American Psychological Association
DIV. 43 SOCIETY FOR COUPLE & FAMILY PSYCHOLOGY

Couple and Family Psychology: Research and Practice


ISSN: 2160-4096

2020, Vol. 9, No. 3, 156–166
http://dx.doi.org/10.1037/cfp0000142

# Attitudes Toward Relationship Treatment Among Underserved Couples

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Attitudinal and instrumental barriers exist for couples broadly that prevent couples from accessing professional relationship help. These barriers may be even more pronounced among couples from low-income, and other underserved, backgrounds. The current study examined how couples' ($N$ = 651 couples) presenting attitudes toward seeking couple treatment, and change in these attitudes, differed as a function of demographic variables within a brief relationship education program, Relationship Checkup (Gordon et al., 2020). Results revealed that individuals who identified as male, a person of color, had lower income, or were cohabiting evidenced poorer baseline attitudes relative to their demographic counterparts. Further, people of color and people who were cohabiting evidenced greater change in attitudes across the intervention relative to their demographic counterparts. Thus, clinicians may benefit from considering that underserved couples appear to face attitudinal barriers in addition to known instrumental barriers (e.g., financial, transportation, childcare, time, etc.). Clinical and research implications are discussed.

*Keywords:* attitudes toward couple therapy, gender differences, people of color, poverty status, marital status



Across the United States, rates of marital and long-term relationship distress are high, and chronic relationship problems are related to significant mental and physical health problems for partners and for their children (Whisman & Uebelacker, 2006). Fortunately, there are numerous preventative interventions and tertiary therapy options available that have been shown to ameliorate relationship distress and associated problems (Christensen et al., 2004; Markman, Rhoades,

This article was published Online First July 2, 2020.

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The current study was funded by the Administration for Children and Families, Grant 90FM0022 (Wischkaemper, Darling, Khaddouma, & Gordon, 2014).

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Stanley, & Peterson, 2013). However, rates of seeking professional help for marital and long-term relationship issues are low, and latencies between identifying a relationship problem and getting help for it are significant (Doss, Rhoades, Stanley, & Markman, 2009; Notarius & Buongiorno, 1992). Many couples are accustomed to keeping relationship difficulties private or turning toward other sources of support, such as close friends or relatives, primary care providers, or clergy, instead of trained relationship professionals (Stewart, Bradford, Higginbotham, & Skogrand, 2016). Further, because of these tendencies, there is a disturbing discrepancy between couples who need assistance in managing relationship issues and those who receive adequate help.

Extensive previous research suggests that this disparity is even more notable among certain demographic groups, in part owing to practical barriers (e.g., financial; proximity and availability of providers) and in part owing to differing belief systems (e.g., cultural distrust of mental health providers and cultural expectations of role enactment, Gonzalez, Alegría, Prihoda, Copeland, & Zeber, 2011). For example, demographic factors such as income and racial and ethnic status seem to play a major role in the help-seeking process, especially for couples-related treatments. In terms of income, financial constraints present significant challenges to low-income families in need of mental health services of all kinds (Keller & McDade, 2000). Enrolling in dyadic therapies can be particularly difficult, given that joint treatment requires both partners to have time in their work schedule and find childcare if necessary. In addition, in some cases, a major impediment is lack of information about available services due to lower social supports and access to treatment resources (Grimes & McElwain, 2008). People of color also appear to be less likely to use mental health care overall, and couple treatments specifically, compared to their White counterparts (Awosan, Sandberg, & Hall, 2011). In part, this hesitance to use couple treatments seems to result from cultural beliefs surrounding treatment, such as higher levels of stigma in communities of color and a preference to use informal or religious supports when seeking general mental health assistance (see Avent, Cashwell, & Brown-Jeffy, 2015; Awosan et al., 2011 for review). However, a large portion of this low utilization pattern is also related to systemic barriers, such as availability of therapists of color, concerns about discrimination, and racial health-care disparities (Powell, Adams, Cole-Lewis, Agyemang, & Upton, 2016; Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). Overall, people of color and people with a low income are understudied in psychological research, particularly in mental health treatment research. Most treatments have been tested on middle-class Caucasians, in part due to logistical barriers for participants such as balancing employment and childcare demands and in part due to research barriers such as exclusion criteria (Kelly & Boyd-Franklin, 2009). For example, there is limited research regarding African American couples in therapy, and the research that is available tends to focus on single-parent homes or parenting concerns (Brody et al., 2004). It is important for the field as a whole to better address the specific needs of people of color by bringing a multicultural approach to intervention research as argued by Kelly and Boyd-Franklin (2009), and although the current study is limited in its ability to draw such conclusions, it takes a step to address historical gaps in research samples by the nature of recruitment methods, intervention delivery format, and altering exclusionary criteria to include cohabiting couples.

There are additional demographic factors that impact access to couples' treatments both independently and in conjunction with racial/ethnic identity and income status, including gender, parenthood status, marital status, and level of relationship distress. Some of these factors have a more limited evidence base in the current literature but appear to play an important role in couples' treatment decisions, particularly for couples of color and couples with a low income. For example, extensive research suggests that men have significantly lower health-care utilization than women and are less likely to show interest in and take steps toward dyadic treatment of any kind (Doss, Atkins, & Christensen, 2003; Mackenzie, Gekoski, & Knox, 2006). These studies indicate that men seek less help largely because of more negative expectations about treatment and stigma regarding help-seeking behavior (Bringle & Byers, 1997; Mackenzie et al., 2006).

Parents may be at particular risk for greater barriers to care given the limitations on their time and availability. Parenting status is most relevant to communities of color because partners are more likely to enter relationships with

children and are more likely to focus on the family and include family in treatment (Boyd-Franklin, Kelly, & Durham, 2008). Some evidence suggests that parents are motivated to make behavioral changes to improve their marital situation for their children, but practical barriers for parents seeking therapy can be high (O'Grady et al., 2015; Petch, Halford, Creedy, & Gamble, 2012). Along these lines, a recent study found that when given an option to choose whether to participate in a brief relationship intervention in their home or a clinical setting, parents were significantly more likely to select the home, even when controlling for income and other demographic variables (Lenger et al., under review). Thus, interventions that aid in accommodating childcare (e.g., flexible delivery setting) may foster more willingness and opportunity to engage in couple interventions.

Further, marital status may play a role in accessing relationship care. At present, the overwhelming majority of research on marital status focuses on its influence in relationship outcomes and shows that cohabitation rather than marriage is related to more negative relationship outcomes (Rhoades, Stanley, & Markman, 2012). However, the role cohabitation plays in help-seeking is relatively unknown. Again, this variable is salient for African American communities, given that rates of marriage are considerably lower when compared to other racial groups, whereas rates of committed relationships and parenting remain high (Boyd-Franklin et al., 2008). Demographic research has found that African American families are often considered single-parent households despite the presence of a partner in the home, and it is necessary to ensure that African American couples are included in interventions and research by specifically broadening the types of relationships that are examined (Boyd-Franklin et al., 2008). Given that this family structure is common and that these differing structures have implications for relationship functioning, research should also investigate whether it has implications for attitudes toward relationship help-seeking.

Research regarding relationship distress and help-seeking has shown mixed results. Although couples who are distressed are more likely to seek relationship counseling, couples with lower distress are more likely to reach out for preventative interventions (Doss et al., 2009; Halford, O'Donnell, Lizzio, & Wilson, 2006). Also, couples in greater distress are more likely to believe that their relationship is irreparable (Johnson et al., 2002; Wolcott, 1986) and thus may choose to dissolve the relationship rather than to get help. In a study of relationship education in couples of color and couples with low income, distressed couples tended to benefit more from relationship education, showing both that these interventions are effective in these groups and that tailoring interventions for specific groups is an important part of providing helpful treatment options (Quirk, Strokoff, Owen, France, & Bergen, 2014). Marital distress is often higher for people of color and for people with low income who are often additionally strained by experiences of poverty and discrimination, and it is essential for these additional barriers to be considered when studying access to care.

Major interventions have been designed to help build motivation for general mental health treatments (i.e., motivational interviewing; Miller & Rollnick, 2013), and public health campaigns have tried to address mental health stigma broadly speaking (see Stuart, 2016 for review). One such intervention, the marriage checkup (MC), focused motivation enhancing strategies on a subset of general mental health treatment by targeting couples who were married. The MC is a brief, motivation-enhancing intervention designed to increase at-risk couples' relationship health. As such, the MC has been shown to benefit mostly White, highly educated, and middle-class couples (Cordova et al., 2005).

On the other hand, the relationship checkup (RC; Gordon et al., 2020) was modeled after the MC but was originally intended to fill a particular gap in relationship help delivery through its brief, nontraditional checkup nature. Participants were given the option to present to an office setting for the checkup or to have facilitators come directly to their homes to deliver the checkup. The RC also strategically includes a wider population than the MC to see how such couples responded to a motivation enhancing relationship health checkup. For example, the RC recruited couples living in a different area of the country with more individuals from rural areas, higher levels of poverty, and lower rates of completed education for adults. The RC also included cohabiting and married couples and

utilized a snowball recruitment method with the intent to help interest people who would not normally present for tertiary treatment.

Traditional couple intervention studies examine how beneficial a particular treatment was for the participating couples. However, couples' attitudes toward dyadic treatment might be an important target for future intervention, particularly for underserved populations. Research suggests a clear relationship between attitudes toward treatment and later treatment-seeking behavior in both individuals and couples (Gonzalez et al., 2011; Heafner, Kang, Ki, & Tambling, 2016). However, researchers have only recently started to target specific demographic groups in need, and they have not tended to focus on receiving help for dyadic issues, although findings suggest that couples of color and couples with low income who attend marital education programs have shown an increase in later help-seeking (Williamson, Trail, Bradbury, & Karney, 2014).

The current study is thus an examination of how attitudes toward seeking couples-related professional help (hereafter referred to as attitudes) vary over time and by demographic group in the RC. Couple therapy treatments in general are unique, in that usually one partner initiates therapy and is thought to want to engage in the therapy more than the other partner; therefore, it is expected that individual partners may differ in both motivation and attitudes toward treatment (Doss et al., 2003). By assessing both partners in our current sample, we hope to examine a range of motivated and reluctant partners. The RC in particular is intended to help address both internal and systemic barriers to couples' interventions. The intervention is brief, can be delivered in the office or at home, and is intentionally marketed as a nontraditional brief intervention that fills a gap between tertiary care and preventative relationship education. This type of intervention is "a less-threatening option for couples to seek early preventative care" and can be thought as the relationship help version of an annual physical or dental checkup (Cordova, 2014). Therefore, the RC is a brief checkup rather than traditional couple therapy (see additional detail in the following text). The RC is designed also to potentially improve attitudes toward traditional therapy that couples might seek in the future. Thus, the current study examines two main research questions:

> *RQ1:* First, do individuals' baseline and postintervention attitudes differ depending on their demographic factors (i.e., gender, racial/ethnic status, poverty status, marital status, parenting status, and relationship distress). Specifically, we expect that baseline and postintervention attitudes will be negatively related to demographic factors, such that men, people of color, individuals with low incomes, individuals who are cohabiting, parents, and individuals with high levels of relationship distress will have less favorable attitudes.
>
> *RQ2:* Next, we will examine whether *change* in attitudes baseline to postintervention differs depending on demographic factors. We expect the attitudes of men, people of color, individuals with low incomes, individuals who are cohabiting, parents, and individuals with high levels of relationship distress will have greater improvement post intervention relative to their demographic counterparts given the original lower baseline values.

## Method

### Participants

Participants consisted of 656 cohabiting and married couples in an intimate committed relationship. Of note, some couples only had one partner who returned their survey(s). Therefore, in total we had 1,307 individuals, represented from these 656 couples, who participated in the RC (Gordon et al., 2020). Couples were excluded from the intervention if one or both partners were under 18 years of age, reported currently feeling unsafe emotionally or physically, and/or not in a self-reported committed relationship. The present study sought to oversample underserved populations. The majority of our sample was Caucasian (74.9%), above the poverty line (69.2%), married (58.5%), parents (58.0%), and for the most part relationally nondistressed (64.6%). The majority of couples were in heterosexual relationships (94%).

Table 1
*Mean and Standard Deviations of Baseline and 1-Month Postintervention Variables of Interest*

| Variables | Time 1 | | | | | Time 2 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *M* | *SD* | Range | Skewness | Kurtosis | *M* | *SD* | Range | Skewness | Kurtosis |
| Attitudes | 13.32 | 4.19 | 0–18 | −1.06 (.10) | .69 (.20) | 15.30 | 7.05 | 0–18 | −.40 (.09) | −1.02 (.17) |
| Relationship satisfaction | 58.00 | 18.23 | 0–81 | −.86 (.11) | .03 (.21) | 63.87 | 16.35 | 0–81 | −1.40 (.09) | 1.64 (.19) |



## Procedure

The RC was an adaptation and expansion of the MC (Cordova et al., 2005), which is a brief, two-session relationship intervention that targets couples who are less likely to attend traditional therapy due to numerous barriers. The intervention seeks to capitalize on a couple's relationship strengths and also discuss areas of relationship concern. The intervention incorporates components of integrative behavioral couples therapy (Christensen et al., 2004) as well as motivational interviewing (Miller & Rollnick, 2013) to help the partners understand one another's concerns as well as generate ideas about how to effectively cope with the concern.

Upon agreeing to participate, each member of the dyad was mailed a baseline packet consisting of measures of individual and relationship functioning. Couples were asked to complete each measure separately from one another to reduce influenced responding. Couples returned their completed measures before the first session of the intervention. Upon completing the intervention, couples were mailed a packet of questionnaires at 1 and 6 months postintervention. To reduce the burden on participants, the 6-month questionnaire only included a subset of the study's measures. Thus, for the present study, we only used the baseline and 1-month postintervention data because the 6-month packet did not contain the measures of interest. All procedures were approved by the university's institutional review board.

## Measures

**Demographic questionnaire.** Each participant reported on demographic variables including gender, race, individual income, marital status, and number of children in the home. Gender included man (0) and woman (1) as self-reported options. Racial status was coded as person of color (0) or White (1). Marital status was coded as cohabiting (0) or married (1). Parenting status was coded as nonparents (0) or parents (1). Poverty status was computed by combining individual partners' reported income into a binned household income variable such that individual income was reported as an interval variable beginning at "less than $10,000" and increasing by $9,000 up through "more than $80,000 per year (partners were asked to round to the nearest $1,000). Couples were coded as living (0) under or at the poverty line or (1) above the poverty line depending on their combined household income and the number of individuals that income supports (i.e., number of children in the home). Poverty line was based on the 2014 federal poverty guidelines (http://familiesusa.org/product/federal-poverty-guidelines#2014). See Table 1 for descriptive statistics of present sample.

**Relationship distress.** Relationship distress was measured using the clinical cutoff criteria of the Couples Satisfaction Index-16 item (Funk & Rogge, 2007). The Couples Satisfaction Index-16 assesses one's global level of relationship satisfaction (e.g., "How rewarding is your relationship with your partner?") with response options ranging from 0 to 4. Responses were summed so that higher scores indicated greater relationship satisfaction. The scale exhibited good internal reliability in the present sample (Cronbach's $\alpha = .83$). In accordance with Funk and Rogge (2007), scores of 51.6 or higher were coded as "Non-Distressed" (0) and scores 51.5 or below were coded as "Distressed" (0). See Table 1 for descriptive statistics of the present sample.

**Attitudes toward professional help-seeking.** Attitudes toward seeking couple therapy was measured using the Attitudes Toward Seeking Professional Psychological Help-Couple Therapy (Cordova, 2014), which was adapted from the Attitudes Toward Seeking Professional Psychological Help (Fischer &

Turner, 1970) in the original Marriage Check-Up project (Cordova, 2014). The Attitudes Toward Seeking Professional Psychological Help-Couple Therapy is a six-item self-report measure of an individual's positive or negative attitude toward couple level professional help seeking (e.g., "I would want to seek professional advice if I was unhappy in my relationship for a long period of time."). Participants' responses ranged from 0 (*disagree*) to 3 (*agree*), with higher scores indicating more positive attitudes. All items were summed for the final score and the scale had good internal reliability (Cronbach's $\alpha = .83$).

## Analytic Plan

For the first research question, we conducted two two-level multilevel models in Mplus examine demographic differences for attitudes at both baseline and 1-month follow-up. For the second research question, we tested a series of three-level multilevel models with restricted maximum likelihood estimation to formulate a combined longitudinal dyadic model in Mplus (Muthén & Muthén, 1998–2011). Specifically, time points (Level 1) are nested within individuals (Level 2), and individuals are nested within couples (Level 3). Because there were only two time-points and two partners in each couple there were not enough degrees of freedom to estimate slopes; therefore, slopes are fixed and only intercepts vary. Gender, racial/ethnic status, and relationship distress were treated as individual-level variables, whereas poverty status, marital status, and parenting status were treated as couple-level variables. Baseline attitudes was controlled for in all models. In each moderating model, we regressed attitudes onto time (0 = baseline, 1 = 1-month postintervention), all demographic variables, and the interaction term (Time × Demographic Variable of Interest). For each model, appropriate items were mean centered to account for multicollinearity of the variable (Aiken & West, 1991).

There were three opportunities for dropout: feedback session (10.1%), 1-month follow-up assessment (34.7%) and 6-month follow-up assessment (40.2%). These missing data were handled within Mplus using full information maximum likelihood, which assumes data missing at random. Therefore, all context variables significantly associated to dropout any time

Table 2
*Multilevel Models of Demographic Differences in Baseline and 1-month Postintervention Attitudes*

| Demographic | Model 1: Demographic differences in attitudes | | Model 2: Demographic differences in attitudes 1-month postintervention | |
|---|---|---|---|---|
| | *B* (*SE*) | ß | *B* (*SE*) | ß |
| Gender (0 = men; 1 = women) | 2.04 (.20)** | .29 | 1.83 (.20)** | .31 |
| People of color (0 = all else; 1 = white) | 0.68 (.36) | .08 | 0.12 (.32) | .02 |
| Poverty status (0 = above poverty line; 1 = at or below poverty line) | −0.66 (.47) | −.08 | −0.40 (.35) | −.06 |
| Marital status (0 = cohabiting; 1 = married) | 1.47 (.40)** | .20 | 0.97 (.32)* | .16 |
| Parenting status (0 = not parenting; 1 = parenting) | −0.60 (.38) | −.08 | −0.48 (.30) | −.08 |
| Relationship distress (0 = not distressed; 1 = distressed) | 0.26 (.31) | .03 | −0.02 (.29) | −.003 |

* $p < .05$. ** $p < .01$.

Table 3
*Multilevel Model Results of Change in Attitudes as a Function of Demographics Over Time*

| Variables | Model 0: Attitudes slope | | | Model 1: Gender | | | Model 2: Minority status | | |
|---|---|---|---|---|---|---|---|---|---|
| | *B* (*SE*) | ß | *d* | *B* (*SE*) | ß | *d* | *B* (*SE*) | ß | *d* |
| Gender | 0.33 (.09)** | .04 | .14 | 0.41 (.06)** | .05 | .27 | 0.33 (.09)** | .04 | .14 |
| Racial/ethnic status | −0.23 (.12)* | −.02 | −.07 | −0.23 (.12)* | −.02 | −.07 | 0.16 (.06)* | .02 | .10 |
| Poverty status | 0.07 (.13) | .46 | .02 | 0.07 (.13) | .19 | .02 | 0.07 (.13) | .30 | .02 |
| Marital status | 0.13 (.11) | .94 | .05 | 0.15 (.11) | .46 | .05 | 0.12 (.11) | .55 | .04 |
| Parenting status | −0.08 (.10) | −.53 | .01 | −0.08 (.10) | −.24 | .01 | −0.08 (.10) | −.37 | −.03 |
| Relationship distress | −0.18 (.10) | −.02 | −.07 | −0.17 (.10) | −.02 | −.07 | −0.17 (.10) | −.02 | −.07 |
| Baseline attitudes | 0.83 (.02)** | .87 | 1.62 | 0.83 (.02)** | .87 | 1.62 | 0.83 (.02)** | .87 | 1.62 |
| Time | 1.11 (.14)** | .13 | .31 | 1.37 (.41)** | .16 | .13 | 1.96 (.34)** | .22 | .23 |
| interaction: Time × Model Demographic | — | — | | −0.17 (.23) | −.03 | −.03 | −1.07 (.36)** | −.12 | .12 |

*Note*. Outcome variable is attitudes.
* $p < .05$. ** $p < .01$.

point (i.e., poverty, marital status, parenting status, minority status, relationship distress) were included in each of the analysis.

## Results

### RQ1: Baseline and Postintervention Attitudes

Results revealed that women and married individuals evidenced significantly more positive attitudes at baseline than their demographic counterparts (i.e., men and cohabiting individuals, respectively). This was also true for demographic differences in attitudes, at 1-month postintervention, with women and married individuals evidencing more favorable attitudes. Interestingly, no significant differences in baseline or postintervention attitudes emerged, as a function of being a person of color, above or below the poverty line, a parent or nonparent, and or relationally distressed or not (Table 2).

### RQ2: Changes in Attitudes

To test our second research question, we examined whether change in attitudes occurred from baseline to postintervention, while controlling for baseline attitudes, and if that change differed by demographics. First, attitudes significantly improved across the intervention (see Model 0 in Table 3). Next, we examined if change in attitudes differed by demographics in a series of three-level multilevel models (see Models 1–6 in Table 3). In each of these models, improvement in attitudes remained significant across the intervention.

Results revealed that attitudes changed similarly (i.e., nonsignificant interaction term) for (a) men and women, (b) individuals above and below the poverty line, and (c) parents and nonparents (see Models 1, 3, and 5 in Table 3). However, attitudes changed differently as a function of (a) being a person of color, (b) marital status, and (c) relationship distress. Specifically, persons of color and nonpersons of color evidenced significant improvement in attitudes; however, persons of color evidenced a greater magnitude of change in attitudes across the intervention ($B = 1.96$, $SE = .34$, $p > .001$) relative to nonpersons of color ($B = .89$, $SE = .14$, $p > .001$). Similarly, both married and cohabiting individuals evidenced significant improvements in attitudes across the intervention; however cohabiting individuals ($B = 1.50$, $SE = .24$, $p > .001$) evidenced a greater magnitude of change in attitudes across the intervention relative to married individuals ($B = .85$, $SE = .16$, $p > .001$). Lastly, relationally nondistressed and relationally distressed individuals evidenced significant improvements in attitudes across the intervention; however, relationally nondistressed individuals ($B = 1.28$, $SE = .16$, $p > .001$) evidenced a greater magnitude of change in attitudes across the intervention relative to distressed individuals ($B = .68$, $SE = .26$, $p > .001$). See Models 2, 4, and 6 in Table 3.

Table 3 (*continued*)

| Model 3: Poverty status | | | Model 4: Marital status | | | Model 5: Parenting status | | | Model 6: Relationship distress | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *B* (*SE*) | ß | *d* | *B* (*SE*) | ß | *d* | *B* (*SE*) | ß | *d* | *B* (*SE*) | ß | *d* |
| 0.33 (.09)** | .04 | .14 | 0.34 (.09)** | .04 | .15 | 0.33 (.09)** | .04 | .14 | 0.33 (.09)** | .04 | .14 |
| −0.24 (.12)* | −.02 | −.08 | −0.24 (.12)* | −.02 | −.08 | −0.24 (.12)* | −.02 | −.08 | −0.23 (.12)* | −.02 | −.07 |
| −0.17 (.07)* | −.56 | −.09 | 0.07 (.13) | .12 | .02 | 0.07 (.13) | .50 | .02 | 0.08 (.13) | .41 | .02 |
| 0.13 (.11) | .49 | .05 | 0.34 (.07)** | .76 | .19 | 0.13 (.11) | 1.03 | .05 | 0.14 (.11) | .81 | .05 |
| −0.08 (.10) | −.28 | −.03 | −0.08 (.10) | −.15 | −.03 | −0.03 (.06) | −.22 | −.02 | −0.07 (.10) | −.44 | −.03 |
| −0.18 (.10) | −.02 | −.07 | −0.17 (.10) | −.02 | −.07 | −0.18 (.10) | −.02 | −.07 | 0.04 (.05) | .00 | .03 |
| 0.83 (.02)** | .87 | 1.62 | 0.83 (.02)** | .87 | 1.62 | 0.83 (.02)** | .87 | 1.62 | 0.83 (.02)** | .87 | 1.62 |
| 0.95 (.14)** | .11 | .26 | 1.50 (.24)** | .17 | .24 | 1.18 (.21)** | .14 | .22 | 1.28 (.16)** | .15 | .31 |
| 0.65 (.37) | .05 | .07 | −0.66 (.29)* | −.07 | −.09 | −0.12 (.28) | −.01 | −.02 | −0.60 (.29)* | −.04 | −.08 |

## Discussion

These results confirm several past findings and extend the field's current understanding of individuals' attitudes toward seeking professional relationship help. Although the current study does not address whether the change in attitudes also contributes to a change in behavior, the findings are a potential step toward that end. Our first research question examined whether demographic characteristics would be related to attitudes. As expected, individuals who identified as male or cohabiting evidenced poorer baseline attitudes relative to their demographic counterparts. These findings are consistent with past literature that suggests that men experience increased attitudinal barriers to seeking treatment (i.e., Mackenzie et al., 2006) and suggests the need to carefully address these barriers in outreach programming designed to increase help-seeking behavior. These findings suggest that marital status is related to attitudes toward help-seeking, which adds to the growing literature regarding the treatment engagement patterns of unmarried couples. Racial status, income level, parenting status, and relationship distress levels did not significantly differ in attitudes at either time point. On one hand, this may result from sampling a population of people who have sought some form of help. However, previous research on similar brief interventions has suggested that this type of program can reach couples historically avoidant of tertiary couple therapy (Morrill et al., 2011) and thus may reflect a true lack of difference on these demographic variables.

Our second research question examined whether the RC brief intervention would improve attitudes in the demographic groups that have historically shown less positive attitudes toward help-seeking. Moderation analyses revealed that the RC improved attitudes in people of color, people who were in nondistressed relationships, and people who were cohabiting. Of note, people across the full spectrum of these demographic groups showed positive change in attitudes, but changes were greater in the specified groups. These findings are especially encouraging, given that people of color are typically less likely to use individual and relationship health care opportunities (Awosan et al., 2011), and it appears that interventions such as the RC might help to bridge the treatment gap for underserved populations. Given that the RC was designed to circumvent numerous barriers to help-seeking and may have increased access for people of color (Gordon et al., 2020), it might be useful for other treatment models to similarly address access and attitudinal barriers.

These findings are also encouraging for cohabiting couples, given that cohabitation is a risk factor for later dissatisfaction (Rhoades et al., 2012), and interventions such as the RC may be able to facilitate more positive attitudes in these couples. Previoua\s literature has not addressed attitudes in cohabitators, but current results sug-

gest that cohabitators have less positive attitudes toward treatment than married couples, and that interventions such as the RC can begin to improve these attitudes. Although not the explicit focus of this article, many cohabiting couples may have held negative attitudes toward treatment including the fear of being judged or low expectations for the benefit of treatment prior to participating in the RC. Having positive or affirming responses to a therapeutic experience that may have been formerly suspect can contribute to changing individual attitudes toward the experience. Similarly, this experience may open doors for people who are not currently distressed but who may find that they need to seek professional assistance at a later time.

Taken together, these results indicate that attitudes toward treatment for relationship issues are sometimes more negative in certain demographic groups, but that specifically designed interventions such as the RC can begin to address both systemic and attitudinal barriers, through home visitation and by packaging it in nonstigmatizing ways. Overall, it is likely that negative beliefs about treatment are closely intertwined with the myriad of systemic variables that also prevent effective help-seeking in specific demographic groups, and it is important for future public policies as well as psychological interventions to overcome barriers of both types. As such, it is crucial that mental health providers across various settings make additional efforts to increase outreach and education efforts to men, people of color, cohabitators, and people with varying levels of distress and types of relationships while recognizing the compounding impact of individual attitudes and their systemic context. This can be done through the implementation of more grassroots types of interventions and organizations, utilizing "snowballing" methods with early participants reaching out to friends and neighbors, as well as through making additional efforts to go to these communities/groups rather than expecting these communities to come in for treatment without having built a prior relationship. Clinicians might accomplish this by focusing on more home-based care, as well as through integrating themselves into communities through already accepted forms of help-seeking, such as religious organizations. Another way to bridge this divide is to create programming that is more accessible than standard tertiary treatment. Programs such as the MC (Cordova et al., 2005) and RC (Gordon et al., 2020) have demonstrated an ability to provide increased access to health care in hard-to-reach populations by creating briefer and more affordable forms of intervention (e.g., Morrill et al., 2011). We anticipate that similar changes in attitudes could be produced by other targeted interventions with similar design and intentions. Creating similar options that are designed to treat a broader array of mental health concerns and that could be accessed and provided through more approachable channels would likely open the door for higher engagement of people of color and other disadvantaged populations.

There are several unique aspects of the study to consider when interpreting the current findings. First, the study was completed in the Appalachian region of Tennessee, which has historically been known as an area of high poverty and a tendency toward self-reliance versus the use of formal help-seeking resources (Elder & Quillen, 2007). Although this view of Appalachia tends to be overstated in the media, it is widely accepted that the unique culture of this region has a significant impact on health behaviors. Further, it should be noted that this study was completed with a sample of help-seeking couples who volunteered to complete a brief relationship intervention. The RC in and of itself was designed to break down resistance to treatment and work around traditional barriers to seeking couple therapy. Consequently, this study's recruitment efforts were specifically targeted toward reaching a broader population and to reaching underserved groups and has accessed couples with at least some willingness to participate in a relationship program. However, research on similar interventions has shown that brief checkups do reach a unique at-risk population who have typically not yet sought formal therapy (Morrill et al., 2011), and it is still likely that the couples with the most negative attitudes toward treatment and/or the most barriers to treatment overall were not reached by the current project, which may limit the variability in attitudes toward couple therapy held by the participants in the sample. Future studies should focus on studying attitudes toward treatment in samples of both help-seekers and those who choose not to seek help.

Finally, although the recruitment efforts in this study were specifically focused on recruiting people from diverse demographic backgrounds and were successful in matching local norms, our study and others still have room to grow in terms of adequately reaching more diverse groups. It is

also important to focus on additional populations, such as same-sex couples, and to better sample people of color such that it is possible to complete more thorough racial and ethnic comparisons. Although there are limitations in the current study, this project represents an important step forward in understanding the barriers to help-seeking in people of color, with low education, and who are living below the poverty line. This study, as well as further research in this area, can help to bridge the gap between available relationship and mental health services and the populations with the greatest need.

## References


Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions*. London, United Kingdom: Sage.

Avent, J. R., Cashwell, C. S., & Brown-Jeffy, S. (2015). African American pastors on mental health, coping, and help seeking. *Counseling and Values, 60,* 32–47. http://dx.doi.org/10.1002/j.2161-007X.2015.00059.x

Awosan, C. I., Sandberg, J. G., & Hall, C. A. (2011). Understanding the experience of Black clients in marriage and family therapy. *Journal of Marital and Family Therapy, 37,* 153–168. http://dx.doi.org/10.1111/j.1752-0606.2009.00166.x

Boyd-Franklin, N., Kelly, S., & Durham, J. (2008). African American couples in therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 681–697). New York, NY: Guilford Press.

Bringle, R. G., & Byers, D. (1997). Intentions to seek marriage counseling. *Family Relations, 46,* 299–304. http://dx.doi.org/10.2307/585128

Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., . . . Neubaum-Carlan, E. (2004). The Strong African American Families Program: Translating research into prevention programming. *Child Development, 75,* 900–917. http://dx.doi.org/10.1111/j.1467-8624.2004.00713.x

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples. *Journal of Consulting and Clinical Psychology, 72,* 176–191. http://dx.doi.org/10.1037/0022-006X.72.2.176

Cordova, J. V. (2014). *The Marriage Checkup practitioner's guide: Promoting lifelong relationship health*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/14321-000

Cordova, J. V., Scott, R. L., Dorian, M., Mirgain, S., Yaeger, D., & Groot, A. (2005). The marriage checkup: An indicated preventive intervention for treatment-avoidant couples at risk for marital deterioration. *Behavior Therapy, 36,* 301–309. http://dx.doi.org/10.1016/S0005-7894(05)80112-1

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. http://dx.doi.org/10.1111/j.1752-0606.2003.tb01198.x

Doss, B. D., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2009). Marital therapy, retreats, and books: The who, what, when, and why of relationship help-seeking. *Journal of Marital and Family Therapy, 35,* 18–29. http://dx.doi.org/10.1111/j.1752-0606.2008.00093.x

Elder, M., & Quillen, J. H. (2007). A reason for optimism in rural mental health care: Emerging solutions and models of service delivery. *Clinical Psychology: Science and Practice, 14,* 299–303. http://dx.doi.org/10.1111/j.1468-2850.2007.00090.x

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35,* 79–90. http://dx.doi.org/10.1037/h0029636

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,* 572–583. http://dx.doi.org/10.1037/0893-3200.21.4.572

Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race and education. *Social Psychiatry and Psychiatric Epidemiology, 46,* 45–57. http://dx.doi.org/10.1007/s00127-009-0168-4

Gordon, K. C., Cordova, J. V., Roberson, P. N. E., Miller, M., Lenger, K. A., Martin, K., . . . Hawrilenko, M. (2020). What works for whom: An evaluation of a brief intervention for community couples. *Family Process*.

Grimes, M. E., & McElwain, A. D. (2008). Marriage and family therapy with low-income clients: Professional, ethical, and clinical issues. *Contemporary Family Therapy, 30,* 220–232. http://dx.doi.org/10.1007/s10591-008-9071-5

Halford, W. K., O'Donnell, C., Lizzio, A., & Wilson, K. L. (2006). Do couples at high risk of relationship problems attend premarriage education? *Journal of Family Psychology, 20,* 160–163. http://dx.doi.org/10.1037/0893-3200.20.1.160

Heafner, J., Kang, H., Ki, P., & Tambling, R. B. (2016). Exploring client expectations in marriage

and family therapy. *The Family Journal, 24,* 256–262. http://dx.doi.org/10.1177/1066480716628582

Johnson, C. A., Stanley, S. M., Glenn, N. D., Amato, P. R., Nock, S. L., Markman, H. J., & Dion, M. R. (2002). *Marriage in Oklahoma: 2001 baseline statewide survey on marriage and divorce*. Oklahoma City: Oklahoma State University, Bureau for Social Research.

Keller, J., & McDade, K. (2000). Attitudes of low-income parents toward seeking help with parenting: Implications for practice. *Child Welfare, 79,* 285–312.

Kelly, S., & Boyd-Franklin, N. (2009). Joining, understanding, and supporting Black couples in treatment. In M. Rastogi & V. Thomas (Eds.), *Multicultural couple therapy* (pp. 235–254). Thousand Oaks, CA: Sage. http://dx.doi.org/10.4135/9781452275000.n12

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging and Mental Health, 10,* 574–582. http://dx.doi.org/10.1080/13607860600641200

Markman, H. J., Rhoades, G. K., Stanley, S. M., & Peterson, K. M. (2013). A randomized clinical trial of the effectiveness of premarital intervention: Moderators of divorce outcomes. *Journal of Family Psychology, 27,* 165–172. http://dx.doi.org/10.1037/a0031134

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Morrill, M. I., Eubanks-Fleming, C., Harp, A. G., Sollenberger, J. W., Darling, E. V., & Córdova, J. V. (2011). The marriage checkup: Increasing access to marital health care. *Family Process, 50,* 471–485. http://dx.doi.org/10.1111/j.1545-5300.2011.01372.x

Muthén, L. K., & Muthén, B. O. (1998-2011). *Mplus user's guide* (6th ed.). Los Angeles, CA: Author.

Notarius, C., & Buongiorno, J. (1992). *Wait time until professional treatment in marital therapy*. Unpublished manuscript, Catholic University of America, Washington, DC.

O'Grady, A. E., Wadsworth, S. M., Willerton, E., Cardin, J. F., Topp, D., Mustillo, S., & Lester, P. (2015). Help seeking by parents in military families on behalf of their young children. *Psychological Services, 12,* 231–240. http://dx.doi.org/10.1037/ser0000027

Petch, J., Halford, W. K., Creedy, D. K., & Gamble, J. (2012). Couple relationship education at the transition to parenthood: A window of opportunity to reach high-risk couples. *Family Process, 51,* 498–511. http://dx.doi.org/10.1111/j.1545-5300.2012.01420.x

Powell, W., Adams, L. B., Cole-Lewis, Y., Agyemang, A., & Upton, R. D. (2016). Masculinity and race-related factors as barriers to health help-seeking among African American men. *Behavioral Medicine, 42,* 150–163.

Quirk, K., Strokoff, J., Owen, J. J., France, T., & Bergen, C. (2014). Relationship education in community settings: Effectiveness with distressed and non-distressed low-income racial minority couples. *Journal of Marital and Family Therapy, 40,* 442–453. http://dx.doi.org/10.1111/jmft.12080

Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2012). The impact of the transition to cohabitation on relationship functioning: Cross-sectional and longitudinal findings. *Journal of Family Psychology, 26,* 348–358. http://dx.doi.org/10.1037/a0028316

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice, 23,* 325–348. http://dx.doi.org/10.1093/fampra/cmi113

Stewart, J. W., Bradford, K., Higginbotham, B. J., & Skogrand, L. (2016). Relationship help-seeking: A review of the efficacy and reach. *Marriage and Family Review, 52,* 781–803. http://dx.doi.org/10.1080/01494929.2016.1157559

Stuart, H. (2016). Reducing the stigma of mental illness. *Global Mental Health, 3,* e17. http://dx.doi.org/10.1017/gmh.2016.11

Whisman, M. A., & Uebelacker, L. A. (2006). Distress and impairment associated with relationship discord in a national sample of married or cohabitating adults. *Journal of Family Psychology, 20,* 369–377. http://dx.doi.org/10.1037/0893-3200.20.3.369

Williamson, H. C., Trail, T. E., Bradbury, T. N., & Karney, B. R. (2014). Does premarital education decrease or increase couples' later help-seeking? *Journal of Family Psychology, 28,* 112–117. http://dx.doi.org/10.1037/a0034984

Wischkaemper, K. C., Darling, E. V., Khaddouma, A., & Gordon, K. C. (2014, November). Attitudes toward relationship treatment in a diverse sample. In H. Williamson (Ed.), *Relationship Interventions for under-represented couples: Symposium conducted at the annual meeting of the Association for Behavioral and Cognitive Therapies (ABCT), Philadelphia, PA*.

Wolcott, I. H. (1986). Seeking help for marital problems before separation. *Australian Journal of Sex, Marriage and Family, 7,* 154–164. http://dx.doi.org/10.1080/1591487.1986.11004353

Received February 15, 2019
Revision received February 20, 2020
Accepted April 20, 2020 ■