health in the 19th century (Grob, 1983). This divide resulted in the perception of credible illnesses, such as medical illnesses, and less credible illnesses, namely mental illness. Throughout American history, this divide in language and practice has resulted in those experiencing mental illness being stigmatized, run out of families and towns, and eventually institutionalized in asylums (Grob, 1983). Seeking mental health treatment or declaring a mental illness is considered to be a distinguishing or isolating factor in society (Corrigan, 2004). An individual with a mental illness is often perceived by the general public to be more violent, more dangerous, less educated, and inherently different than the average population (SAMSHA, 2013). General perceptions and attitudes about individuals with mental illnesses are deteriorating due to sensationalized media coverage and the mass shootings attributed to those with mental illness (Kim, Smith, & Kang, 2015).

Starting in the 1950s, treatment of mental health issues became a community and societal goal (Grob, 1983). Since this time, mental health professionals have been working to reduce public stigma by de-stigmatizing mental health issues (Kim et al., 2015). Organizations and groups, including the United States Department of Health and Human Services, continue to work on discrediting "common myths" about mental illness, therapy, and mental health treatment (United States Department of Health and Human Services, 1999; American Psychological Association, 2009). Large-scale public health campaigns focused on de-stigmatizing mental

health, therapy, and mental illness have included celebrities, storytelling campaigns, and education; however, this outreach has not been proven to be entirely effective at diminishing stigma and improving service utilization (United States Department of Health and Human Services, 1999). One common stigmatizing belief these public health campaigns seek to address is the belief that therapy is only for the severely mentally ill, such as those living with schizophrenia (United States Department of Health and Human Services, 1999). This belief precludes those living with potentially less severe, but still influential, mental health issues or concerns, including those experiencing relational distress, from seeking treatment. Many of the above listed campaigns focus on the stigma associated with individual mental illness. Unfortunately, the only efforts made to decrease stigma associated with couple therapy appear to come from the American Association of Marriage & Family Therapists (AAMFT) and include legislative initiatives and social media postings.

Research focused on understanding and addressing public-stigma is not a priority. The last time the United States even studied the public stigma associated with mental illness and mental health treatment on a large scale was 1999 (United States Department of Health and Human Services, 1999). This may be due to the overwhelming effects of long-standing and ingrained beliefs about mental health care and the challenge of personalizing an often “unseen” illness.

The dominant cultural history of the United States has long placed a negative public stigma on bad relationships or public struggling; therefore, individuals in relationships may be unwilling to label themselves as “having problems” by seeking treatment, which lowers their motivation to seek effective services (United States Department of Health and Human Services, 1999). It is hypothesized that individuals hide their need for relational distress as a way to avoid

seeking mental health treatment because they are afraid of the effects of public stigma (Corrigan & Matthews, 2003). Similarly, as a society, the dominant cultural in the United States promotes “pulling oneself up by the bootstraps” and being self-made rather than asking others for help or showing weakness, which has likely impacted views of treatment seeking (United States Department of Health and Human Services, 1999). Any action that challenges these societal norms would result in someone being placed in a stigmatized group. Unfortunately, public stigma affects not only those experiencing a mental illness, but also those in the community who are fearful to interact with or employ those with mental illnesses (Corrigan & Penn, 1999; Corrigan, 2004) and in the case of couples, the individuals, children, and communities who experience the negative outcomes of relational distress (Anderson, 2014; Butterworth & Rodgers, 2008; Lebow et al., 2012). It is hypothesized that individuals and couples who believe relational distress and couple therapy are stigmatized by society are less likely to admit they need help and be motivated to seek couple therapy (Corrigan, 2004; Vogel et al., 2007).

Self-stigma. In contrast to public stigma, self-stigma reflects the negative effect mental illness has on an individuals’ self-esteem or self-worth because they identify themselves as being part of ‘the unacceptable’ in society (Vogel et al., 2006). Individuals with high degrees of self-stigma may be unwilling to seek mental health treatment, including couple therapy, because they believe it will prove that they are weak or inferior (Vogel et al., 2006). These individuals may also view themselves as “inadequate” for needing to seek help from another; therefore, they may not seek treatment, as this would mean that they would have to acknowledge failure (Nadler & Fisher, 1986). Higher levels of self-stigma are also associated with lower psychological functioning, including higher levels of distress and lower self-esteem (Vogel et al., 2006). Individuals with high levels of self-stigma also often hold more negative beliefs about mental

health treatment, meaning they are less likely to seek effective therapies (Wade et al., 2011). By not seeking help, the individual can maintain a positive self-image, unthreatened by the views of outsiders (Ames, 1983; Vogel et al., 2006). However, their distress may increase because they do not believe in and are unable to obtain any viable treatment (Corrigan & Matthews, 2003).

Much of the current self-stigma research has focused solely on the individual, which ignores the impact of others on the individual and the ways in which self-stigma may influence couples differently than individuals (Swindle, Heller, & Pescosolido, 1997; United States Department of Health and Human Services, 1991; Grob, 1983; Vogel et al., 2006). A few unique studies have considered the public stigma directed at couples and families but they were focused on already stigmatized couples. Goldberg and Smith (2014), found that stigma impacts adoptive heterosexual and LGBTQ couples' involvement in their children's schooling. Heterosexual adoptive parents appeared to be more impacted by higher levels of perceived adoption-stigma whereas LGBTQ parents were more likely to overcome the stigma and engage with the school (Goldberg & Smith, 2014). This may be due to movements in society and advocacy in regards to LGBTQ parents (Goldberg & Smith, 2014). Bratter and King (2008) explored divorce rates among interracial couples and identified interracial couples as more likely to divorce. They found that the experience of stigma was highly gendered and race-based in couple relationships (Bratter & King, 2008). For example, white women may be less accepted by their non-white partner's culture and may perceive higher-stigma towards raising interracial children because they are not used to navigating life as a minority (Bratter & King, 2008). Stigma research has also focused on couples that live with a transmittable illness such as HIV/AIDS (Talley & Bettencourt, 2010). Stigma towards HIV/AIDS was found to end relationships and isolate individuals (Talley & Bettencourt, 2010). However, no known research

has tried to understand the role of stigma for couples in the general population who are seeking couple therapy. For this reason, this study explored stigma as a barrier to motivation to seek couple therapy with a general population sample rather than focusing on an established stigmatized group or problem.

Health Belief Model

The Health Belief Model (HBM) was originally developed in the 1950s to explain why preventative health care screenings were not being taken advantage of, specifically screenings to detect for tuberculosis (Hochbaum, 1958). Since then, the HBM has become the most commonly used theory in health education (National Cancer Institute, 2003). The original model proposed that personal beliefs are the most important element in making health care decisions (Hochbaum, 1958), including decisions to seek mental health treatment such as couple therapy. These personal perceptions are influenced by the four main constructs associated with the model: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. Each of these constructs has been found to predict an individual's likelihood of taking action or to explain their health care decisions (Rosenstock, 1966). The HBM also includes an individual's experience of cues to action. Cues to action are personal encounters with the problem or solutions that make the problem and its negative consequences more relevant to the individual, which in turn, makes them more likely to increase readiness to act. Due to the need for the HBM to serve as a predictive model for help-seeking behavior, recent literature has suggested the inclusion of motivation to change and self-efficacy as individual factors that may impact and individual's beliefs about seeking help (Graham, 2002). Thus, the HBM encourages the consideration of modifying variables, such as individual characteristics, which influence the main HBM variables. Any single factor may not be enough to motivate change, therefore, the

study included these contextualizing and individual factors to identify their role in an individual's motivation to seek couple therapy and in hopes of expanding the predictive power of the HBM (Graham, 2002). The HBM model suggests that as perceived susceptibility of the problem, perceived severity of a negative outcome, perceived benefits of seeking help, and cues to action increase, the perceived barriers to accessing treatment will be overcome and the individual will have positive beliefs about treatment seeking.

The HBM has primarily been utilized with medical help-seeking behavior (Rosenstock et al., 1994) however the American Psychological Association [APA] (2013) has encouraged the application of the HBM to explore the underutilization of mental health care services (Sullivan et al., 2004). Two more recent studies have applied the four of the main constructs of the HBM to beliefs about seeking premarital counseling (Borowski & Tambling, 2015) and adolescent's beliefs about attending therapy (O'Connor, Martin, Weeks, & Ong, 2014). Borowski and Tambling (2015), found that perceived susceptibility, perceived barriers, and perceived benefits were predictors of an individual's intention to participate in premarital therapy (Borowski & Tambling, 2015). Many common formal barriers were also supported by this research including cost of therapy, proximity of services, and scheduling convenience (Borowski & Tambling, 2015). Another study explored what factors predicted engagement in help-seeking behavior for adolescents (O'Connor et al., 2014). They surveyed adolescents only on the four main constructs of the HBM. O'Connor et al., (2014) found that perceived benefits of seeking help, perceived barriers to seeking help, and social support were direct predictors of help-seeking behavior. They found that perceived susceptibility was not a significant predictor unless the individual was already health conscious (O'Connor et al., 2014). These studies utilized only the four main constructs of the HBM but continued to find mixed results in the predictive power of

all of the HBM constructs. This may be due in part to other factors such as individual or relational distress and stigma towards help seeking behavior, which were not explored by these studies. It is also possible that mental health treatment seeking is uniquely different than seeking help for other health concerns. Although HBM constructs have shown some predictive power with individual mental health and premarital therapy (Borowski & Tambling, 2015; O'Connor et al., 2014), the HBM has not previously been used to evaluate an individual's motivation to seek couple therapy.

Perceived susceptibility. According to the HBM, perceived susceptibility is a strong force in encouraging individuals to adopt healthy behavior (Rosenstock, 1966). Perceived susceptibility is an individual's perception that they are likely to experience "the problem." If individuals perceive their health or future to be at risk (i.e., perceive themselves as being more susceptible), then they are more likely to follow through on healthier behaviors and preventative behaviors, such as getting vaccinated or practicing safer sex (Belcher et al., 2005). However, if individuals do not perceive themselves as being susceptible to the risks of a certain behavior or disease, then they often ignore preventative measures or healthy behaviors (Rosenstock, 1966). For example, older adults are less likely to practice safe-sex because they do not perceive themselves being susceptible to HIV/AIDS (Maes & Louis, 2003). Similarly, although college students may perceive themselves to be at risk of sexually transmitted diseases, they do not perceive themselves to be susceptible to catching the disease because of their age and associated perceived invincibility or lack of responsibility (Lewis & Malow, 1997). This means that college students are less likely than older individuals to change their behavior when it comes to something such as practicing safer sex (Lewis & Malow, 1997). In addition to age, another important modifying factor related to perceived susceptibility is education (Rosenstock, 1966).

Individuals may not understand how a disease is contracted; therefore, they may not understand how their behavior increases their potential susceptibility to given condition or outcome (Lewis & Malow, 1997). If an individual is not well educated on the potential dangers of a disease or has been given misinformation, they may not perceive themselves as being susceptible because they do not fully understand the consequences of their behavior, so it does not seem as important to them (McCormick-Brown, 1999). However, when perceived susceptibility is combined with perceived severity (i.e., belief about the seriousness of a disease or course of action), people tend to be more likely to act because they perceive a greater threat (Stretcher & Rosenstock, 1997). For example, those related to someone with a serious genetic disease, such as breast cancer, are more likely to engage in healthy behaviors because they perceive themselves to be more susceptible to the disease (Forsyth & Goetsch, 1997).

Perceived susceptibility & relational distress. Although statistics about divorce are prevalent and often commonly known, many couples do not believe that they will get divorced and do not see themselves as being susceptible to divorce in second or later marriages, which are even more likely to end in divorce (Bramlett & Mosher, 2001). Individuals enter relationships in hopes that they will be successful, therefore, they may not perceive themselves as being susceptible to the failings of others (Bramlett & Mosher, 2001). If individuals believed that divorce was a likely outcome for their relationship, they may be more likely to seek preventative measures, including pre-marital counseling or couple therapy (Borowski & Tambling, 2015). However, premarital counseling rates are very low (Valiente, Belanger, & Estrada, 2002) and less than one-fourth of couples report having sought marriage counseling prior to their divorce (Sullivan et al., 2004; Wolcott, 1986).

Couples may not perceive their relationship as being susceptible to divorce or even relational distress, in part due to the stigma of being a couple with marital issues. They also may not perceive their conflict as being bad enough to require intervention. Since retrospectively the majority of couples reported that it was “too late” for help, it appears that the possibility of divorce is not enough to motivate change (Wolcott, 1986). Additionally, couples may not believe they are susceptible to divorce because of other protective factors (i.e., religion; Pargament, 1997). If perceived susceptibility was the only predictive construct in the HBM (Rosenstock, 1966), then statistics about the prevalence of divorce should result in people believing they are susceptible to divorce and relational distress. Clearly based on the ongoing prevalence of high divorce rates and low couple therapy attendance perceived susceptibility alone is not a motivator (US Department of Health and Human Services, 1999). This study seeks to understand the role of perceived susceptibility, as part of the larger context of the HBM, to determine the extent to which perceived susceptibility may be relevant to an individual’s motivation to seek couple therapy.

Perceived severity. Perceived severity is an individual’s perception of how serious “the problem” would be if the person experienced it (Rosenstock, 1966). Perceived severity is often related to actual knowledge about a problem, including medical knowledge about a disease or information about the negative consequences caused by an illness (McCormick-Brown, 1999). For example, although the flu may appear to be a minor setback to most people, an individual with other pre-existing conditions (e.g., heart or breathing problems) is more like to perceive the flu as being serious. Other factors besides knowledge may also influence an individual’s perception of the severity of a given condition; these factors include financial flexibility and preparedness for the problem (i.e., sick days or health insurance; McCormick-Brown, 1999). In

these cases, individuals who are able to take time off or seek medical care without a great cost may see the problem as less serious (McCormick-Brown, 1999). Again, perceived severity alone does not motivate someone to act; rather, it contributes to the additive effect of the other HBM factors.

Perceived severity & relational distress. Partners may not perceive relational distress to be a serious concern in their relationship as each individual may have a different threshold for distress or different expectations about relational conflict or bliss (Busby et al., 1995).

Individuals may also ignore the severity of the problem by normalizing their experience of relational distress until the relationship becomes irreparable (Busby et al., 1995). Partners in distressed relationships may be unaware of the severity of their conflict, as divorced couples frequently report that they did not think anything was wrong with their relationship (Wolcott, 1986). Although divorce may be seen as a serious outcome, couples may not perceive relational distress to be serious until they have lived with it for a long time or it escalates (Busby et al., 1995). Others may not even perceive divorce as a serious outcome because it has become normalized by society or it would provide relief from a toxic relationship (Busby et al., 1995). It is important to assess an individual's perceived severity towards divorce when conceptualizing what constructs may impact an individual's motivation to seek couple therapy. The HBM provides this established framework (Rosenstock, 1966).

Perceived benefits. Perceived benefits are based on an individual's beliefs about whether or not making a change in their life will benefit them overall (Rosenstock, 1966). If individuals believe that adopting a healthier or different behavior will make a positive difference in their lives, then they are more likely to engage in that behavior (Rosenstock, 1966). For example, individuals who perceive that quitting smoking will have positive benefits for their

health are more likely to overcome barriers and quit smoking (Turner, Hunt, DiBrezza, & Jones, 2004). If individuals do not perceive the benefits as outweighing the risks, then they are less likely to change their behavior (Turner et al., 2004). It is important to note, however, that perceived benefits alone do not appear to encourage people to follow through on preventative health care (Graham, 2002; Turner et al., 2004). Rather, it may be the compounding effects of perceived severity and susceptibility, along with the perceived benefits of making change, which may eventually lead an individual to seek treatment. That is, the perceived benefits must outweigh the barriers to making change and the person must perceive themselves as being susceptible to a serious problem (Center for Disease Control and Prevention, 2004). Unfortunately, even in these situations, people still struggle to adopt new habits, often by minimizing or ignoring the benefits of making needed changes (Turner et al., 2004).

Perceived benefits & couple therapy. Mental health treatment is effective at improving mental health disorder symptomology, general well-being, and relationship functioning (Wampold, 2001). However, research rarely focuses on society's perception of the benefits of therapy. Research is often focused on identifying the efficacy of therapy at treating mental illnesses or relational distress, which researchers and clinicians perceive as the benefit of therapy (Biancosino, 2004). Most research on benefits typically considers them retrospectively (Doss et al., 2003; Wolcott, 1986); for example, individuals are asked after therapy about the benefits of seeking therapy, which is a time during which benefits are obviously clearer. Individuals who experience the benefits of therapy are aware that it reduced their symptoms, improved well-being, or reduced conflict (Sprenkle, 2003; Wampold, 2001). These, however, are not perceived benefits because they have been experienced after the fact. It should not be a prerequisite for someone to have experienced the benefits in order to perceive them in the future. The individuals

and couples that overcome the barriers to accessing treatment may be inherently aware of the benefits of seeking treatment, whereas those who do not seek treatment may not perceive any benefits to therapy. One study on intention to seek couple therapy supported this hypothesis. Bringle and Byers (1997) found that couples who had previously sought couple therapy were predisposed to seek couple therapy again in the future. These couples were aware of the effectiveness of couple therapy and saw it as a potential benefit to their relationship going forward (Bringle & Byers, 1997). This is a potential limitation of the application of the HBM to couple therapy. If individuals need to have attended therapy to be aware of its benefits then they are not likely to be highly motivated by perceived benefits. This research excluded individuals who had sought couple therapy as this was not a retrospective analysis and it wanted to address this potential concern with the HBM and perceived benefits.

Even if individuals do not perceive therapy as being beneficial, it has been shown to be effective. Couple therapy is an effective treatment approach for individuals, couples, and families (Piper et al., 2011; Matusiewicz et al., 2010). Some well-established benefits of behavioral couple therapy include reduction of relational conflict and improved couple relationships (Shadish & Baldwin, 2005). Emotion-focused couple therapy has been shown to improve interpersonal connections, emotional responsiveness, and reduction of conflict (Anker et al., 2010). In general, couple therapy has been shown to improve communication, decrease conflict, and improve healthy emotional expression (Doss et al., 2004; Johnson & Talitman, 1997). Overall, the evidence of the effectiveness of mental health treatment indicates that it should be a useful tool for reducing relational distress (Piper et al., 2011; Matusiewicz et al., 2010). However, research indicates that the majority of individuals are unaware of the benefits

of couple therapy and consequently are not motivated to seek couple therapy (Albrecht et al., 1983; Wolcott, 1986; Henderson, Evans-Lacko, & Thornicroft, 2013)

Individuals and partners who perceive therapy to be beneficial are more likely to seek therapy and, if they have a positive experience early on in therapy, they are more likely to continue treatment (Horwitz et al., 2012). Research focused on healthy lifestyle interventions for individuals with serious mental illness highlighted the perceived benefits for the identified patient of involving the client's family or significant other (Aschbrenner et al., 2012). According to the study participants, family involvement in their treatment helped them feel more understood, enhanced their relationships, and promoted healthy support (Aschbrenner et al., 2012). Aschbrenner et al. (2012) research focused on severe individual mental health illness and the benefits of familial involvement in treatment; however, no known research has explored the perceived benefits of couple therapy for individuals experiencing relational issues. It is possible that couples may perceive couple therapy to offer similar positive benefits as individual therapy, such as increased quality of relationships (Aschbrenner et al., 2012). This research includes an assessment of perceived benefits of couple therapy, however the response categories are based on literature that establishes the effectiveness of couple therapy rather than on individual's reports. Based on the limitations of a survey, the open-ended questions were added to potentially examine the benefits or expectations individuals would have towards couple therapy.

Perceived barriers. Individuals face a variety of barriers when attempting to access mental health treatment. Perceived barriers can be formal (e.g., high cost, lack of transportation, lack of resources) and/or informal (e.g., negative perception or stigma, lack of awareness about available services) factors that prevent individuals and couples from seeking mental health services. The HBM considers the individual's perception of barriers to be the most significant

factor in determining whether or not a person will make a change (Janz & Becker, 1984). An individual's perception of barriers does not have to be based on fact or reality; if they perceive something to be a barrier they will act as such, whether or not it is perceived to be a barrier by others (Turner et al., 2004).

Perceived barriers & individual therapy. The vast majority of research on barriers to mental health treatment has been conducted with individuals dealing with individual mental health disorders. This is, in large part, due to the prevalence of grant funding focused specific diagnoses, but is also due to the individual focus of the majority of mental health experts who conduct clinical research such as psychologists (Sheras & Koch-Sheras, 2008). For these reasons, the barriers experienced by individuals seeking mental health treatment are well established. Formal barriers to seeking mental health treatment are the structural and logistical problems associated with scheduling and maintaining an appointment with a therapist (Bazargan et al., 1998). They include a lack of transportation to and from appointments, the costs of mental health treatment and lack of insurance coverage, a lack of proximity to available services, limited child care options, an inability to take time off from work, or an inability to find timely appointments (Bazargan et al., 1998).

Informal barriers to seeking mental health treatment are more ambiguous and rooted in the psychology of the individual (Bandura, 1977; Bazargan et al., 1998; Knerr et al., 2009). These barriers include lack of self-efficacy, fear of the unknown, lack of understanding, awareness, or misconceptions about therapy, fears about confidentiality or privacy, sense of personal stigma, and a belief that the problem is not significant enough or is already too serious to fix (Connors et al., 2000; Knerr et al., 2009; Moore et al., 2013; Tambling & Johnson, 2008; Vogel et al., 2007).

These well-established formal and informal barriers are not exclusive to mental health treatment, as they have been documented in a wide range of areas for intervention including smoking cessation, dental hygiene (Anagnostopoulos, 2011), and in follow-up for treatment of psychosis (Cramer & Rosenheck, 1998). To address informal and formal barriers to seeking services, other fields have developed targeted public health campaigns, the sharing of personal stories, and specifically targeting and reducing barriers that affect some communities more than others (Boydell, Pong, Volpe, Tillexzek, Wilson, & Lemieux, 2006). Although organizations such as the United States Department of Health and Human Services (US DHHS), continue to work on discrediting “common myths” about mental illness, therapy, and mental health treatment, these campaigns have not yet proved to be entirely effectively at diminishing barriers and improving service utilization (United States Department of Health and Human Services, 1999). The field of mental health may be able to incorporate or develop these effective approaches from other fields to improve access to treatment.

Perceived barriers & couple therapy. Like individual mental health therapy, barriers to seeking couple therapy include both established formal and informal barriers. If each individual in the relationship is experiencing their own formal and informal barriers to treatment, those barriers may have a compounding negative effect on a couples’ ability to seek couple therapy. In order to attend couple therapy, the couple must act as a unit in their decision to seek treatment. If they are both experiencing their own personal barriers, it is unclear as to whether some barriers become couple-barriers to seeking therapy or whether the individual with more barriers or more power in the relationship “wins.” Potential relational barriers to seeking couple therapy are hypothesized to include the role that one spouse, particularly the female, may take in identifying the issues, identifying couple therapy as the solution for the couple, and initiating couple therapy

(Bringle & Byers, 1997; Doss et al., 2003; Good, Dell, & Mintz, 1989). Based on the research indicating men are less likely to seek therapy or see it as beneficial, it would require a highly invested female and a partner that is willing to follow this chosen course of action for the couple to actually arrive in couple therapy (Bringle & Byers, 1997; Good et al., 1989). Another potential relational barrier is each partner's view of what couple relationships should look like (Ledered & Jackson, 1968). Couples may accept certain issues or have unrealistic expectations based on their families of origin, gender role expectations, or the influence of the media (Eidelson & Epstein, 1982). Any of these factors could keep the couple from seeing something such as relational distress as being a problem, thereby preventing them from seeking couple therapy.

Couples may also avoid couple therapy due to the personal nature of relational issues and the private nature of marriages. For example, if the couple or an individual in the relationship believes that their issues are too private to discuss with others (Wolcott, 1986), or does not believe that couple therapy can help with their identified issues, then they are unlikely to seek couple therapy (Bringle & Byers, 1997). In a study by Bringle and Byers (1997), both men and women were more likely to agree that couple therapy would be the appropriate course of treatment if they perceived the problem to be serious, such as intimate partner violence, or if they realized they are facing the possibility of divorce. However, they did not believe that couple therapy was appropriate for disagreements over housework, in-laws, children, or finances (Bringle & Byers, 1997).

It is clear that formal, informal, and relational barriers play a significant role in the motivation to seek couple therapy. By incorporating the five constructs of the HBM, this research helped examine the potential negative effect of barriers on motivation to seek couple

therapy. The inclusion of other individual variables (demographics) and contextual factors (distress and self-stigma) also helped increased the understanding of how other factors can help or hinder someone's ability to overcome barriers and access treatment. Factors that help reduce the negative effect of barriers on an individual's motivation to seek couple therapy are essential to identify in order to improve upon access to treatment.

Cues to action. After the initial development of the HBM, cues to action were added to assess personal experience of the problem and how that exposure impacts individual readiness to act (Turner et al., 2004). Fundamentally, individuals see "it" [whatever health improvement] as relevant and important, but they do not get provoked to action without a personal connection to the problem or solution (i.e. someone they know attends therapy). Cues to action are strategies that activate the individual into a state of action and may include people, places, and experiences such as media reports (Turner et al., 2004). Cues to action can also include personal testimonies from friends or family members that activate an individual's desire to act. For example, if an individual knows someone who went to couple therapy and they tell the individual about the process and share positive information about the experience, then the individual may be more activated to seek couple therapy themselves. Thus, cues to action have the ability to bring the problem, potential solution, or negative consequences of not acting, "up-close-and-personal" for the individual by taking the problem out of the hypothetical and making it more of a reality. This dose of reality, from the cues to action, increases the individual's perceived susceptibility to the problem and may demonstrate the severity of it, which, along with the other HBM constructs (i.e., perceived benefits and barriers), can lead the person towards healthier behaviors (Stretcher & Rosenstock, 1997). For example, an individual experiencing relational distress should be more motivated to seek couple therapy if they know someone who went

to couple therapy on the brink of divorce and who had a positive outcome (Stretcher & Rosenstock, 1997). Due to the relatively new conceptualization of cues to action, they have not yet been used in the literature on individual therapy or help-seeking. Similarly, no current research has applied or identified cues to action to seeking couple therapy. This study included a simple examination of individual's proximity to divorce and couple therapy as potential cues to act. Open-ended questions also asked individuals about what other resources they might be using for support to identify what help-seeking behavior with which they are motivated to engage.

Demographic Variables

Due to the ideals and opinions of each individual in the relationship, the decision to seek couple therapy is a complicated process. This study considered multiple individual variables that impact seeking mental health treatment and applied them to seeking couple therapy. As already discussed, contextual factors such as relational distress and self-stigma along with the five constructs of the HBM, were hypothesized to predict motivation to seek couple therapy. However, it is important to consider other more salient variables that impact an individual such as gender and income. Previous research on the major constructs of the HBM supports the inclusion of individual demographic characteristics (Turner et al., 2004) when assessing the likelihood behavior change. For this study, these included gender, socioeconomic status, education, and religion (Turner et al., 2004). By including these demographic factors this research developed a more nuanced understanding of the impact of barriers on an individual's motivation to seek couple therapy. Individual factors have been established to impact individual help-seeking behavior therefore their inclusion allowed this research to account for the possibility of individual variation in motivation to seek couple therapy.

Gender. Gender is considered an important factor when considering help seeking behaviors (Butcher, Rouse, & Perry, 1998). An assessment of gender within the individual research on help-seeking behavior yields mixed results. Research on a large sample of undergraduate men found that they are less motivated to make changes to their behavior based on a change to their attitudes or perceptions (Good et al., 1989). Another study of 338 undergraduates found women to be more likely than men to have favorable beliefs about seeking help in general (Butcher et al., 1998). Another investigation into race and gender found that adult white men are more likely to report greater mistrust of helpers and fear of the mental health care system than non-white men (Ojeda & Bergstresser, 2008). Mistrust towards the provider is predictive of negative therapy outcomes (Sprenkle, 2003), indicating gender may serve as a risk factor towards positive therapeutic outcomes. Ojeda and Bergstresser's (2008) study also indicates the multiple individual variables that may impact an individual's beliefs about seeking help. Vessy and Howard (1993) pulled data from multiple large epidemiological surveys and found that women are more likely than men to seek individual therapy, however once they have accessed services, no gender difference was found. Conversely, Kessler et al. (2001) found that gender did not influence the seeking of mental health treatment for a serious mental illness in a nationally representative household survey. It is unclear as to whether or not gender influences actually seeking individual therapy or just affects how quickly someone moves through the Transtheoretical Model of Change (TTMC) stages of change prior to seeking treatment (Bradford, 2012; Tambling & Johnson, 2008; Tambling & Ketring, 2013).

Research on gender and couple therapy presents similar mixed results. Wolcott's (1986) retrospective analysis of divorced individuals, found that women hold more favorable opinions about seeking couple therapy than men. Doss et al. (2004) also conducted a retrospective

analysis of couples who had accessed couple therapy. Men and women reported differences in expectations in regard to intimacy, communication, affection, satisfaction, and concerns about divorce (Doss et al., 2004). The resulting mismatch in expectations may lead one partner to perceive a problem within the relationship, whereas the other partner does not believe a problem exists. Men appear to hold different beliefs about what qualifies as worth seeking treatment (Bringle & Byers, 1997). Specifically, in a study of 222 couples, men indicated that they did not believe that couple therapy was appropriate for relationship issues including disability or illness, sex, jealousy, money, housework, in-laws or how to raise children (Bringle & Byers, 1997; Good et al., 1989). Men and women did not know if couple therapy was beneficial for problems with trust or dullness in the relationship (Bringle & Byers, 1997).

It is concerning that men do not perceive couple therapy as being relevant for some of the most commonly cited reasons people seek treatment (e.g., sex, jealousy, and parenting; Doss et al., 2004). An examination of 750 couples focused on developing a model of marital competence found that women are more in tune with the loss of positivity in their relationships (Carroll, Badger, & Yang, 2006). Men appear to be less affected by an increase of negativity in the relationship, meaning that the women may notice a change in the relationship prior to the male and become more distressed faster (Carroll et al., 2006). If men do not perceive couple therapy to be beneficial for the common causes of relational distress and they are less likely than women to notice increased negativity in the relationship, women would likely be more motivated to seek couple therapy than a male partner (Bringle & Byers, 1997; Carroll et al., 2006; Doss et al., 2004).

It is also appears that stigma influences help-seeking behavior in genders differently (Ojeda & Bergstresser, 2008). An examination of adults reporting unmet mental health needs,

found that adult white men were more susceptible to public stigma and held more negative beliefs about mental health (Ojeda & Bergstresser, 2008). Men and women not only experience different levels of stigma towards seeking mental health, they also appear to tolerate the effects of stigma differently (Vogel et al., 2006). Specifically, women appear better able to handle the effects of stigma and report more positive attitudes towards therapy (Vogel et al., 2006).

Overall, research studies find that gender is not yet a well-established factor when it comes to understanding seeking mental health treatment and specifically seeking couple therapy (Doss et al., 2003; Doss et al., 2004). For this reason, it is incredibly important to understand the impact of gender on seeking mental health so that intervention and education can be targeted towards those individuals with less favorable beliefs about therapy. To help address this gap in the literature, this research considered the effect of gender on the contextualizing factors (i.e., stigma and relational distress) and the HBM constructs, as they relate to motivation to seek couple therapy.

Socioeconomic status. Socio-economic status is an important consideration when considering factors that may influence an individual's motivation to seek couple therapy. This study used income as an assessment for an individual's SES based on the connections between financial resources and barriers to seeking treatment (Bazargan et al., 1998). Individuals with fewer resources may be less likely to know about available services and more likely to be affected by a lack of formal resources that support accessing therapy (Bazargan et al., 1998). Specifically, individuals with lower incomes have been found to be more vulnerable to resource-based barriers to accessing mental health treatment such as lack of transportation, exorbitant costs of mental health treatment, lack of proximity to services, limited childcare options, an inability to take time off from work, or an inability to find timely appointments (Bazargan et al.,

1998; Staggs, Long, Mason, Krishnan, & Riger, 2007). Additionally, individuals with lower incomes may not know someone who has benefited from therapy, which is an important cue to action. The risk factors caused by having a lack of financial resources may be a reason for different treatment seeking behaviors (West, Kantor, and Jasinski, 1998).

In regards to the contextual factors, the relationship between income and stigma appears to be mixed. An examination of stigma towards mental illness in different income based countries found that middle-income countries had less stigma towards mental illness than high-income countries and low-income countries (Koschorke et al., 2014). This may indicate that very high income and very low income have greater associations with stigma. Research on stigma towards low-income women who obtain an abortion found that higher rates of abortion stigma were associated with higher rates of psychological distress in low-income populations (Gelman et al., 2017). Gelman et al.'s (2007) research also supports a connection between income and distress but focused on a highly stigmatized population and a very distressing medical procedure. The impact of having a low income has not been thoroughly examined in the context of seeking couple therapy, but given the findings from the existing literature, it was predicted to negatively impact an individual's motivation to seek couple therapy.

Education. Higher rates of education have been associated with decreased negative outcomes including substance use, violence, and trauma (National Institute on Drug Abuse, 2002). This is thought to be because educated individuals may have greater access to resources (Kirby & Keon, 2006), which reduces barriers to seeking mental health treatment, including couple therapy. The role of education on stigma and distress is not commonly studied. A small study of eighteen high school students found that an anti-stigma educational campaign was successful, however, this was preliminary research with a small group of students (Chen, Koller,

Krupa, & Stuart (2016). This initial research indicated that targeted educational campaigns could decrease stigma (Chen et al., 2016). Another study on the impact of education and stigma had mixed results. A Canadian juror pool was educated on mental illnesses in conjunction with the Not Criminally Responsible on Account of Mental Disorder defense. Unfortunately, in both mock trial scenarios, education increased the likelihood of a guilty verdict for depression but not for schizophrenia and a substance use disorder (Yamamoto, Maeder, & Fenwick, 2017). Current research indicates an assorted role of education on stigma.

No known research applies the HBM to educational levels, however, a recent study of pregnant Iranian women found that educating them about their own health and the health of their baby using the framework provided by the HBM increased positive outcomes (Khoramabadi, 2016). Higher levels of education may be associated with greater perceived severity of a problem because the individual has a greater understanding of their susceptibility and the negative consequences (McCormick- Brown, 1999). Education may also reduce an individual's perceived barriers to treatment and increase access to events or individuals that serve as positive cues to action (Rosenstock, 1966). Educated individuals may have more to lose from divorce or more access to material on the negative consequences of divorce and relational distress, which may increase their perceived susceptibility and perceived severity (Rosenstock, 1966). For these reasons, education is an important modifying variable that will likely positively impact an individual's motivation to seek couple therapy. Due to the lack of research on the role education plays on an individual's motivation to seek couple therapy, this study included education as an individual variable within the context of the HBM.

Religion. Religion is often reported to be a means of coping with mental illness (Pargament, 1997). A study of 34 families through semi-structured interviews found that

religious beliefs were the most commonly cited (67%) resiliency factor for individuals caring for a loved one with a mental illness (Jonker & Greeff, 2009). For these families, religious beliefs may have shielded them from feeling overwhelming levels of distress while care taking a loved one (Jonker & Greeff, 2009). Religious beliefs may not only help individuals and families cope but they may serve as a barrier to divorce. In couple relationships, individuals may share religious beliefs that prohibit them from getting divorced. As a result, these couples would not perceive themselves as being susceptible to divorce. However, they may also perceive divorce to be a very serious outcome because it is prohibited or highly stigmatized by their religion (Wesselmann & Graziano, 2015).

In addition to being relevant to the HBM factors, religion may also influence an individual's experience of stigma. While stigma largely influences therapy attendance, no known studies have explored the link between religious beliefs and stigma in seeking therapy (Wesselmann & Graziano, 2015), however some religious groups maintain very stigmatizing beliefs about mental illness (Wesselmann & Graziano, 2015). For instance, certain religious belief systems attribute mental illness to a demonic possession (Armentrout, 2004) or believe it is caused by a sinful lifestyle, which results in divine punishment (Armentrout, 2004). Mental illness has also been blamed on a lack of follow through with prayer/faith (White et al., 2003). Some religious groups even use language and suggestions that ingrain mistrust in the practice of therapy for their believers (Armentrout, 2004). Lastly, some religious groups may encourage or require individuals to talk to a religious leader rather than a mental health clinician about their difficulties (Armentrout, 2004). If an individual shared these religious beliefs that suggest mental illness is a punishment or due to a sin, then they would be more likely to stigmatize others, or themselves, for needing a therapist. Ingrained stigmatizing beliefs are likely to serve

as a barrier to seeking mental health treatment, including couple therapy, because mental health treatment is seen as being in contradiction with an individual's religious beliefs. This research conceptualized religious belief to be a modifying factor that impacts the contextualizing factors of relational distress and stigma along with the HBM constructs.

Motivation to Seek Couple Therapy

The Transtheoretical Model of Change (TTMC; Prochaska & DiClemente, 1982) is the primary model of motivation to change that uses a stage-based conceptualization of how people change. It provides the necessary framework to identify how motivated or likely an individual or couple is to seek therapy (Prochaska & DiClemente, 1982). The TTMC includes five stages of change: precontemplation (not perceiving something to be a problem), contemplation (being ambivalent about making a change right now), preparation (taking the necessary steps to successfully engage in change actions), action (doing the things necessary to make change), and maintenance (actively maintaining the steps of change) (Prochaska & DiClemente, 1982). Initially, an individual may not perceive something to be a problem, such as relational distress. However, the TTMC would suggest that, over time, the individual may start contemplating the relational distress as a negative in their life and start preparing to take the necessary steps to change it. Research on couples who reported they did not know they had a problem in their relationship prior to their divorce supports the conceptualization that they were in precontemplation stage about a problem existing in their relationship (Doss et al., 2003). Individuals in the action and maintenance stages recognize that a relational distress causes negative relational consequences, exists in their relationship, have sought help for that problem, and are making or maintaining concrete changes to improve their relational distress. Often times, individuals who successfully and willingly seek mental health treatment are in the

preparation or action stages (DiClementi et al., 1991). However, individuals who are mandated into treatment are frequently in the precontemplation or contemplation stages of change (DiClementi et al., 1991).

It is important to be aware of a client's stage of change on the TTMC in order to match an appropriate intervention to the client; this is known as a stage-matched intervention (DiClementi et al., 1991). Additionally, individuals who have higher levels of motivation have been found to have higher levels of engagement in therapy (Orlinsky & Howard, 1986). Motivation influences an individual's experience of seeking treatment or engaging in health promoting activities (Prochaska & DiClemente, 1982). More specifically, motivated individuals, as a result of a variety of internal or external pressures, are more likely to engage in a change behavior (Rollnick, Heather, Gold, & Hall, 1992). The impact of motivation on individuals is clear, however, the roll of motivation on couple therapy remains under-investigated. Recent studies have focused on adapting current individual measurements of motivation such as the URICA (McConaughy, Prochaska, & Velicer, 1983) into relational measures of motivation that can be used with couple populations (R-URICA; Tambling & Johnson, 2012). An exploratory and confirmatory factor analysis of the R-URICA with a sample of couples in therapy supported the theoretically derived stages of precontemplation and action stages of change (Tambling & Johnson, 2012; Tambling, & Ketring, 2014). This research utilized the R-URICA as a measure of a couple's motivation to seek couple therapy, which continues to advance this literature (Tambling, & Ketring, 2014).

Transtheoretical model of change and the health belief model. The HBM constructs are considered to predict an individual's likelihood, or readiness, to make a change (Rosenstock, 1966). Readiness to change has been defined in the research on motivation as the action stage of

change. Therefore, the HBM constructs should be predictive of the different stages of change as hypothesized by the TTMC (Prochaska & DiClemente, 1983). Thus far these two models have not yet been connected by research. Since motivation to change is not always directly correlated with actual change in behavior it is only one of many factors that influences whether an individual seeks out mental health therapy as a means to a change (De Leon, Melnick, & Tims, 2001). This research seeks to assess some of those other potential factors including individual factors, distress, stigma and the HBM constructs. The different effects of the HBM, stigma, relational distress, and individual variables on an individual's motivation to seek therapy are unclear and convoluted by the minimal amount of research on the topic. Although the TTMC and the HBM have both been applied separately to individual treatment seeking behavior, they have not been applied to seeking couple therapy. This research will draw together all of these factors that have demonstrated importance in individual treatment seeking research to identify what is predictive of motivation to seek couple therapy.

Transtheoretical model of change & couple therapy. Even though motivation to change is a well-established and necessary component of successfully making a change (Prochaska & DiClemente, 1983), because the TTMC is based on an individual perspective, very little research has focused on motivation to change as a relational construct (Bradford, 2012). Research on couples' motivation to change has often treated the couple as a unit and ascribed a single stage of motivation to the couple unit rather than assessing each individual's motivation to change (Bradford, 2012; Bradford et al., 2010). A dyadic measure of couple motivation to change has yet to be established. In fact, research has yet to clarify whether or not each individual's motivation to change matters in the decision to seek couple therapy or how each individual's motivation to change influences their partner's motivation to change.

Individual factors, such as gender are hypothesized to impact individual motivation to change. Gender appears to impact an individual's perception of issues in a couple relationship (Ojeda & Bergstresser, 2008). More specifically, as discussed previously, men are less likely to be motivated by negative attitudes about their relationship and are more likely to have negative beliefs about seeking treatment (Good et al., 1989; Ojeda & Bergstresser, 2008). Furthermore, preliminary research indicates that the female partner may serve as the "relationship barometer," meaning they become distressed sooner, identify a problem as existing, and move the couple towards change (Faulkner, Davey, & Davey, 2005). If the woman serves as a relationship barometer, it does not mean that their partner's stage of change does not matter but rather highlights the complicated role of motivation in couple therapy. This study will measure gender as an individual factor in hopes of gaining greater understanding into the role of gender on motivation to seek couple therapy.

Applications of the TTMC to mental health treatment encourage stage-matched interventions (Procaska & DiClementi, 1983). However, this approach does not account for the multiple and potentially different stages of motivation to change that exist in a couple relationship. Mismatched motivation to change would result in mismatched interventions, which would not only be unequally effective but potentially damaging to the non-motivated partner (Procaska & DiClementi, 1983). Mismatches in partner's motivation to seek therapy and make changes are considered to be a reason for early termination or drop-out (Tambling & Johnson, 2008). This supports the examination of motivation to change from a relational perspective. This research will explore individual motivation to seek couple therapy, however it is very possible that mismatches in motivation to seek couple therapy between partners are a reason for not seeking therapy in the first place.

The Present Study

According to the HBM (Rosenstock, 1966), individuals are likely to engage in preventative health care or treatment if they perceive that they are susceptible to a condition and believe it has serious consequences for their lives which, which when combined, lead individuals to perceive a threat. In the case of couples experiencing relational distress, the threat is divorce. Individuals are likely to seek treatment for a perceived threat if they believe the treatment will benefit them and that the barriers to accessing that treatment are not too great (Strecher & Rosenstock, 1997). They are also more likely to seek treatment if they are “cued” into action by recent positive or negative personal experiences in regards to the same perceived threat. However, if they do not perceive themselves or their relationship to have a problem, they are less likely to be motivated to make a change (Prochaska & DiClementi, 1992).

Although a large number of couples experience relational distress, which has serious negative effects for individuals and families and can lead to divorce (Johnson et al., 2002; Gottman & Gottman, 2013), many individuals do not seek couple therapy (NSDUH Report, 2008). This is despite evidence that couple therapy can result in beneficial change and a reduction of relational distress (Wampold, 2001). In order to address this gap in the literature and the resulting hardship individuals and couples experience (Shah & Beinecke, 2009), this study utilizes the HBM factors (Rosenstock, 1966) and contextualizing factors (i.e. perceived stigma and relational distress), which have been linked to motivation to seek mental health services, to predict an individual’s motivation to seek couple therapy. Given the literature on individual help-seeking behavior, individual demographic variables were also hypothesized to impact an individual’s motivation to seek couple therapy. These demographic variables included gender (Carroll et al., 2006), importance of religious belief (Armentrout, 2004), socio-economic

status (Boyd-Franklin, 1989), and education (National Survey of Drug Use and Health Annual Report, 2008). With a better understanding of why individuals in relationships are not motivated to seek couple therapy, mental health practitioners and community members can better address the barriers that discourage couples from attending therapy. The research questions and hypotheses that guided the current study are as follows:

RQ 1: To what extent do individual demographic characteristics predict motivation to seek couple therapy?

Hypothesis 1: Demographic characteristics will impact an individual's motivation to seek couple therapy.

Hypothesis 1a. Being a woman will be associated with greater motivation to seek couple therapy.

Hypothesis 1b. Lower SES will be negatively related to motivation to seek couple therapy.

Hypothesis 1c. Higher levels of education will be positively associated with motivation to seek couple therapy.

Hypothesis 1d. Importance of religious belief will be negatively related to motivation to seek couple therapy.

RQ 2: To what extent do individual contextualizing factors (i.e., perceived stigma and relationship distress) predict motivation to seek couple therapy when controlling for demographic characteristics?

Hypothesis 2: While controlling for demographic characteristics (i.e., gender, SES, education, and importance of religious belief), the contextualizing factors of relational

distress and perceived stigma will be significant predictors of an individual's motivation to seek couple therapy.

Hypothesis 2a. Higher levels of stigma will be negatively associated with motivation to seek couple therapy.

Hypothesis 2b. Higher levels of relational distress will be positively associated with an individual's motivation to seek couple therapy.

RQ3: To what extent does the Health Belief Model variables predict motivation to seek couple therapy when controlling for demographic characteristics and contextualizing factors?

Hypothesis 3: Controlling for demographic characteristics (i.e., gender, SES, education, and importance of religious belief) and contextualizing factors (i.e., relational distress and perceived stigma) the Health Belief Model factors will significantly contribute to variation in individual's motivation to seek couple therapy.

Hypothesis 3a. Greater rates of perceived susceptibility will be positively associated with greater to motivation to seek couple therapy.

Hypothesis 3b. Higher rates of perceived severity will be positively associated with greater motivation to seek couple therapy.

Hypothesis 3c. A greater perception of barriers will be negatively associated with motivation to seek couple therapy.

Hypothesis 3d. A higher perception of benefits will be positively associated with motivation to seek couple therapy.

Hypothesis 3e. Increased cues to action will be positively associated with motivation to seek couple therapy.

Given the lack of literature on this topic, an exploratory research question was added to gain additional insight.

RQ4: What are individual's personal perceptions of the role of couple therapy and how do they commonly cope with relational distress?

Figure 1 summarizes the predicted relationships between motivation to seek couple therapy and the contextualizing factors (i.e., relational distress and perceived stigma), the Health Belief Model Factors (i.e., perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action), and the demographic control variables (i.e., gender, SES, education, and importance of religious belief).

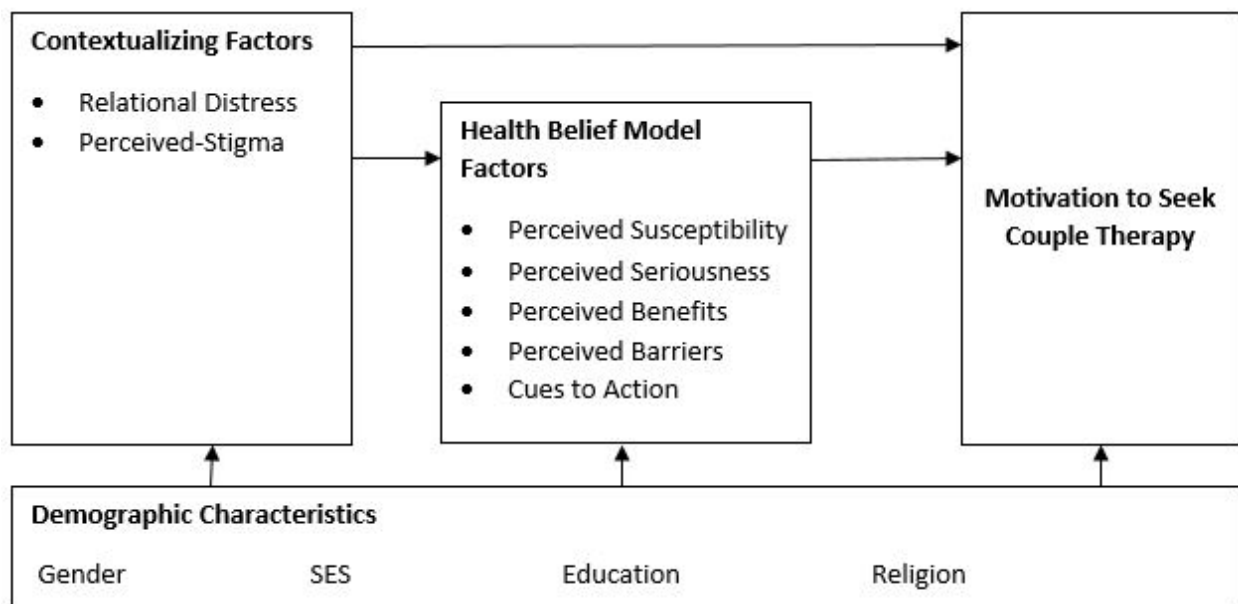


Figure 1. Conceptual model: Proposed relationships between variables and the outcome variable.

Chapter 3

METHODOLOGY

Design Overview

In order to expand the limited research on factors that predict an individual's motivation to seek couple therapy, the present study utilized an online survey that included 109 quantitative questions to assess demographic variables, two contextualizing factors (relational distress and perceived self-stigma), and the HBM variables (perceived... susceptibility, severity, barriers, benefits, and cues to action). It also included five open-ended questions to explore other barriers not assessed and identify individual perceptions towards couple therapy.

Sample

A national convenience sample was recruited online through Qualtrics panels (<https://www.qualtrics.com/research-suite/>). A total of 163 participants completed the survey online in an average of 32.4 minutes with a range from 6 minutes to 59 minutes. This was more than a sufficient number of participants needed to achieve adequate statistical power based on the number of variables needed for the hierarchical multiple regression analysis. The intended sample size was 115 participants (Green, 1991; $N > 104 + m = 115$; Green, 1991). During the data cleaning process, five participants were removed based on them skipping three or more sequential questions on any one scale. The final analysis included 158 participants.

Inclusion criteria. The inclusion criteria were as follows: Participants were required to (a) be 18 years of age or older; (b) be currently in a committed cohabitating/partnered/married relationship of over a year; (c) have no prior or current couple therapy with their current partner; (d) be the only individual in their relationship to take the survey. Three other requirements for participation were included: (a) the individual had to acknowledge being aware of the risk

associated with completing an online survey about their relationship; (b) they had to read the consent and agree to participate in the study; (c) commit to providing thoughtful and honest answers (added after soft-launch). All of the inclusion questions were “forced responses” to ensure that people had to make an affirmative selection otherwise they were unable to continue with the survey.

The inclusion criteria were based on ethical standards, current relationship research, and the needs of the current project. Individual’s had to be over the age of 18, in order to legally consent. In terms of the second inclusion criterion, a uniform definition of a committed relationship has not formally been agreed upon in the literature; therefore, to ensure that participants' relationships were viewed as being valuable to them and not just a casual dating relationship, a cohabitating partnered or married relationship of over a year was required. This definition aligns with the most commonly used definition in the literature of a "serious relationship," which requires that individuals need to have been together for over a year and perceive themselves as being committed to one another (Halford, Pepping, & Petch, 2015). In addition, research on the "honeymoon phase," which is defined as the first year of a relationship, hypothesizes that couples in the first year of their relationship may be unwilling to identify relational problems or do not perceive their relationship to be under threat (Manning & Smock, 2005). The recruitment documents and the survey itself included non-gendered language and partnered/marriage language so as to include those who have not been able to get legally married based on cost, beliefs, or discrimination especially against the LGBTQ community. For the third inclusion criterion, due to the desire to assess reasons people may or may not be motivated to seek couple therapy with their current partner, it was important that they have not previously sought therapy together. This study only focused on individual reasons for not seeking couple

therapy; therefore, it was important that only one member of the couple relationship completed the survey as the data was not being collected or assessed dyadically.

The final three participant requirements assessed risk and participants' willingness to complete the survey. Due to the potentially sensitive nature of the questions, it was important to ensure that participants had read the consent document and understood the potential risks of filling out a survey about positive and negative aspects of their relationship on a potentially public device. After the soft-launch (i.e., pilot testing, which is described in more detail below), Qualtrics staff suggested asking people to indicate that they would honestly and competently complete the questions rather than just clicking responses randomly.

Procedures

Survey development. The survey that was used for the study was developed in spring and summer of 2017. Common demographic questions were included to better understand the sample population and control for individual variables that have mixed results in the current literature. Following a review by the researcher's dissertation committee and a peer researcher, the final survey utilized the R-URICA to assess motivation to change along with the Couple Satisfaction Inventory (CSI-32) to screen for relationship distress rather than two other potential measures of the same variables, which had initially been proposed. The commonly used and validated self-stigma scale was also included (SSOSHS). The peer researcher reviewed the survey and demographic questions to identify any errors or constructs that were overlooked.

The scale to measure the five HBM constructs towards couple therapy was adapted from a HBM scale that was used to identify individual's perceptions towards premarital programs (Sullivan et al., 2004). Adaptations to this scale included changing "seeking premarital therapy" to "seeking couple therapy" and the elimination of future language such as "future marriage" to

"current marriage." Greater detail about scale adaptation can be found in the *Measures* section below. Once the survey was finalized and approved following the dissertation proposal, approval from Virginia Tech's Internal Review Board was submitted on June 7, 2017, and approved on September 11, 2017 (see Appendix A). The survey was then entered into Qualtrics for an initial soft-launch.

Recruitment. In order to collect a national sample of a wide range of individuals in couple relationships, a Qualtrics panel was used. Qualtrics is an online portal that allows individuals around the country to be recruited to complete surveys for an incentive that is based on the length of the survey. Participants who are interested in completing surveys are able to self-register with Qualtrics or can be recruited through businesses, advertisements, or universities. Potential participants are able to complete surveys on computers, tablets, or on mobile devices. For this study, individuals were recruited by Qualtrics through multiple access points including panel announcement boards, emails, text messages, and app notifications. After seeing the initial notification they proceeded through a double-opt-in procedure, meaning that after they identified that they were willing to participate and self-identified as meeting the criteria, they were then contacted and asked to formally opt into the survey (see Appendix B). Once they had access to the survey they had to affirm all of the necessary inclusion criteria and consent (see Appendix C) before beginning the actual survey questions. As stated above, consent was required before anyone was allowed to proceed to the survey. Participation was incentivized by a payment of \$6.50 to complete the 109-item survey.

Soft launch. The online survey was opened for a soft-launch on October 30, 2017, to collect between 5%-10% of the data needed. The necessary soft-launch data was collected in less than 24 hours and the survey was closed for review. The initial data was downloaded to

identify the median length of response and examine any potential problems with the questions or responses. An initial examination identified two people who had not completed the survey with due diligence as their responses were consistently one or two numbers even within the text-required responses. It was suggested by Qualtrics staff to add a question at the start of the survey requesting people to "commit to providing thoughtful and honest answers." This question was added to the end of the inclusion criteria and was a requirement for participation.

The median response time was found to be 10.8 minutes during the soft-launch. For the official survey, a time-check was put in place to eliminate anyone who took less than one-third of the median time of the soft-launch. This ensures that individuals thoughtfully respond to the questions rather than providing answers solely to receive the incentive for completion, as was identified with two individuals during the soft-launch.

Question 30 was modified after the soft-launch from "please identify a common point of conflict in your current relationship" to include "Even if conflict is rare, please identify a recent point of frustration or stress that has come up in your relationship." This change was made due to responses that said, "we rarely fight" or "we do not have a lot of conflict." This change resulted in all but one person, in the formal data collection process, identifying a point of conflict. No other changes were made from the soft-launch to the official survey. Following the soft-launch, the data collection process was re-opened and participants were again recruited through the Qualtrics panel. Participant recruitment and data collection were completed on November 1, 2017 due to the recruitment and accessibility to the target population provided by Qualtrics.

Participant removal. Participants who did not meet the inclusion criteria, who started but did not fully complete the survey, and who responded in less than one-third the median time (3.6 minutes) from the pilot or soft-launch were excluded from the sample. Those who did not

meet the inclusion criteria were not allowed access to the survey. Participants who did not fully complete the survey, that is, they started but did not finish, were not saved. The time-check requirement was included to eliminate anyone who could not have possibly read each question but rather was clicking random responses purely for the incentive.

Measures

Demographic characteristics. This research controlled for demographic variables that have demonstrated varied effects on mental health treatment according to the literature; this included gender, socio-economic status, education level, and religiosity (see Appendix D). Participants were asked to indicate their self-identified gender. The response options for self-identified gender included male; female; transgender; not listed, please explain; and prefer not to answer. As indicated before, gender differences have been seen in research on why people seek individual therapy and couple therapy (Ojeda & Bergstresser, 2008).

Income was assessed because lower income levels are associated with higher barriers to seeking treatment and less access to a range of services (Bazargan et al., 1998; Kirby & Keon, 2006). Participants were asked to report their total household income before taxes. The provided income categories starting under \$10,000 and ranging up to \$70,000 + in \$9,000 incremental increases. Participants were also given the opportunity to report that they didn't know their total household income or preferred not to answer.

Education was included in the study because education has not been well examined as a barrier or potential asset to seeking therapy. One study found that higher levels of education have been associated with higher clinical success rates, which would indicate that those individuals accessed treatment (Wright, Sabourin, Mondor, McDuff, & Mamodhousen, 2007). Participants were asked to identify a level of education by selecting one of the following options:

some middle school, some high school, high school graduate, GED, some college, associates, college graduate, and graduate degree. Participants were also given the option to add an option that was not listed.

Finally, participants were asked to identify their religious affiliation and were able to select from the following categories: Protestant, Catholic, other Christian, Jewish, Muslim, Buddhist, unaffiliated (atheist, agnostic), and not listed, please explain. Religious affiliation does not indicate the level of religious involvement or importance of religion to a person's life, therefore participants were also asked to rank how important their religious beliefs were to them on a scale of 1 (not at all important) to 5 (incredibly important).

In addition to the control variables already described, other demographic information was collected including participants' ethnicity, age, employment status, number of children in the current or from a prior relationship, and prior mental health treatment engagement. See Appendix B for the demographic questions included in the survey.

Contextualizing factors. As indicated in Figure 1, two contextualizing factors were included in the hypothesized model. These factors were included because the current literature indicates that relational distress and perceived self-stigma may serve as barriers to accessing treatment and would, therefore, impact an individual's motivation to seek therapy (Butterworth & Rodgers, 2008; Vogel et al., 2006).

Self-stigma. Self-stigma was measured using the 10-item Self-Stigma of Seeking Help Scale (SSOSHS; Appendix E), which was developed and validated by Vogel et al. (2006). The SSOSHS scale measures self-stigma related to 1) attitudes toward and 2) intent to seek psychological help. The 10-items on the SSOSHS are responded to using a Likert scale that ranges from 1 (strongly disagree) to 5 (strongly agree). Example questions include "I would feel

inadequate if I went to a therapist for psychological help” or “My self-esteem would increase if I talked to a therapist.” Five of the items (i.e., 2, 4, 5, 7, and 9) on the SSOSHS are reversed scored so they were reverse coded after data collection during analysis. Once all of the responses are assigned the accurate value, the values are added to determine a total score. The highest possible self-stigma score is 50. The SSOSH has a unidimensional factor structure and ranges from good reliability (.91) to acceptable test-retest reliability (.72) (Study 1; Study 4; Vogel et al., 2006). All items load at $>.50$, indicating that each variable has a strong relationship to the factor being measured, which is self-stigma in this case (Vogel et al., 2006). In terms of criterion validity, the SSOSH has been successfully used to differentiate, over a 2-month period, those who sought psychological help and those who did not (Vogel et al., 2006). In the present study, Cronbach’s alpha was .896.

Relationship distress. Relationship distress was measured with the Couple Satisfaction Index (CSI-32; Funk & Rogge, 2007; Appendix F). The CSI-32 is a brief assessment of an individual's couple satisfaction in their current relationship. The 32-item scale includes multiple different types of Likert-scale response categories. For example, participants were asked, "how often do you think things between you and your partner are going well" on a scale from "All of the time" (5) to "Never" (0). However other questions asked people to consider "I still feel a strong connection with my partner" on a scale of "not at all true" (0) to "completely true" (5). No items are reverse scored as each response has a numerical value ascribed to it. The total scale score is determined by tallying each response rating to create a total score. Scores range from 0 to 161 and higher scores indicate higher levels of relationship satisfaction. Scores above 104.5 are considered to denote relational distress (Funk & Rogge, 2007). The CSI is reported to have strong convergent validity with other relationship satisfaction surveys such as the Dyadic

Adjustment Scale (Spanier, 1976) and Marital Adjustment Scale (Locke & Wallace, 1959), which were incorporated into its development (Funk & Rogge, 2007). The reliability of the scale is measured at a Cronbach's alpha of .98 (Funk & Rogge, 2007). In the present study, Cronbach's alpha was .94.

Health belief model factors. The original Health Belief Model (HBM; Appendix G) scale was developed in 1994 to assess a women's likelihood of following through with self-breast examinations (Champion, 1994). A recent study, *Predicting Participation in Premarital Prevention Programs*, adapted the original HBM into a scale to predict participation in premarital prevention programs (Sullivan et al., 2004). In order to adapt the HBM for the intention to seek therapy services, Sullivan et al. (2004) adapted the original HBM scale (Champion, 1994) by conducting four different focus groups with 32 newly married adults between the ages of 20 and 54, some of whom received premarital counseling and some of whom did not. Following analysis of the focus group data, and based on a previous HBM assessment used to explain the likelihood of seeking mammography screening (Aiken et al., 1994), a 23-item HBM scale was developed to assess the HBM constructs (i.e., perceived... susceptibility, severity, barriers, benefits; cues to action) as they apply to the intention to seek mental health therapy services (Sullivan et al., 2004). This measure has since been used successfully in another premarital study (Borowski & Tambling, 2015), lending additional support to its validity with regard to mental health services. While the present study and the premarital programming study are similar in their intent to predict seeking therapeutic services, they are different in the timing and/or perceived reason for seeking those services (pre-marriage vs. post-marriage).

For this study, the HBM measure was adapted from the premarital HBM scale (Sullivan et al., 2004) to reflect couple therapy (vs. premarital counseling). Modifications of the survey were kept to a minimum in order to help maintain the validity of the scale developed by Sullivan et al. (2004). When possible, the language was changed from future marriage (as the original scale was used to assess pre-marital couples) to a current marriage. For example, “How easy do you think staying happily married will be for you?” was altered to read, “How easy is it to stay ‘happily married’ for you?” In the process of adapting the HBM for the current study, one question was eliminated as it read “Do you think that you would resent going to premarital counseling if it was required in order to get married?” This question was eliminated because it could not be altered into an appropriate question about couple therapy. To ensure that the alterations made were necessary and clear, my dissertation committee and a peer researcher with expertise in couple therapy reviewed the survey. This process did not result in any further suggestions or alterations to the scale.

Perceived susceptibility. To assess perceived susceptibility to divorce, the HBM premarital scale included 3 questions and 1 question with 4 parts. To adapt the questions for this study, “future partner” or “future marriage” was removed from the questions. Example questions included, “What do you believe is the chance that you and your spouse will ever get divorced?” and “How likely do you think it is that you would ever suggest divorce?” The response options for all of the questions were on a 5-point Likert scale, ranging from “not at all” to “very.” In terms of scoring, the first item, “how easy is it to stay ‘happily married’ for you” was reverse coded so “very” resulted in a score of one and “not at all” was scored as a five. Each item-response was then added together to create an overall scale score, with scores ranging from 7 to 35. The higher the score on the HBM susceptibility scale, the greater the degree of

perceived susceptibility of divorce. Prior research indicated that the Cronbach's alpha (.82) was adequate for the perceived susceptibility to marital problems scale (Sullivan et al., 2004). The present study had a Cronbach's alpha of .91.

Perceived severity. This sub-scale utilized 20-questions to assess an individual's perceived severity of relational conflict and divorce. Again, this study made minor modifications to the Sullivan et al. (2004) scale and only removed the "future" language from pre-marital questions. To determine a participants' perception of the perceived severity of divorce on their relationship they were asked, "How bad do you think it would be if... you experienced marital problems?" or "How bad do you think it would be if... you had trouble in your marriage?" Response options were on a Likert scale ranging from 1 (not at all) to 5 (extremely). In creating the scale score, the following five items were reverse coded: "If you got divorced, how likely is it that you... would enter another serious relationship again; could ever get married again; would be able to fully recover; would eventually be able to move on?" Reverse scored items were re-coded during the data analysis process so they could be summed to create a total scale score (1 became extremely; 5 was not at all). Total perceived severity of divorce responses ranged from 20 to 100, with higher total scores indicating more serious perceived consequences of divorce. Prior studies indicated that the Cronbach's alpha was adequate for the perceived the perceived severity of marital problems scale (.84 for men and .83 for women; Sullivan et al., 2004). This study did not distinguish between genders and had a total Cronbach's alpha of .84.

Perceived barriers. The HBM premarital scale (Sullivan et al., 2004) initially included 10 questions related to perceived barriers to accessing treatment but was modified to nine for this project. One question on the original scale was dropped because it asked, "Do you think that you

would resent going to premarital counseling if it was required in order to get married?" This item could not be made relevant to barriers to seeking couple therapy. Other questions on the scale were adapted by replacing "premarital therapy" with "couple therapy." For example, "Do you think going to premarital counseling means you have a problem in your relationship?" was revised to read, "Do you think going to couple therapy means you have a problem in your relationship?" All questions had response options on a Likert scale of 1 (not at all) to 5 (very). Each question asked something different such as "how convenient" or "how easily could you find a place to go," which impacted the meaning of the Likert scale responses. Six of the nine items (Q95: 2-4; 8-10) were reverse coded on the scale but were adjusted before data analysis so that all of the items were summed in order to create a total scale score. The possible scores ranged from 9 to 45, with higher scores indicating greater perceived barriers to accessing treatment. Prior research identified an adequate Cronbach's alpha for the perceived the perceived barriers scale (.82 for men and .76 for women; .68 when men and women were combined; Sullivan et al., 2004). This study had a total Cronbach's alpha of .58. This alphas level is on the low range of acceptable.

Perceived benefits. The HBM premarital scale included three benefits of seeking couple therapy questions, one with seven sub-questions, for a total of 9 questions. This study maintained all of the questions but again modified the language to reflect couple therapy and participants' current marriage instead of premarital counseling and a future marriage. An example of the modification performed was to remove "pre-marital counseling in the following example and add "couple therapy:" "To what extent would pre-marital counseling [became couple therapy] help you to keep your marriage happy? Responses were on a Likert-scale ranging from 1 (not at all) to 5 (definitely) and were based on the question. For the example

above the Likert scale was asking would couple therapy "not at all" or "definitely" keep your marriage happy. Each response was added to create a scale score, whereas higher scores reflect greater perceived benefits of seeking couple therapy. No items were reverse coded on this scale, therefore, the results were simply summed. Total scores ranged from 9 to 45 and higher scores indicate higher perceived benefits of seeking couple therapy. Prior research identified a very good Cronbach's alpha of .92. (Sullivan et al., 2004). The Cronbach's alpha in this study was .94.

Cues to action. Cues to action, or personal exposure to the problem or solution that provoke "readiness," are believed to influence the four primary constructs of the HBM model. (Turner et al, 2004). Cues to action are activating experiences that increase awareness and personal proximity to the problem or potential solutions to the problem (Stretcher & Rosenstock, 1997; Turner et al., 2004). In this study, cues to action were conceptualized as personal experiences with divorce and couple therapy, particularly within the family or close friendships, which would increase motivation to seek couple therapy. Research indicates that exposure matters rather than degree of exposure, therefore, these were assessed categorically rather than on a Likert scale as in the original scale (Turner et al., 2004). Participants were asked to respond to four yes (2) or no (1) questions: (1) "Have any of your family members divorced?" (2) "Have any of your close friends divorced?" (3) "Have you ever known anyone who went to couple therapy?" (4) "Has anyone suggested to you that you should go to couple therapy?" These questions were assessed by a peer researcher and are based on other questions assessing cues to act. A "yes" response indicated exposure to the cue to act therefore more "yes" responses should predict a higher likelihood to have motivation to seek couple therapy. Score totals ranged from 4-8 and higher scores indicate higher cues to act.

Motivation to seek couple therapy. The University of Rhode Island Change Assessment (URICA; McConaughy, Prochaska, & Velicer, 1983) was developed based on the TTMC (Prochaska & DiClementi, 1982) and included 32-items to assess the four of the stages of change. Although widely used, the URICA is theoretically driven and the validity, scoring method, and factor structure of the URICA came under criticism (Tambling & Johnson, 2008). Therefore, Tambling and Ketring (2014) set out to modify the URICA to address common criticisms by conducting an EFA (Tambling & Johnson, 2012) and CFA. The goal of their research was to develop the best fitting model that could be utilized to predict outcomes in couple therapy. These analyses resulted in a briefer 14-item scale with three subscales (action, seeking assistance, and ambivalence). An individual in action is currently taking steps and making changes to address the identified problem. Those seeking assistance are considering making a change but do not have the individual resources or individual ability to make the change. Lastly, those who are ambivalent see both the pros and cons of making a change and have not committed to making a change. Further, the CFA demonstrated good fit to the data ($\chi^2 = 332.22$, RMSEA = .098, NFI = .92, CFI = .94). The questions were modified to specifically ask about relational problems and couple therapy. Questions included “I am doing something about the relational problems that have been bothering me” and “maybe couple therapy will be able to help me.” These questions changed the words “this place” to “couple therapy.” Four items are reverse coded, which are 19, 20, 21, and 24 on the initial URICA. The Revised-University of Rhode Island Change Assessment (R-URICA; Appendix H) has a total sum score of 70 and a low score of 14. The higher the score on the R-URICA, the higher the individual's motivation to seek couple therapy. Past estimates of internal consistency reliability have ranged

from $\alpha = .60$ to $.79$ for the total scale (Tambling & Ketring, 2014). The Cronbach's alpha for this study was $.59$, which is on the low range of acceptability.

Open-Ended Questions

After the demographic questions and before starting the survey scales, participants were asked an open-ended question to prime them for the scale items (see Appendix I). They were asked to consider a common point of conflict in their relationship or the most recent point of conflict in their relationship. The response to this open-ended question were thematically categorized to identify the most common points of conflict.

Five open-ended questions were also included at the conclusion of the survey. They were used to identify barriers that were not assessed by the scales and to explore what individuals thought about couple therapy in general. These questions asked: (1) "How much would you be willing to pay per session of couple therapy?" (2) "In general, what kinds of topics do you think would be valuable and important to cover in couple therapy?" (3) "What have you heard about couple therapy? What do you imagine it to be like?" (4) "Many people face barriers when seeking therapy or help for their relationship. What are some of the primary reasons you wouldn't seek couple therapy?" (5) "People do a lot of things to improve their relationship: talk to a friend, read books, use social media resources, etc. What are some things you've done to improve your relationship?"

Data Analysis

Preliminary analyses. Upon collection of 163 responses, the survey was closed and the data was imported to SPSS (SPSS 21.0, IBM, 2012) from Qualtrics. Before any analyses were performed, the data were assessed for missing data, outliers, normal distribution, and multicollinearity. Normality, linearity, and homoscedasticity were then assessed for to check for

the required assumptions associated with hierarchical regression including, (Snyder & Mangrum, 2005).

Missing data. An initial visual examination of the data, followed by a frequency analysis, revealed five participants who had skipped 3 or more questions in a row on the scales at the end of the survey. Due to the large sample size, these participants were removed from the sample. The resulting sample that was tested formally for missing data included 158 participants. Missing data were identified through a missing values analysis (SPSS 21.0), which examined the data for any patterns of missingness. The dataset included minimal missing data, with less than 20 missing data points across the entire sample. The MCAR test identified less than 2% of missing data and failed to reject the null hypothesis at a $p = .543$ significance; therefore, the data did not have any patterns of missingness and the data was considered to be missing at random (MCAR; Tabachnick & Fidell, 2013). Three questions were identified to have more than 2% of missing data and they were missing four responses (2.5%), six responses (3.8%), and five responses (3.2%) respectively. These items were spread throughout the survey (Q36, Q86, and Q97). Question 36 asked, "My view of myself would not change if I make the choice to see a counselor." Question 86 asked individuals where on a scale from "lonely to friendly they felt about their relationship." Lastly, question 97 asked, "to what extent would discussing relationship issues with a neutral professional be helpful to your relationship." Since there was an extremely small amount of data missing and the sample size was large enough, these 15 cases with missing data were replaced using the partial imputation method of the expectation maximization (EM) algorithm (Dempster, Laird, & Durbin, 1977). This algorithm removed error from the data set while using the observed variables and correlations to substitute missing data (Keith, 2006).

Outliers. As a result of using an online survey, completion and the limited responses provided by the online platform, no data entry errors occurred. Demographic variables with options for open-ended responses, such as age, length of relationship, and the number of children, were assessed for outliers by examining frequencies. No outliers were identified. All scale scores included in the main analysis were plotted to check for outliers, which did not reveal any outliers

Normal distribution. To assess for normal distribution in the data, the data was plotted and no large (>3) z-scores were found. Then multivariate normality was tested to identify any skewness or kurtosis. Skewness testing identifies any symmetry in the data and kurtosis testing determines whether the data was pulled heavily in either direction (heavy/light tailed distribution). All of the scales used in the model were assessed for skewness, which should hover around 0. Stigma, perceived susceptibility, and cues to action were positively skewed and relationship satisfaction, perceived severity, perceived barriers, perceived benefits, and motivation to seek couple therapy were negatively skewed. However, skewness for each scale remained close to zero across all variables; therefore, the main study variables were considered to be normally distributed (Tabachnick & Fidell, 2013). Kurtosis was not expected, as the sample size was well over 100 but all of the scales approached zero when tested for Kurtosis.

Multicollinearity. Multicollinearity was assessed by examining correlations between the predictor variables in each regression model that approached 1.0 (generally above .90) and calculating squared multiple correlations (Kline, 2010). The model was tested for tolerance and variance inflation factor (VIF) with collinearity statistics. Tolerance values should not be below .20, as this would indicate a linear combination of the independent variables. The VIF (1/Tolerance) measures the impact of collinearity among variables in the regression model and

should not be above 10 (Keith, 2006; Tabachnick & Fidell, 2013). VIF scores for each block of variables in the regression model stayed around 1, likely indicating the absence of multicollinearity.

Hierarchical regression analyses. The primary goal of this research was to understand how much variance each of the independent variables (i.e., demographic factors, perceived self-stigma, relational distress, and the five HBM factors) accounted for in the dependent variable (i.e., motivation to seek couple therapy). To answer this question, a regression analysis was necessary because the predictor variables (or independent variables, as termed if this were an experimental design) are assumed to influence, based on current literature, motivation to seek couple therapy and, yet, are assumed to be not highly correlated with each other. Regression analysis enables the researcher to determine which variables have predictive ability beyond those already included in the model (Tabachnick & Fidell, 2013). More specifically, hierarchical regression was selected to address the research question because it allowed for testing of the theory-based mechanisms between the independent variables and the one dependent variable (Kline, 2010; Keith, 2006; Tabachnick & Fidell, 2013). Hierarchical regression is most appropriate with variables that have the potential for intervention due to its predictive nature (Tabachnick & Fidell, 2013). Again, this substantiates the decision to select variables that can be affected by the individual, society, or the therapist along with a criterion variable (i.e., motivation to attend couple therapy) that has been well-substantiated as a potentially meaningful outcome variable in both clinical and non-clinical populations (Bradford, 2012). The intention of this research was to identify which variables were important in influencing participants' motivation to seek couple therapy; therefore, the variables were entered as blocks into the regression analysis. This made it possible to test the conceptual model depicted in Figure 1.

Model 1. In order to test Hypothesis 1, demographic characteristics that were hypothesized to be associated with an individual's motivation to seek couple therapy were entered into Model 1. These demographic characteristics include gender, socio-economic status, education level, and religiosity. As discussed previously, prior research has indicated that these demographic characteristics influence clinical outcomes, treatment-seeking behavior, and distress management (Bradford, 2012; US Department of Health and Human Services, 1999; Wright et al., 2006). The regression equation for Model 1, which allowed for a testing of Hypothesis 1, is as follows:

$$(\text{Motivation to Seek Couple Therapy})' = A + b(\text{gender}) + b(\text{socio-economic status}) + b(\text{education level}) + b(\text{religiosity})$$

Model 2. In order to test Hypothesis 2, the demographic factors remained in the model and the contextualizing factors of relational distress (Busby et al., 1995) and perceived self-stigma (Vogel et al., 2006) were entered in Model 2. The regression equation for Model 2 is as follows:

$$(\text{Motivation to Seek Couple Therapy})' = A + b(\text{relational distress}) + b(\text{perceived self-stigma}) + [b(\text{gender}) + b(\text{socio-economic status}) + b(\text{education level}) + b(\text{religiosity})]$$

Model 3. In order to test Hypothesis 3, the factors of the HBM were entered into Model 3. The demographic factors and contextualizing factor remained in Model 3. The HBM factors added in Model 3 included perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action. The regression for Model 3 is as follows:

$$(\text{Motivation to Seek Couple Therapy})' = A + b(\text{perceived susceptibility}) + b(\text{perceived severity}) + b(\text{perceived barriers}) + b(\text{perceived benefits}) + [b(\text{relational distress}) + b(\text{perceived self-stigma})] + [b(\text{gender}) + b(\text{socio-economic status}) + b(\text{education level}) + b(\text{religiosity})]$$

Open-ended question analysis. The brief responses to each of these questions were exported from Qualtrics into Excel, where they were sorted alphabetically. The researcher then

identified the most common responses and grouped them into like categories by first identifying exactly the same response (i.e. “communication” and “communication”). Then in a second sorting step, very similar responses were grouped together into like categories (i.e. “communication” and “talking together”). A third sorting step included grouping similar ideas and themes in responses (i.e. “communication” and “we avoid talking about things that could cause conflict”). The final categorization identified broad but key themes in responses and grouped them together to create the most common response categories (i.e. “power struggles” included “she wants to be my parent and is always telling me what to do” and “I am disabled now and he doesn’t do things the way I want him to, says he’s right”). Individuals were able to offer more than one response for each question, which were delineated by commas in the response box. During data analysis, these responses were separated from each other and grouped into different like categories when appropriate. The goal was to identify the most common responses that participants shared. These responses can be used in the future to inform research questions and scale development as they identified gaps in the current literature and highlighted the need for more systemic scales, especially when assessing barriers, benefits, and motivation.

Chapter 4

RESULTS

Participant Characteristics

The sample consisted of 158 participants who met the inclusion criteria, completed the entire survey, and were not eliminated during the cleaning of the data due to skipping three questions in a row. All participants were (a) over the age of 18, (b) currently in a cohabitating-committed relationship of longer than a year, (c) did not have a partner taking the survey, and (d) had not engaged in and were not engaged in couple therapy with their current partner. After data cleaning, every scale had an N of 158 including the opened ended questions. Additional demographic information about the sample is available in Table 1.

Table 1
Sample Demographics

	Frequency	%	M	SD
Age			45.12	15.57
20-29	25	15.8		
30-39	42	26.6		
40-49	33	20.9		
50-59	25	15.8		
60-69	25	15.8		
70-79	7	4.4		
80-89	1	0.6		
Gender				
Male	25	15.8		
Female	133	84.2		
Transgender	0			
Not Listed	0			
Sexual Orientation				
Heterosexual/Straight	144	91.1		
Gay/Lesbian	3	1.9		
Bisexual	8	5.1		
Explain: Pansexual	1	0.6		
Prefer not to answer	1	0.6		
Ethnicity				

Hispanic/Latino	16	9.8
Non-Hispanic/Latino	146	89.6
Race		
Asian	7	4.3
Black/African American	7	4.3
White	148	90.8
Not Listed	1	0.6

Participants ranged in age from 20 to 84 years old ($M = 45.12$, $SD = 15.57$). They primarily identified as heterosexual ($n = 144$, 91.7%) and white ($n = 144$, 91.1%). With regard to employment, the majority of the sample was employed either part time (12.7%; $n = 20$) or full time (40.5%; $n = 64$). In terms of education, the majority had completed some college (27.8%; $n = 44$) or graduated college (29.1%; $n = 46$). Twelve (7.6%) participants listed themselves as full-time students and two (1.3%) as part-time students. Additional information about participants education level and employment status is presented in Table 2.

Table 2
Sample Demographics: Education & Employment

	Frequency	%
Education Level		
Some high school	2	1.3
High school graduate	32	20.3
GED	1	0.6
Some college	44	27.8
Associates	14	8.9
College graduate	46	29.1
Graduate degree	18	11.4
Not listed: Cosmetology	1	0.6
Employment Status		
Part time	20	12.7
Full time	64	40.5
Disability	10	6.3
Not seeking work	16	10.1
Seeking employment	8	5.1
Retired	22	13.9

Not listed: homemaker	13	9.6
Not listed: student	1	0.6
Not listed: business owner	1	0.6
Not listed: seasonal worker	1	0.6

In regards to income, the majority reported making over \$70,000 annually ($n = 51$, 32.3%). The second two most commonly reported income brackets were \$20,000-\$29,000 ($n = 21$, 13.3%) and \$50,000-\$59,000 ($n = 21$, 13.3%).

Table 3
Household Income

	Frequency	%
Under \$10,000	2	1.3
\$10,000-\$19,000	14	8.9
\$20,000-\$29,000	21	13.3
\$30,000-\$39,000	17	10.8
\$40,000-\$49,000	14	8.9
\$50,000-\$59,000	21	13.3
\$60,000-\$69,000	13	8.2
\$70,000 +	51	32.3
Do not know	1	0.6
Prefer not to answer	4	2.5

Demographic data related to family structure revealed that participants identified as being married ($n = 126$, 79.7%), in a domestic partnership ($n = 13$, 8.2%), legal partnership ($n = 8$, 5.1%), life-partners ($n = 6$, 3.8%), or engaged ($n = 5$, 3.2%). The average length of participants' committed relationships ranged from two years to 60 years and 6 months. ($M = 18.48$ years, $SD = 14.61$). The majority of participants had children with their current partner ($n = 94$, 59.5%). Of those, 31 (19.6%) had one child, 36 (22.8%) had two children, 18 (11.4%) had three children, eight (5.1%) had four children, one (0.6%) had six children, and one (0.6%) reported nine children. Thirty-one (19.6%) participants reported having children with a partner outside of their current relationship: eighteen (11.4%) participants reported one child, ten (6.3%) reported two

children, one (0.6%) participant reported three children, and two (1.3%) participants reported four children. Of all the participants that reported having children, seventy-eight participants reported that the children lived with them full time (49.4%), two participants reported that the children lived with them part-time (1.3%), and seventy-two participants reported that children did not live with them (45.6%).

Participants were asked about prior therapy experience, and the majority of the sample had no prior therapy experience of any kind ($n = 112$; 70.9%), however five (3.1%) participants reported that their partner had been to individual therapy for problems in their relationship.

The majority of the sample reported having a religious affiliation. The most commonly reported religious affiliation was protestant ($n = 45$, 28.5%) followed by Catholic ($n = 36$, 22.8%). Those who selected “Not listed” reported being pagan ($n = 4$, 2.6%), Wiccan ($n = 2$, 1.3%), and Hindu ($n = 2$, 1.3%). One (0.06%) participant reported being a druid, one (0.06%) participant reported they were a Jehovah’s Witness, one (0.06%) participant reported they were Lutheran, one (0.06%) participant reported they were Mormon, one (0.06%) participant reported they were Unitarian Universalist, one (0.06%) participant reported they were Baptist, and one (0.06%) participant reported they were Christian.

Table 4
Sample Demographics: Religion & Spirituality

	Frequency	%	M	SD
Religious Affiliation				
Protestant	45	28.5		
Catholic	36	22.8		
Other Christian	28	17.7		
Jewish	1	0.6		
Muslim	1	0.6		
Buddhist	2	1.3		
Unaffiliated	28	17.7		

Not listed	15	9.5		
Importance of Spirituality			3.43	2.566
1 (not at all)	34	21.5		
2	12	7.6		
3	31	19.6		
4	32	20.3		
5 (very)	47	29.7		

To assess current skills and resources, participants were asked about all of the items/actions they may have used to improve their current relationship, 34.2% ($n = 54$) reported using religious or spiritual guidance, 31.6% ($n = 50$) reported using self-help books, 27.8% ($n = 44$) reported talking to peers, 20.9% ($n = 33$) reported using media (TV, Movies, podcasts), and 10.1% ($n = 16$) reported attending an individual or couple retreat. Participants could select more than one option so these are not mutually exclusive responses.

Common conflict. All 158 participants provided one point of conflict in their relationship or the most recent thing they had conflict over ($N = 158$). Common points of conflict ranged widely and included flirting ($n = 1$), driving ($n = 1$), or leaving socks on the floor ($n = 1$). However, the most commonly reported problems were finances/bills/money ($n = 62$, 39%), power struggles ($n = 18$, 11%), communication ($n = 17$, 10.7%), and intimacy ($n = 13$, 8%). This provides context into the types of problems causing distress in individual's relationships.

Preliminary Analysis

As described in Chapter 3, all assumptions of the data necessary for the hierarchical regression analysis were met. Scale scores for regression analysis are presented in Table 5. In regards to motivation to change, the sample varied (range = 25-59), in their level of motivation to seek couple therapy, with possible responses on the survey ranging from 14-70. The R-URICA does not currently have cutoff scores to determine, low, moderate, or high levels of motivation to change. In regards to self-stigma, participants reported just below average levels of self-stigma

and scores ranged from no self-stigma to the highest possible level of self-stigma (50). On the second contextualizing factor, relationship dissatisfaction, the cut-off score is 104.5 and 33 participants reported scores at 104 or lower (20.9%), with two individuals reporting the lowest reported score of 55.

In regards to the HBM substance, on the susceptibility sub-scale participants reported a wide range of perceptions of their susceptibility to divorce from 7 to 34 with a total possible score of 35. They also reported a range of perceived severity towards divorce from 28 to 100 with 105 being the highest possible score. In regards to perceived barriers, they ranged from 14 to 37 with a total possible score of 45. The range reported on the perceived benefits scale from 9 to 45 indicated that participants ranged from believing that couple therapy is very beneficial to not believing it would be beneficial at all (highest possible score is a 45). Lastly, individuals reported some cues to act (4) up to the highest possible cues to action (8).

Table 5
Scale Scores for Regression Variables

	M	SD	Min	Max
Motivation to Seek Couple Therapy (URICA)	42.31	5.80	25	59
Self-Stigma	23.17	8.45	10	50
Couple Satisfaction Inventory (CSI-32)	125.51	27.16	55	160
Susceptibility	15.60	7.19	7	34
Severity	70.52	13.46	28	100
Barriers	27.05	3.67	14	37
Benefit	30.19	8.50	9	45
Cues to Action	6.25	1.01	4	8

Bivariate analysis. Bivariate analyses were conducted prior to the hierarchical regression analyses and detailed Pearson r correlations are presented below in Table 6.

Motivation to seek couple therapy was significantly and positively correlated with perceived

stigma ($r = .133, p < .049$), relationship satisfaction ($r = .196, p < .007$), and cues to action ($r = .183, p = .011$). This means that participants who were more motivated to seek couple therapy experienced higher rates of stigma towards couple therapy but also had higher levels of relationships satisfaction and more positive and personal associations with seeking couple therapy, as measured by cues to action. Motivation to seek couple therapy was also negatively and significantly correlated with income ($r = -.245, p < .001$) indicating that as income decreased so did motivation to seek couple therapy. Motivation to seek couple therapy also decreased as perceived benefits to seeking therapy increased ($r = -.191, p < .008$); as perceived benefits to seek therapy increased motivation to seek therapy decreased. Women, the majority of the sample, were positively associated with higher perceived benefits to seeking couple therapy ($r = .173, p < .015$). Higher rates of income were positively correlated with higher rates of perceived severity of divorce ($r = .155, p < .027$) indicating that as individuals make more money the perceived severity of getting a divorce increases. People, who perceived their religion to be more important, perceived greater severity towards the consequences of divorce ($r = .214, p < .004$) and higher perceived benefits to seeking couple therapy ($r = .194, p < .008$). Individuals' who placed more importance on their religion had less perceived stigma towards seeking treatment ($r = -.186, p < .010$) and perceived less barriers to seeking couple therapy ($r = -.252, p < .001$). As religious importance increased so did the perceived severity of getting divorced but they believed therapy would be more beneficial, experienced less self-stigma, and believed there were less barriers towards seeking couple therapy. Participants who reported higher levels of perceived stigma also reported higher rates of perceived barriers to seeking treatment ($r = .166, p < .019$) and higher personal cues to act ($r = .202, p < .006$). Higher levels of self-stigma were associated with higher perceived barriers and yet high cues to act. Conversely, as perceived

stigma increased, perceived benefits to seeking couple therapy decreased ($r = -.300, p < .000$); higher rates of stigma are associated with lower perceived benefits of couple therapy.

Relationship satisfaction was positively correlated with perceived benefits to seek couple therapy ($r = .165, p < .020$) meaning that higher relationships satisfaction is associated with higher perceived benefits to seek couple therapy. Perceived barriers were negatively correlated with perceived benefits ($r = -.465, p < .000$); indicating that as barriers go up benefits of couple therapy decrease.

Table 6
Correlation Matrix

Variables	1	2	3	4	5	6	7	8	9	10	11	12
1. URICA	--											
2. Gender	-0.001	--										
3. Income	-0.245***	0.144*	--									
4. Religion	0.106	0.039	-0.12	--								
5. Education	-0.168**	0.102	0.503***	-0.039	--							
6. Stigma	0.133*	0.009	-0.003	-0.186**	0.099	--						
7. CSI	0.196**	0.015	-0.083	0.023	-0.085	0.073	--					
8. Susceptibility	-0.095	0.064	0.044	0.106	0.154*	0.057	-0.700	--				
9. Severity	-0.122	0.048	0.155*	0.214**	0.178*	0.020	-0.031	0.12	--			
10. Barriers	-0.091	0.058	-0.115	-0.252***	0.017	0.166*	-0.069	-0.054	0.092	--		
11. Benefits	-0.191*	0.173*	0.031	0.194**	0.012	-0.300***	0.165*	0.007	0.022	-0.465***	--	
12. Cues to Act	0.183**	-0.002	-0.02	-0.092	0.082	0.202**	0.054	-0.040	-0.068	-0.027	-0.072	--

*p>.05. **p>.01. ***p>.001.

Hierarchical Regression Analysis

A hierarchical regression analysis was utilized to test the three main research hypothesis: (Hypothesis 1) Demographic characteristics will impact an individual's motivation to seek couple therapy; (Hypothesis 2) While controlling for demographic characteristics (i.e., gender, SES, education, and religion), the contextualizing factors of relational distress and perceived stigma will be significant predictors of an individual's motivation to seek couple therapy; (Hypothesis 3) Controlling for demographic characteristics (i.e., gender, SES, education, and religion) and contextualizing factors (relational distress and perceived stigma) the HBM factors will significantly contribute to variation in individual's motivation to seek couple therapy. Hierarchical regression was conducted to determine the extent to which demographic variables (i.e., gender, education, religion, and income), contextual factors (i.e., self-stigma and couple satisfaction), and HBM variables (i.e., susceptibility, severity, barriers, benefits, and cues to action) predicted an individual's motivation to seek couple therapy. In Model 1, which tested Hypothesis 1, the demographic variables were entered into the regression equation. In Model 2, the contextual factors of self-stigma and couple satisfaction were entered into the analyses, along with the demographic variables. Finally, in Model 3, the HBM variables (e.g., perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action) were added to equation, along with the demographic variables and contextualizing factors.

For the analysis, the F score was used to determine statistical significance of each model; however, at each step of block entry, the change in the R^2 was used to determine the statistical significance of the addition of that particular block of variables, while controlling for the variables that were already included in the model (Keith, 2006). The R^2 is the proportion of variance in the dependent variable, which can be explained by the independent variables (Keith,

2006). The standardized regression coefficients were used to assess the relative importance of each of the predictor variables, while controlling for the other variables in the model. The standardized regression coefficients will be highlighted in the presentation of the findings, as they can be used to inform intervention recommendations by identifying significant variables (Keith, 2006). Summary results of the hierarchical regression analysis for motivation to seek couple therapy are reported in Table 7.

Table 7
Hierarchical Regression Analysis Summary Results (N = 158)

Predictor	<i>b</i>	Motivation	
		ΔR^2	β
Model 1		.070*	
Gender	.517		.033
Income	-.528		-.208*
Importance of Spirituality	.295		.077
Education	-.215		-.064
Model 2		.050**	
Gender	.408		.026
Income	-.468		-.184*
Importance of Spirituality	.396		.103
Education	-.252		-.075
Self-Stigma	.101		.147
Relational Distress	.034		.160*
Model 3		.120**	
Gender	1.526		.097
Income	-.503		-.198*
Importance of Spirituality	.407		.106
Education	-.203		-.061
Self-Stigma	.027		.039
Relational Distress	.057		.265*
Susceptibility	.076		.094
Severity	-.032		-.073
Barriers	-.358		-.226*
Benefits	-.238		-.348**
Cues to Action	.800		.139

* $p > .05$ ** $p > .01$

Model 1. The first model, which included the four demographic variables (i.e. gender, income, religion, education), had a significant R^2 of .070 ($F(4, 151) = 2.83, p = .027$) and adjusted R^2 of .045. Hypothesis 1a, 1c and 1d were not supported, in that gender, education, and importance of spirituality were not significant predictors of individual motivation to seek couple therapy. Hypothesis 1b was significant, such that participants with lower SES reported a lower motivation to seek couple therapy ($\beta = -.208, p = .025$).

Model 2. In order to test Hypothesis 2, the second model included the self-stigma and couple satisfaction variables, in addition to the demographic variables. The model was statistically significant with ($F(6, 149) = 3.372, p = .004$). The model had a R^2 of .120, adjusted R^2 of .084, and a significant R^2 change of .050 ($p = .017$). Hypothesis 2a was not supported; that is, self-stigma did not predict individual motivation to seek couple therapy in this population. Hypothesis 2b was supported, suggesting that lower levels of relationship distress are associated with higher levels of individual motivation to seek couple therapy ($\beta = .160, p = .040$). Income remained a significant predictor ($\beta = -.1840, p = .043$) indicating that lower levels of income are associated with high levels of motivation to seek couple therapy.

Model 3. In Model 3, hypothesis 3 was tested, which included the addition of HBM variables to the model, while controlling for demographics, self-stigma and couple satisfaction. The overall model statistically significant with ($F(11, 144) = 4.119, p = .000$). Model 3 had an R^2 of .239 and an adjusted R^2 of .181, indicating that it accounted for 18.1% of variance in the outcome of motivation to seek couple therapy. The model also had a significant R^2 change of .120 ($p = .001$), which accounted for an increase of 12% of the motivation to seek couple therapy ($p = .001$). In the final model, income, relational satisfaction, perceived barriers of couple therapy, and perceived benefits of couple therapy were significant predictors of motivation to

seek couple therapy. Having a lower SES was associated with higher motivation to seek couple therapy ($\beta = -.198, p = .028$). Higher relationship satisfaction was associated with greater motivation to seek couple therapy ($\beta = .265, p = .017$). Finally, participants with higher perceived barriers of couple therapy ($\beta = -.226, p = .012$) and greater perceived benefits of couple therapy ($\beta = -.348, p = .000$) reported lower motivation to seek couple therapy.

Open-Ended Questions

As discussed previously, five open-ended questions were included at the end of the quantitative survey (Appendix I). These questions explored other potential barriers to seeking couple therapy, which were not assessed in other parts of the survey.

Cost of couple therapy. In response to the question, “How much would you be willing to pay per session of couple therapy?” the average reported amount was \$58, with the responses ranging from \$0 to \$500 ($SD = 62$). Two participants wrote in that couple therapy should be covered by a standard co-pay from their insurance company and four people wrote that they had no idea about the cost. Eighteen people wrote that they wouldn’t pay anything for therapy. The majority of responses reported that they would pay between \$25 and \$100 per session with only five people reporting \$200 or higher.

Therapy topics. Analysis of the response to the question “In general, what kinds of topics do you think would be valuable and important to cover in couple therapy?” revealed twenty-two response categories. Individuals were allowed to report more than one reason but 158 people responded to the question, which resulted in 209 individual responses. The most common response category was communication ($n = 44, 21\%$). Other popular categories were finances ($n = 27; 13\%$), intimacy ($n = 21; 10\%$), and conflict ($n = 21; 10\%$). Twenty-four

participants (11.5%) also reported not knowing what couple therapy would help with. All of these responses are shown in Table 8 below.

Table 8
Couple therapy topics self-report (N =158)

Category	Response Rate
Communication	44
Finances	27
I don't know	24
Intimacy	21
Conflict	21
Family	8
Parenting	7
Trust and honesty	7
Compromise over differences	6
Emotion	5
Expectations	5
Understanding	5
Stress	4
Compromise	4
Religion and values	4
Affair	3
Background	3
Boundaries	3
Individual needs	3
Future goals	2
Self- control, selfishness	2
Health	1

Perception of couple therapy. In response to the questions, “What have you heard about couple therapy? What do you imagine it to be like?” a 158 individual provided 191 unique responses. Thirty-nine (20.4%) of them reported negative views of couple therapy stating things such as it would be “pointless,” “invasive,” “I’d be told to leave with my kids,” “people break-up,” “doesn’t work in real life,” and “it would cause conflict.” A total of 52 (27.2%) respondents said they did not know what to expect in couple therapy and another three (1.6%) reported that they only know what they have “seen on TV” or “in the movies.” The majority of respondents

($n = 79$, 41.3%) indicated that couple therapy was a place for talking, more specifically about things you would not normally talk about. Positive responses were considered to include “work on issues and find agreement,” “talking about feelings and expectations,” and “talk about things you don’t talk about normally.”

Personal barrier to couple therapy. The fourth open ended question asked people to respond to the following, “Many people face barriers when seeking therapy or help for their relationship. What are some of the primary reasons you wouldn’t seek couple therapy?” One hundred and fifty-eight respondents provided 182 unique responses. The most commonly reported barrier to seeking couple therapy was the cost of therapy ($n = 55$, 30.2%). Participants provided a wide range of reasons for seeking therapy that did not always follow common themes and included many personal reasons. The second most commonly reported barrier was the fear of asking for help or the difficulty being vulnerable ($n = 25$, 13.74%). Participants reported feeling embarrassed or ashamed about having to talk to an outsider and one went as far to say, “that it would mean I’m a failure.” Within the sample, 16 (8.79%) participants did not believe they had a need for couple therapy. Participants also reported that their partner is the reason that they are not seeking therapy ($n = 15$, 8.24%); they reported “my partner wouldn’t go,” “he wouldn’t be honest,” and “we’d both need to want to go and work at it, but that won’t happen.” Others believed that therapy would cause more problems or bring up things from the past ($n = 14$, 7.69%). They reported that couple therapy would be “explosive,” “cause new problems,” and “It would mean I would never trust my partner again.” In support of the current literature, 15 participants reported formal barriers to seeking couple therapy (8.19%); these included transportation, child-care, lack of access, and time. Four participants (2.2%) reported that therapy does not work so they would not attend and four (2.2%) others beliefs that couple

therapy would need them to change who they were, which served as a barrier to seeking treatment. Two (1.1%) reported that they would only talk to a spiritual leader or their religion prohibits them from talking to a non-spiritual leader. Two (1.1%) individuals reported that a therapist “would not share their views” and “would judge them for decisions in their relationship (we’re not monogamous).”

Self-Improvement in your relationship. In response to the question, “People do lots of things to improve their relationship (talk to friends, read books, use social media resources, etc.). What are some things you’ve done to improve your relationship?” 158 respondents provided 202 unique responses to this question. The majority of participants ($n = 66$, 32.67%) reported that they work at their relationship by “trying to compromise,” “work on the problem,” and “don’t go to bed angry.” Books, podcasts, and social media were the second most common response ($n = 38$, 18.81%). Thirty-seven (18.32%) reported that they talk to a friend, family member, or other married person for advice to improve their relationship. Twenty (9.90%) participants reported that they just avoid the topic or conflict all together because they “tried talking but she just gets mad so it doesn’t work” or they saw “no point.” Sixteen (7.92%) participants reported spending focused “time together” including “dating,” “alone time,” and “traveling together.” Participants reported turning to spiritual resources such as prayer, sermons, meditation, or spiritual leaders to help their relationship ($n = 15$, 7.43%). Other responses included focusing on their own behavior and improving themselves ($n = 6$, 2.97%) or using humor in the relationship to defuse conflict ($n = 3$, 1.49%). Two more unique responses included a participant reporting, “we have kids” and another reporting “we watch divorce court.”

Chapter 5

DISCUSSION

High rates of couple distress and divorce remain in the United States despite the established effectiveness of couple therapy, which indicates that couple therapy continues to be underutilized (Gottman & Gottman, 2013; Sprenkle, 2003). In addition, little is known about individual perceptions of couple therapy and about the barriers individuals face when considering whether or not to attend couple therapy. In order to reduce individual and relational distress, it is important that clinicians, researchers, and community members have a more comprehensive understanding as to why some seek couple therapy while others continue to live in or end contentious relationships. The effects of untreated relational distress reach far beyond the bedroom; relational distress has been associated with increased individual mental health problems (Cano & O'Leary, 2000), role impairment, poor work performance, and compromised health (Whisman & Uebelacker, 2006). The majority of the current research on barriers to seeking therapy has focused on individual mental health treatment and often focuses on isolated areas of investigation such as stigma research (Vogel et al., 2007) and informal and formal barriers to seeking treatment (Baker-Ericzén et al., 2013). The few studies that have examined couple therapy have been retrospective, specifically sampled clinically distressed individuals or couples, or were not grounded in a help-seeking theory (Bringle & Byers, 1997; Doss et al., 2003; Halford & Snyder, 2012; Wolcott, 1986). While these contextualizing factors have been researched and established in the context of individual therapy, it is unclear whether individuals considering couple therapy face similar or different barriers. To address this gap in the understanding of motivation to seek couple therapy, this study utilized the current literature on barriers to individual treatment (i.e., stigma, relationship distress, and demographic variables) to

identify the extent to which these factors may similarly impact individuals seeking couple therapy. To further expand the understanding of an individual's beliefs about seeking couple therapy, this study utilized the HBM (Rosenstock, 1966) to conceptualize additional factors that may be impacting an individual's motivation to seek couple therapy.

Demographic Factors

This research explored the impact of individual demographic factors on an individual's motivation to seek couple therapy. Specifically, the prior research identified mixed outcomes for the role of gender (Carroll et al., 2006), religious beliefs (Armentrout, 2004), socio-economic status (Boyd-Franklin, 1989), and education (National Institute on Drug Abuse, 2002). Some prior research has identified that men report higher perceived barriers, stigma, and mistrust of mental health treatment (Ojeda & Bergstresser, 2008) and that women report more favorable beliefs towards seeking help (Butcher, et al., 1998), however another study found no effect on treatment seeking based on gender (Kessler et al., 2001). These mixed results indicate that the role of gender on seeking mental health treatment is unclear (Vessy & Howard, 1993).

Similarly, the importance an individual places on their religious belief has unclear effects on motivation to seek mental health treatment. Individuals may seek religious counseling rather than mental health treatment, especially when it comes to couple therapy (Pargament, 1997). This may be due to the sharing of negative and stigmatizing beliefs about mental illness in religious communities (Wesselmann & Graziano, 2015), which would negatively impact treatment-seeking behavior. Likewise, the role of education and income has not been conclusively examined when it comes to their impact on seeking couple therapy. Higher education levels are often associated with greater upward mobility, higher socioeconomic status, and greater access to other protective factors for health and wellness (National Institute on Drug

Abuse, 2002). Similarly, since higher income is often associated with higher education levels, it is not surprising that socioeconomic status is conceptualized as reducing barriers to mental health treatment such as cost, transportation, scheduling, and childcare (West, Kantor, & Jasinski, 1998). For these reasons, higher levels of education and a higher income were hypothesized to reduce barriers to accessing couple therapy. The first research question of this study explored if these four demographic variables predict an individual's motivation to seek couple therapy.

Of the four hypothesized demographic predictors, income was the only demographic characteristic that made a significant contribution to an individual's motivation to seek couple therapy. Results indicated that higher income levels were negatively associated with motivation to seek couple therapy, signifying that higher income earners were less likely to be motivated to seek couple therapy. Although research has proposed that higher levels of income should reduce barriers to accessing treatment, it has not previously been used to predict motivation to seek couple therapy (Kirby & Keon, 2006; West, Kantor, & Jasinski, 1998). Individuals with higher incomes may have greater access to other resources that help reduce distress or prevent relational distress such as support systems and less conflict over finances, which was a commonly reported source of conflict. These individuals may not be motivated to seek couple therapy because they do not perceive the need for it. It is also possible that as income increases the pressure to remain married due to one's social obligations or stigmatizing beliefs about divorce in one's social network also increase, which prevents someone from being willing to publically ask for help from a couple therapist.

Regression analysis indicated that higher income levels were positively associated with higher perceived severity of divorce and lower perceived barriers to couple therapy. These results continue to support the belief that higher income levels are associated with other

protective factors and more resources, which helps an individual overcome potential barriers to seeking treatment (Busby et al., 1995). The association between income and perceived severity of divorce suggest that individuals believe that they would suffer greater consequences as of the result of a divorce; they may believe they would lose access to their social network or be stigmatized by their peers.

This research on these individual factors supports the assorted results in the literature, as many studies have struggled to identify a clear role of gender (Kessler et al., 2001), income (Coker, 2005; West, Kantor, and Jasinski, 1998), and religious beliefs (Armentrout, 2004) on seeking mental health treatment. The negative relationship between income on motivation to seek couple therapy and positive relationship with perceived severity of divorce indicates that higher income levels may increase an individual's perceived threat of divorce but prevent them from seeing couple therapy as an appropriate course of treatment. Although income was not associated with self-stigma, it is possible that these individuals perceive higher public stigma due to their social support network or the potential ramifications of divorce on their way of living.

Contextualizing Factors

This study explored two common contextualizing factors that may impact an individual's motivation to seek couple therapy: self-stigma and relational distress. The addition of these two factors, along with the demographic variables, made a statistically significant contribution to an individual's motivation to seek couple therapy. In Model 2, lower income levels, higher levels of self-stigma, and lower levels of relationship distress were significant predictors of an individual's motivation to seek couple therapy. From Model 1 to Model 2, income continued to remain a significant predictor of motivation to seek couple therapy. Model 2, however, focused on the impact of two contextualizing factors.

Stigma towards those with mental illness or needing mental health treatment is pervasive in the United States (Corrigan & Matthews, 2003). Therefore, it is important to include self-stigma as a contextualizing factor when examining reasons why individuals or couples do or do not seek mental health treatment. An individual's internalization of the larger community's negative beliefs towards something or someone, defined as self-stigma, serves as a barrier to accessing individual therapy (Vogel et al., 2007). Individuals do not want to be associated with or labeled as "one of those people" who needs mental health treatment (Vogel et al., 2007; Wade et al., 2011). High levels of self-stigma may also cause an individual to feel less than or "unacceptable" to society (Vogel et al., 2007; Wade et al., 2011), which reduces their belief that they are worthy of help or treatment. These negative beliefs about one's self were hypothesized to impact motivation to seek couple therapy.

Findings did not support hypothesis 2a, which predicted that higher rates of self-stigma would be associated with lower motivation to seek couple therapy. In the literature on individual therapy, stigma is believed to impact an individual's willingness to acknowledge a problem that would associate them with a stigmatized group (Vogel et al., 2007; Wade et al., 2011), which was hypothesized to then impact their willingness to seek treatment for that problem. This was not the case in this study.

This research was based on the individual construct of stigma, which has never been expanded to consider relational stigma or the role of individual stigma on a relational intervention, such as couple therapy (Swindle et al., 1997). High self-stigma means an individual perceives that seeking psychological help would impact their self-worth and make them feel inferior (Vogel et al., 2007; Wade et al., 2011), however, it does not consider the impact of couple therapy on an individual. For example, many respondents cited their partner or

partner's behavior as a common source of conflict, which may mean that if they perceived themselves as needing help they would experience stigma but they believe couple therapy would "fix" their partner, who is the source of the problem (Becvar & Becvar, 1982). Individuals may see couple therapy as less threatening because it treats either the relationship or their partner's behavior but wouldn't threaten their self-perception. Similarly, they may perceive relational conflict to be negative but not as damaging as having an individual mental illness. Current research has only explored individual experiences of stigma and stigma towards things that are well established by the community as the worst of the worst (i.e. substance use disorders, mental illness, and sexually transmitted diseases; Bratter & King, 2008; Talley & Ann Bettencourt, 2010). Divorce, couple distress, and couple therapy may be perceived as too common to be threatening to the individual's self-worth (National Center for Family & Marriage Research, 2009). Another possible explanation is that once an individual is motivated to seek couple therapy, the need for it is so great that it overwhelms any experiences of self-stigma. It is necessary that future research identifies better measures of individual constructs for relational settings or identifies relational constructs such as the potential existence of relational-stigma.

Regression analysis indicated that higher levels of stigma were associated with higher perceived barriers to seeking treatment, which is supported by the individual literature (Bazargan et al., 1998). Self-stigma may serve as a barrier to accessing couple therapy. Higher rates of self-stigma were associated with lower perceived benefits of treatment, indicating that self-stigma may cloud someone's ability to perceive couple therapy as beneficial. It is also possible that, as proposed before, perceived benefits of couple therapy have not been clearly articulated to the general population (Henderson et al., 2013).

Another important factor hypothesized by this study to predict motivation to seek couple therapy was the level of distress in the couple relationship. Individual experiences of distress have been shown to impact help-seeking behavior; the lower an individual's distress level, the more likely the individual is to seek individual treatment (Butterworth & Rodgers, 2008). This indicates that distress may serve as a barrier to seeking treatment. In the research on couple therapy, the role of relational distress on seeking treatment and success in treatment had varied results. Distressed couples are considered to need couple therapy more than others, though research indicates that distressed couples may be less likely to seek treatment (Gottman & Gottman, 1999). It was hypothesized that couples experiencing higher levels of relational distress would be more in need of treatment and therefore more motivated to seek treatment.

Hypothesis 2b, (i.e., higher levels of relational distress will be positively associated with an individual's motivation to seek couple therapy) was statistically significant; however, it was in the opposite direction than hypothesized, indicating that lower relational distress (or higher relational satisfaction) was predictive of greater motivation to seek couple therapy. Individual research has found that lower levels of distress are associated with greater likelihood of seeking treatment (Butterworth & Rodgers, 2008) because less-distressed individuals are not as overwhelmed by their experience of distress and are therefore more equipped to seek support. This research supporting this finding is also true in couple relationships. One critique of some of the research on the efficacy of models such as Emotion Focused Couple Therapy is that, on the whole, the couples treated had low levels of distress (Johnson & Talitman, 1997). This research supports the idea that couples with lower levels of distress may be more likely to seek treatment in general, which is why these studies may have been conducted with less distressed couples. It

would also indicate that since less distressed couples are seeking treatment, these models are effective for the population that is accessing therapy (Sprenkle, 2003).

Distress is the most commonly cited reason for relationship dissolution (Lebow et al., 2012) and many couples live in distress for an extended period prior to divorce (Bradbury et al., 2000). In this study, higher distress levels were associated with more perceived susceptibility of divorce. This indicates that perceived susceptibility alone is not enough to help someone overcome their distress levels. It possible that as distress builds over time their desire to work on their relationship in couple therapy decreases, therefore higher distressed couples are not motivated to seek couple therapy as they have given up on the relationship. This research found that higher distress was associated with lower perceived benefits. This indicates that distress may be serving as a barrier that prevents individuals from perceiving couple therapy as beneficial to their problems. Accessing couples before they are overwhelmed by distress is necessary for couple therapists. It is important that couple therapy is perceived as beneficial event for minor problems or as a preventative intervention for individuals before they become too distressed with their relationship.

Health Belief Model

With a better understanding of why individuals in relationships do not attend couple therapy, mental health practitioners and community members can better address those factors to reduce barriers and encourage couple therapy attendance in a way that makes it relevant and beneficial. To better explore this gap in the literature, the final research question included the theoretical framework provided by the HBM (Rosenstock, 1966) to predict an individual's motivation to seek couple therapy. The majority of research on individual or relational help-seeking behavior is not grounded in an established theoretical framework, which provides

structure to test, explore, and interpret interconnected factors. This is especially important when exploring human-behavior and relationships, which have many interconnected parts. The HBM helps identify what factors have previously been established to impact individual help-seeking behavior and allows for the integration of other factors from the literature to develop a well-grounded model of individual's motivation to seek couple therapy. The HBM includes five constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action. Each of these constructs is thought to predict an individual's likelihood to act on a potential solution to their problem or explain their health care decisions (Rosenstock, 1966). In the current study, all five constructs were examined to determine the extent to which they predicted an individual's motivation to seek couple therapy while accounting for the influence of the key demographic characteristics and the contextualizing factors already discussed.

Model 3, which included the addition of the five HBM constructs (Rosenstock, 1966) was found to be a significant predictor of an individual's motivation to seek couple therapy when controlling for demographic variables and contextualizing factors. Income remained a significant negative predictor of motivation to seek couple therapy in Model 3. Similarly, lower rates of relational distress continued to be a significant predictor of higher rates of motivation to seek couple therapy. In Model 3, hypothesis 3c was significant, which established that lower barriers are a significant predictor of an individual's motivation to seek couple therapy. That is, individuals who perceived high barriers to seeking couple therapy were less motivated to seek couple therapy. This research supports the literature, which documents that individuals who perceive higher barriers to seeking treatment are less likely to seek treatment or follow through on treatment (Bazargan et al., 1998). The HBM model predicted that perceived barriers will be the most significant factor in whether or not a person will make a change (Janz & Becker, 1984).

As many of the other HBM factors were not significant predictors of an individual's motivation to seek couple therapy, it is possible that high barriers to accessing treatment are the ultimate decider as to whether or not an individual is motivated to seek couple therapy. In the open-ended responses, many individuals listed cost and other formal barriers as the main reason they would not be seeking treatment, which is supported by this outcome. It is necessary to address an individual's perception of barriers, whether or not they are perceived to exist by others, in order to improve access to couple therapy (Turner et al., 2004).

Conversely, higher perceived benefits were also negatively associated with motivation to seek couple therapy. Hypothesis 3d had predicted that higher perceived benefits would be associated with higher motivation to seek couple therapy, but this was not the case. In this sample higher benefits towards couple therapy negatively predicted their likelihood to be motivated to seek couple therapy. It is possible that, although someone perceives something to be beneficial, it does not necessarily seem it as beneficial for them and, therefore, does not increase their motivation to seek couple therapy. Individuals may acknowledge the intrinsic benefit of couple therapy but not see it as necessary for their relationship as they do not think they have a need for it as their relationship is not distressed or conversely, their relationship is no longer worth helping. Higher relationship satisfaction was associated with higher perceived benefits, which supports the belief that individuals who are more satisfied in their relationship are able to see the potential benefits of couple therapy, however, they may not feel the need to access it. Again, they believe it will help others but it is not personally connected to their perceived need for it. This finding continues to call into question the application of perceived benefits to motivation to seek couple therapy if the majority of individuals are unaware of the actual benefits of therapy.

Perceived susceptibility (hypothesis 3a), perceived severity of the consequences of divorce (hypothesis 3b), and cues to action (hypothesis 3e) were not statistically significant predictors of an individual's motivation to seek couple therapy. These factors may be more relevant for individual help-seeking or diseases but not for relational interventions, such as couple therapy, and the more nebulous topic of divorce. An individual may understand that they are susceptible to cancer if it runs in their family (cue to act) and they see the serious and life-altering consequences of the disease (Rosenstock, 1966). However, divorce is not nearly as predictable or translatable from individual to individual or family to family. Some may perceive divorce not to be a serious outcome because they are a child of divorce and understand that it was the best for their family; it is not perceived as serious. It is well established that couples do not perceive their relationships to be susceptible to divorce (Bramlett & Mosher, 2001) and yet 50% of relationships end in divorce (CDC, 2012). Susceptibility may come too late in the relationship dissolution process; couples may not realize they are likely to divorce until they are about to do so. Lastly, couple relationship and couple distress may not be impacted by cues to act because it is believed to be a personal experience and each couple believes their relationship to be unique. Future research should be focused on making these individual constructs more applicable to couple relationships.

HBM & relational topics. This is the first research of its kind to apply the HBM to motivation to seek couple therapy and the findings partially supported the application of the HBM to marriage and family therapy. The application of the HBM to motivation to seek couple therapy helps add an important theoretical framework to the research on relational treatment seeking. Although the HBM has some utility in predicting an individual's motivation to seek couple therapy, not all of its constructs may be as relevant to motivation to seek couple therapy.

Perceived susceptibility in the HBM would indicate that, if someone perceived themselves to be susceptible to divorce, they would be more likely to seek preventative measures, including pre-marital counseling or couple therapy, in order to maintain or improve their relationship (Borowski & Tambling, 2015). However, pre-marital counseling rates are low and divorce rates continue to be high (Valiente et al., 2002). It is possible that perceived susceptibility is no longer as applicable to couple relationships because attitudes towards divorce have changed and it less of a concern so individuals continue to believe their relationship is invincible to the threat of divorce. Similarly, individuals may not perceive relational distress to be a serious concern or they may normalize their experience of distress until it is too late (Busby et al., 1995). Therefore, perceived severity of divorce is not as applicable to couple relationships and predicting motivation to seek couple therapy as it may be to other individual or health-related factors. It was hypothesized that individuals may see "it" [couple therapy] as relevant and important but they require personal exposure to the helpfulness of couple therapy, from a friend or family member, or are triggered by witnessing the negative consequences of divorce (cues to action). This was not true in this study, as cues to action were not enough to motivate someone to seek couple therapy. This study may not have assessed the cues to action that would motivate someone to seek couple therapy. It is also possible that witnessing the negative consequences of divorce and the potential benefits of couple therapy from a friend or family member are not enough to motivate someone to couple therapy. The prevalence of divorce may have normalized its possibility for individuals in couple relationships, which decreases the impact of perceived susceptibility and perceived severity of divorce and normalizes potential cues to action.

Personal Experiences

Participants indicated a wide variety of opinions and an overall lack of knowledge about couple therapy in their open-ended responses. The perceived cost of therapy ranged from manageable to relatively unaffordable and it appeared that most participants hoped it fell in line with an average insurance co-pay. These results indicate that individuals have little awareness about the cost of couple therapy or the potential for insurance coverage. In the research, the cost is an established formal barrier to seeking help (Bazargan et al., 1998). Individuals in this study reported cost as the number one barrier when asked about barriers to seeking couple therapy. It is necessary to educate couples about the expected cost of therapy. Couples who would be interested in seeking therapy need to have an accurate understanding of the cost so that it does not serve as an unnecessary barrier.

Couples were also asked about what topics would be valuable or beneficial to cover in therapy. The most common set of responses focused on improved communication. They also noted that couple therapy could help with financial discord, intimacy problems, and relational conflict, which are examples of relational distress (Lebow et al., 2012). These were some of the most common points of conflict individuals reported in their current relationships when asked earlier in the survey. This indicates that they perceived that couple therapy could address some of the points of conflict they were experiencing; in general couple therapy is perceived as being relevant to address relational distress (Johnson & Talitman, 1997). An individual's perception that couple therapy is relevant to their relational distress would be an important step in seeing it as beneficial and worth pursuing. Unfortunately, as distress increases in the relationship, couples are less motivated to seek couple therapy, which is supported by the individual research (Butterworth & Rodgers, 2008). Unfortunately, couples often wait until it is too late to seek

treatment or avoid seeking help altogether (US Department of Health and Human Services, 1999). Couple therapy has been found to be more effective with less distressed couples (Halford & Snyder, 2012) and this research found that less distressed couples are more motivated to seek treatment. Once couples are overwhelmed by their relationship conflict, they see the relationship as hopeless or are too overwhelmed to identify and overcome barriers to treatment. It is necessary to treat relational distress before it serves as a barrier to seeking treatment and negatively impacts all members of the family (Butterworth & Rodgers, 2008; Laumakis et al., 1998; Whisman, 2013).

Expectations for couple therapy were not addressed by any of the scales, therefore individuals were asked to share what they imagine therapy to be like or what they've been told about couple therapy. Their perceptions ranged widely from believing that couple therapy would be helpful and beneficial to perceiving couple therapy to be a place that leads to divorce. Many people reported extremely negative perceptions of couple therapy, including a belief that it is invasive, harmful, and invades into a highly private couple relationship. It is easy to imagine that these beliefs would keep someone from seeking any form of couple therapy. Education that demystifies couple therapy and combats the common myths reported in movies and television would help to better educate the general public and potentially improve positive regard for couple therapy.

Although individuals were asked about perceived barriers to couple therapy in the HBM scale, these were pre-determined barriers that may or may not impact individuals in couple relationships. To address this, individuals were asked to identify the primary reasons they would not seek couple therapy. Individuals most commonly reported the cost of therapy and other formal barriers such as transportation and access (Bazargan et al., 1998). This supports

community efforts to address the formal barriers to seeking treatment and its inclusion in insurance policies to reduce cost. Individuals also reported that they did not want to be vulnerable with someone they didn't know and that it would cause them to feel like a failure. These negative self-perceptions are due to internalized self-stigma (Nadler & Fisher, 1986; Vogel et al., 2007). Although formal barriers have an established role (Bazargan et al., 1998), it is clear that informal barriers including stigma impact the decision-making process and also need to be addressed. Participants were also concerned that couple therapy would bring up old problems or make new ones for their relationship. Although this is a legitimate concern, the role of couple therapy is not to bring up conflict and leave it unresolved. Individuals are not considering the role of the therapist or the actual intervention that couple therapy would provide to reduce the conflict and help couples talk about it differently than they would do so at home (Gottman & Gottman, 2013). Lastly, a common concern was that the therapist would be judgmental or not share the participants' beliefs. Individuals appear to be assuming that the therapist will act similarly to friends, family members, or general society rather than perceiving the therapist to be a trained expert who is used to hearing confidential and vulnerable topics. Again, greater public education about the role of couple therapists and the services they provide would potentially alleviate some of these concerns.

Even though individuals reported barriers to accessing couple therapy and concerns about the process, they still found ways to work on their relationship. Individuals and couples are often very creative and resilient and this sample highlighted the fact that individuals use a variety of non-therapy techniques to improve their relationships. Participants reported talking to friends and family members for advice, trying to talk to their partners more or compromise in fights, and spending more quality time together dating or working out. Individuals may be more inclined to

talk to peers or family members because they perceive it to be a private matter and something for which an outsider would judge them (Wolcott, 1986). Others, however, appear to avoid the topic entirely, just drop it, or live with the conflict because they have children, which unfortunately may exacerbate the distress (Lebow et al., 2012; Sprenkle, 2003). Research indicates that staying together for children may cause increased risks for those children both during their childhood (Laumakis et al., 1998) and through their adulthood (Whisman, 2013). This research indicates that couples may be using a wide range of tools to improve their relationship, however, many continue to suffer from ongoing conflict and increasing rates of distress, which has the potential to lead to divorce (Doss et al., 2003). It is important that couple therapy is seen as a potential tool for these individuals. It is also important for therapists to ask the couple what other things they have tried before couple therapy as this may inform the things they have tried to do and didn't find helpful or untapped resources.

Overall, individuals provided insightful responses that supported the role of formal and informal barriers to seeking treatment in general but now, specifically couple therapy (Bazargan et al., 1998; Vogel et al., 2007). Individuals also revealed the potential reason that self-stigma did not negatively correlate with motivation to seek couple therapy; the things that they perceived as stigmatizing were not addressed on the self-stigma scale because they highlighted relational factors. They also endorsed the belief that self-stigma may not adequately address relational help-seeking because they perceive their partner to be the problem, therefore, their own self-worth is not threatened. Negative expectations about the role of couple therapy continue to be reinforced by movies, television, and myths rather than an accurate understanding of the role of couple therapy and couple therapists. Thankfully, barriers to accessing treatment, myths, and stigmatizing beliefs can be addressed.

Limitations

A number of limitations are evident. First, this study was conducted through an online recruitment service, which limits the diversity of the sample to those in a Qualtrics panel with the time to complete an online survey. While online surveys are considered to be reliable (Sue & Ritter, 2012), the researcher cannot ensure who is taking the survey or that they take the survey honestly. Providing the survey online increased certain demographic characteristics such as age, length of relationship, and religious belief that could have been achieved with a more localized study; however, it did result in a predominantly female, heterosexual, Caucasian sample. Qualtrics panels recruit individuals who are willing to take surveys for reimbursement, which may be a potentially unique part of the population who has time to dedicate to completing a survey and is potentially invested in contributing to research. Demographics from this survey indicates that only 40% worked full time while the rest were unemployed, employed part-time, retired, stay-at-home parents, or disabled. This limits the generalizability of this sample. Another potential demographic limitation is the majority female sample. Research seems to indicate that women have more favorable opinions of help-seeking behavior (Butcher et al., 1998), which may mean they were more likely to have favorable outcomes towards couple therapy without consideration of any of the other factors. It may also mean they are more likely to sign up to be in a Qualtrics panel because they see it as helpful. Overall, the lack of diversity in the demographics, limits the generalizability of the results, especially with regard to sample-sex couples and other ethnic groups.

A second limitation is the adaptation of the HBM scale. The scale had been developed for and used with premarital couples. This scale has not been validated for use with married individuals and couple therapy. For the purpose of this study, the scale underwent minor

revisions to change language from “future marriage,” (as was used with premarital individuals) to “current relationship/marriage.” Future research should validate that the scale is accurately measuring the construct that it is intended to measure, especially in its application to a relational intervention. Cues to action had not previously been addressed with this population, therefore it is possible that these were not accurate or appropriate cues to increase an individual's readiness to be motivated to seek couple therapy. In general, the HBM has been used to predict health-seeking behavior such as vaccines and medical treatment (Strecher & Rosenstock, 1997), but has not been used extensively to measure beliefs about mental health treatment. Individuals may not consider diseases and relational distress similarly. The negative consequences of an illness such as disability or death are negative outcomes that everyone wants to avoid whereas couple conflict or divorce may not be as salient and avoidable. Therefore, future research should examine whether HBM constructs are solely individual constructs or whether they can be applied to relational-help seeking behaviors as well.

Third, the analysis performed cannot determine causality. Longitudinal research would be necessary to make claims of causality, even though hierarchical regression analysis allows for the possibility to identify, which variables have a higher influence (Keith, 2005). Therefore, while this research indicates which variables have more predictive capability than others in determining an individual's motivation to seek couple therapy, it cannot state which barriers cause an individual not to be motivated to seek treatment.

Fourth, within a hierarchical regression model, there is the possibility of specification errors within the model. It is impossible for the researcher to have accounted for all possible independent variables that might impact the dependent variable in order to develop the best model (Cohen, Cohen, West, & Aiken, 2003). This study did not examine, for example, the

perceived severity of the problem. Couples struggling with infidelity or intimate partner violence may be inherently different, in terms of motivation to seek couple therapy, than those frustrated over socks being left on the floor (Cummings & Davies, 2011). The research also did not account for individual mental health diagnoses such as depression or bipolar disorder, which are related to relational distress and may serve as barriers to seeking treatment (Whisman, 2013).

Fifth, as a whole the third model did not account for a large portion of an individual's motivation to seek couple therapy. This indicates that there are likely other variables that should be included in the model such as individual mental health diagnoses, other demographic variables including length of relationship and race, and the impact of the partner on the decision-making process (Thompson, Bazile, & Akbar, 2004). It also may indicate that the scales used measured relational constructs, which are not as applicable to relational help-seeking behavior.

Sixth, the alpha levels on two of the scales, perceived barriers (.58) and the motivation to change scale (.59) were noticeably low. It is possible that the current barrier scale didn't accurately measure current barriers to seeking couple therapy because it is based in the individual literature. The barriers that individuals face when seeking individual therapy may not be relevant to individuals who are seeking couple therapy. For example, the scale didn't account for the role of the partner as a potential barrier or asset to seeking treatment. This scale needs to be updated to identify current barriers to seeking therapy and modified into a relational scale, which would include the role of the partner. In regards to the low alpha for the R-URICA scale, the action subscale may need to be dropped or modified by future research. The R-URICA has three subscales: action, seeking assistance, and ambivalence toward change. Since individuals in this study were asked about future motivation to seek couple therapy, the action subscale may not have been relevant and therefore impacted the internal consistency of the scale. Future

research should identify whether the action scale is relevant and whether or not a measure of motivation to seek couple therapy should be distinctively different than a scale to measure motivation to seek individual therapy.

Finally, individual responses to assess motivation to seek couple therapy were used in this research, which significantly limits the understanding of the couple's decision-making process. This research focused on the individual's perceptions but it is impossible to limit the impact of their partner on their decision-making process. Individuals reported that the largest barrier to seeking couple therapy was their partner, however, this study did not measure that impact through data collection or analysis. The impact of the partner may be a determining factor in an individual's motivation to seek couple therapy.

Directions for Future Research

Individual factors. Results of the present study have many implications and guidance for future research. One important addition to this research would be the inclusion of a more diverse sample population. Research has indicated that race is an important variable to assess when it comes to help-seeking behavior and mistrust of outsiders (Henshaw & Freedman-Doan, 2009). Due to the homogenous nature of the current sample, this could not be examined within the context of the present study. Future research should also seek to include greater gender, racial, and sexual orientation diversity along with more same-sex couple populations to identify if relational distress and motivation to seek couple therapy are similar or dissimilar to this sample. This research did not identify demographic trends in gender, education, or importance placed on religious belief however the literature indicates that these factors impact individual help-seeking behavior (Butcher et al., 1998; Kirby & Keon, 2006). It is necessary for future

research to clarify the impact of these factors on relational help-seeking behavior by recruiting a more diverse sample population.

Stigma. The present study did not have the expected outcome in regards to the role of self-stigma on motivation to seek couple therapy. Self-stigma was not a predictive of decreased motivation to seek couple therapy, as was hypothesized; therefore, it is possible that self-stigma is not an accurate measure of the stigma experienced by an individual who is considering seeking couple therapy. Couple therapy is a relational experience that impacts both partners in the relationship differently, however, the current self-stigma scale only asks the individual about their own experience and did not account for the additive or compounding effect of participants thinking about their partner while responding (Vogel et al., 2007). Research needs to identify whether the individual construct of stigma has the same impact on an individual's decision to seek couple therapy. The present study indicates that individuals may not experience self-stigma because they are not threatened by seeking treatment because they perceive their partner to be the problem. No current scale exists to measure relational experiences of stigma (Vogel et al., 2007) and future research should focus on the inclusion of dyadic data collection and analysis using the Actor Partner Interdependence Model to address this question (Cook & Kenny, 2005).

It is also necessary for future research to identify whether couple therapy evokes the same type of public stigma as individual therapy in the larger society. Individual therapy is stigmatized because of its association with severe mental illness, which is perceived as scary and threatening by society (Vogel et al., 2006). Couple therapy may not be as stigmatized due to the normalization of divorce or it may be stigmatized for other reasons such as an individual's fear of being vulnerable about problems in their relationship, as suggested by some participants in the present study. A broad survey to identify or rank what society deems as worth stigmatizing and

why would help identify what individuals are internalizing to cause self-stigma and whether or not it is relevant to couple therapy.

Relational distress. Future research on the impact of distress on motivation to seek couple therapy should focus on identifying the cut-off point at which distress becomes a barrier to accessing treatment. Within the current study, individuals with lower levels of relational distress had higher motivation to seek couple therapy, which is supported in the individual help-seeking literature (Butterworth & Rodgers, 2008). High levels of distress appear to serve as a barrier to accessing help, therefore, research should focus on identifying individual's and couple's thresholds for distress to ensure that interventions are effective. Future research should also focus on identifying which types of interventions or therapy models that are effective with individuals with low, moderate, and high levels of distress; different treatments may be more effective with different populations and should be targeted to those populations. This research focused on a general population rather than focusing on more or less distressed couples, which was a limitation of prior research (Doss et al., 2003; Wolcott, 1986).

Another important area for future research is the evaluation of different treatment modalities and interventions with highly distressed couples. Current evaluation research indicates that many interventions are effective with less distressed couples (Anker et al., 2010; Shadish & Baldwin, 2005), therefore future research should recruit individuals and couples with different levels of distress in order to perform t-testing or ANOVA testing to identify if any group differences exist in the effectiveness of different models.

Health belief model. This research was based on the application of individual constructs to a relational treatment. It is necessary for future research to apply dyadic analysis techniques, such as the Actor Partner Interdependence Model (APIM, Cook & Kenny, 2005) to determine

the role each partner has on the decision to seek couple therapy. It is possible that one partner's opinion completely outranks the other's desire to seek couple therapy. Future research should also identify whether the individual constructs of the HBM are applicable to relational treatment seeking. For example, this study did not find perceived susceptibility and perceived severity to be significant predictors while other studies have found them to make significant contributions to the prediction of help-seeking behavior (Graham, 2002). Future research should explore whether these constructs apply to couple behavior and help-seeking behavior in couple relationship or whether there are more appropriate relational constructs.

For example, this research did not find perceived severity of divorce to be associated with high motivation to seek couple therapy. One potential explanation for this is that some couples in the study had already given up on their marriage, therefore divorce was not a negative motivating outcome. Future research could include a measure or assessment to identify whether individuals wanted to remain married. Individuals who want to remain married would be hypothesized to see divorce as a serious threat (Busby et al., 1995) whereas for others staying together might be a more negative consequence. This study did not assess desire to stay married but future research should consider this as a factor.

Future research could incorporate in-depth interviews on the HBM factors to identify if they are applicable to couple therapy. Perceived severity and susceptibility may not have the same predictive power or current scales may not be assessing them accurately. Interviews or focus groups could explore the factors that individuals and couples see as relevant to their motivation to seek couple therapy and provide insight into how to more accurately measure these constructs. Due to the limited research on relational constructs that impact motivation to seek

couple therapy, qualitative research would allow greater input about individual's lived-experience.

Benefits. In the present study, higher perceived benefits of seeking treatment were associated with lower motivation to seek couple therapy. Future research needs to examine the potential explanations for this outcome including the development of a scale to identify whether differences exist between those who perceive therapy to be beneficial in general and those who perceive it to be beneficial for them. Individuals may not be motivated by the potential helpfulness of an intervention when other barriers such as the perceptions of their partner and their distress remain high.

Interviews could again be used to assess what benefits would actually motivate a person to seek treatment and what benefits people actually perceive to exist. Individual reports about their expectations for couple therapy indicated that they had a wide range of opinions and beliefs ranging from it "causes people to get divorced" to it is "helpful to resolve and prevent conflict." These wide-ranging expectations indicate that individuals may be unaware of the potential benefits couple therapy can provide so, although they assume it may be beneficial for someone, it does not feel personally relevant to them. In-depth interviews are needed to address potential nuances in people's perception of benefits and motivation to seek couple therapy.

Barriers. This research found that lower barriers were a significant predictor of an individual's motivation to seek couple therapy in the third model. These results indicate that reducing barriers to accessing couple therapy is a necessary step to improving access to couple therapy and reducing relational distress. Although formal barriers such as cost, transportation, and scheduling serve as barriers to accessing treatment, this research encourages greater investigation of the informal barriers such as fear or lack of understanding about the process of

couple therapy and concerns about the role of the therapist on individuals' decision-making process, which was highlighted in individual responses. Research needs to examine what types of educational tools and resources would reduce these informal barriers. Research could expose people to different scenarios or interventions to identify whether their negative perception decreased from a pre-test to a post-test. This type of research would also contribute to the development of an accurate scale of cues to action.

Furthermore, as with all of the current constructs tested in this study, barriers were assessed as an individual construct and the individual's partner was not assessed as a potential barrier. Individuals reported that their partner served as a barrier to accessing treatment in their open responses, however, no current measure exists to explore relational barriers to help-seeking behavior. An initial qualitative exploration of barriers faced by couples would aid in the development of a measure, which would be a significant contribution to the literature. As with most all research focused on couple relationships, dyadic analysis utilizing the APIM would significantly expand awareness into the role each individual plays on their partner's decision to seek couple therapy (Cook & Kenny, 2005).

Cues to Action. As indicated above, research that incorporates identifying what scenarios or stories cause changes in an individual's perception towards seeking couple therapy would help identify the impact of benefits, barriers, and cues to action. Cues to action are the newest addition to the HBM (Turner et al., 2004) and they are personal experiences that are meant to increase readiness to act. The current research did not indicate that individual exposure to divorce or couple therapy increased an individual's motivation to seek couple therapy. Future research should seek to identify what are considered meaningful cues to action

in regards to couple therapy as this has not previously been explored. The incorporation of cues to act to a relational benefit and barriers scale would be a significant contribution to the field.

Relational conflict. Lastly, this research asked people to call to mind a common point of conflict or the most recent point of conflict and individual responses ranged from leaving the socks on the ground to repeated infidelity and being hated by step-children. In a relationship, these problems should not be seen as equal. Current scales assess relational distress focused around constructs such as communication, decision-making processes, and satisfaction (Busby et al., 1995). Although these were commonly reported sources of conflict, relational conflict is a fluid and dynamic variable. Individuals who completed the survey may have just finished a significant fight with their partner or may have just returned from a relaxing weekend away together. These individuals would be primed to respond differently to the survey based on the fluid nature of relational conflict. Future research should include questions that identify the most recent point of conflict, the most common topic of conflict, and allow individuals to rank how much each of those impacts them. It would also be beneficial to ask about the frequency and volatility of their relational conflict. This would help provide context to the role conflict plays in their lives and how it may be impacting their motivation to seek couple therapy.

Clinical Implications

Although couple therapy is effective at reducing relational distress many couples continue to live with high rates of relational conflict (Matusiewicz et al., 2010). This research suggests that individuals with lower income levels, higher levels of relational satisfaction, lower perceived barriers, and lower perceived benefits are more likely to be motivated to seek couple

therapy. These results have many implications for the location of clinical services, target populations, the marketing of the field as a whole, and types and timings of intervention.

In order to address the formal barriers to accessing treatment, such as cost, transportation, and access, clinical services need to be located in the communities they intend to serve and consider an individual who is using public transportation. When possible, providers should provide services on a sliding fee scale, provide payment plans, work with insurance providers, or partner with another provider who is able to do so as to reach those who do not have significant financial means. If providers are able to offer more flexible scheduling options including evenings or even weekend hours, they would likely attract and a more diverse population of clients.

This research also supported the role of couple therapy as a preventative intervention rather than a crisis based intervention. As distress levels increase, couples are less likely to seek couple therapy; therefore services need to be offered before a couple is distressed or help prevent distress from occurring in general. Couple therapists should promote preventative therapy by offering relational “check-ups” or once a month appointments for couples that could benefit from added support, without it being too invasive or time-consuming. One potential way to normalize couple therapy is to provide it as a preventative service right alongside other preventative health care services. For example, therapists partnered with other preventative healthcare service providers such family physicians and other outpatient providers through integrative care facilities. This would not only help normalize couple therapy but it would promote the integration of mental health care into the medical field. Any modification of services, including the location and time frame in which they are provided, would make couple therapy more approachable. It may also be beneficial to offer or encourage the use of more generalized mental

health screening tools by other health care providers or imbedded clinicians, in order to identify those with risk factors to make warm-handoff referrals to mental health treatment. Providers who are able to help clients address the formal barriers to seeking treatment will have clients who are better able to seek and follow through with mental health services including couple therapy.

Although formal barriers play a significant role in treatment-seeking behavior, informal barriers such as myths about the process and a lack of awareness of the services provided are impacting an individual's decision to seek couple therapy. Providers, their licensing boards, and associations are the only ones able to educate the general public on the role and benefits of couple therapy. Public health and advertising campaigns could be utilized combat the myths shown in movies and TV shows. By increasing awareness about the role of couple therapy and decreasing barriers, friends or family may be more inclined to encourage their loved one to access couple therapy when individuals turn to them for support. It is also important to destigmatize the process by normalizing those who seek treatment. Any individual who attends couple therapy could be encouraged to speak more widely about their experience, especially those with large audiences such as celebrities and influencers.

Another strategy for normalizing couple therapy or accessing couples through more creative techniques would include the use of social media and technology. Based on a common response of using books or podcasts, it is important for couple therapists to utilize these mediums to provide education to these couples. Clinicians could develop self-help material that promotes the incorporation of couple therapy or preventative services. Gottman and Gottman (1999) have been very effective at accessing a larger population with their clinical techniques and translating therapy and research for a more lay population. It is necessary for clinicians to demystify the

process and combat common misperceptions in order to improve treatment accessibility and clinical outcomes.

Addressing barriers, promoting early access, and normalizing couple therapy will likely increase an individual's motivation to seek couple therapy, however, clinicians then need to measure their client's distress levels and intervene appropriately. A client or couple's distress impacts their ability to access services but it may also impact their success once in therapy. Many treatment modalities have been shown to be effective with less distressed populations (Shadish & Baldwin, 2005), which may be due to the type of people who are accessing therapy in the first place, but it is important that clinicians are also equipped with techniques for highly distressed couples.

Lastly, once a couple has accessed therapy the therapist needs to address their expectations and potential concerns early on in treatment. Couples may be arriving with a lot of misinformation and confusion about the process of couple therapy, which may lead to dropout when expectations are not met or as a result of feeling uncomfortable in the therapy room. By asking about expectations, the therapist may be able to alleviate some concerns and improve retention and outcomes (Sprenkle, 2003).

The role of the clinician should reach far beyond the therapy room. In order to make therapy more approachable, therapists are responsible for educating the general public about their services, when and why couple therapy is appropriate, and collaborating with other treatment providers to reduce barriers. This research identified factors that can be addressed by clinicians and through future research to improve the accessibility and success of couple therapy.

Conclusion

National divorce rates hover around 50%, yet the majority of couples do not seek couple therapy for relational distress prior to divorcing (Center for Disease Control, 2012; Johnson et al., 2002). Of those that seek treatment, most report waiting over six years before seeking help (Center for Disease Control, 2012). By not seeking couple therapy in a timely manner, distressed couples increase their risk for individual mental health problems (Cano & O'Leary, 2000), family conflict (Whisman & Uebelacker, 2006), and an increased likelihood of divorce (Butterworth & Rodgers, 2008). Although couple therapy is effective for treating relational distress, divorce rates remain high because people are not accessing treatment. Findings from this study highlighted certain factors that may impact an individual's motivation to seek couple therapy including income level, relationship distress, formal and informal barriers to seeking treatment, and confusion around the perceived benefits of couple therapy.

Findings from this study contribute to the literature on help-seeking behavior, specifically couple therapy, and individual factors that cause variation in why some individuals seek couple therapy while others do not. Overall, this initial application of the HBM (Rosenstock, 1966) to couple therapy indicated that certain HBM constructs may not be as relevant for individuals deciding to see couple therapy. Future work should identify whether individual and relational constructs are similar when an individual is considering couple therapy and develop more appropriate tools to measure the effects of the relationship on individual help-seeking behavior. It is necessary to improve access to couple therapy for the general population, not just couples in crisis. To do this clinicians and researchers should focus on educating society about the role and benefits of couple therapy while working with the local and national legislature to reduce formal barriers to accessing treatment. As educational campaigns demystify the process and providers focus on de-stigmatizing mental health services, individuals who have sought couple therapy

should be encouraged to share their story and advocate for others to access services. This research is the first step to better understand individual's motivation to seek couple therapy and expanding the individual help-seeking literature into couple and family research.

References

- Ackerman, F., Colapinto, J. A., Scharf, C. N., Weinshel, M., & Winawer, H. (1991). The involuntary client: Avoiding pretend therapy. *Family Systems Medicine, 9*, 261-266. doi: 10.1037/h0089211
- Albrecht, S. L., Bahr, H. M., & Goodman, K. L. (1983). *Divorce and remarriage: Problems, adaptations, and adjustments*. Westport, CT: Greenwood Press.
- American Psychological Association (APA) (2013). *Children's mental health: How many children have mental health disorders?* Retrieved from <http://www.apa.org/pi/families/children-mental-health.aspx>.
- Ames, R. (1983). Help-seeking and achievement orientation: Perspectives from attribution theory. In B. M. DePaulo, A. Nadler, & J. D. Fisher (Eds.), *New directions in helping: Vol. 2. Help seeking* (pp. 165-186). San Diego, CA: Academic Press.
- Anagnostopoulos, F. G. (2011). Self-efficacy and oral hygiene beliefs about toothbrushing in dental patients: A model-guided study. *Behavioral Medicine, 37*, 132-139. doi: [10.1080/08964289.2011.636770](https://doi.org/10.1080/08964289.2011.636770)
- Anderson, J. (2014). The impact of family structure on the health of children: Effects of divorce. *The Linacre Quarterly, 81*(4), 378-387. doi:10.1179/0024363914Z.00000000087
- Anker, M. G., Owen, J., Duncan, B. L., & Sparks, J. A. (2010). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal of Consulting and Clinical Psychology, 78*, 635-645. doi:10.1037/a0020051
- Armentrout, D. P. (2004). The normal and pathological genesis of depression: The "Heart Cry" biblical model of depression revisited. *Journal of Psychology and Christianity, 23*, 40-50.

- Aschbrenner, K. A., Bartels, S., Mueser, K. Carpenter-Song, E., & Kinney, A. (2012). Consumer perspectives on involving family and significant others in a healthy lifestyle intervention. *Health & Social Work, 37*, 207-215. doi: [10.1093/hsw/hls032](https://doi.org/10.1093/hsw/hls032)
- Austin, L., Ahmad, F., McNally, M., & Stewart, D.E. (2002). Breast and cervical cancer screening in Hispanic women: A literature review using the health belief model. *Women's Health Issues, 12*, 122-128 doi: [10.1016/S1049-3867\(02\)00132-9](https://doi.org/10.1016/S1049-3867(02)00132-9)
- Baker, A., & Cementon, E. (2014). Evidence-based interventions for comorbidity: Substance use, mental health and physical health. *Australian and New Zealand Journal of Psychiatry, 48*, 79-80.
- Baker-Ericzén, M. J., Jenkins, M. M., & Haine-Schlagel, R. (2013). Therapist, parent, and youth perspectives of treatment barriers to family-focused community outpatient mental health services. *Journal of Child and Family Studies, 22*, 854-868. doi:10.1007/s10826-012-9644-7
- Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25*, 729-735. doi: [10.1037/0012-1649.25.5.729](https://doi.org/10.1037/0012-1649.25.5.729)
- Bazargan, M., Bazargan, S., & Baker, R. S. (1998). Emergency department utilization, hospital admissions, and physician visits among elderly African American persons. *Gerontologist, 38*, 25–36. doi: [10.1093/geront/38.1.25](https://doi.org/10.1093/geront/38.1.25)
- Becvar, R. J., & Becvar, D. S. (1982). *Systems theory and family therapy: A primer*. Washington, D.C: University Press of America.
- Belcher, L., Sternberg, M.R., Woloski, R.J., Halkitis, P., & Hoff, C. (2005). Condom use and perceived risk of HIV transmission among sexually active HIV positive men who have

- sex with men. *Aids Education and Prevention*, 17, 79-89. doi:
[10.1521/aeap.17.1.79.58690](https://doi.org/10.1521/aeap.17.1.79.58690)
- Biancosino, B. L. (2004). Patient opinions on the benefits of treatment programs in residential psychiatric care. *Canadian Journal Of Psychiatry*, 49, 613-620. doi:
[10.1177/070674370404900907](https://doi.org/10.1177/070674370404900907)
- Blaine, B. (2000). *The psychology of diversity: Perceiving and experiencing social difference*. Mountain View, CA: Mayfield.
- Blais, R. K., Hoerster, K. D., Malte, C., Hunt, S., & Jakupcak, M. (2014). Unique PTSD clusters predict intention to seek mental health care and subsequent utilization in US veterans with PTSD symptoms. *Journal of Traumatic Stress*, 27, 168-174. doi: 10.1002/jts.21898
- Borowski, S. C., & Tambling, R. B. (2015). Applying the health belief model to young individuals' beliefs and preferences about premarital counseling. *The Family Journal*, 23, 417-426. doi:10.1177/1066480715602221
- Boyd-Franklin, N. (1989). *Black families in therapy: A multisystem approach*. New York, NY: Guilford.
- Boydell, K. M., Pong, R., Volpe, K., Tilleczek, E., Wilson, E., & Lemieux, S. (2006). Family perspectives on pathways to mental health care for children and youth in rural communities. *The Journal of Rural Health*, 22, 182-188. doi:10.1111/j.1748-0361.2006.00029.x
- Bradbury, T. N., Fincham, F. D., & Beach, S. R. H. (2000). Research on the nature and determinants of marital satisfaction: A decade in review. *Journal of Marriage and the Family*, 62, 964-980. doi: [10.1111/j.1741-3737.2000.00964.x](https://doi.org/10.1111/j.1741-3737.2000.00964.x)

- Bradford, K. (2012). Assessing readiness for couple therapy: The stages of relationship change questionnaire. *Journal of Marital and Family Therapy*, 38, 486-501. doi:10.1111/j.1752-0606.2010.00211.x
- Bradford, K., LaCoursiere, J. A., & Vail, A. (2010). Individual adjustment, readiness for relationship change, and dyadic adjustment. *Journal of Couple & Relationship Therapy*, 9, 293-311. doi:10.1080/15332691.2010.515531
- Bramlett, M. D., & Mosher, W. D. (2002). Cohabitation, marriage, divorce, and remarriage in the United States. *Vital and Health Statistics*, 22, 1-93.
https://www.cdc.gov/nchs/data/series/sr_23/sr23_022.pdf
- Bratter, J. L., & King, R. B. (2008). "But will it last?": Marital instability among interracial and same-race couples. *Family Relations*, 57, 160-171. doi:10.1111/j.1741-3729.2008.00491.x
- Bray, J. H., & Jouriles, E. N. (1995). Treatment of marital conflict and prevention of divorce. *Journal of Marital and Family Therapy*, 21, 461-473. doi:10.1111/j.1752-0606.1995.tb00175.x
- Bringler, R. G., & Byers, D. (1997). Intentions to seek marriage counseling. *Family Relations*, 46, 299-304. doi:10.2307/585128
- Busby, D. M., Christensen, C., Crane, D. R., & Larson, J. H. (1995). A revision of the dyadic adjustment scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy*, 21, 289-308. doi:10.1111/j.1752-0606.1995.tb00163.x
- Butcher, J., Rouse, S., & Perry, J. (1998). Assessing resistance to psychological treatment. *Measurement and Evaluation in Counseling and Development*, 31, 95-108.

- Butterworth, P., & Rodgers, B. (2008). Mental health problems and marital disruption: Is it the combination of husbands and wives' mental health problems that predicts later divorce? *Society Psychiatry Psychiatric Epidemiology*, *43*, 758-763. doi: [10.1007/s00127-008-0366-5](https://doi.org/10.1007/s00127-008-0366-5)
- Coker, D. (2005). Shifting power for battered women: Law, material resources, and poor women of color. In N. J. Sokoloff & C. Pratt (Eds.), *Domestic violence at the margins: Readings on race, class, gender, and culture* (pp. 369–388). New Brunswick, NJ: Rutgers University Press.
- Coker, A. L., Derrick, C., & Lumpkin, J. L. (2000). Help-seeking for intimate partner violence and forced sex in South Carolina. *American Journal of Preventive Medicine*, *19*, 316–320.
- Cano, A., & O'Leary, K. D. (2000). Infidelity and separations precipitate major depressive episodes and symptoms of nonspecific depression and anxiety. *Journal of Consulting and Clinical Psychology*, *68*, 774-781. doi:10.1037/0022-006X.68.5.774
- Carroll, J. S., Badger, S., & Yang, C. (2006). The ability to negotiate or the ability to love: Evaluating the developmental domains of marital competence. *Journal of Family Issues*, *27*, 1001-1032. doi:10.1177/0192513X06287248
- Center for Disease Control and Prevention. (2004). Program operations guidelines for std prevention: community and individual behavior change interventions. *Community and Individual Behavior Change Interventions*. Retrieved from <https://www.cdc.gov/std/program/community.pdf>
- Center for Disease Control and Prevention (2015). *Suicide and self-inflicted injury*. Washington, DC: U.S. Department of Health and Human Services.

- Champion, V. L. (1999). Revised susceptibility, benefits, and barriers scale for mammography screening. *Researching in Nursing and Health*, 22, 341-348. doi: 10.1002/(SICI)1098-240X(199908)22
- Chen, S., Koller, M., Krupa, T., & Stuart, H. (2016). Contact in the classroom: Developing a program model for youth mental health contact-based anti-stigma education. *Community Mental Health Journal*, 52, 281-293. doi: 10.1007/s10597-015-9944-7
- Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology*, 78, 225-235. doi:10.1037/a0018132
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, N.J: L. Erlbaum Associates.
- Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Mahway, NJ: Lawrence Erlbaum.
- Connors, G. J., DiClemente, C. C., Dermen, K. H., Kadden, R., Carroll, K. M., & Frone, M. R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol*, 61, 139-149. doi: 10.15288/jsa.2000.61.139
- Cook, W., & Kenny, D. (2005). The Actor-Partner Interdependence Model: A model of bidirectional effects in developmental studies. *International Journal of Behavioral Development*, 29. doi: 10.1080/0165025044400040
- Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., Wang, N. Y., & Ford, D. E. (2003). The acceptability of treatment for depression among African

- American, Hispanic, and White primary care patients. *Medical Care*, *41*, 479–489. doi: [10.1097/01.MLR.0000053228.58042.E4](https://doi.org/10.1097/01.MLR.0000053228.58042.E4)
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*, 614-625. doi: [10.1037/0003-066X.59.7.614](https://doi.org/10.1037/0003-066X.59.7.614)
- Corrigan, P. W., & Matthews, A. K. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health*, *12*, 235-248. doi: [10.1080/0963823031000118221](https://doi.org/10.1080/0963823031000118221)
- Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*, 765-776. doi: [10.1037/0003-066X.54.9.765](https://doi.org/10.1037/0003-066X.54.9.765)
- Corrigan, P., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, *9*, 35-53. doi: [10.1093/clipsy.9.1.35](https://doi.org/10.1093/clipsy.9.1.35)
- Cramer, J., & Rosenheck, R., (1998). Compliance with medication regimens for mental and physical disorders. *Psychiatric Services*, *49*, 196-201. doi: [10.1176/ps.49.2.196](https://doi.org/10.1176/ps.49.2.196)
- Crane, D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the Kansas marital satisfaction scale and the Revised Dyadic Adjustment Scale. *The American Journal of Family Therapy*, *28*, 53-60. doi: [10.1080/019261800261815](https://doi.org/10.1080/019261800261815)
- Cummings, M. E., & Davies, P.T. (2011). *Marital Conflict and Children: An Emotional Security Perspective*. New York, NY: Guilford.
- de Larocque, G., Wecker, A., Usubelli, L., Aubague, S., & Michaud, P. (2015). Spouse-aided therapy for addiction. *Sexologies*, *24*, e75-e77. doi: [10.1016/j.sexol.2015.09.001](https://doi.org/10.1016/j.sexol.2015.09.001)
- De Leon, G., Melnick, G., & Tims, F. M. (2001). The role of motivation and readiness for change in treatment and recovery. In F. M. Tims, C. G. Leukefeld, & J. J. Hart (Eds.),

Relapse and recovery in addictions, (pp. 143-171). New Haven, CT: Yale University Press.

Dempster, A.P, Laird, N.M., & Rubin, D.B. (1977). Maximum likelihood from incomplete data via the EM algorithm. *Journal Of The Royal Statistical Society*, 39, 1-38. doi: 10.1.1.133.4884

Department of Health and Human Services (1999). *Mental health: A report of the surgeon general*. Washington, DC: US Public Health Services

Department of Health and Human Services (2003). *New freedom commission on mental health, achieving the promise: transforming mental health care in America. Final report*. Rockville, MD. DHHS Pub. No. SMA-03-3832

DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Velicer, W. F., Velasquez, M. M. and Rossi, J. S. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation and preparation stages of change. *Journal of Consulting and Clinical Psychology*, 59, 295-304. doi: [10.1037/0022-006X.59.2.295](https://doi.org/10.1037/0022-006X.59.2.295)

Doss, B. D., Simpson, L. E., & Christensen, A. (2004). Why do couples seek marital therapy. *Professional Psychology: Research And Practice*, 35, 608-614. doi: [10.1037/0735-7028.35.6.608](https://doi.org/10.1037/0735-7028.35.6.608)

Doss, B., Mitchell, A., Georgia, E., Biesen, J., & Rowe, L. (2015). Improvements in closeness, communication, and psychological distress mediate effects of couple therapy for veterans. *Journal of Consulting and Clinical Psychology*, 83, 405-415. doi:10.1037/a0038541

- Doss, B. D., Atkins, D. C., & Christensen, A. (2003). Who's dragging their feet? Husbands and wives seeking marital therapy. *Journal of Marital and Family Therapy*, *29*, 165-177. doi: [10.1111/j.1752-0606.2003.tb01198.x](https://doi.org/10.1111/j.1752-0606.2003.tb01198.x)
- Eidelson, R. J., & Epstein, N. (1982). Cognition and relationship maladjustment: Development of a measure of dysfunctional relationship beliefs. *Journal of Consulting and Clinical Psychology*, *50*, 715-720. doi:10.1037/0022-006X.50.5.715
- Erel, O., & Burman, B. (1995). Interrelatedness of marital relations and parent-child relations - A metaanalytic review. *Psychological Bulletin*, *118*, 108-132. doi: [10.1037/0033-2909.118.1.108](https://doi.org/10.1037/0033-2909.118.1.108)
- Eubanks Fleming, C. J., & Córdova, J. V. (2012). Predicting Relationship Help Seeking Prior to a Marriage Checkup. *Family Relations*, *61*(1), 90–100. doi: [10.1111/j.1741-3729.2011.00686.x](https://doi.org/10.1111/j.1741-3729.2011.00686.x)
- Forsyth, L. H., & Goetsch, V. L. (1997). Perceived threat of illness and health protective behaviors in offspring of adults with non-insulin dependent diabetes mellitus. *Behavioral Medicine*, *23*, 112-120. doi: [10.1080/08964289709596367](https://doi.org/10.1080/08964289709596367)
- Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the couples satisfaction index. *Journal of Family Psychology*, *21*(4), 572-583. doi: [10.1037/0893-3200.21.4.572](https://doi.org/10.1037/0893-3200.21.4.572)
- Gelman, A., Rosenfeld, E. A., Nikolajski, C., Freedman, L. R., Steinberg, J. R., & Borrero, S. (2017). Abortion stigma among Low-Income women obtaining abortions in western pennsylvania: A qualitative assessment. *Perspectives on Sexual and Reproductive Health*, *49*, 29-36. doi: [10.1363/psrh.12014](https://doi.org/10.1363/psrh.12014)
- Goffman, E. (1963). *Stigma*. Englewood Cliffs, NJ: Prentice Hall.

- Goldberg, A., & Smith, J. (2016). Predictors of race, adoption, and sexual orientation related socialization of adoptive parents of young children. *Journal of Family Psychology, 30*, 397-408. doi:10.1037/fam0000149
- Good, G. E., Dell, D. M., & Mintz, L. B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology, 36*, 295-300. doi:10.1037/0022-0167.36.3.295
- Gottman, J. M., & Gottman, J. S. (2013). Difficulties with clients in Gottman method couples therapy. In A. W. Wolf, M. R. Goldfried, & J. C. Muran (Eds.), *Transforming negative reactions to clients: From frustration to compassion*, 91–112. Washington, DC: American Psychological Association. doi: 10.1037/13940-004
- Graham, M.E. (2002). Health beliefs and self breast examination in black women. *Journal of Cultural Diversity, 9*, 49-54.
- Green S. B. (1991). How many subjects does it take to do a regression analysis? *Multivariate Behavioral Research, 26*, 499-510. doi: 10.1207/s15327906mbr2603_7
- Grob, G. (1983). *Mental illness and American society 1975-1940*. Princeton, NJ: Princeton University Press.
- Halford, W. K., Pepping, C. A. & Petch, J. (2015). The gap between couple therapy research efficacy and practice effectiveness. *Journal of Marital and Family Therapy, 42*, 32-44.
- Halford, W. K., & Snyder, D. K. (2012). Universal processes and common factors in couple therapy and relationship education: Guest editors: W. Kim Halford and Douglas K. Snyder. *Behavior Therapy, 43*, 1-12. doi:10.1016/j.beth.2011.01.007

- Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health, 103*, 777-780
doi:10.2105/AJPH.2012.301056
- Henry, G. T. (1990). *Practical sampling*. Newbury Park, CA: Sage.
- Henshaw, E. J., & Freedman-Doan, C. R. (2009). Conceptualizing mental health care utilization using the health belief model. *Clinical Psychology: Science and Practice, 16*, 420-439.
doi:10.1111/j.1468-2850.2009.01181.x
- Horwitz, S., Demeter, C., Hayden, M., Storfer-Isser, A., Frazier, T. W., Fristad, M. A., & ... Findling, R. L. (2012). Parents' perceptions of benefit of children's mental health treatment and continued use of services. *Psychiatric Services, 63*, 793-801. doi:
[10.1176/appi.ps.201100460a](https://doi.org/10.1176/appi.ps.201100460a)
- IBM Corp. (2012). IBM SPSS Statistics for Windows (Version 21.0) [Computer Software]. Armonk, NY: IBM Corp.
- Jacob, T., & Krahn, G.L. (1988). Marital interactions of alcoholic couples: Comparison with depressed and nondistressed couples. *Journal of Consulting and Clinical Psychology, 56*, 73-79.
- Janz N. K., & Becker M. H. (1984). The health belief model: a decade later. *Health Education Quarterly, 11*, 1-47. doi: [10.1177/109019818401100101](https://doi.org/10.1177/109019818401100101)
- Johnson, C. A., Stanley, S. M., Glenn, N. D., Amato, P. A., Nock, S. L., & Markman, H. J. (2002). *Marriage in Oklahoma: 2001 baseline statewide survey on marriage and divorce (S02096 OKDHS)*. Oklahoma City, OK: Oklahoma Department of Human Services.

- Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy*, *23*, 135-152. doi: [10.1111/j.1752-0606.1997.tb00239.x](https://doi.org/10.1111/j.1752-0606.1997.tb00239.x)
- Jonker, L., & Greeff, A. (2009). Resilience factors in families living with people with mental illnesses. *Journal of Community Psychology*, *37*, 859-873. doi:10.1002/jcop.20337
- Keith, T. Z. (2006). *Multiple regression and beyond*. Boston, MA: Pearson.
- Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, R., Laska, E. M., & Leaf, P. J. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*, 987-1007.
- Khoramabadi, M., Dolatian, M., Hajian, S., Zamanian, M., Taheripanah, R., Sheikhan, Z., ... Seyed-Moghadam, A. (2016). Effects of Education Based on Health Belief Model on Dietary Behaviors of Iranian Pregnant Women. *Global Journal of Health Science*, *8*, 230-239. doi: [10.5539/gjhs.v8n2p230](https://doi.org/10.5539/gjhs.v8n2p230)
- Kiecolt-Glaser, J. K., Malarkey, W. B., Chee, M., Newton, T., Cacioppo, J. T., Mao, H., & Glaser, R. (1993). Negative behavior during marital conflict is associated with immunological down-regulation. *Psychosomatic Medicine*, *55*, 395-409. doi: [10.1097/00006842-199309000-00001](https://doi.org/10.1097/00006842-199309000-00001)
- Kiecolt-Glaser, J. K., & Newton, T. (2001). Marriage and health: His and hers. *Psychological Bulletin*, *127*, 472-503. doi: [10.1037/0033-2909.127.4.472](https://doi.org/10.1037/0033-2909.127.4.472)
- Kim, J., Smith, T. W., & Kang, J. (2015). Religious affiliation, religious service attendance, and mortality. *Journal of Religion and Health*, *54*, 2052-2072. doi:10.1007/s10943-014-9902-

- Kirby, M.J.L., & Keon, W.J. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology.
- Kline, R. B. (2010). *Principles and practice of structural equation modeling* (3rd ed.). New York, NY: Guilford.
- Knerr, M., Bartle-Haring, S., McDowell, T., Adkins, K., Delaney, R. O., Gangamma, R., Glebova, T., Grafsky, E., & Meyer, K., (2011). The impact of initial factors of therapeutic alliance in individuals and couples therapy. *Journal of Marital and Family Therapy*, 37, 182-199. doi: 10.1111/j.1752-0606.2009.00176.x.
- Koschorke, M., Padmavati, R., Kumar, S., Cohen, A., Weiss, H.A., Chatterjee, S., Pereira, J., Naik, S., John, S., Dabholkar, H., Balaji, M., Chavan, A., Varghese, M., Thara, R., Thornicroft, G., & Patel, V. (2014). Experiences of stigma and discrimination of people with schizophrenia in India. *Social Science and Medicine*, 123, 149-159. doi: 10.1016/j.socscimed.2014.10.035 25462616
- Kreider, R. M. & Riels, J. M. (2002). *Number, timing, and duration of marriages and divorces: 1996. Household Economic Studies*. Washington, DC: US Census Bureau.
- Larke, J. (1985). Compulsory treatment: Some practical methods of treating the mandated client. *Psychotherapy*, 22, 262-268.
- Laumakis, M.A., Margolin, G., John, R.S. (1998). The emotional, cognitive, and coping responses of preadolescent children to different dimensions of marital conflict. In: G.W. Holden, R. Geffner, E.N. Jouriles (Eds.) *Children exposed to marital violence: Theory, research and applied issues*. Washington, DC: APA. (pp. 257-288). doi: [10.1037/10257-008](https://doi.org/10.1037/10257-008)

- Laumann, E. O. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago, IL: University of Chicago Press.
- Lebow, J. L., Chambers, A. L., Christensen, A., & Johnson, S. M. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy*, 38, 145-168. doi:10.1111/j.1752-0606.2011.00249.x
- Leonard, K. E., & Roberts, L. J. (1998). The effects of alcohol on the marital interactions of aggressive and nonaggressive husbands and their wives. *Journal of Abnormal Psychology*, 107, 602-615. doi:10.1037//0021-843X.107.4.602
- Lewis, J. E., & Malow, R. M. (1997). HIV/AIDS risks in heterosexual college students. *Journal of American College Health*, 45, 147-155.
- Lin, E., Goering, P., Offord, D., Campbell, D., & Boyle, M. (1996). The use of mental health services in Ontario: Epidemiologic findings. *Canadian Journal of Psychiatry*, 41, 572-577. doi: 10.1177/070674379604100905
- Locke, H. J., & Wallace, K. M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, 21, 251-255.
- Maes, C. A., & Louis, M. (2003). Knowledge of AIDS, perceived risk of AIDS, and at-risk sexual behaviors of older adults. *The Journal of the American Academy of Nurse Practitioners*, 15, 509-516.
- Manning, W. D., & Smock, P. J. (2005). Measuring and modeling cohabitation: New perspectives from qualitative data. *Journal of Marriage and Family*, 67(4), 989-1002. doi:10.1111/j.1741-3737.2005.00189.x

- Matusiewicz, A. K., Hopwood, C. J., Banducci, A. N., & Lejuez, C. W. (2010). The effectiveness of cognitive behavioral therapy for personality disorders. *The Psychiatric Clinics of North America*, 33, 657-685. doi: [10.1016/j.psc.2010.04.007](https://doi.org/10.1016/j.psc.2010.04.007)
- McConaughy, E.A., Prochaska, J.O., & Velicer, W.F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research and Practice*, 20, 368-375.
- McCormick-Brown, K. (1999). Health belief model. In Jones and Barlett Publishing (Eds.), *Health belief model (ch. 4)*. Retrieved from <http://www.jblearning.com/samples/0763743836/chapter%204.pdf>.
- McLeod, J. (2003). *Doing counseling research (2nd ed.)*. Thousand Oaks, CA; Sage.
- McLeod, J. D., & Uemura, R. (2012). Substance Use, Distress, and Adolescent School Networks. *Journal of Research on Adolescence*, 22(3), 438–452.
<https://doi.org/10.1111/j.1532-7795.2012.00787.x>
- Moore, L. E, Tambling, R. B., Anderson, S. R. (2013). The intersection of therapy constructs: The relationships between motivation to change, distress, referral source, and pressure to attend. *American Journal of Marriage and Family Therapy*, 41, 245-258.
- Morrill M.I., Fleming, C.E., Harp, A.G., Sollenberger, J.W., Darling, E.V., & Cordova, J.V. (2011). The marriage checkup: Increasing access to marital health care. *Family Process*, 50, 471-485.
- Nadler, A., & Jeffrey, D. (1986). The role of threat to self-esteem and perceived control in recipient reaction to help: Theory development and empirical validation. In L. Berkowitz (Eds.), *Advances in Experimental Social Psychology*, 19, 81-122. doi: [10.1111/j.1545-5300.2011.01372.x](https://doi.org/10.1111/j.1545-5300.2011.01372.x)

- National Cancer Institute (2003). *Theory at a glance: A guide for health promotion practice*. Washington, DC: U.S. Department of Health and Human Services.
- National Center for Family & Marriage Research (2010). *Married and cohabitating couples, 2010*. Ann Arbor, MI: Interuniversity Consortium for Political and Social Research. doi: 10.3886/ICPSR31322.v1
- National Survey of Drug Use and Health Annual Report (2008). *Substance abuse and mental health services administration*. Washington, DC: US Department of Health and Human Services.
- Nelson, T. S., & Sullivan, N. J. (2007). Couple therapy and addictions. *Journal of Couple & Relationship Therapy, 6*, 45-56. doi: 10.1300/J398v06n01_05
- Obama Committee (2016) *Preparing for the future substance use disorder parity task force: Final report*. Washington, DC: US
- O'Connor, P. J., Martin, B., Weeks, C. S., & Ong, L. (2014). Factors that influence young people's mental health help-seeking behavior: A study based on the Health Belief Model. *Journal of Advanced Nursing, 70*(11), 2577-2587. doi:10.1111/jan.12423
- O'Hare, T. (1996). Court-ordered versus voluntary clients: Problem differences and readiness for change. *Social Work, 41*, 417-422. doi: [10.1093/sw/41.4.417](https://doi.org/10.1093/sw/41.4.417)
- Obama, B.H. (2012). *Executive order: Improving access to mental health services for veterans, service members, and military families*. Washington, DC: White House.
- Ojeda, V. D., & Bergstresser, S. M. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions and attitudes among adults reporting unmet need. *Journal of Health and Social Behavior, 49*, 317-334. doi:10.1177/002214650804900306

- Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.), 311-381. New York, NY: Wiley.
- Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice*. New York, NY: Guilford.
- Piper, W., Ogrodniczuk, J., Joyce, A., & Weideman, R. (2011). *Short-term group therapies for complicated grief: Two research-based models*. Washington, DC: American Psychological Association.
- Prochaska, J., & DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, *19*, 276-288. doi: [0.1037/h0088437](https://doi.org/10.1037/h0088437)
- Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short 'readiness to change questionnaire for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction*, *87*, 743-754. doi.10.1111/j.1360-0443.1992.tb02720.x
- Rosenstock, I. M. (1966). Why people use health services. *Milbank Memorial Fund Quarterly*, *44*, 94-124.
- Rosenstock I.M., Strecher V.J., Becker M.H. (1994) The Health Belief Model and HIV Risk Behavior Change. In: DiClemente R.J., Peterson J.L. (Eds.) *Preventing AIDS. AIDS Prevention and Mental Health*. Springer, Boston, MA.
- Schonbrun, Y. C., Strong, D. R., Wetle, T., & Stuart, G. L. (2011). A qualitative investigation of barriers to entry into couples' treatment for alcohol problems. *Journal of Substance Abuse Treatment*, *41*, 399-406. doi: 10.1016/j.jsat.2011.06.002

Schottenfeld, R. (1989). Involuntary treatment of substance abuse disorders-impediments to success. *Psychiatry-Interpersonal and Biological Processes*, 52, 164-176.

doi:10.1080/00332747.1989.11024441

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy*, 29(4), 547-570. doi: 10.1111/j.1752-0606.2003.tb01694.x

Shah, A. H., & Beinekcke, R.H. (2009). Global mental health needs, services, barriers, and challenges. *International Journal Of Mental Health*, 38, 14-29. doi: 10.2753/IMH0020-7411380102

Sheras, P. L., & Koch-Sheras, P. R. (2008). Commitment first, communication later: Dealing with barriers to effective couples therapy. *Journal of Contemporary Psychotherapy*, 38, 109-117. doi:10.1007/s10879-008-9082-4

Shumway, S. T., Wampler, R. S., Dersch, C., & Arredondo, R. (2004). A place for marriage and family services in employee assistance programs (EAPs): A survey of EAP client problems and needs. *Journal of Marital and Family Therapy*, 30, 71-179. doi: 10.1111/j.1752-0606.2004.tb01223.x

Snyder, D. & Mangrum, L. (2005). Approaches to prediction: Correlation, regression, and classification techniques. In D. Sprenkle & F. Piercy (Eds.), *Research methods in family therapy* (pp. 368–402). New York, NY: Guilford.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38, 15–28. doi: 10.2307/350547

- Sprenkle, D. H. (2003). Effectiveness research in marriage and family therapy: Introduction. *Journal of Marital and Family Therapy, 29*, 85-96. doi: 10.1111/j.1752-0606.2003.tb00385.x
- Sprenkle, D., & Blow, A. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30*, 113-129. doi: 10.1111/j.1752-0606.2004.tb01228.x
- Staggs, S. L., Long, S. M., Mason, G. E., Krishnan, S., & Riger, S. (2007). Intimate partner violence, social support, and employment in the postwelfare reform era. *Journal of Interpersonal Violence, 22*, 345–367.
- Stigma. (2017) In *Merriam Webster's dictionary*. Springfield, MA: Merriam-Webster. Retrieved from <https://www.merriam-webster.com/dictionary/stigma>
- Stretcher, V., & Rosenstock, I. M. (1997). The Health Belief Model. In K. Glanz, F.M. Lewis, & B.K. Rimer, (Eds.). *Health behavior and health education: theory, research and practice*. San Francisco, CA: Jossey-Bass.
- Sue, V. M., & Ritter, L. A. (2012). *Conducting Online Surveys* (2nd ed.). Los Angeles: SAGE Publications.
- Sullivan K. T., Pasch L. A., Cornelius T., & Cirigliano E. (2004). Predicting participation in premarital prevention programs: The health belief model and social norms. *Family Process, 43*, 175–193. doi: 10.1111/j.1545-5300.2004.04302004.x
- Swindle, R., Heller, K., Pescosolido, B., & Kikuzawa, S. (2000). Responses to nervous breakdowns in America over a 40-year period: Mental health policy implications. *American Psychologist, 55*(7), 740-749. doi:10.1037/0003-066X.55.7.740
- Tabachnick, B. G., & Fidell, L.S. (2013). *Using multivariate statistics* (6th ed.). Boston, MA: Pearson.



- Talley, A. E., & Ann Bettencourt, B. (2010). A relationship-oriented model of HIV-related stigma derived from a review of the HIV-affected couples literature. *AIDS and Behavior, 14*, 72-86. doi:10.1007/s10461-008-9493-y
- Tambling, R., & Johnson, L. N. (2008). The relationship between stages of change and outcome in couple therapy. *The American Journal of Family Therapy, 36*, 229-241. doi: [10.1080/01926180701290941](https://doi.org/10.1080/01926180701290941)
- Tambling, R. B., & Johnson, L. N. (2012). An exploratory factor analysis of the University of Rhode Island Change Assessment among couple therapy clients. *The Family Journal, 20*, 59–65. doi: 10.1177/1066480711429537.
- Tambling, R. B., & Ketring, S. A. (2014). The R-URICA: A confirmatory factor analysis and a revision to the URICA. *Contemporary Family Therapy, 36*, 108-119. doi:10.1007/s10591-013-9279-x
- Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*, 19-26. doi: [10.1097/NNR.0b013e31827bf533](https://doi.org/10.1097/NNR.0b013e31827bf533)
- Turner, L. W., Hunt, S. B., DiBrezzo, R., & Jones, C. (2004). Design and implementation of an osteoporosis prevention program using the health belief model. *American Journal of Health Studies, 19*, 115-121.
- Valiente C. E., Belanger C. J., Estrada A. U. (2002). Helpful and harmful expectations of premarital interventions. *Journal of Sex and Marital Therapy, 28*, 71-77. doi: 10.1080/009262302317251034
- Vessy, J. T., & Howard, K. L., (1993). Who seeks psychotherapy? *Psychotherapy, 30*, 546-553. doi: [10.1037/0033-3204.30.4.546](https://doi.org/10.1037/0033-3204.30.4.546)

- Vogel, D. L., Wade, N. G., & Haake, S. (2006) Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337. doi: [10.1037/0022-0167.53.3.325](https://doi.org/10.1037/0022-0167.53.3.325)
- Vogel, D. L., Wade, N.G., & Hackler, A.H. (2007). Perceived public stigma and willingness to seek counseling: The mediating roles of self-stigma and attitudes towards counseling. *Journal of Counseling Psychology, 54*, 40-50. doi: 10.1037/0022-0167.54.1.40
- Wade, N., Post, B., Cornish, M., Vogel, D., & Tucker, J. (2011). Predictors of the change in self-stigma following a single session of group counseling. *Journal of Counseling Psychology, 58*, 170-182. doi:10.1037/a0022630
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.
- Weakland, J. H., & Jordan, L. (1992). Working briefly with reluctant clients: Child protective services as an example. *Journal of Family Studies, 14*, 231-254. doi: 10.1046/j..1992.00455.x
- West, C. M., Kantor, G. K., & Jasinski, J. L. (1998). Sociodemographic predictors and cultural barriers to help-seeking behavior by Latina and Anglo American battered women. *Violence and Victims, 13*, 361–375.
- Wesselmann, E. D., & Grazuano, W. G. (2015). "Sinful and/or possessed? Religious beliefs and mental illness stigma": Erratum. *Journal of Social and Clinical Psychology, 34*, 642. doi: [10.1521/jscp.2010.29.4.402](https://doi.org/10.1521/jscp.2010.29.4.402)
- Whisman, M. A. (2013). Relationship discord and the prevalence, incidence, and treatment of psychopathology. *Journal of Social and Personal Relationships, 30*, 163-170. doi:10.1177/0265407512455269

- Whisman, M. A., & Beach, S. R. H. (2012). Couple therapy for depression. *Journal of Clinical Psychology, 68*, 526-535. doi:10.1002/jclp.21857
- Whisman, M. A., & Uebelacker, L. A. (2006). Impairment and distress associated with relationship discord in a national sample of married or cohabiting adults. *Journal of Family Psychology, 20*, 369-377. doi:10.1037/0893-3200.20.3.369
- White, S. A., McKay, K., Jackson, H., Park, J., Martin, B. J., & Taylor, L. C. (2003). Christians and depression: Attributions as mediators of the depression-buffering role of Christian social support. *Journal of Psychology and Christianity, 22*, 49-58.
- Wolcott, I. H. (1986). Seeking help for marital problems before separation. *Australian Journal of Sex, Marriage and Family, 7*, 154-164. doi: 10.1080/1591487.1986.11004353
- World Health Organization (2003). *Investing in mental health*. Geneva, Switzerland: Department of Mental Health and Substance Dependence.
- World Health Organization (2005). *Mental health policy, plans and program*. Geneva, Switzerland: Department of Mental Health and Substance Dependence.
- Wright, J., Sabourin, S., Mondor, J., McDuff, P., & Mamodhousen, S. (2007). The clinical representativeness of couple therapy outcome research. *Family Process, 46*, 301-316. doi:10.1111/j.1545-5300.2007.00213.x
- Yamamoto, S., Maeder, E., & Fenwick, K. (2017). Criminal responsibility in Canada: Mental disorder stigma education and the insanity defense. *International Journal of Forensic Mental Health, 16*, 313-335. doi: 10.1080/14999013.2017.1391357

Appendix A

Virginia Tech Institutional Review Board Approval

 VirginiaTech	Office of Research Compliance Institutional 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:	September 20, 2017 
TO:	Megan Leigh Dolbin-MacNab, Lyn Moore
FROM:	Virginia Tech Institutional Review Board (FWA00000572, expires January 29, 2021)
PROTOCOL TITLE:	Individual Role in Seeking Couple Therapy: Contextualizing Perceptions of Benefits and Barriers through the Health Belief Model
IRB NUMBER:	17-606
Effective September 20, 2017, 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:	Exempt, under 45 CFR 46.110 category(ies) 2
Protocol Approval Date:	September 20, 2017
Protocol Expiration Date:	N/A
Continuing Review Due Date*:	N/A
*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.	
<i>Invent the Future</i>	
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY <i>An equal opportunity, affirmative action institution</i>	

Appendix B

Recruitment Material

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Individual Role in Seeking Couple Therapy: Contextualizing Perceptions of Benefits and Barriers through the Health Belief Model

Investigator(s):

Megan Dolbin-MacNab, PhD

mdolbinm@vt.edu / (540) 231-6807

Lyn Moore O'Connell, MA IMFT

lmoo@vt.edu / 703-628-2188

The purpose of this research study is to explore the reasons an individual may or may not seek couple therapy for conflict in their relationship. The results are anonymous and no identifying information will be collected or shared. Results of the study will be used for professional publications and presentations. One hundred and fifteen people are being surveyed.

To be included in the study, you must be:

1. 18 years of age or older and able to consent to participate.
2. You must be in a committed, cohabitating/partnered/married relationship for over one year.
3. You cannot currently be attending or have previously attended couple therapy with your current partner.
4. Your partner cannot have already completed this survey.

This research request is voluntary and your participation is anonymous. Participating in the study involves completing a brief multiple-choice (20-minute) survey, which can only be completed online. The survey questions ask you about your current relationship and include topics such as perceived susceptibility of your relationship, perceived severity of divorce, perceived benefits to attending couple therapy, perceived barriers to attending couple therapy, awareness of other couple's relationships and how they handle distress, relational satisfaction, and motivation.

Risks. There are no significant risks to participating in this study; however, you may be asked to recall a time during which you had conflict with your partner or be asked to think about the topic of divorce. Recalling these a negative event may cause emotional distress; you are able to stop completing the survey at any time and may skip a question you choose not to answer. Please consult a mental health professional should you be experiencing overwhelming distress.

Any survey completed online has inherent risks due to potential breaches in privacy or the ability for someone else using your same device to see your responses. If you are concerned about your partner or someone else viewing your responses, you are encouraged to complete the survey in a private location and are encouraged to clear your browser history after you have submitted the survey.

Benefits. No promise or guarantee of benefits has been made to encourage you to participate. However, your participation will add to the understanding of couple relationships, access to therapy, and help people find better ways to support their couple relationship.

Compensation. When you are invited to take the survey by Qualtrics via email, you will be compensated for the amount you agreed upon before you entered the survey.

Freedom to Withdraw. It is important for you to know that you are free to withdraw from this study at any time without penalty. You are free not to answer any questions that you choose or respond to what is being asked of you without penalty. Should you withdraw or otherwise discontinue participation, you will be compensated for the portion of the project completed in accordance with the Compensation section of this document. Any of your responses will be immediately deleted and not collected by the researcher.

By completing and submitting the survey you are providing your consent for its use in this research project. Please confirm your agreement by positively (“yes”) answering the first question on the survey. Should you have any questions about the research or the protocol please contact Lyn Moore O’Connell at lmoo@vt.edu or Dr. Megan Dolbin-MacNab at mdolbinm@vt.edu

Should you have any questions or concerns about the study’s conduct or your rights as a research subject, or need to report a research-related injury or event, you may contact the VT IRB Chair, Dr. David M. Moore at moored@vt.edu.

Please click on the following link to proceed to the survey: www.Qualtrics.com/SURVEYLINKADDEDHERE

Appendix C**Inclusion Criteria**

Q1 I am currently 18 years of age or older

- Yes (1)
 No (2)

Skip To: End of Block If I am currently 18 years of age or older = No

Q2 I am currently in a committed cohabiting partnered/married relationship and have been for over one year.

- Yes (1)
 No (2)

Skip To: End of Block If I am currently in a committed cohabiting partnered/married relationship and have been for over on... = No

Q3 I am not currently attending or have previously attended couple therapy with my partner.

- Yes (1)
 No (2)

Skip To: End of Block If I am not currently attending or have previously attended couple therapy with my partner. = No

Q4 I do not believe, to the best of my knowledge, that my partner has completed this survey.

- I do NOT believe my partner has completed the survey (1)
 I do believe my partner has completed the survey (2)

Skip To: End of Block If I do not believe, to the best of my knowledge, that my partner has completed this survey. = I do believe my partner has completed the survey

Q5 I am aware of the risks associated with completing a survey about my relationship online.

- Yes (1)
 No (2)

Skip To: End of Block If I am aware of the risks associated with completing a survey about my relationship online. = No

Q6 Have you reviewed the consent agreement and agree to participate in this study?

- Yes (1)
- No (2)

Skip To: End of Block If Have you reviewed the consent agreement and agree to participate in this study? = No

Q109

We care about the quality of our survey data and hope to receive the most accurate measures of your opinions, so it is important to us that you thoughtfully provide your best answer to each question in the survey.

Do you commit to providing your thoughtful and honest answers to the questions in this survey?

- I will provide my best answers (1)
- I will not provide my best answers (2)
- I can't promise either way (3)

Skip To: End of Block If We care about the quality of our survey data and hope to receive the most accurate measures of yo... != I will provide my best answers

End of Block: Pre-Screen Questions

Appendix D**Demographic Questions**

Q7 What is your age

Skip To: End of Block If What is your age < 18

Q8 What is your gender?

- Male (1)
- Female (2)
- Transgender (3)
- Not listed. Please Explain: (4) _____
- Prefer not to answer (5)

Q9 Do you consider yourself to be:

- Heterosexual/straight (1)
- Gay/Lesbian (2)
- Bisexual (3)
- Not listed. Please Explain: (4) _____
- Prefer not to answer (5)

Q10 Have you had a prior significant relationship that lasted over a year or in which you were married?

- Yes (1)
- No (2)

Q11 How long have you been in your current relationship. Please provide years and months.

Q12 How would you define your current relationship?

- Legal partnership (1)
- Domestic partnership (2)
- Life-partners (3)
- Engaged (4)
- Married (5)

Q13 What is your ethnicity?

- Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) (1)
- Not Hispanic or Latino (2)

Q14 What is your race

- American Indian or Alaska Native (1)
- Asian (2)
- Black or African American (3)
- Native Hawaiian or Other Pacific Islander (4)
- White (5)
- Not listed. Please explain: (6) _____

Q15 What is your religious or spiritual preference?

- Protestant (1)
- Catholic (2)
- Other Christian (3)
- Jewish (4)
- Muslim (5)
- Buddhist (6)
- Unaffiliated (Atheist, Agnostic) (7)
- Not listed. Please explain: (8) _____

Q17 How important is your religion or spirituality to your life on a scale of 1 (not at all) to 5 (incredibly important)?

- 1 (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)

Q18 What is your highest level of education?

- Some middle school (1)
- Some high school (2)
- High school graduate (3)
- GED (4)
- Some college (5)
- Associates (6)
- College graduate (7)
- Graduate degree (8)
- Not listed. Please Explain: (9) _____

Q19 What is your current employment status?

- Employed part time (1)
- Employed full time (2)
- Unable to work (Disability) (3)
- Unemployed, and not presently seeking work (4)
- Unemployed, but seeking work (5)
- Retired (6)
- Not listed. Please explain: (7) _____

Q20 Are you currently a student?

- Full time (1)
- Part time (2)
- Not a student (3)

Q21 Please indicate your total household income (before taxes).

- Under \$10,000 (1)
- \$10,000 – \$19,999 (2)
- \$20,000 - \$29,999 (3)
- \$30,000 – \$39,999 (4)
- \$40,000 – \$49,999 (5)
- \$50,000 – \$59,999 (6)
- \$60,000 – \$69,999 (7)
- \$70,000 + (8)
- Do not know (9)
- Prefer not to answer (10)

Q22 Do you have children with your current partner?

- Yes (1)
- No (2)

Q23 If you have children in your current relationship, please complete the following:

- How many biological children? (1) _____
- How many step-children? (2) _____
- How many adopted children? (3) _____

Q24 Do you have children outside of your current relationship?

- If yes, how many: (1) _____
- No (2)

Q25 Do any of these children currently reside with you?

- Yes, full-time (1)
- Yes, part-time (2)
- No (3)

Q26 Have you ever sought therapy/counseling by yourself?

- Yes, for this relationship (1)
- Yes, unrelated to any relationship (2)
- No prior therapy experience (3)

Q27 Have you previously sought therapy/counseling with a previous partner?

- Yes (1)
- No (2)

Q28 Has your current partner sought individual therapy related to your current relationship?

- Yes (1)
- No (2)

Q29 Please select any of the following items/things you have used to improve your current relationship. (Select all that apply)

- Self-help books (1)
- Media (TV shows, Movies, Podcasts) (2)
- Peer recommendations/suggestions (3)
- Religious/Spiritual guidance (4)
- Individual/Couple retreat (5)

Q30 Please identify the most common point of conflict in your current relationship. Even if conflict is rare, please identify a point of frustration or stress that might come up in the relationship.

Appendix E

Self-Stigma Scale

People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Appendix F

Couples Satisfaction Index (CSI-32)

Please indicate the degree of happiness, all things considered, of your relationship.

Extremely Unhappy 0	Fairly Unhappy 1	A Little Unhappy 2	Happy 3	Very Happy 4	Extremely Happy 5	Perfect 6
----------------------------------	-------------------------------	---------------------------------	-------------------	---------------------------	--------------------------------	---------------------

Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occa- sionally Disagree	Fre-quent ly Disagree	Almost Always Disagree	Always Disagree
Amount of time spent together	5	4	3	2	1	0
Making major decisions	5	4	3	2	1	0
Demonstrations of affection	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occa- sionally	Rarely	Never
In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
How often do you wish you hadn't gotten into this relationship?	0	1	2	3	4	5

	Not at all TRUE	A little TRUE	Some- what TRUE	Mostly TRUE	Almost Completely TRUE	Completely TRUE
I still feel a strong connection with my partner	0	1	2	3	4	5
If I had my life to live over, I would marry (or live with / date) the same person	0	1	2	3	4	5
Our relationship is strong	0	1	2	3	4	5
I sometimes wonder if there is someone else out there for me	5	4	3	2	1	0
My relationship with my partner makes me happy	0	1	2	3	4	5
I have a warm and comfortable relationship with my partner	0	1	2	3	4	5
I can't imagine ending my relationship with my partner	0	1	2	3	4	5
I feel that I can confide in my partner about virtually anything	0	1	2	3	4	5

I have had second thoughts about this relationship recently	5	4	3	2	1	0
For me, my partner is the perfect romantic partner	0	1	2	3	4	5
I really feel like part of a team with my partner	0	1	2	3	4	5
I cannot imagine another person making me as happy as my partner does	0	1	2	3	4	5

	Not at all	A little	Some-what	Mostly	Almost Completely	Completely
How rewarding is your relationship with your partner?	0	1	2	3	4	5
How well does your partner meet your needs?	0	1	2	3	4	5
To what extent has your relationship met your original expectations?	0	1	2	3	4	5
In general, how satisfied are you with your relationship?	0	1	2	3	4	5

	Worse than all others (Extremely bad)			Better than all others (Extremely good)		
How good is your relationship compared to most?	0	1	2	3	4	5

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
Do you enjoy your partner's company?	0	1	2	3	4	5
How often do you and your partner have fun together?	0	1	2	3	4	5

For each of the following items, select the answer that best describes *how you feel about your relationship*. Base your responses on your first impressions and immediate feelings about the item.

INTERESTING	5	4	3	2	1	0	BORING
BAD	0	1	2	3	4	5	GOOD
FULL	5	4	3	2	1	0	EMPTY
LONELY	0	1	2	3	4	5	FRIENDLY
STURDY	5	4	3	2	1	0	FRAGILE
DISCOURAGING	0	1	2	3	4	5	HOPEFUL
ENJOYABLE	5	4	3	2	1	0	MISERABLE

Appendix G

Health Belief Model Scales

Select the answer that best represents your opinion today (ranging on a scale from not at all to extremely bad).

	Not At all (1)	(2)	Neutral (3)	(4)	Very (5)
How easy is it to stay “happily married” for you? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are there things about your relationship that make you think you may have problems later on? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What do you believe is the chance that you and your spouse will ever get divorced? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How likely do you think it is that you would experience relational problems? (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How likely do you think it is that you would ever suggest divorce? (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How likely do you think it is that your partner would ever suggest divorce? (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How likely do you think it is your relationship will end in divorce? (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How bad do you think it would be if... (ranging on a scale from not at all to extremely bad)

	Not at all (1)	(2)	(3)	(4)	Extremely bad (5)
...you experienced marital problems? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... you had trouble communicating? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... you had a lot of conflict/arguments with your partner? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... you had trouble in your marriage? (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... you got divorced? (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much does marital conflict (e.g., having a lot of arguments) disrupt each of the following aspects of your life? (ranging on a scale from not at all to extremely)

	Not at all (1)	(2)	(3)	(4)	Extremely (5)
Personal health and physical comfort (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional well-being (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial well-being (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-esteem (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall quality of life (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much would divorce disrupt each of the following aspects of your life... (ranging on a scale from not at all to extremely disruptive)

	Not at all (1)	(2)	(3)	(4)	Extremely (5)
Personal health and physical comfort (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional well-being (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial well-being (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-esteem (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall quality of life (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you got divorced, how likely is it that you...

	Not at all (1)	(2)	(3)	(4)	Extremely (5)
...would enter another serious relationship again? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... could ever get married again? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... would be able to fully recover? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... would eventually be able to move on? (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To what extent do you believe that you and your partner can handle problems that might come up in your relationship? (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Select the options that first comes to mind, ranging from "not at all" to "very."

	Not at all (1)	(2)	(3)	(4)	Very (5)
How convenient do you think it would be to participate in couple therapy? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If you wanted to go to couple therapy, how likely is it that you would be able to find a place to go? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How effective do you believe couple therapy would be to resolve relational problems? (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If you went to couple therapy, how likely is it that it would reveal things about your relationship that you don't want to know? (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How likely is it that the expense of couple therapy would keep you from going? (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you think going to couple therapy means you have a problem in your relationship? (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you think that a therapist or counselor would be a good person to help your marriage? (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you think that a religious minister would be a good person to help your marriage?
(9)

How likely do you think it is that you could find a couple therapist that you could really trust?
(10)

To what extent would couple therapy...

Not at all (1) (2) (3) (4) Definitely (5)

...help you to keep your marriage happy?
(1)

...help with any problems you and your partner might already have?
(2)

...help identify and prevent possible future problems?
(3)

...help you stay married?
(4)

...help you to explore why you got married?
(5)

...help you learn tools to help you deal with problems later on?
(6)

...help you to communicate and solve problems better?
(7)

To what extent would discussing relationship issues with a neutral professional be helpful to your relationship?

- Not at all
- 2
- 3
- 4
- Definitely

Has anyone suggested to you that you should go to couple therapy?

- Yes
- No

To what extent would learning more about each other help your marriage?

- Not at all
- 2
- 3
- 4
- Definitely

Have any of your family members divorced?

- Yes
- No

Have any of your close friends divorced?

- Yes
- No

Have you ever known anyone who went to couple therapy?

- Yes
- No

Q102 If yes, did they report to you a good experience?

- Yes
- No

Appendix H

Modified R-URICA

Each statement describes what a person might think when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of what you think right now, not what you have felt in the past or would like to feel. “Here” refers to the place of treatment or the problem.

1 = Strongly Disagree

2 = Disagree

3 = Undecided

4 = Agree

5 = Strongly Agree

3. I am doing something about the problems that had been bothering me. 1 2 3 4 5
7. I am finally doing some work on my couple conflict. 1 2 3 4 5
14. I am really working hard to change. 1 2 3 4 5
17. Even though I’m not always successful in changing, I am at least working on my problems. 1 2 3 4 5
19. I wish I had more ideas on how to solve the problem. 1 2 3 4 5
20. I have started working on my problems but I would like help. 1 2 3 4 5
21. Maybe couple therapy will be able to help me. 1 2 3 4 5
23. I may be part of the problems, but I don’t really think I am. 1 2 3 4 5
24. I hope that couple therapy will have some good advice for me. 1 2 3 4 5
25. Anyone can talk about changing; I’m actually doing something about it. 1 2 3 4 5
26. All this talk about therapy is boring. Why can’t people just forget about their problems?
29. I have worries but so does the next guy. Why spend time thinking about them? 1 2 3 4 5
30. I am actively working on my relationship. 1 2 3 4 5
31. I would rather cope with my relationship than try to change it. 1 2 3 4 5

Three subscales:

Action 3, 7, 14, 17, 25, 30

Seeking Assistance 19 and 24

Ambivalence 23, 26, 29, 31

Total score method of scoring—Reverse score the Ambivalence items, add Action items and Seeking Assistance items to the reverse scored Ambivalence items.

Altered question 7, 21, 24, 26, 30, and 31

Appendix I

Open-Ended Questions

How much would you be willing to pay per session of couple therapy?

In general, what kinds of topics do you think would be valuable and important to cover in couple therapy?

What have you heard about couple therapy? What do you imagine it to be like?

Many people face barriers when seeking therapy or help for their relationship. What are some of the primary reasons you wouldn't seek couple therapy?

People do lots of things to improve their relationships. Talk to friend, read books, use social media resources etc. What are some things you've done to improve your relationships?
