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Attitudes Toward Couple Therapy in
Helping Profession Graduate Students

by

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Thesis Submitted in Partial Fulfillment
of the Requirements for the Master's of Social Work

Wilfrid Laurier University

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Abstract

A core issue of couple therapy is the evident delay in help-seeking behaviours among distressed couples. This study had two main objectives. The first objective was to examine if there is a negative stigmatization associated with attendance at couple therapy and whether this is related to a person's willingness to attend. The second objective was to examine whether couple therapy is perceived as a resource to be used once distress levels are severe and other options have been exhausted. This study used a survey methodology with qualitative components and participants consisted mainly of graduate students enrolled in helping profession programs. Overall attitudes toward seeking marital therapy were found to be significantly related to willingness to seek help. Those who were less willing to seek help for a relationship issue had less positive attitudes toward help seeking. This finding was consistent across the 4 subscales of the attitudes toward help seeking scale (ASPPH-MT), including stigma tolerance ($r = .38, p < .00$). The qualitative components of this study illustrated elements of stigma of couple therapy attendance, which addressed the first objective of this study, as well as a stigma of having relationship difficulties and needing external help to resolve these conflicts. It was found that significantly more people indicated that above moderate to severe distress is necessary prior to seeking couple therapy than people who indicated that mild to moderate distress is necessary ($\chi^2(1, N = 106) = 77.396, p < .001$) which addressed the second objective of this study. Overall, in this sample, the findings provided important clarification for two factors: (i) that there is a perception that couple therapy attendance is stigmatized and one's sensitivity to that stigma is related to willingness to seek help and (ii) that couple therapy and attendance is a resource for those who are significantly distressed.

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Introduction

Purpose of Study

The quality of intimate relationships can have significant influence on our lives and well-being. Intimate relationships are considered to be the most important social relationship people have in their lives. They may also be the most challenging relationships. Divorce and marital break down are commonplace in North America, with 41% of first Canadian marriages ending in divorce (Statistics Canada, 2011). To cope with distress, there are many avenues that can be accessed by couples ranging from self-help books to seeking professional counselling. As will be discussed in detail throughout this study, couple therapy is often sought once distress has reached detrimental points of severity (Bringle & Byers, 1997; Doss, Atkins, & Christensen, 2003; Johnson & Lebow, 2000). As an outcome of seeking help at the point of severe distress, the injuries to the relationship are often beyond repair and therapy is less effective for these couples (Doss et al., 2003).

What leads some couples to seek counselling and not others? What contributes to couples waiting for significant periods of time before seeking help? How is couple therapy perceived in general? This study aspires to reveal underlying perceptions and attitudes that exist about couple therapy, and how these relate to the delay in help seeking behaviours. The purpose of this study was to examine and address two main objectives. The first objective was to examine if there is a negative stigmatization associated with attendance at couple therapy and whether this is related to a person's willingness to attend. The second objective was to examine whether couple therapy is perceived as a resource to be used once distress levels are severe and other options have been exhausted, as opposed to a resource that does not need to be prefaced by distress.

What led me to this research?

I have always been fascinated by relationships and found it disheartening that marital breakdown is so common. On a personal note, I come from a family with divorced parents and this experience helped me to recognize that marriage can be extremely challenging. From this experience and my passion to hear about relationships, I decided to work with couples and this interest expanded to my desire to research this topic. I began working with a family therapist/relationship expert five years ago, Ashley Howe, learning about her experiences with couple therapy and the work she has done with couples. I began facilitating relationship retreats for couples. Each retreat or program is based upon couple therapy principles designed by or presented by John Gottman. Each retreat or program uses questions that facilitate positive responses and encourages the couple to delve into the romantic history of the relationship. The retreat was created as a way to facilitate therapeutic benefits for couples and aimed to work as a preventive buffer. Ashley Howe created the retreats because she reported feeling a constant sense of frustration in couple therapy, as many couples came with severe distress that was often ‘beyond repair’, and often one partner was already “checked out” of the relationship.

Through my experience as a relationship retreat facilitator, many couples would cautiously ask me questions such as, “Is this couple therapy? Because *we* do not need therapy”, leading me to question what is aversive about couple therapy. Couples have often admitted that they were afraid the retreat would be couple therapy and that subsequently, that would mean that they were in trouble. From my observations these couples are not isolated in their perspectives. Concerns such as these, and seemingly general perceptions of what attending couple therapy means to the couple/relationship, inspired this study. As an outcome of these experiences and from reviewing the literature on this topic, it has become a passion of mine to learn more about

what deters couples from seeking help. Furthermore, it is important to understand the aversion to couple therapy as it could help to encourage couples at all stages of distress which could benefit the field of couple therapy.

Literature Review

Marriage & Relationships

The literature section focuses on how relationships are viewed in North American culture and how relationship quality can influence well-being. Romantic relationships are highly esteemed in North American culture in terms of status, intrinsic value, and personal well-being. In terms of societal status, being in a committed relationship is perceived as being significantly more valuable than being single (DePaulo & Morris, 2005; Dush & Amato, 2005; Spielmann et al., 2013). A satisfying marriage is reported as one of the most important life goals among adolescents (Roberts & Robins, 2000), and when asked about expectations of what marriage could provide to them, 39.4% of adolescents reported that they expect that his/her partner will fulfill all of his/her needs (Johnston, Bachman & O'Malley, 2001). The nature of this expectation emphasizes how embedded the perspective is that romantic relationships are inherently valuable, specifically that obtaining a happy marriage can ensure that one's needs will be satisfied and fulfilled. It is evident that a satisfying marriage is considered highly valuable and something that is aspired to as a life goal. It is also noteworthy that these statistics reflect the views of a population (adolescents in the 1990s in Canada) that has been exposed to a high parental divorce rate of nearly 50% (Statistics Canada, 2006). The exposure to divorce (and likely marital discord) highlights how deeply rooted the hope and desire for a successful and satisfying marriage is, as these individuals are hopeful in spite of witnessing marital breakdown in their own families. Overall, it is evident that having a satisfying marriage/relationship is considered to

be a positive life goal for many individuals, one that is valued above being single in Canadian culture.

The importance placed on attaining a satisfying relationship is relevant to this research, as it emphasizes how much value is placed upon achieving a satisfying relationship. As will be discussed in detail further into this study, the strong emphasis on having a satisfying marriage could also be linked to what delays couples from seeking help when the relationship may not be satisfying. Given the importance placed on having a satisfying relationship one might speculate that many couples would utilize resources to improve their relationships in order to maintain relationship quality over time, however, this is not the case. The next section discusses the composition of intimate relationships in North American culture and how relationship trends are changing.

Relationship Composition and Trends

In spite of the emphasis and importance placed on marriage and relationships, divorce and relationship conflict are still prevalent in Canada. Divorce has been common in Canada since 1968, at which point couples were first permitted to legally divorce based solely on the basis of marital breakdown (Statistics Canada, 2009). In the first 30 years following this change, first marriages had a divorce rate of approximately 50%, second marriages 68% and third marriages were closer to 80% (Statistics Canada, 2009). These statistics are assumed to be lesser than the actual percentage, as many couples do not legally divorce for financial reasons and common-law couples are not included in this statistic (Statistics Canada, 2009). In spite of these disheartening rates of divorce, relationship trends have been changing.

In recent years, marital rates have slowed. The current divorce rate of first marriages in Canada has decreased from 50% to 41%, common-law relationships are more prevalent and

couples are waiting until they are older to marry (Statistics Canada, 2009, 2011). Couples are more regularly using cohabitation as a pathway to marriage and out of wedlock fertility rates are increasing (Stevenson & Wolfers, 2007). These relationship trends are speculated to be reflective of generational changes, economical changes and perhaps changing attitudes toward the institution of marriage (Hou & Myles, 2008; Johnson, 2003). Generational differences that contribute to these changes include the increasing number of young adults staying in post-secondary education longer and leaving the family home later (Statistics Canada, 2011). Economical changes include the rising cost of purchasing a home and increased cost of attaining an education (Hou & Myles, 2008; Stevenson & Wolfers, 2007).

A less tangible change speculated to be negatively influencing relationship quality and to be contributing to heightened levels of relational conflict is the increasing prevalence of mental health concerns (Twenge, 2000). The current generation of young adults have higher rates of anxiety and depression than past generations, which is considered to decrease relationship satisfaction for the individuals in the relationship (Twenge, 2000). Intimate relationships are considered to be negatively influenced specifically in terms of relationship stability and satisfaction (Twenge, 2000). The increased presence of mental health concerns, and subsequent increase in relational discord, further emphasizes the importance of learning more about why people are averse to attending couple therapy as these couples could benefit from help-seeking. It is well-documented that couples with mental health issues are more likely to experience difficulty in relationships (Whisman & Uebelack, 2006), and in consideration of the increased prevalence of mental health issues, the current generation of young adults may have a greater need for professional relationship help than past generations (Twenge, 2000).

Identity and Relationships

A noteworthy element of romantic relationships is the influence they can have on a person's self-image. Identity and intimate relationships are considered interwoven in the development of a person's life (Montgomery, 2005). There is a strong relationship between intimate relationships and identity development throughout adolescence and young adulthood (Silliman & Schumm, 2004). In addition to the connection of intimacy to personal development, research has also shown that relationship breakdown and divorce can cause significant disruption in personal identity (Degarmo & Kitson, 1996).

Research has illustrated that relationship status is associated with how a person perceives him or herself, and asking a person to simply consider no longer being in the relationship can cause significant distress (DePaulo & Morris, 2005; Speilman et al., 2013). In accordance with this research, individuals in less than satisfactory relationships have been shown to have a difficult time leaving partners, as it is interpreted as not only a loss of the relationship but also loss of identity (DePaulo & Morris, 2005; Dush & Amato, 2005). Speilman, et al. (2013) found that individuals in less than satisfactory relationships were less likely to leave their partners due to a fear of being single. These findings further demonstrate the notion that Canadian society allots greater value to being in a committed relationship than being single (DePaulo & Morris, 2005; Speilman, et al., 2013). This research is indicative that there may be additional meanings associated with a person's relationship status, such that being seen as a person in a relationship is considered to be important. This research may be indicative that the decision to seek professional help for relationship issues could also be associated with underlying meanings, as this can also relate to how others view your relationship. For example, if the fear of being viewed as single is significant enough to remain in an unhappy relationship, there may also be significant concerns

as to how being part of a couple who is seeking help for a relationship is viewed by others. It is possible that there is concern over not only how others view relationship status, but also the relationship quality (needing help versus not needing help). This leads to the next section which focuses on relationship quality, and why improving marital health can be beneficial to not only the relationship but also to both partner's physical and mental health.

Marital Health

Marital health is defined as the mutual perception that one another's life is positively affected by the other's behaviours and presence (Hawkin & Booth, 2005). A healthy relationship is associated with positive effects such as increased life satisfaction, higher levels of self-esteem, and physical health (Berry & Worthington, 2001; Hawkin & Booth, 2005). Benefits can extend to not only the individuals in the happy relationship, but also to their children and even to the overall community well-being (Cummings & Davies, 1994; Gottman, 1994; Whisman & Bruce, 1999). Unsatisfactory relationships, however, are associated with negative effects such as the increased prevalence of mental health problems, including suicidal ideation, and increased levels of both depression and anxiety (Hawkin & Booth, 2005; Kiecolt-Glaser, & Newton, 2001; Whisman & Uebelacker, 2006). Unhappy relationships are also associated with negative health behaviours and physical issues, which is speculated to reflect a lack of energy invested in maintaining physical health as a result of the relationship conflict (Berry & Worthington, 2001). The physical health outcomes are related to higher levels of cortisol, the stress hormone, in individuals with distressed relationships, which is related to serious issues such as heart disease (Berry & Worthington, 2001). It is evident that there appears to be a strong relationship between relationship quality and physical well-being.

As discussed previously, there is a relationship between mental health concerns and increased levels of relationship conflict (Twenge, 2000). It is speculated that the relationship between distress and relationship discord can be explained by a third variable, such as mental health. Specifically, it is suggested that the mental distress is a result of a pre-existing psychiatric disorders suffered by one or both individuals in the relationship, as opposed to being a reflection of relationship conflict (Whisman & Uebelacker, 2006). For example, it is speculated that if a spouse suffers from depression, the couple could experience distress. Even when researchers controlled for pre-existing mental illness, relationship distress was still shown to account for a greater amount of variability to psychological impairment than mental illness contributed (Whisman & Uebelacker, 2006). These findings illustrate the power that relationship discord can have on a person's mental health (Whisman & Uebelacker, 2006). In the treatment of major depressive disorder, there is evidence to support that emotion-focused couple therapy (EFT) is more effective than pharmacological interventions (Dessaulles, Johnson, & Denton, 2003). Relationship conflict can be a driving factor in a person's mental health issues and a positive relationship can be a protective one (Dessaulles et al., 2003; Whisman & Uebelacker, 2006). The mental health impacts can extend to severely suicidal ideation, as research has shown that individuals experiencing relationship distress are more likely to have increased incidences of suicidal ideation (Kaslow, Thompson, Brooks, & Twomey, 2000; Whisman & Uebelacker, 2006). The relationship between mental health concerns and intimate relationship quality emphasizes the importance of examining the perceptions of relationship treatments, as seeking help could be critical to a person's mental well-being (Dessaulles et al., 2003).

In addition to reduced psychological well-being, relationship discord is also considered to detract from external factors such as work and social functioning. It is speculated that individuals

in less than satisfactory relationships have less emotional energy to invest in other areas, such as employment, friendships, and family (Whisman & Uebelacker, 2006). Individuals experiencing marital distress are more likely to be less productive in the workplace, miss working days (Forthofer, Markman, Cox, Stanley, & Kessler, 1996) and have lower levels of job satisfaction (Rogers & May, 2003). These findings highlight why resolving relational conflict is relevant to individuals outside of the couple. It is in the best interests of employers, family, and friends that relationship conflict is treated for both the individual's well-being as well as functioning in other societal roles (Forthofer, et al., 1996; Whisman & Uebelacker, 2006).

In consideration of the importance placed on intimate relationships, the prevalence of relational conflict and the negative effects of remaining in an unhappy relationship, it would be reasonable to presume that many couples would want to utilize services that could help to resolve and prevent relationship conflict. Couple therapy is an empirically supported resource designed specifically to aid couples to improve relationship quality, yet only 19% of divorced couples and a mere 10% of married couples have sought counselling (Bringle & Byers, 1997; Jacobson & Addis, 1993; Johnson, 2003). Research also strongly supports that seeking couple therapy early is more effective than seeking help once distress is severe (Doss et al., 2003; Dessaules et al., 2003). Literature notes that the evident aversion to couple therapy has existed historically (Gurman & Frankel, 2002), but has not specifically addressed what it is about attending couple therapy that delays couples from seeking help. The next section discusses the history and growth of the practice of couple therapy.

History of Couple Therapy

Married couples have been noted to seek clinical relationship advice from as far back as the 1930s. However, the form for which this help has been sought and provided has changed

drastically across the century (Gurman & Fraenkel, 2002). Couples in distress would contact their minister or clergy in the early 1900s (many still do) and mainly they were given education on the importance of marriage from a religious standpoint. In the 1930s, however, clinicians began to establish more specific facilities which were termed “marital counselling” institutes (Gurman & Fraenkel, 2002). In these institutes, clinicians provided advice, however these sessions were not facilitated by therapists, but were facilitated by obstetricians, gynaecologists, and “family life educators” (Broderick & Schrader, 1981; Gurman & Fraenkel, 2002). In spite of this progressive movement in the couple therapy field in the 1930s, researchers reflect that this progress came to a halt for approximately forty years, likely a result of the Great Depression and the Second World War (Gurman & Fraenkel, 2002). Couple therapy began to progress once again in the 1970s in concurrence with family therapy, meaning that couples were not regularly seen on their own about their marriage but as a family unit. It was not until 1986 that couple therapy was recognized on its own accord, which is when researchers and clinicians began to actively examine this type of therapy (Gurman & Fraenkel, 2002). Couple therapy has made significant progress in the last century however, it is still a relatively young field and in need of development and advancements (Gurman & Fraenkel, 2002; Johnson & Lebow, 2000). Although couple therapy has been progressing, the stigma has not yet been well-researched in the literature. A main focus of this thesis is to examine whether there is an existing stigma associated with couple therapy attendance.

Stigma

Stigma is a variable of interest in the present study. Stigma theory emphasizes how groups can inform knowledge and influence others’ perceptions, (Goffman, 1962). This study intends to examine whether attendance at couple therapy is stigmatized and to explore whether it

is seen as a resource utilized only by the most severely distressed couples. Goffman (1962) was the first to acknowledge and conceptualize stigma theory, which describes the interactional process of collectively devaluing particular groups or identities, leading to stigmatization. Stigmatization has become a popular topic in research during the past twenty years, as research has shown that stigma can significantly impact one's health, well-being, and behaviours (Link & Phelan, 2001; Link, Struening, Neese-Todd, Asmussen & Phelan, 2001).

Although stigmatization can be found in a plethora of circumstances such as stereotypes and prejudices, the common element in all of these scenarios is the power and influence it encompasses (Link & Phelan, 2001, 2014). The hypothesized stigma of attending couple therapy is representative of this power, as this stigma may be one of the contributing factors to couples remaining in conflict longer prior to seeking help. In theory, if couples choose not to seek help due to the potential cost of stigma, stigma would be influencing these individuals in a significant way that may alter how they cope, or do not cope, with relationship conflict. By influencing the decision making process of whether or not to seek help, stigma represents the power that societal pressures can have on a person's actions.

Many areas of the helping profession, including attendance at psychotherapy, mental health medication adherence, and having psychiatric diagnoses, are all well researched and linked in relation to stigma. Mental illness has historically been a heavily stigmatized area and a significant amount of research has been focused on the consequential effects of that stigma (Kohn et al., 2004; Thornicroft, 2008). Mental health stigma has a detrimental effect on individuals' self-esteem and self-efficacy (Kessler et al., 1998), and the fear of this stigma can significantly interfere with treatment (Kohn et al., 2004; Sirey et al., 2001). In terms of those who did not seek help, one out of four people who indicated that they needed mental health treatment

indicated that they did not access help due to a perception of stigma (Kessler et al., 2001). Individuals being treated for mental health issues such as major depressive disorder are more likely to stop taking medication if they perceive mental health stigma (Sirey et al., 2001). Researchers propose that individuals avoid seeking treatment and interrupt treatment because they do not want to be labelled as "mentally ill" (Sirey et al., 2001). Stigma prevents many individuals who are in need of treatment from actively seeking it or adhering to treatment once they participate (Kessler, 2005; Sirey et al., 2001) and this is a well-established area of concern for researchers and clinicians (Jacobson & Addis, 1993).

Unfortunately, the fear of stigma is a valid concern among the mental health community. Studies have shown that individuals with mental health concerns are socially rejected, avoided, treated more negatively, and perceived less favourably compared to individuals without mental health issues (Link & Phelan, 2001; Sibicky & Dovoio, 1986). Sibicky & Dovoio (1986) demonstrated that it did not matter if the individual authentically suffered from mental health concerns, as in their particular study participants were manipulated to believe that other participants were attending psychological therapy (even though they were not) and stigmatization still occurred. The perceived therapy attending participants were treated negatively and rated as less socially attractive in comparison to and by the non-therapy attending participants. These participants, who were unknowingly assigned to the therapy attending role, even began to act in less socially desirable ways after interacting with the other participants in response to their poor treatment (Sibicky & Dovoio, 1986). This study is one of many, that illustrates that individuals who attend psychotherapy are negatively stigmatized and this potential treatment deters many people in need from seeking help (Kohn et al., 2004; Sirey et al., 2001). It is possible that the attendance at couple therapy is subject to a similar stigmatization and as

occurs with individual therapy, this may deter couples in need from seeking help. In recognition of the potential influence of stigma of couple therapy, researchers and clinicians have explored alternative methods of attracting couples to therapy, such as 'the marriage check-up'.

'The Marriage Check-Up'

Although it is not thoroughly understood at this point, the noted aversion to couple therapy has motivated researchers to create alternative methods of providing therapy to distressed couples. Researchers designed an alternative to couple therapy, coined “the marriage check-up”, which consists of two therapy sessions utilizing motivational interviewing techniques (Cordova, Scott, Dorian, Mirgain, Yaeger & Groot, 2005). Couples who were considered ‘at-risk’ for marital breakup and who were not planning to seek therapy were recruited (Cordova et al., 2005). Cordova et al. (2005), found that after the marriage check-up, ‘at-risk’ couples’ relationship distress lessened and these benefits were retained at a one year follow-up. The study underscored the potential benefit of couple therapy to couples with mild distress and to couples that may have not considered therapy (Cordova et al., 2005). The study also showed the possible benefits of presenting couple therapy in an alternative method. Although participants were aware they were attending couple therapy, using the term “marriage check-up” instead of couple therapy seemed to make attendance more attractive. As discussed earlier, couples wait an average of six years before they seek help and this study highlighted that such couples may have resolved distress much earlier had they not delayed seeking help (Johnson, 2003). The marriage check-up is a progressive step in the interest of attracting couples to therapy earlier. However, the barriers to seeking therapy are yet to be fully addressed and understood. One of the well-researched factors, however, is gender.

Gender Differences in Seeking Couple Therapy

Factors that lead couples to seek therapy have been examined and well-documented specifically in terms of gender differences. Studies consistently find that men and women report significantly different views on what issues would constitute a need for professional help (Bringle & Byers, 1997). Women are more likely to recognize that a problem exists and to ask for help for general, physical, and psychiatric problems (Campbell & Johnson, 1991; McMullen & Gross, 1983). When asked about attitudes toward couple therapy, men are reluctant to describe what issues would merit a need for help, however, men do describe issues such as sexual problems and potential divorce as factors that would motivate them to seek help (Bringle & Byers, 1997). In general, men typically have less positive attitudes toward help-seeking which is directly linked to reluctance to seeking help (Bringle & Byers, 1997; Doss, Atkins & Christensen, 2003; Kiecolt-Glaser & Newton, 2001). Women, on the other hand, consider issues such as trust, substance abuse, communication, depression, and chronic conflict as only a few of the many reasons sufficient to seek therapy (Bringle & Byers, 1997). It is well documented that women have more positive attitudes toward couple therapy in comparison to men, and since couple therapy requires both partners to agree to therapy, gender differences are an important factors to consider (Bringle & Byers, 1997; Doss et al., 2003). The only two issues that warrant therapy that both men and women appear to agree on are the consideration of divorce and physical/mental abuse (Doss et al., 2003).

Although research shows that women have more positive attitudes toward couple therapy, these attitudes may not be enough to suffice seeking help if their male partner has negative attitudes (Eubanks, Fleming & Cordova, 2012). Research has also shown that while low relationship quality predicts help seeking behaviours in women, quality of relationship is not an

indicator of similar behaviours in men (Eubanks Fleming & Cordova, 2012). As might be expected, it is well documented that men are commonly persuaded by their wives to attend couple therapy (Bringle & Byers, 1997; Eubanks Fleming & Cordova, 2012). As studies have noted that partner refusal influences whether couple therapy is possible, relationship distress is noted as the main reason individuals seek individual psychotherapy (Doss et al., 2003). The prevalence of seeking individual therapy for relationship concerns may be reflective of the challenge of convincing an unwilling partner to attend couple therapy, as people are willing to seek help because of these problems (Doss et al., 2003). Men and women do agree, however, on reasons to evade couple therapy, such as the preference to resolve problems on their own, lack of time, cost of therapy, and uncertainty of benefit (Uebelacker, Hecht & Miller, 2006). In addition to gender differences, research has also been conducted on the general attitudes and associated theories in relation to couple therapy.

Attitudes and Behaviours

Researchers who have examined attitudes and behaviours indicate that intentions are influenced by a person's attitudes toward seeking help as well as the subjective norms associated with that behaviour, which is termed theory of reasoned action (Ajzen & Fishbein, 1980). Bringle and Byers (1997) speculated that the conceptual framework of the theory of reasoned action provides insight as to what prevents couples from seeking professional help. They examined one aspect of this framework which looked at attitudes toward professional help seeking. The study found that positive attitudes were associated with greater likelihood of seeking couple therapy, which indicated that perspectives of help seeking influence the decision to seek help (Bringle & Byers, 1997). Ajzen and Fishbein (1980) proposed the theory of reasoned action as a framework to help explain the factors contributing to voluntary behaviour.

Their theory of reasoned action suggests that voluntary behaviours are determined by an individual's intentions, which are considered to be a function of his/her attitudes toward the behaviour and his/her subjective norms. Subjective norms are defined as a person's perception of societal pressures to conform as well as others' beliefs regarding the appropriateness of certain behaviours (Ajzen & Fishbein, 1991).

Bringle and Byers (1997) suggested that the theory of reasoned action is applicable in understanding couples' intentions to seek, or not seek, couple therapy. They measured subjective norms with two 7-point scales, one asking 'what your friends would think of you should you seek marital counselling to resolve marital conflict,' and the other stating, 'I want to do what my friends want me to do'. Bringle and Byers (1997) found that attitudes toward couple therapy were a strong predictor of positive intentions to seek therapy. In addition to these findings, their results also illustrated that subjective norms were significantly related to the likelihood of seeking marital therapy, which led the authors to speculate that stigmatization of couple therapy may be contributing to the delay in help seeking (Bringle & Byers, 1997). The results of this study provided evidence that stigmatization of couple therapy requires further investigation, as the authors measured subjective norms and not stigmatization (Bringle & Byers, 1997). In order to examine whether a relationship exists between perceived stigma and willingness to seek couple therapy, stigma needs to be measured. The present study aims to bridge this gap by measuring stigma specifically as it pertains to a person's immediate social network and larger societal pressures. Bringle and Byers' (1997) research illustrates a critical point that is foundational to the present proposed study, which is that the decision to seek couple therapy is not necessarily a private choice as respondents gave serious weight and concern about others'

expectations. In addition to these findings, it is well documented that couple therapy is largely attended by a specific demographic as noted below.

Cultural Factors

Couple therapy is accessed mainly by Caucasian, middle-class, and well educated couples (Jacobson & Addis, 1993; Johnson, 2000). The majority of research on couple therapy has a similar demographic which is considered to indirectly influence the practice of couple therapy, as findings and discoveries would adhere to what this population requires (Johnson, 2000). In addition to the cultural disparity, the majority of couple therapy research is focused on heterosexual couples and does not account for how homosexual couples differ. For example, a study has found lesbian relationships are more emotionally fused than heterosexual couples (Laird & Green, 1996), which could change the nature of what would or would not work for that couple. In addition to relational differences that may exist, a therapist treating homosexual or interracial couples would also need to be aware of the challenges the couples may have encountered from societal stigma associated with homosexuality (Bernstein, 2000; Laird & Green, 1996). Therapists need to be aware of any personal biases that they may hold that could influence their work with these couples. For example a therapist with rigid religious views on homosexuality would likely not be an ideal fit for homosexual couples (Bernstein, 2000). In efforts to combat this potential dilemma, the American Psychology Association made an amendment to the code of ethics that psychologists with minimal knowledge of a particular minority group are not to work with these individuals (Marsela & Yamada, 2004), as it could be damaging. The differences between heterosexual and homosexual couples are an important factor to consider for this research, as homosexual couples may have vastly different reasons for not attending therapy than heterosexual couples.

As discussed throughout this proposal, the attitudes and perspectives of when to seek couple therapy are unclear; however, attendance appears to be associated with having a severely distressed relationship. If this hypothesis about distress level is correct, then attendance in couple therapy by individuals who have already accepted that their relationship is severely distressed, could be accompanied by a sense of failure and inconsistent self-image (Degarmo & Kitson, 1996). As mentioned earlier, many couples report that they felt they were 'too late' to be helped and research supports this notion, which leads to the question of how distressed does a couple think they need to be in order to decide therapy is needed? If couples believe that they are beyond the point of relationship repair, then what happened in between the point of 'not enough distress' and 'too much distress'? If couple therapy is perceived as a resource only for relationships under severe distress, this may be contributing to why so many couples are waiting to seek therapy at points of severe distress and are already considering divorce (Bringle & Byers, 1997). This leads to the question, "How effective is couple therapy in aiding distressed couples?"

Couple Therapy Effectiveness

Overall, couple therapy has been demonstrated as being effective in aiding couples to resolve conflict (Johnson, 2003). Researchers have been examining couple therapy over the past thirty years however, the effectiveness has been debated as the findings are inconsistent in research settings versus clinical practice (Jacobson & Addis, 1993; Johnson, 2003; Snyder, Castellani & Whisman, 2006). Research studies consistently report high success rates when testing couple therapy methods and techniques (Johnson, 2003). Research studies are often comparing a particular type of couple therapy to a no treatment condition, which reviewers speculate may be one factor that contributes to an inflated level of success (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Snyder, Castellani & Whisman, 2006). In spite of the high

success rates in research settings, researchers report that couple therapy in practice has a more meagre success rate (Jacobson & Addis, 1993; Johnson, 2003). It is evident that couple therapy is found to be significantly more successful when studied in a research setting than it is when practiced outside those settings. (Jacobson & Addis, 1993; Johnson, 2003).

The inconsistency between the success rates of couple therapy in research versus practice is speculated to be reflective of several factors. These factors include: the comparative effect, the often short duration of clinical studies, and the therapists' abilities and training (Jacobson & Addis, 1993). Therapists involved in research studies are well supervised and trained extensively on the therapy techniques being examined which can "optimize" results (Johnson, 2003). Couple therapists in practice do not necessarily have stringent training as their education may have placed less emphasis on couple therapy methods as opposed to individual therapy (Jacobson & Addis, 1993). For example, many couple counsellors are social workers who may or may not have taken courses on marital therapy. It is also speculated that because research studies are often short in duration (minimal follow-up), the positive effects may not be reflective of long-term resolution (Jacobson & Addis, 1993; Johnson, 2003). It is also noteworthy that the majority of couples participating in research studies are white, middle to upper class and highly educated individuals. If a more diverse population was utilized results may be different (Johnson, 2000). It is well documented that couple therapy can be effective for couples (Jacobson & Addis, 1993; Johnson, 2003). However, the most important factor which determines this effectiveness is the satisfaction and distress level of the relationship (Johnson, 2003; Dunn & Schwebel, 1995).

Is it 'too late'?

The initial distress level, that is, how distraught the couple perceives their marital issues to be at the beginning of therapy, can account for 46% of the variance of therapy effectiveness

(Dunn & Schwebel, 1995; Johnson, 2003). Research studies on behaviour modification couple therapy (Dunn & Schwebel, 1995; Johnson, 2003) and emotion focused couple therapy (Johnson, 2003; Johnson, Hunsley, Greenberg, & Schindler, 1999) found that distress level accounts for the most variability and is the biggest predicting factor of therapy effectiveness above any other factors (therapist training, etc). The distress level is strongly associated with the success of therapy, which means that mildly distressed couples are more likely to resolve their conflicts in therapy than severely distressed couples (Johnson, 2003). These findings highlight the consequences of waiting until conflicts are severe, as couples are less likely to reconcile their issues (Johnson, 2003). Furthermore, this finding may provide insight into the seemingly debatable effectiveness of couple therapy. If the majority of couples seeking therapy are past the point of resolving their issues, it creates a large barrier for how couple therapy is viewed by society. For example, if a person knows five couples who have sought couple therapy, four of which divorced and indicated they sought counselling near the end of the marriage, this person may assume both that couple therapy is ineffective and that it is a resource sought once distress is severe. This is an example of a subjective norm which has been shown to be negatively related to a person's likelihood to seek couple therapy (Bringle & Byers, 1997). These findings and this perspective highlight why it is critical to address the factors that contribute to what deters couples from seeking help earlier.

Wolcott (1986) exclaimed that the most predominant reason that deters couples from seeking help noted in research is that couples report not seeking therapy because they believed it was already 'too late' to resolve the problems. This finding highlights the issue of attracting couples into therapy early, as often one partner is no longer committed to the relationship (Doss et al., 2003; Wolcott, 1986) when distress levels become extreme. Unfortunately, it is evident

from the literature that 46% of all couples that do enter therapy are already seriously considering divorce (Bringle & Byers, 1997). These findings illustrate that couples may be willing to seek therapy if they feel it is merited, but their issues have become too severe for the relationship to be helped. Couple therapists and researchers regularly refer to this issue in an anecdotal way, stating that many couples are in fact ‘too late’ to resolve their issues (Cordova, et al., 2007; Gottman & Gottman, 1999). In accordance with these anecdotes, research has found that couples delay seeking professional help for an average of six years from the onset of marital distress (Notarius & Boungiorno, 1992, as cited in Gottman & Gottman, 1999). Inevitably a large portion of couples start therapy with years’ worth of conflict to address (Doss, Rhoades, Stanley & Markman, 2009; Wolcott, 1986). This study aims to explore this trend. This study incorporated qualitative components, these components will be analyzed using thematic analysis.

Thematic Analysis

Thematic analysis was used as the method to code and analyze the qualitative data from this study. Thematic analysis is a method used for identifying and reporting patterns and themes within data (Braun & Clarke, 2006). It is considered to be an effective method for organizing data sets in detail (Braun & Clarke, 2006) and allows the interpretation of various factors of the topic being explored (Boyatziz, 1998). Thematic analysis calls for the researcher to take an active role in the process, suggesting that the researcher should be examining and interpreting the data throughout each step of the analysis (Braun & Clarke, 2006). Whereas other qualitative analyses often suggest researchers take a passive role and delay making interpretations, thematic analysis indicates that it is more useful for the researcher to begin interpreting from the second read through of the data (Braun & Clarke, 2006). The objective of thematic analysis is to identify

themes present in the data that reflect the research questions and the overall meaning depicted by the majority of the data (Braun & Clarke, 2006).

Braun and Clarke (2006) suggested that specific guidelines be followed in thematic analysis, including that the inductive interpretations be closely linked to the actual data and be driven by analytic interests. Through this analysis, a latent level of interpretation can then be made by looking at underlying meanings, assumptions and ideologies (Braun & Clarke, 2006) which aligns well with the objectives of this present study. Thematic analysis allows for data to be examined on a deeper level than discourse analysis, as it calls for more than description of data (Braun & Clarke, 2006). Thematic analysis goes beyond the surface and explores sociocultural conditions (Braun & Clarke, 2006), which is what this study aims to explore.

Method

Hypotheses

The first study hypothesis focused on attitudes toward marital therapy and willingness to seek help. The first hypothesis assumed that there is a positive relationship between attitudes toward seeking help and one's willingness to seek couple therapy. As a second part of this hypothesis, hypothesize that there is a negative stigma associated with attending couple therapy and that this contributes to the unlikelihood that a person will seek couple therapy. Subjective norms have been found to be significantly related to a person's likelihood to seek couple counselling (Bringle & Byers, 1997). These findings are suggestive that attendance of couple therapy is negatively stigmatized and this is referred to in much of the current research, but has yet to be well documented, empirically. In the present study, stigma, attitudes, and willingness to seek couple therapy were explored with the intention of bridging the current gap in the literature on this topic.

The second study hypothesis was that gender differences will be present in the data. Research has consistently shown that men have more ambivalent attitudes toward couple therapy than women and are less motivated to seek professional help (Bringle & Byers, 1997; Doss, Atkins & Christensen, 2003). Women and men are found to differ on what reasons justify attending therapy with women consistently reporting more positive attitudes toward help seeking (Doss, Atkins, & Christensen, 2003).

The third study hypothesis focused on relationship satisfaction. Assumption was that relationship satisfaction will be negatively associated with likelihood to attend couple therapy. Doss et al. (2003) found that women with low relationship satisfaction were more willing to seek help. Relationship satisfaction will be explored in the data analysis and be examined from an open-ended standpoint (not specific to gender) as currently only a handful of studies have studied this variable in relation to couple therapy perspectives.

The fourth study hypothesis focused on the results from the 'Distress Scale'. Participants' ratings of how distressed couples ought to be to seek therapy are examined. I hypothesize that individuals will be more likely to indicate that couple therapy is required for 'severely distressed' relationships in comparison to 'mildly distressed' relationships. Researchers consistently find that many couples enter therapy after they are already considering divorce (Bringle & Byers, 1997), which negatively influences the effectiveness of the therapy. Perceiving couple therapy as a resource intended only for severely distressed couples could be preventing couples from seeking help earlier when it could be more effective. Participants are given a Visual Analogue Scale to indicate on a horizontal line the point at which they think couples should seek therapy (anchored between 'Mild Distress' and 'Extreme Distress').

Study Objectives

- 1) To describe attitudes/perceptions toward couple therapy and help-seeking behaviours based on both quantitative and qualitative data.
- 2) To analyze the relationship between participants' attitudes toward help seeking in relation to willingness to seek couple therapy.
- 3) To describe perceptions regarding 'how much' distress merits seeking couple therapy.
- 4) To determine if hypotheses are supported by quantitative and qualitative data and to discuss the data in relation to previous literature.
- 5) To discuss the implications of these findings in terms of future research and practice.

Variables of Interest

Variables being measured (detailed list of variables is listed in Appendix A):

- 1) Willingness/likelihood to seek couple therapy (participants are asked to rate the likelihood that they would pursue couple therapy if they were experiencing relational conflict on 7-point Likert scale);
- 2) Attitudes toward seeking marital therapy (four composite factors: recognition of need for psychotherapeutic help; stigma tolerance; interpersonal openness; and confidence in mental health practitioner). Instrument: Attitudes Toward Professional Help Seeking - Marital Therapy (ASPPH-MT; Fischer & Turner, 1970 – adapted by Cordova, 2007);
- 3) Perception of distress level required before couple therapy should be accessed: Visual Analog Scale;
- 4) Demographics including: gender; ethnicity; relationship type/status (single, in a dating relationship, married, other, divorced and currently single, separated); sexual orientation (homosexual, heterosexual or other); program of study; year of study.

- 5) Relationship satisfaction (RAS; Hendrick, 1988);
- 6) Previous counselling experience and type (between individual, couple, and family).

Participants

Graduate students were recruited for this study for two reasons. The first reason being that this population was a convenience sample as these individuals were accessible to recruit and the second reason being to minimize the possibility that participants were younger than 22 years of age. This restriction was used in order to benefit the objectives of this study, as an older sample is more likely to include participants who have reflected on relationships and conflict within relationships (Silliman & Schumm, 2004). Initially, the plan was to send an email to all graduate students at Wilfrid Laurier University. Unfortunately, the permission to email all graduate students was reneged due to administrative issues. This led to a fairly specific sample as only Social Work and Seminary were emailed directly, the nature of the sample is discussed throughout the analysis and discussion.

Quantitative Methodology Design

The framework of this study is survey-based with two qualitative components. The design of this study followed a survey methodological framework by adhering to the following procedures: a) objectives defined; b) survey frame; c) determination of survey design; d) design of questionnaire; e) collecting and processing of data; and (f) analysis of data (Rea & Parker, 2012). The survey (including narrative components) was tested through the use of a pilot survey, which included 10 people (who were not eligible to be included in actual survey population) who completed the survey and provided feedback on the design and length for completion time. Feedback was then incorporated, such as wording of certain questions and layout, and survey completion time was based on the pilot testing which reported to average between 8-15 minutes.

The survey was designed with a web-based program called Survey Monkey and conducted entirely online, as web-based surveys have been found to be an efficient method for conducting survey research (Schmidt, 1997). Questions were formatted to promote participants' responses by placing short and simpler questions early in the survey and placing lengthier questions closer to the end (Rea & Parker, 2012).

Procedures

Social work and seminary students were sent an email inviting them to participate in the study with the incentive of being entered into a draw for a \$100. Graduate students were all notified about the survey through the Graduate Students Bulletin with a link to the survey with the same invitation, however, only a small portion of the sample accessed the survey through this avenue. Upon study completion, one participant was notified by email of that his/her name had been drawn and was successfully transferred the prize. Demographic information was collected from participants at the beginning of the online survey. In order to gather an understanding of this sample's demographic composition participants were asked to indicate their gender (were given 3 choices: female, male, or other with the option to describe), age, program, year of program, relationship status, relationship length, counselling experience, counselling length, ethnicity, and sexual orientation.

Measures

The Attitudes toward Seeking Professional Help – Marital Therapy Questionnaire.

The *The Attitudes toward Seeking Professional Help – Marital Therapy Questionnaire* (ASPPH-MT; Fischer & Turner, 1970) is a 28-item measure adapted from the original Attitudes toward Seeking Professional Help measure (see Appendix C). The ASPPH-MT measures attitudes toward seeking professional help with marital health. Negative attitudes have been

found to indicate that an individual perceives marital therapy as ineffective, expensive, shameful, and/or worthless (Cordova, 2007), whereas positive attitudes indicate a perception of marital therapy as being appropriate, useful, and “normal” (Cordova, 2007). Authors of the ASPPH-MT reworded items in the original measure to account for attitudes specific to marital therapy (Cordova, 2007). For example, the ASPPH-MT replaced the term ‘psychiatrist’ with ‘marriage counsellor’, the item on the original measure was “I would be uneasy going to a psychiatrist because of what people would think” which was rephrased to “I would be uneasy going to a marriage counsellor because of what people would think” (Cordova, 2007; Cordova et al., 2012). This scale has been shown to be internally reliable and reliability will be checked in the analyses section (Cronbach’s $\alpha = .81$; Cordova et al., 2012).

The ASPPH-MT measures four factors including: recognition of a need for therapeutic help; stigma tolerance; interpersonal openness; and confidence in helping professionals (Fischer & Turner, 1970). The ASPPH-MT is essential to the exploration of the hypotheses in this study. The scale for this measure was adapted slightly, instead of a four-point scale this study used five points ranging from strongly disagree to strongly agree. Composite subscales and overall scores were examined for reliability with a Chronbach's Alpha (.74), which according to Fisher & Turner (1970) meets the requirements for reliability of this measure as it is greater than .70.

Relationship Assessment Scale

Relationship satisfaction has been found to predict (or be negatively associated with) help-seeking behaviours (Doss et al., 2003; Doss, Rhoades, Markman &, 2009). The RAS is a 7-item Likert scale that measures a person’s subjective satisfaction with his/her intimate relationship. The RAS is applicable to most types of intimate relationships, whereas other relationship satisfaction measures are specific to married couples (Vaughn, Matyastik & Baier,

2010). Marital ‘adjustment’ ratings can be indicative of the nature of a relationship and is not always accounted for which creates a barrier for effectively measuring relationship satisfaction. The RAS, however, is correlated strongly ($r = .80$) with the Dyadic Adjustment Scale (DAS), indicating convergent validity (Vaughn & Matyastik; Baier, 2010). The RAS is utilized in the proposed study as it is a reliable and valid measure of relationship satisfaction and takes little time to complete (approximately 2 to 3 minutes).

Visual analog scale.

Visual Analog Scale (VAS) is a simple instrument used to measure a person’s perspective. VAS is used regularly in medical practice to assess patient’s pain levels and is considered to be an effective form of measurement (Clark, Lavielle & Martinez, 2003). The advantage of VAS is that it is straightforward and can be quickly administered (Torrance, Feeny & Furlong, 2001). Using a VAS in this study provides an efficient method to explore the question of what level of distress justifies therapy. Participants read the following item: “Please mark on the following scale what level of distress you think should be present for a couple to reasonably require couple therapy:”

Minimal Distress

Extreme Distress



Qualitative Methods Design

Qualitative components.

Qualitative components were included in this study as a way to complement the quantitative measures and gain greater insight about how participants view couple therapy, and

were examined using thematic analysis. A qualitative component allows for the participants' voices to be imbedded in the research (Patton, 2005). Furthermore, it provides the opportunity to explore new areas that this study may have not addressed or considered, such that participants have the freedom to provide any information they choose, which could not be gained through only asking close-ended quantitative questions. Specifically, the qualitative questions are open-ended and designed to prompt descriptive responses, which allows for participants' to describe views of stigma, which complements the quantitative items of stigma tolerance measured with the ASPPH-MT. The qualitative components are not double-barrelled or suggestive in nature, which adheres to the research on how to conduct ethical and accurate qualitative research (Patton, 2005; Herman & Bentley, 1993). The first qualitative item (Therapy Attendance Item) is designed to address stigma of attending couple therapy, this item asks participants to consider if they were in couple therapy if they would share this information with friends and family and to describe their reasoning. The second item (Distress Item) is designed to elicit perceptions about how much distress participants feel merits seeking help.

Ethical Considerations

This study was approved by the Research Ethics Board at Wilfrid Laurier University. For the clearance confirmation refer to Appendix C. The survey was open for students to participate from November 14th, 2014 until December 31st, 2014. Once the study was closed for participation, an email address was randomly chosen from the sample and one student was contacted and awarded the incentive of \$100 through an email transfer. Studies that have conducted similar surveys have not reported any ethical issues, which indicate that the chances of ethical concerns are minimal. Although ethical concerns are not a major concern of this study, it is possible that participants may have the desire to talk about any relationship concerns that the

questions may have brought up for them with a professional. Counselling services and crisis line contact information along with the purpose and intent of this survey were provided to participants in the inviting email. Participants will be informed of their ability to withdraw from the study at any point without any penalty. Participants will be welcomed to offer feedback or concerns if they arise during the data collection process. One participant indicated that she felt that one question was exclusive to transsexual individuals (question asking about sexual orientation), for future studies this feedback will be retained and incorporated into the demographics questions pertaining to sexual orientation. For more details, refer to the consent form included as Appendix D. Participants were only able to access the study if they indicated that they reviewed and agreed to the consent form.

Results

Participants

The response rate for this study was approximately 10% of those who received the email (approximately 1000) inviting them to participate, not including the posting on the Graduate Students newsletter as a minimal portion of the sample was recruited through this avenue. One hundred and seventeen ($N = 117$) higher education students participated in the study. The majority of the sample was female, ($N = 117$, female, $n = 96$, male, $n = 20$, gender queer, $n = 1$). The age ranged from 22 to 51 years, with an average of 32.7 years ($SD = 7.72$), a median of 31 years, and a mode of 27 years. The majority of participants indicated that they were currently in a relationship, 43.6% married, 26.5 % in a dating relationship, 9.4% in a domestic partnership, 7.7% engaged, 1.7% are divorced and currently single, and 9.2% never married. The majority of the participants indicated that they are heterosexual ($N = 117$, heterosexual, $n = 104$, homosexual, $n = 12$, bisexual, $n = 1$), identified themselves as White/Caucasian ($N = 117$,

White/Caucasian, $n = 103$, Non-White, $n = 14$), and indicated that they had attended counselling at some point (78% has attended). Most individuals indicated that they had attended individual therapy ($n = 81$), whereas others attended family therapy ($n = 14$) and couple therapy ($n = 28$). For those individuals who attended some form of therapy, some attended more than one type ($N=117$, attended one type only, $n = 59$, attended two types, $n = 27$, attended three types, $n = 2$). The majority of participants indicated that they were Social Work students ($N=117$, Social work, $n = 76$, Seminary, $n = 21$, other, $n = 20$).

Data Analysis

Data were collected in Microsoft excel files and converted into SPSS files. Incomplete survey responses were deleted (14 participants), and all variables (listed in Appendix) were recoded numerically. The goal of the data analysis was to explore attitudes toward couple therapy and to determine if the hypotheses were supported. In this section, the reliability of measures will be examined, and the nature of the sample is examined. The first step of this analysis is to check the reliability of the measures.

Reliability of Measures

The first step of the quantitative analysis was to run reliability checks. The Attitudes Towards Seeking Professional Help - Marital Therapy (ASSPH-MT) was analyzed by performing a Chronbach's Alpha and from this test it is evident that the overall attitudes measure ($\alpha=.74$, 29 items), the subscale 'recognition of need' ($\alpha=.75$, 8 items), the subscale 'stigma tolerance' ($\alpha=.68$, 5 items), the subscale 'openness' ($\alpha=.70$, 6 items), and the subscale 'confidence in therapy' ($\alpha=.68$, 9 items) were all reliable.

The Relationship Assessment Scale (RAS), which consists of 7 items, was also found to be reliable with a robust Chronbach's Alpha ($\alpha=.92$). The next section examines the nature of

this sample, as indicated earlier this sample may have a positive bias to counselling as they are entering the helping profession. The next section examines whether this bias is present within the sample between the programs of study.

Nature of Sample

This sample is composed mostly of graduate students who are entering the helping profession (social work and seminary students) and most of these individuals have attended some form of counselling. Research demonstrates that mental health professionals are more likely to believe in the value of the treatment they provide, and a fair portion of these individuals may be providing therapy in their careers (Jorm et al., 1997). The nature of this sample indicates that these individuals are more likely to be positive about couple therapy than those who are not in helping profession studies. The first analysis performed is a test to examine whether there is a significant difference between participants in helping profession programs in comparison to those in other programs.

A one-way ANOVA was performed, testing whether any significant differences were present between the 3 program types, social work, and seminary studies and other. The 'other' category consists of participants from various graduate programs, including the following: history, criminology, chemistry, communication studies, business, child and youth studies, biology and math. These participants were grouped into one category as there were not enough from each program to suffice separate categories. Variables included in this analysis are the following: overall attitudes toward marital therapy, subscales of the ASSPH-MT, willingness to seek couple therapy, relationship satisfaction, and distress scale ratings. There were no significant differences found between programs on any of these variables, the table from this analysis can be viewed in Table 3, following the appendices on page 122. This indicates that

there is not a significant difference in this sample between programs. The next section focuses on the results of this study, starting with the descriptives analysis.

Quantitative Results or Scores

This section discusses the descriptives of the entire sample in terms of attitudes toward marital therapy, willingness to seek help, relationship satisfaction and distress scale ratings.

Following the descriptives section, the hypotheses will then be examined and discussed in detail.

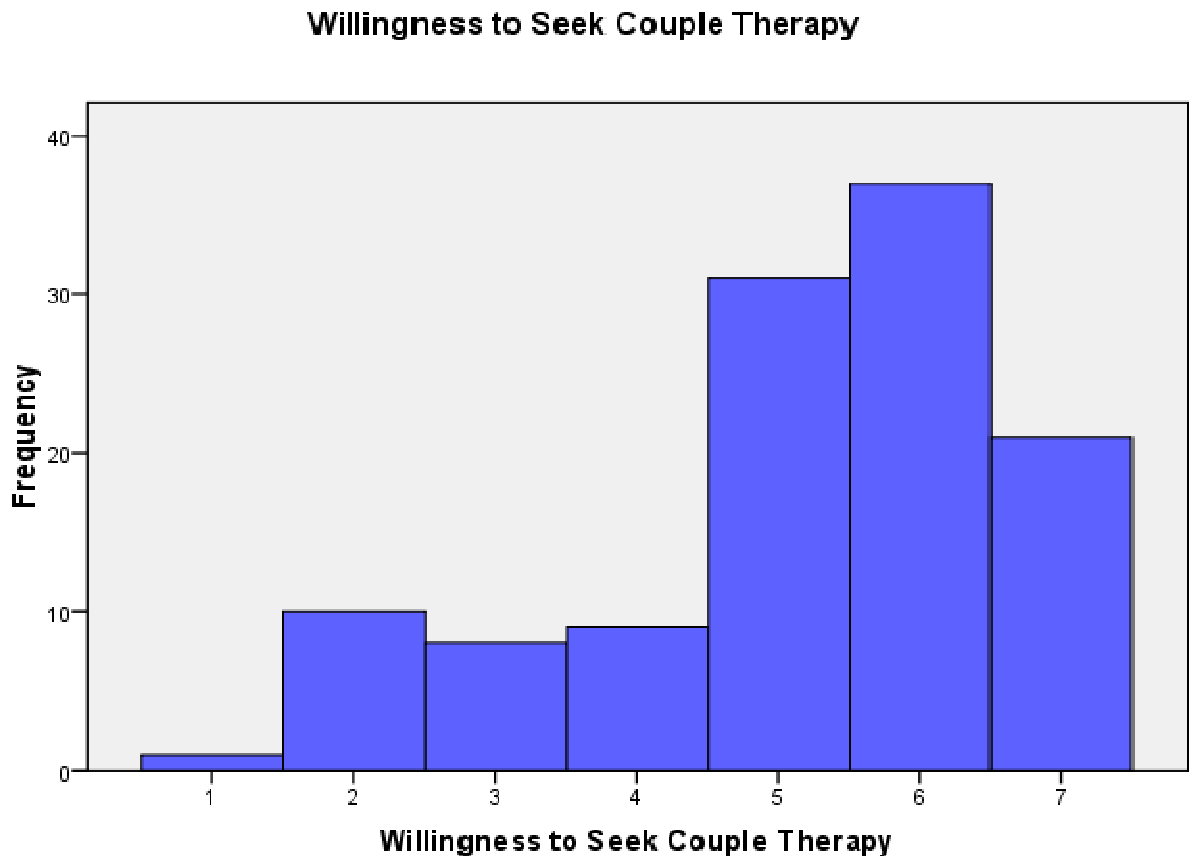
Descriptives analysis *or Scores*

Willingness to seek couple therapy item

Participants' willingness to seek couple therapy was examined with a 7-point, single item. Participants were asked to rate how likely they would be to seek therapy if they were in a distressed relationship from 1 to 7, 1 indicating 'not at all likely' and 7 indicating 'very likely'.

The average response for this measure was 5.17 ($SD = 1.51$, variance = 2.28, range = 6), with a median of 5 and a mode of 6. The frequencies are displayed below in Figure 1.

Figure 1. Willingness to Seek Couple Therapy frequency bar chart



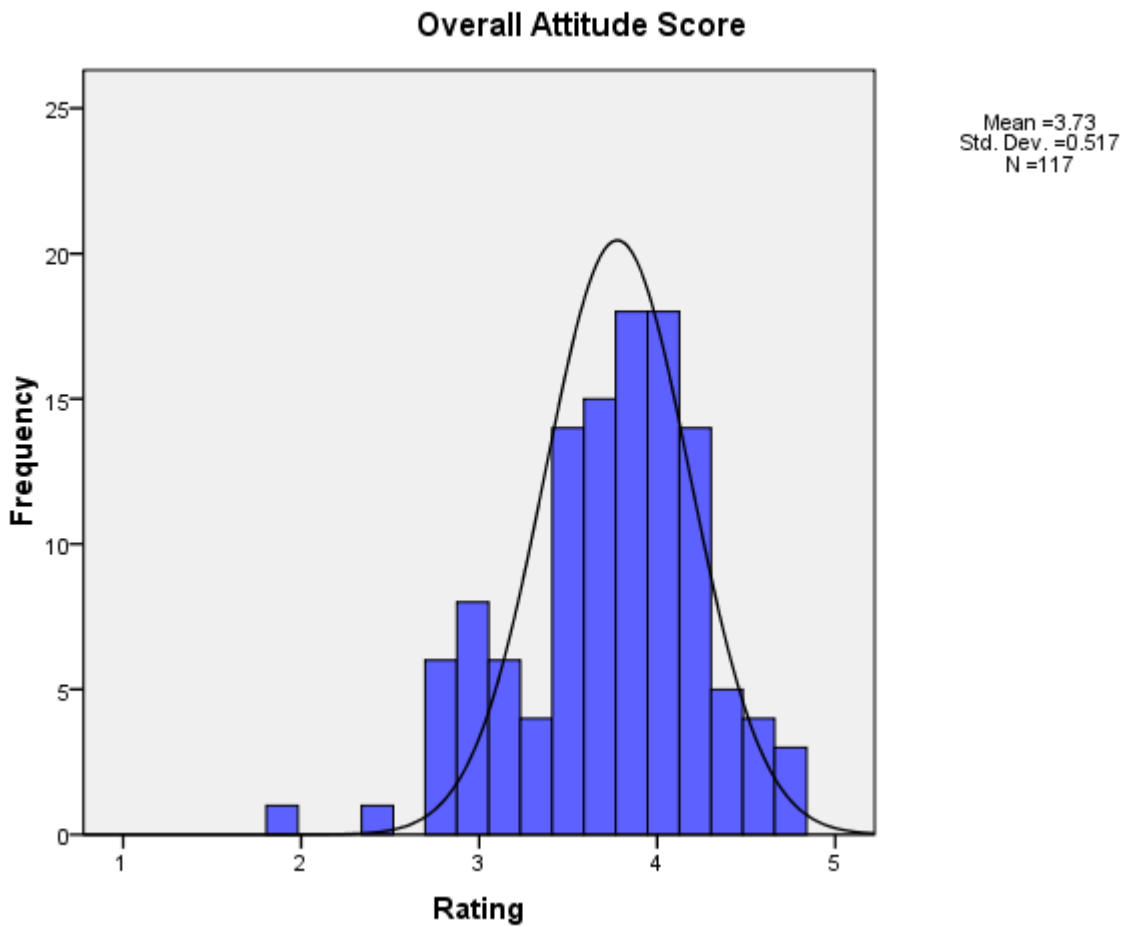
As Figure 1 displays, the majority of participants are on the right side of the scale indicating that they would be willing to seek help if they were in a distressed relationship. This trend is in accordance with expectations, as this sample is primarily students enrolled in helping profession programs (Social Work & Seminary students, $n = 99$) and are expected to have more positive views toward help seeking than the others (Jorm et al., 1997).

Attitudes toward Professional Help-Seeking

The ASSPH-MT aims to measure attitudes toward seeking marital therapy, as described earlier this measure is a 28-item scale and participants are asked to rate how much they agree with each item from a scale of 1 to 5. The ASSPH-MT scale was completed by all participants ($N = 117$). As described earlier, this scale measures the following: an overall attitude toward seeking marital therapy and 4 subscales. The 4 subscales include stigma tolerance, recognition of a need for help, interpersonal openness and confidence in marital therapy. Each of the subscales were calculated and averaged according to the number of items to generate a score of 1 to 5 for each participant. This was also done for the overall attitude toward seeking marital therapy. The total score was then divided by the total number of items (28) for a score ranging from 1 to 5. The frequencies for the overall attitude score, the 4 subscales and 3 individual items will be discussed in detail in this analysis and each is accompanied by a histogram for a visual display of the distribution of the sample.

The overall attitude average for this sample was 3.73 ($SD=.52$), the median for the sample was 3.82 and the mode was 3.5. These frequencies are displayed below in Figure 2.

Figure 2. Histogram of 'Overall Attitudes Score'

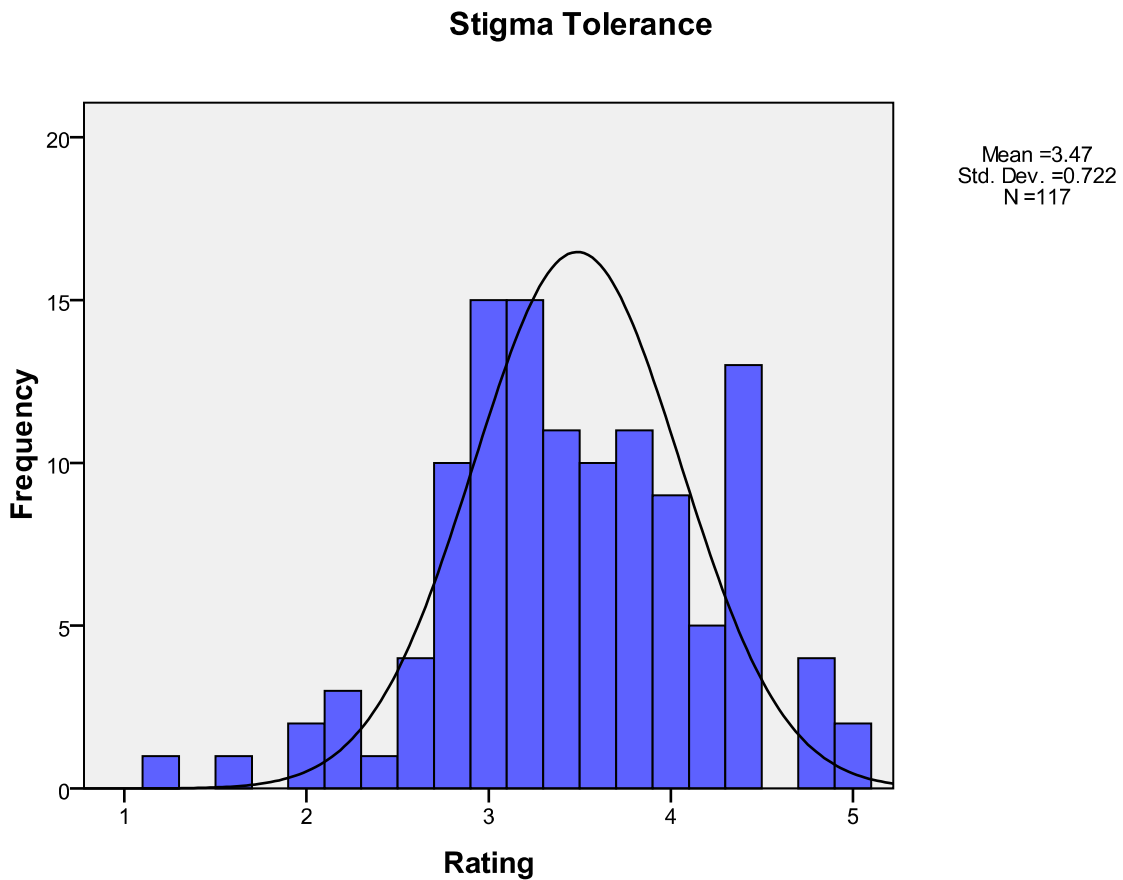


The majority of participants were between 3.5 and 4, indicating positive attitudes toward seeking professional help. As discussed previously, it was expected that this sample may have positive views toward help seeking as most participants are enrolled in helping profession programs. This histogram demonstrates that there is a trend to the positive side of the scale, which is in accordance with this expectation. It appears that most participants have positive attitudes about seeking marital therapy.

Subscale Stigma Tolerance

The first composite subscale examined was stigma tolerance. Stigma tolerance items intend to measure a person's tolerance level to the stigma of seeking marital therapy; higher scores indicate that the person is more tolerant. For example, a person with a high tolerance rating would have indicated that they are not influenced by the stigma, whereas a person with a low rating may choose to avoid seeking help because of the stigma. In this sample, the average score for stigma tolerance is 3.47 ($SD = .72$), the median is 3.4 and the mode is 3. The distribution for the stigma tolerance subscale is displayed in Figure 3 below.

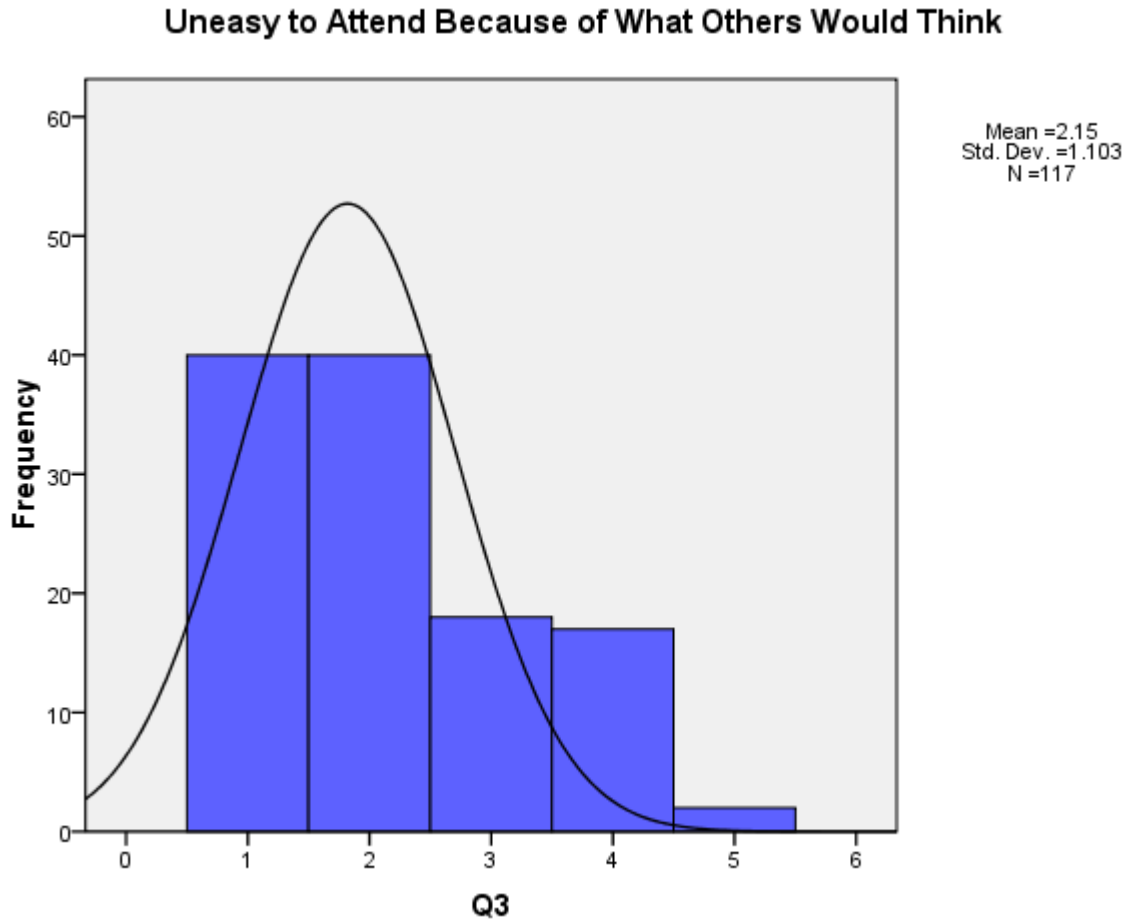
Figure 3. Histogram of Stigma Tolerance Scores



From viewing the histogram, it can be seen that the data for the stigma tolerance subscale is more widely distributed than the overall attitudes score, as the majority of the data appears to range between 2.5 and 4.5 (compared to 3.5 to 4 for overall attitude). As mentioned, the mode for this subscale is 3, which indicates that a large portion of participants ($n = 30$) were in between for stigma related items. This is noteworthy as it indicates that participants are uncertain of how they felt about stigma related items as opposed to the other subscales, in the other 3 subscales the mode is 4 indicating agreement. Overall, it appears that most participants rated fairly positively on this scale, indicating that they have high levels of tolerance to the stigma of marital therapy. As noted in the qualitative findings, stigma was prevalent in participants' responses and as discussed earlier stigma is a variable of interest in this study. In reflection of these factors, stigma tolerance was examined more closely by analyzing 2 individual items which are a part of the stigma subscale and 1 item which reflects negative perceptions of the couples' character for seeking help.

The first item examined is item 3 of the ASSPH-MT scale, this item states 'I would feel uneasy going to a marriage counselor because of what people might think'. This item was chosen as it specifically addresses whether stigma would influence a person's willingness to seek out marital therapy. The overall subscale of stigma tolerance represents how resilient participants are to the stigma, but not all items specifically address whether the decision to attend would be compromised by the stigma. This item had an average score of 2.15 ($SD = 1.1$), a median of 2 and a mode of 2. The distribution for this item is displayed in Figure 4 below.

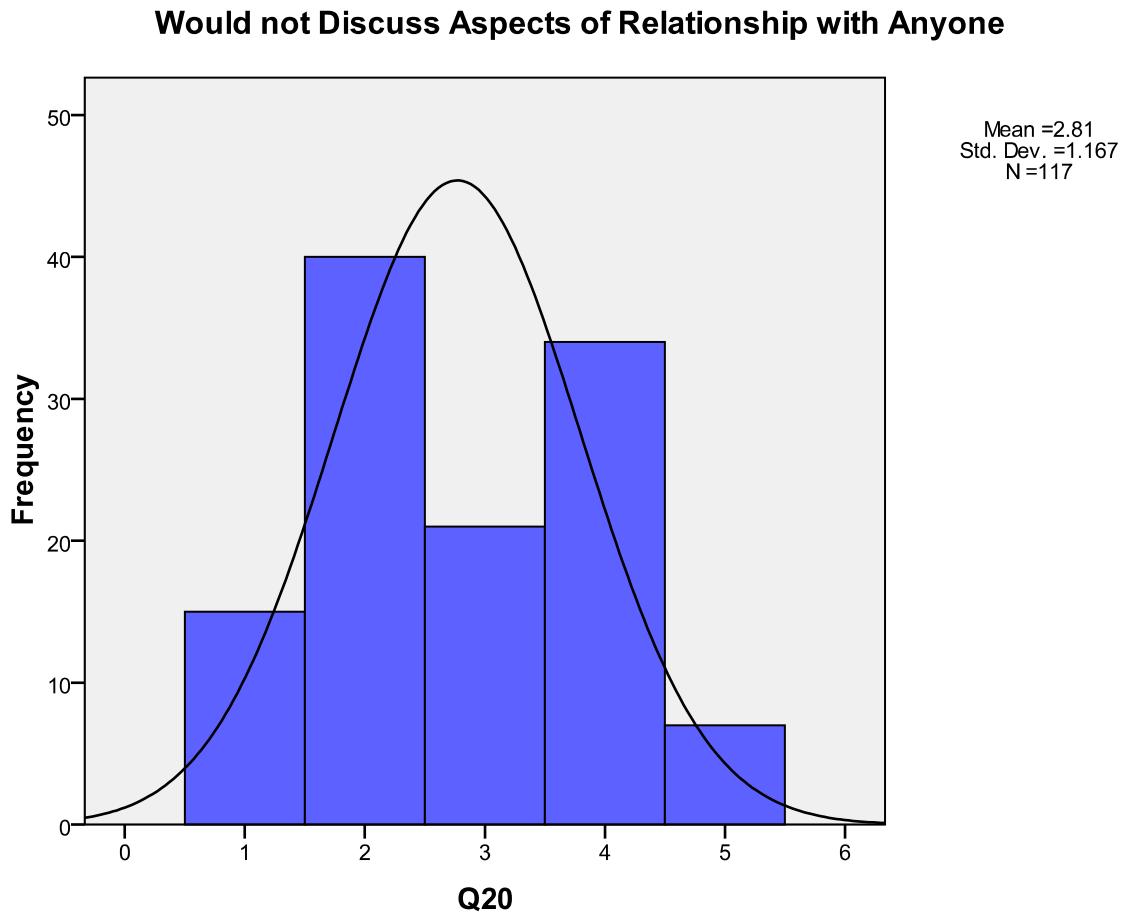
Figure 4. Histogram of Item 3 (I would feel uneasy going to a marriage counselor because of what others might think)



The histogram for this item demonstrates that there is a negative skew to the left side of the scale, indicating that the majority of the participants chose 'disagree' or 'strongly disagree'. The majority of participants ($n = 80$) disagreed or strongly disagreed, and one third (%) were uncertain, agreed with the statement or strongly agreed with the statement ($n = 38$). This indicates that most participants would not allow stigma to compromise their decision to seek help, and about one third indicated their decision would, or might, be influenced by the stigma. Overall, most participants reported that stigma would not deter them from seeking help.

The next item of the stigma subscale looked at is item 20, which states 'there are some aspects of my relationship that I would not share with anyone'. This item was chosen as it addresses an element of privacy and by examining this quantitative item can either complement or contradict the theme of privacy which emerged from the qualitative findings. This item had an average of 2.81 ($SD = 1.17$), a median of 3 and a mode of 2. The distribution for this item is displayed below in Figure 5.

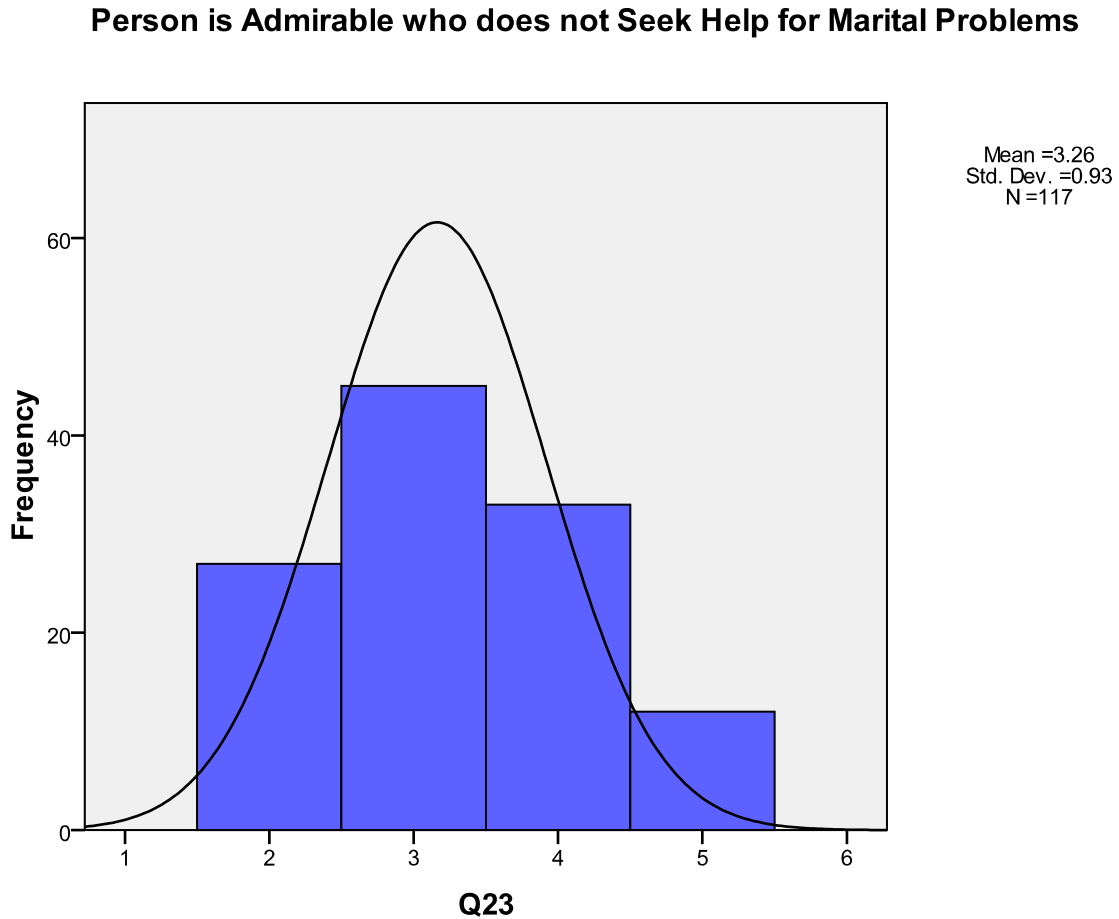
Figure 5. Histogram Item 20 (there are aspects of my relationship that I would not share with anyone)



As the histogram in Figure 5 displays, the largest portion of participants 'disagreed' with this item ($n = 40$), and the second most common response was 'agreed' ($n = 34$). There were also a fair number of participants who were uncertain about this item ($n = 21$). This indicates that although most participants have high stigma tolerance, a fair amount do not agree with sharing certain aspects of their relationship. This finding is in accordance with the qualitative data on privacy, which demonstrated that a portion of participants felt relationship details are a private matter.

The next item examined is item 23 of the ASSPH-MT scale, which states 'there is something admirable in the attitude of a person who is willing to cope with his or her marital problems without resorting to help'. This item was chosen for two reasons, the first reason being that this item addresses the perception of a relationship between a person's character and help seeking behaviours. The second reason is that this statement associates seeking help with being less capable (admirable to not need the help), and this is a theme which emerged from the qualitative data. The average score for this item was 3.26 ($SD = .93$), the median was 3 and mode was 3. The figure below shows the distribution for this item.

Figure 6. Histogram of Item 23 (there is something admirable in the attitude of a person who is willing to cope with his or her marital problems without resorting to help)

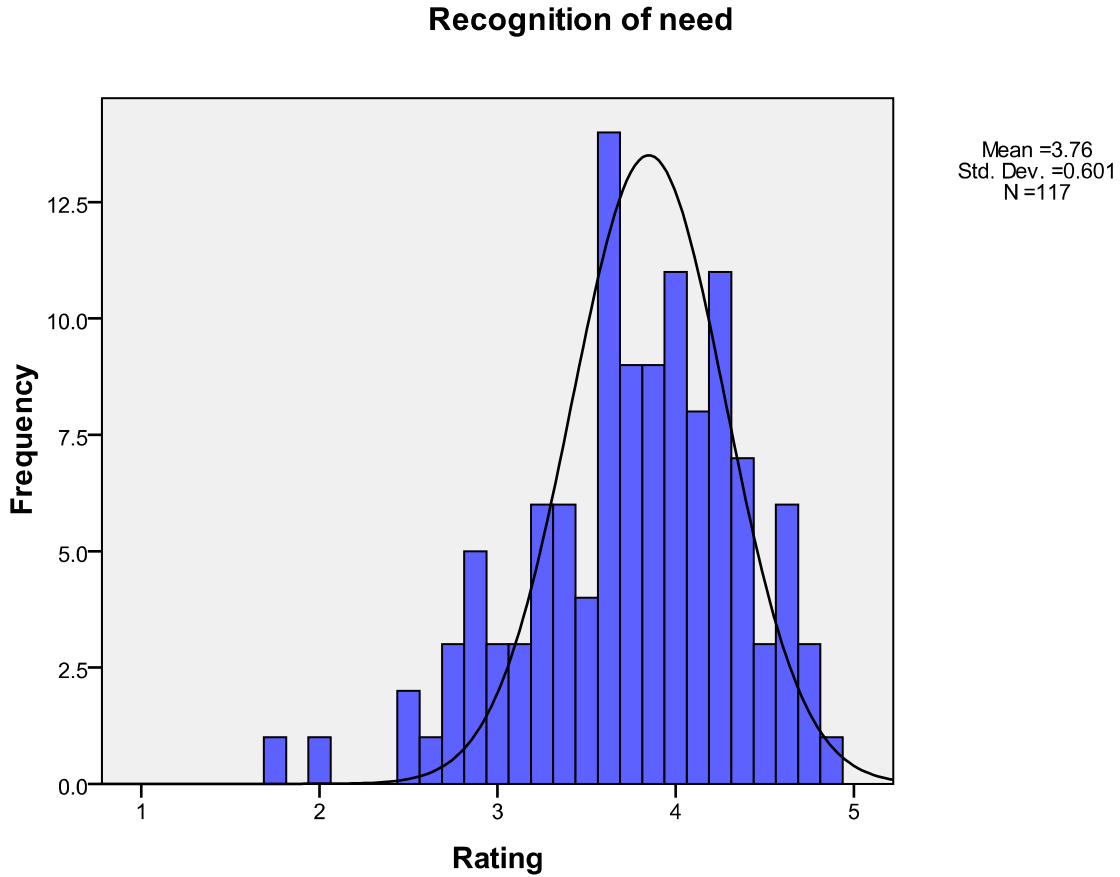


The histogram shows that the most common response was uncertainty about this item, and more people agreed or strongly agreed ($n = 44$) with this item than those who disagreed ($n = 26$). This demonstrates that although participants have a high stigma tolerance, it appears that many participants perceive that a person who does not need help for their marital problems is admirable. This finding is in accordance with the qualitative theme of 'couples' capability'. This theme represented participants who indicated that couples who seek help is due to a lack of ability.

Subscale Recognition of Need

The subscale 'recognition of need' aimed at measuring a person's ability to recognize a need for seeking marital therapy. This subscale aimed to examine participants' ability to recognize when marital therapy could be beneficial. This subscale measures whether a person is able, and willing, to identify that marital therapy could be useful under certain conditions. For example, one of the items included in this subscale states 'I would rather be advised by a close friend than a professional, even for a serious problem'. This subscale has an average score for this factor is 3.76 ($SD = .6$), the median is 3.88 and the mode is 4. The distribution can be viewed in the histogram below in Figure 7.

Figure 7. Histogram of Recognition of Need Subscale.

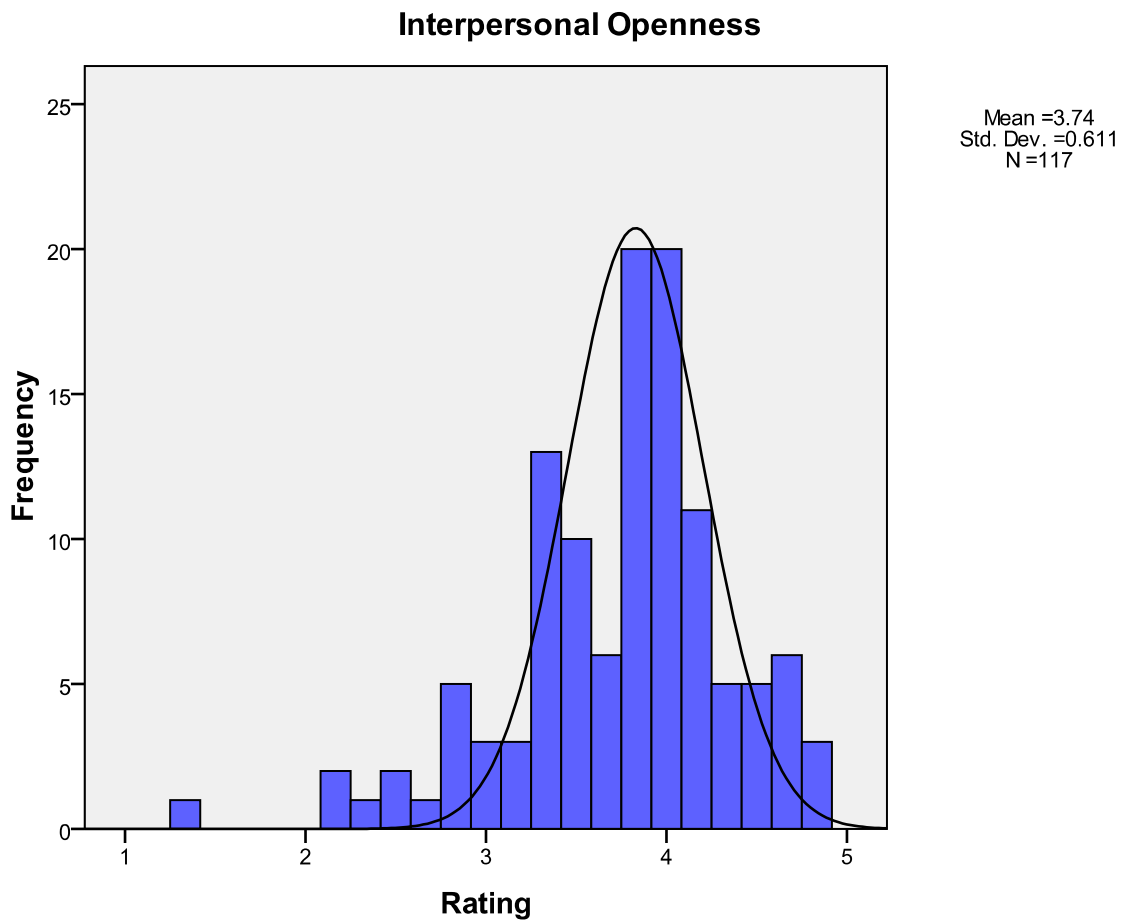


It appears that most participants are between 3.5 and 4 for this item, indicating that most participants agreed with most statements included in this subscale. The histogram demonstrates that there is a positive skew for this subscale, which indicates that most participants were able to and willing to recognize a need for seeking marital therapy. This trend is in congruence with expectations that this sample, those entering the helping profession, would be able to recognize, and validate, a need for help.

Subscale Interpersonal Openness

The subscale 'interpersonal openness' measured how willing a person is to self-disclose about their relationship with others (for example 'I would willingly confide intimate matters to an appropriate person if I thought it might help my relationship'). For this subscale, the average score is 3.74 ($SD = .61$), the median is 3.83 and the mode is 4. The distribution is displayed in the histogram listed below in Figure 8.

Figure 8. Histogram of Interpersonal Openness

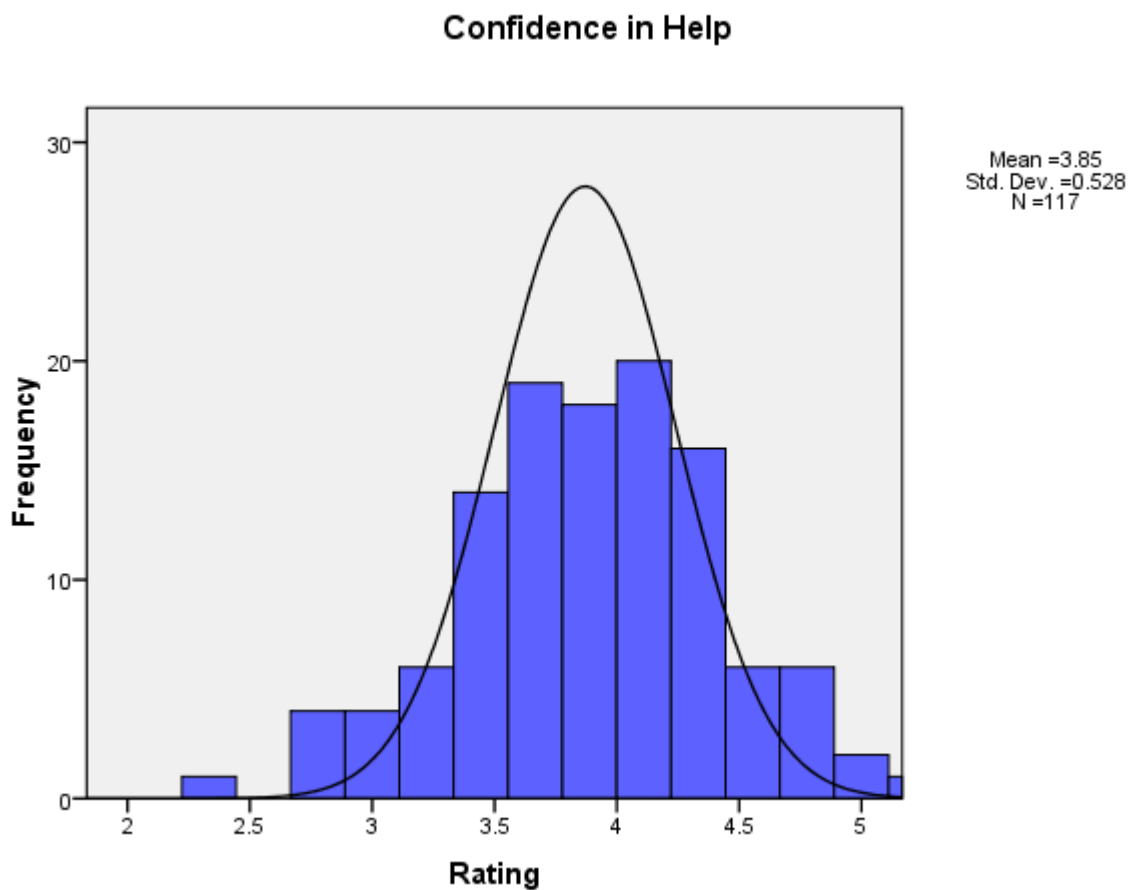


The histogram of this subscale demonstrates that there were a large number of participants scoring between 3.75 and 4. This indicates that a fairly large portion of participants scored positively on interpersonal openness.

Subscale Confidence in Help

The subscale 'confidence in help' measured how much the individual believes in the value and benefit of marital therapy. The average for this subscale is 3.85 ($SD = .53$), with a median of 3.78 and a mode of 4. The distribution is displayed below in Figure 9.

Figure 9. Histogram of Confidence in Help Subscale

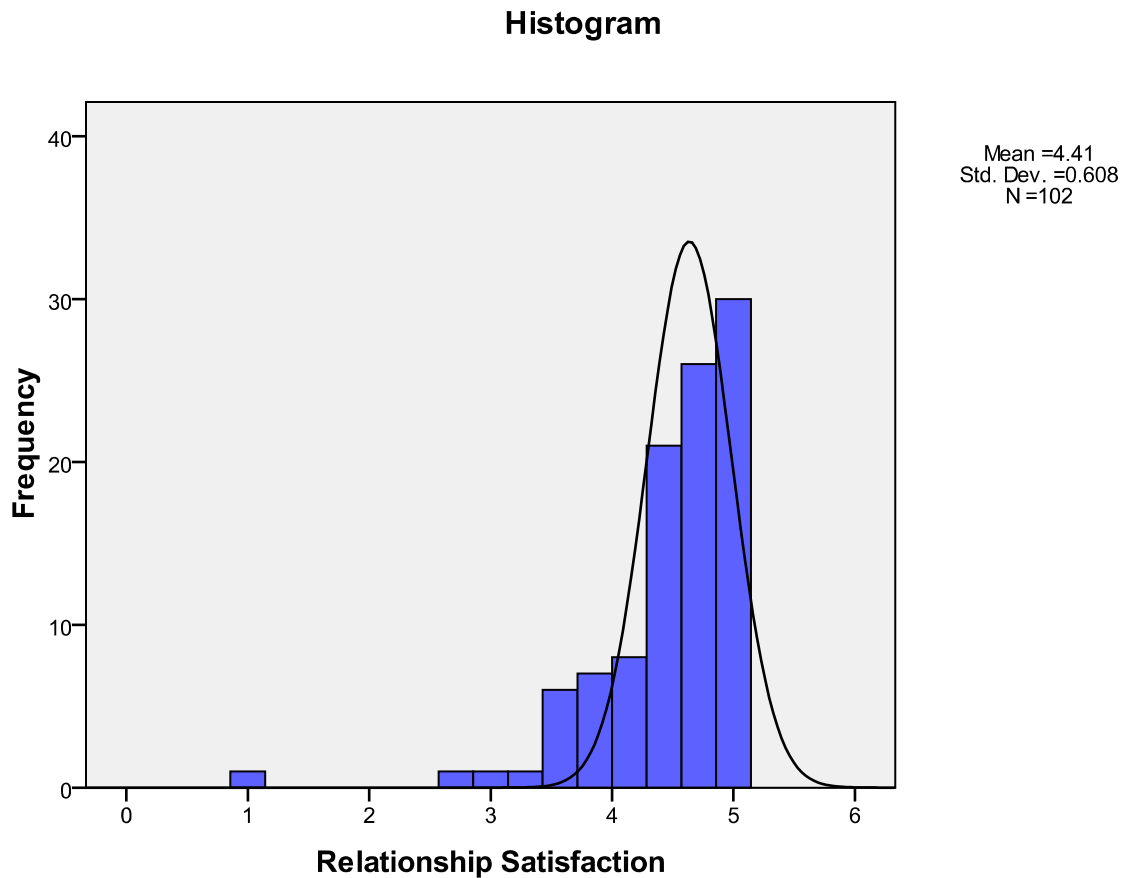


The histogram demonstrates that a large portion of participants rated between 3.5 and 4.4, which indicates many participants, indicated highly positive beliefs in the benefit and value of marital therapy. This trend is consistent with the research, as mental health professionals are more likely than the general population to believe in the effectiveness of the treatments they work with in their field (Jorm et al., 1997).

Relationship Satisfaction

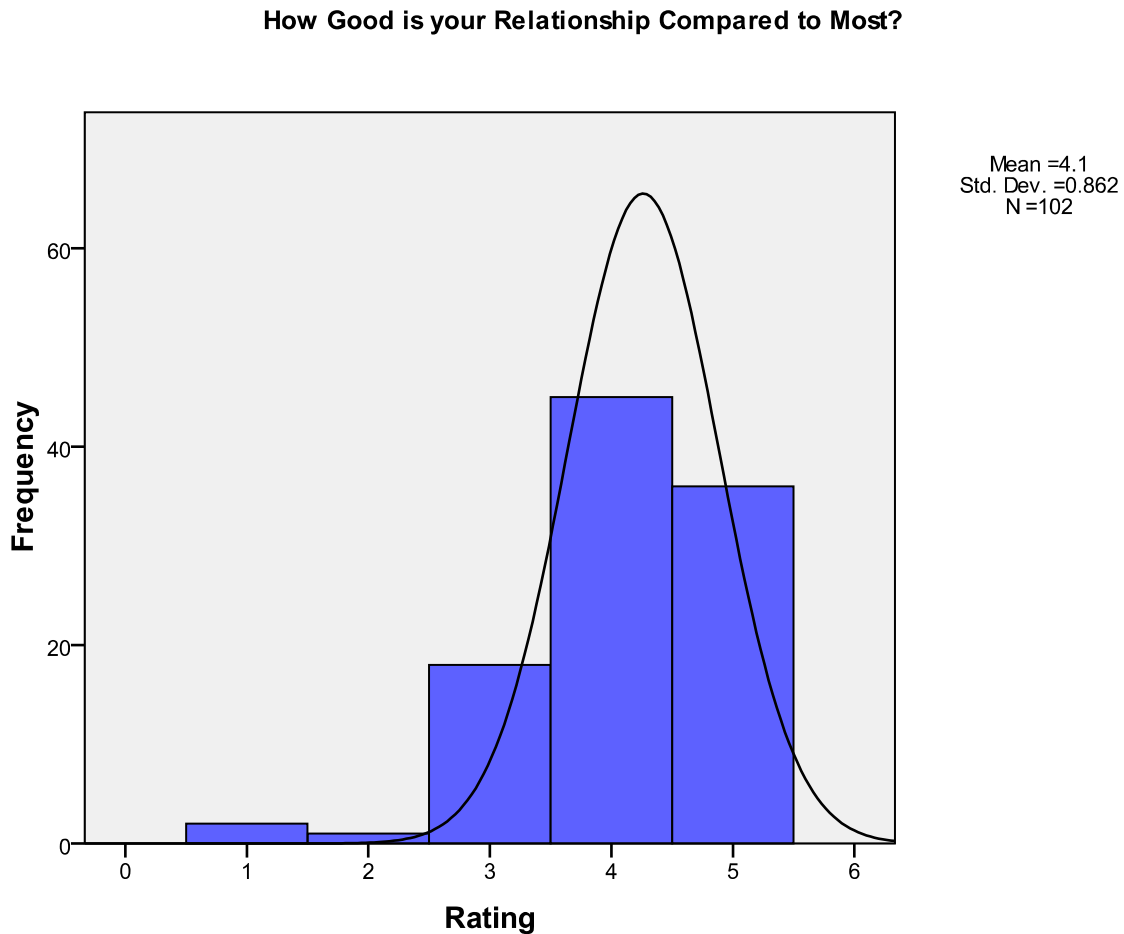
The RAS scale was completed by participants who indicated that they were currently in relationships ($n=102$). Participants rated on a scale of 1 to 5 for each item of the 7-item the scale. The items in the RAS scale were used to generate an overall relationship satisfaction score (an average from all 7 items) for these participants. In addition to the overall satisfaction, two items from the scale were examined more closely. The average relationship score was 4.41 ($SD = .61$), with a median of 4.57, a mode of 5 and the variance is .38.

Figure 10. Histogram of Relationship Satisfaction



As depicted in the histogram and from the high average for this measure, it is clear that the data is skewed positively. It appears from these findings that participants in this sample report that they perceive very high levels of satisfaction in their relationships. As this rating is especially high, a few items from this scale were examined more closely. The item 'How good is your relationship compared to most?' was examined, 1 indicating 'poor' and 5 indicating 'excellent'. The average for this item is 4.1 (SD=.86), the median is 4, and the mode is 4. The histogram below shows the distribution for this item in Figure 11.

Figure 11. Histogram for Item 3 of RAS (How good is your relationship compared to most?)

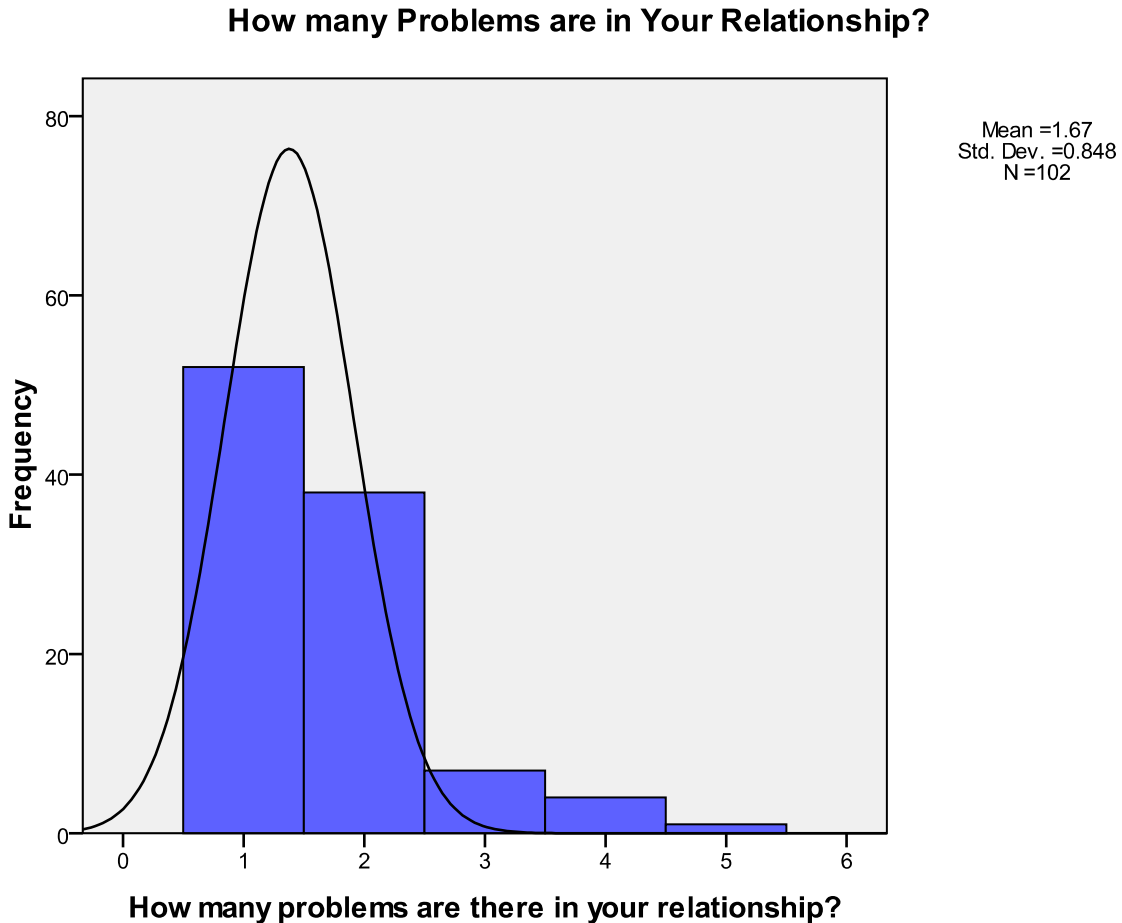


The histogram demonstrates that the responses were positively skewed, as the majority of the data are in the '4' and '5' columns, indicating near excellent and excellent responses. This indicates that the majority of participants perceive their relationships are better than most. This item is in congruence with the finding that the majority of participants perceive their relationships to be very satisfying, as it could be expected that highly satisfying relationships are above average.

The next item examined is item 7, 'How many problems are there in your relationship?' This item was chosen as a way to examine the relationship satisfaction from a negatively worded

item, as most of the items are worded positively (5 positive items, 2 negative). The average score for this item was 1.67 (SD=.85), the median was 1 and the mode was 1. The histogram below shows the distribution for this item in Figure 12.

Figure 12. Histogram of Item 7 (How many problems are there in your relationship?)

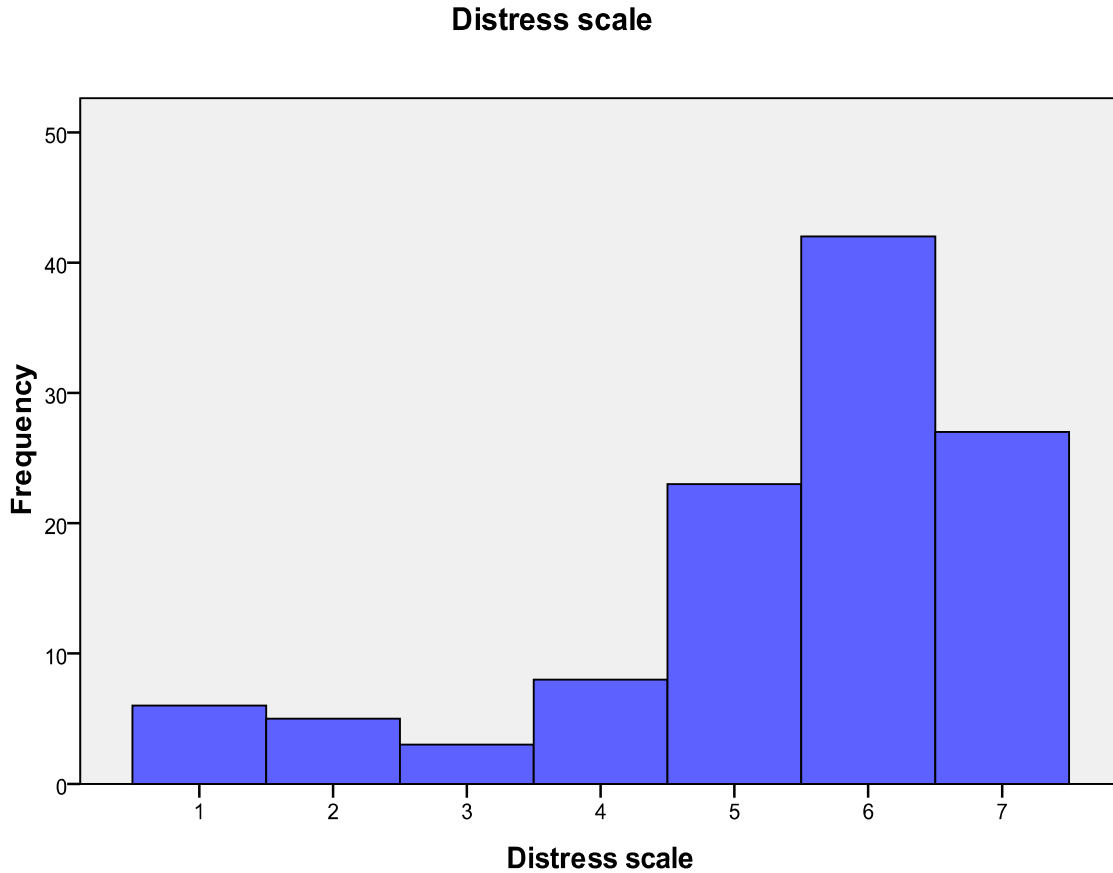


As shown in the histogram and the low average, it appears that the majority of participants indicated that they perceived very few problems in their relationship and very few participants in the other categories indicated average to very problematic relationships. The scores for this item are in congruence with the overall satisfaction rating however, are not expected of any sample due to the lack of variability in responses.

Distress Scale Item.

The objective of the distress scale item was to examine what level of distress participants believe merits a need to seek out couple therapy. The distress item asked participants to rate on a scale of 1 to 7 how much 'distress' they believe is necessary for couple therapy to be initiated. The average response for this item was 5.44, with a median and mode of 6. The frequencies are displayed below in Figure 13.

Figure 13. Distress Scale Item Frequency Ratings



This bar chart demonstrates that the data was positively skewed to the right side of the scale, indicating that the majority of the sample reported that above moderate to severe levels of distress are necessary prior to seeking couple therapy. Although this trend was initially expected prior to learning the nature of the sample, it was unexpected that this trend would be as strong with this sample. This trend is significant as it demonstrates that there is a general assumption that above moderate to severe distress is necessary to seek help.

Summary of Descriptives

The results show that overall the majority of this sample indicated that they would be willing to attend couple therapy if they were in a distressed relationship. The results also demonstrate that the majority of participants have very positive attitudes toward seeking marital therapy. The positive attitudes were evident across all 4 of the subscales, with confidence in help having the highest scores. The lowest of the positive attitudes was the subscale stigma tolerance, which was examined more closely. From examining the individual items, it appears that the majority of participants would not let stigma interfere with their decision to attend therapy. It did appear, however, that participants agreed with the belief that those who seek out therapy for marital problems are perceived as less admirable than those who go without help.

This sample reported exceptionally high levels of relationship satisfaction, which has a few possible explanations. One option being that this sample may be unique in that these participants are mostly all in very satisfying relationships. Another explanation might be that because this sample represents mostly young individuals who are in their first few years of marriage, that this may have contributed to the positive skew as relationship satisfaction is negatively related to relationship length (Bonds-Raacke, Bearden, Carriere, Anderson & Nicks, 2001). It is also possible that this measure was ineffective in this study and is not an accurate depiction of this sample's relationship satisfaction.

It appears that this sample perceives that seeking marital therapy ought to be prefaced by moderate to significant levels of distress. This is an interesting trend as it was expected that this sample of primarily social work and seminary students would be less likely to hold this belief. This finding may reflect the strength and ingrained nature of this perspective. This trend is in

accordance with research, as it has been found that nearly half of couples seeking therapy are at the point of distress that they are considering divorce (Doss, Atkins & Christensen, 2003).

In social science research, social desirability can often contribute to skewing measures to appear more positive (Constantine & Ladany, 2000; King, & Bruner, 2000). It is common in these types of measures for participants to respond in more socially desirable ways (Constantine & Ladany, 2000). The potential for a slight social desirability bias can help to explain the lack of a normal distribution among these scales.

As demonstrated throughout the findings of this study, there were varying levels of positivity toward couple therapy. This disparity may reflect that certain attitudes are more ingrained than others. For example, although most participants had positive views of seeking marital therapy, they also indicated that couple therapy should be prefaced by significant distress and reflects a lack of capability. The scores for the distress scale item will be examined more closely in the following section to examine this speculation.

The next section focuses on the four hypotheses. Each hypothesis is examined, and the support or lack of support is discussed in detail.

Qualitative Results

Data was thematically analyzed using the guidelines in Braun and Clarke (2006), the first step of this analysis involved re-reading of the qualitative data. The data from the two qualitative items were analyzed separately. The first 'therapy attendance item', referred to whether participants would be willing to share attendance with others. The second 'distress item' referred to participants' opinions on how distressed relationships should be before therapy is sought.

Therapy Attendance Item

The first qualitative item asked participants, "Do you think you would tell friends and friends and relatives if you were in couple therapy? What might be the reasons that you would or would not share such information?" Of the 117 participants, 112 responded to this item generating 9 pages of data. It became evident from reading through the data, that the way to organize responses was based on willingness to share couple therapy attendance with others in their social sphere as answers tended to be on a continuum from a willingness to share to an unwillingness to share.

Responses were grouped into five categories of willingness: "Yes, definitely", "Yes, but only to certain people", "Maybe/ I am not sure", "No, unless certain conditions were met", and "Definitely not". Data from the five categories were condensed into three categories given that the middle three categories tended to overlap. Thus the final three categories were, Yes, Maybe, and No. Those in the 'Yes' category indicated that they would be willing to share with others that couple therapy was being attended. The 'Maybe' category represented those who were ambivalent about telling others, or indicated certain restrictions on what reasons might motivate them to share. The 'No' category represented those who indicated that they would not be willing to share with others that couple therapy was being attended.

In order to determine 'themes' in each of the categories, the common phrases and wording were counted for every category and potential theme. For example, the number of times the word 'trust' was used in the "Maybe" category was enough to be seen as "prevalent" and thus it became a theme. These phrase and word counts are included and can be viewed in Appendix H. There was minimal overlap of themes in between the categories. For example, the theme of stigma was generated almost entirely by participant data that indicated that they would not be

willing to share ('No' category). There were themes which did overlap between the 'Yes' and 'Maybe' category. For example, the phrase 'need to trust those I tell' was predominantly present in the 'maybe' category but also appeared minimally in the 'yes' category and thus it did not constitute a theme in the 'yes' category. Any significant overlap is addressed in the thematic map, which demonstrates the connections of themes to categories visually (see Figure 3).

As indicated earlier, thematic analysis allows for researchers to use judgment in identifying themes in the data which may be due to the “keyness” of the message as opposed to prevalence (Braun & Clarke, 2006). The “keyness” of a theme is not determined solely based on quantifiable prevalence, rather, on if it captures an important message in the data (Braun & Clarke, 2006. P82). This method is beneficial as it allows for the researcher to acknowledge messages that are important because they relate to the research interests, rather than focusing on only the messages that were common. This practice was used in this analysis for certain themes. For example, the theme of Family Judgment was identified based on the importance it presented in the data. An objective of this study is to uncover the underlying reasons as to what negative perceptions might exist around seeking couple therapy. The “family judgment” theme addresses this aim quite directly. An example of this type of response follows:

P: I would not tell my family members' as I would be perceived as a failure.¹

The following section describes the themes according to the three categories ('Yes', 'No' or 'Maybe). Examples from the data set are included.

¹ Responses were paraphrased to protect confidentiality which is in accordance with the ethical clearance for this study which did not allow for the use of full quotations

Themes & Categories

'Yes' Category

The following themes represent 'reasons' participants described as to why they would be willing to share couple therapy attendance with others. The following three themes were determined: stigma reduction, honesty and a desire for support.

Stigma reduction.

One of the themes that emerged from the 'Yes' category was a desire to reduce stigma. This theme was generated from responses which indicated that the participant would be motivated to share with others, because they felt it could help to reduce an existing stigma of couple therapy. The following are examples from the data set.

P: I would tell others as I believe in the value of counselling, and want to help to de-stigmatize counselling through the process of open conversation.

P: Yes. I believe it's the best way to break down the barriers of stigma.

Social support.

Another theme identified from the 'Yes' category was that participants indicated that if they were in couple therapy, they would expect to have a desire for social support. The desire for social support presented itself in responses that indicated they would divulge therapy attendance, as they would expect and want the support from family and friends. The following are examples of these types of responses:

P: Yes, I would share because I would want the emotional support from others in addition to the therapy.

P: One of the motivating reasons for sharing with others would be out of a need for emotional support for my husband and I.

Honesty.

A final theme from the 'Yes' category was honesty. The theme, 'Honesty' reflects participant responses indicating that they would tell others because they personally value honesty and openness. The following are examples of these responses:

P: I value being an honest person, so yes I would tell people

P: Yes I would share because disclosure is part of being authentic and honest, which is an important part of who I am.

'Maybe' category

This category was generated because there were many responses that indicated that therapy attendance would be shared, or not shared, based on certain scenarios and conditions. This category represents the participants who were ambivalent about whether they would share or not, and those who indicated what conditions would elicit sharing (such as, I would share if it came up). The three themes from this category were helpful input, trust and closeness, and family judgment.

Helpful input.

This category represents those participants who indicated that they may share couple therapy attendance, if they wanted advice about the therapy or if the therapist indicated it would be helpful to their therapy process for the couple to disclose.

P: If we were advised by the counsellor I would share with others, but only if it would be beneficial.

P: I would share with others who also had experiences with relationship problems and could offer supportive advice. I would also want a second opinion on what the counsellor was saying.

Trust and closeness.

This theme represents participants who may tell others, if they felt they could trust them or were extremely close with them.

P: I can imagine only telling my two best friends and sister, because I am close to them and could trust them.

P: I would tell those I am really close with, I wouldn't tell others because I would not want to be judged, pitied and embarrassed.

Family Judgment

As mentioned, this theme was not chosen based on commonality. This theme emerged as the responses were more personal and in-depth than others, and addresses an objective of this study. Participants indicated that family members would be judgmental of couple therapy attendance and this might deter them from sharing. This theme was often associated with parents having stigmatized views of therapy and non-progressive perspectives toward counselling.

P: I would not tell family. My family thinks counselling is "silly" and for "crazy" people. Unfortunately, they do not understand the potential benefits of counselling.

P: I would likely not share with family members because I would not want them to judge me or my partner. I would only tell them in the context of explaining that our relationship was in serious trouble.

P: My family would view my partner negatively if they were told and would think we could not make it on our own, so I would only tell friends and not my family.

'No' Category

This category represents participants who indicated that they would not be willing to share couple therapy attendance with others. The following three themes were generated from this category: Stigma, relationship viewed negatively, and 'It's personal'. Although each of these themes represents a unique message, there are elements of stigma in each of these themes.

Stigma.

An especially prevalent theme for why not to share included significant concerns about stigma. They expressed stigma in several ways as noted in the following paraphrasing.

P: I would not share due to stigma, I do not want to be viewed as a person who is suffering.

P: I wouldn't share because I don't want to be pitied and judged. There is a stigma associated with counselling and certain judgments will be made about the couple, the relationship, the likelihood of the relationship surviving, couple therapy is not normalized yet.

It is noteworthy that stigma and stigma related phrases had a high level of prevalence in the data, as they were mentioned at higher rates than all other themes (refer to Appendix H). This is relevant as it demonstrates that with the participants in this study stigma is commonly associated with perceptions of couple therapy, which was the intention of this qualitative item.

'It's Personal'.

Another theme of the 'No' category was an emphasis on privacy and that attending couple therapy and relationship issues are a personal matter. As mentioned, there were elements of stigma in this theme such as in the first example listed below.

P: Therapy is a personal and private concern, I wouldn't air my dirty laundry about my relationship for people to judge.

P: Relationship and couple issues should be kept private, they are personal so I would not share this info with others

Relationship viewed negatively.

Another theme and reason noted as to why participants would not share with others was the fear that others would construct a negative perception of their relationship if others knew they were in couple therapy. This theme encompassed concerns such as being seen as weak for their inability to fix their problems without external help and that the couple would be seen as likely to break up.

P: Embarrassing to admit we could not make it on our own. People would think we are incapable.

P: I would be afraid that people would think we would not make it as a couple, that we were weak and could not do it on our own.

P: It would be embarrassing that my husband and I couldn't fix things without assistance. Others would encourage the end of the relationship.

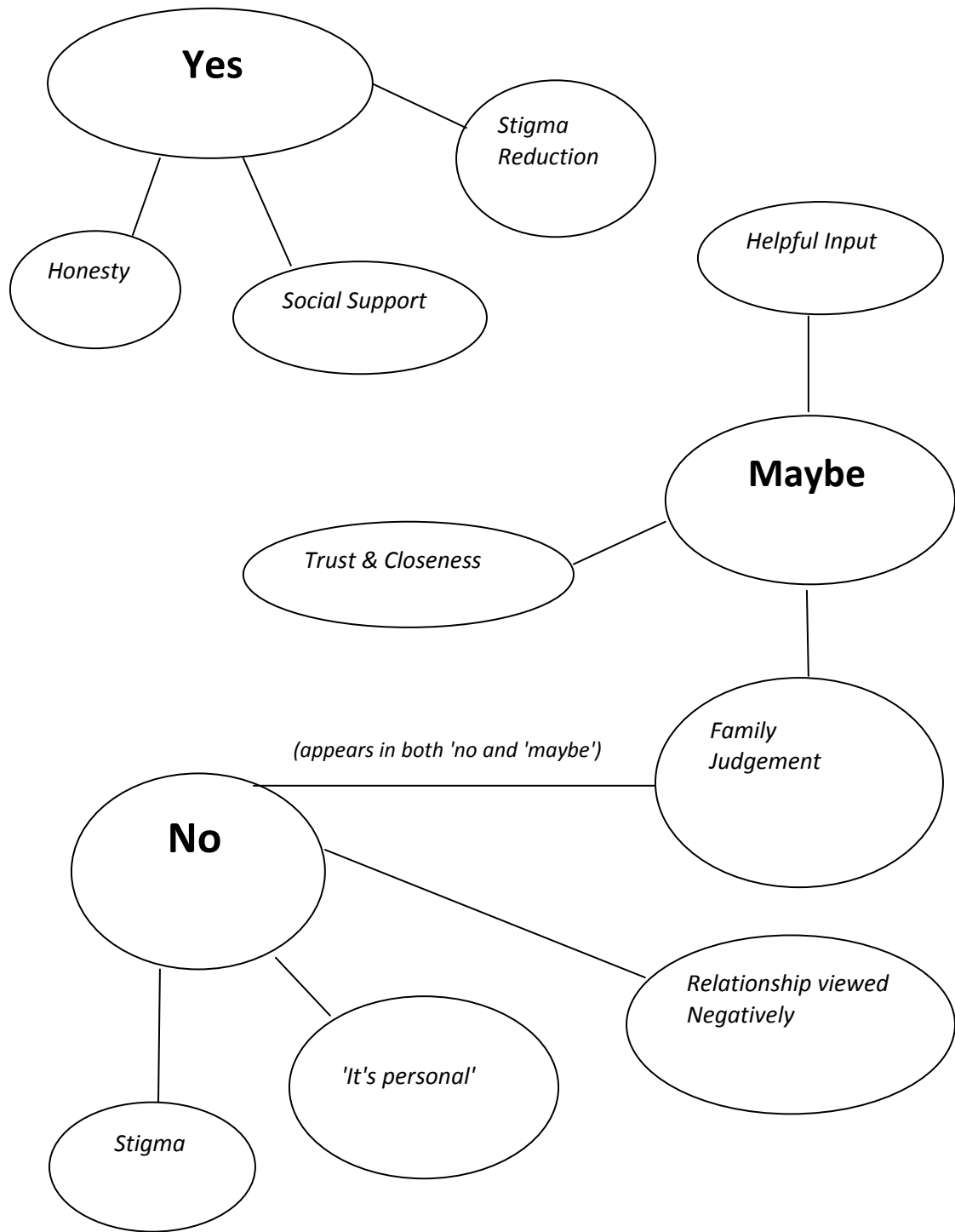
Overall, the analysis of this item demonstrates that many beliefs exist about the perception of couple therapy. These themes show that there is a general understanding that attending couple therapy has an associated stigma. Participants indicated significant concerns

and reservations about sharing therapy attendance. The meaning of the themes will be addressed in detail in the discussion section.

Thematic Map

In accordance with the thematic analysis guidelines, a thematic map was generated for this item. Initially, all of the potential themes were included. The development of the map helped to distinguish more succinct themes that represented the most important messages (Braun & Wilkinson, 2003). The map is shown below in Figure 14.

Figure 14. Therapy Attendance Narrative Thematic Map



Distress Item

The second qualitative analysis focused on the qualitative data associated with the 'distress scale'. The distress scale item asked participants to rate on a likert scale the following statement, "Couple therapy is often accessed at varying points of 'distress' or conflict in relationships. Please evaluate on the following scale *how much* relationship distress you think should be present for a couple to seek therapy." This qualitative component followed up the distress scale item and asked the following: "If you would like to explain your response to the last question, use this space to describe your reasoning." This qualitative item elicited fewer and shorter responses than the first qualitative item, which was expected as it was explicitly explained to participants that this was an optional item to be answered if participants wanted to explain their quantitative response. This item generated three pages of data ($n = 50$). The data were analyzed with the same procedures as the first narrative question. In the analysis of the 'distress item', the same procedures were followed as were described for the 'couple therapy' analysis. Data was read through thoroughly and patterns were noted using the same coding procedures to identify patterns. These data were organized into two groups, which were 'no distress needed' and 'above moderate to severe distress needed'. The categories reflect the type of response, for example, responses that indicated 'help can be sought anytime' was categorized in the 'no distress needed' category. The category 'significant distress needed' represents responses indicating that couple therapy is appropriate only when above moderate to severe distress levels are being experienced in the couple relationship. The next section describes the themes in each category with examples from the data.

Categories/Themes

No distress needed.

In this category of responses, two themes were identified: prevention and partner refusal.

Prevention.

The theme prevention emerged from responses indicating that couple therapy can be sought as a preventative measure.

P: Relationships can always grow and be better, so if it is in the couple's budget, go talk to someone. Prevention is a great starting point for success.

P: I think it can be helpful to be proactive and go before issues even arise, as I have learnt in past relationships waiting till things became severe did not help.

Partner Refusal.

The theme of 'partner refusal' represents participants who indicated that they would want to seek help without any distress, however their partner would not be willing to attend.

P: I love therapy, I would go even just to chat. As for me and likely many others though, the hard part is convincing the other partner to attend.

P: I would be willing to go early on in distress, it is hard to solicit the other partner to go and becomes a factor of who 'wins' the argument.

Significant distress needed

This category represents responses indicating that moderate to significant distress ought to be present before couples seek therapy. Three themes that arose from this category: no communication, couples capability, and needs to be severe.

No Communication.

The theme 'no communication' emerged from responses which indicated that couple therapy ought to be sought once the couple has stopped communicating with one another.

P: I think counselling is a good option if both partners are still committed to the relationship. The best time to go would be once communication breaks between them.

P: I think couples should seek help when they are at an impasse and unable to move beyond it without help.

Couples' capability This theme emerged from responses that indicated that couple therapy should be sought if the couple is incapable of resolving issues themselves. This theme reflects responses that suggested that the couples 'should' be able to work things out on their own, and if this is not working then couple therapy should be sought.

P: Marriage is hard. If you can't resolve problems on your own you are screwed. When it is too much and you have done everything and are not getting anywhere, it might be good to get an outside perspective.

P: Issues arise in relationships. A couple should work out bumps on their own. If things get serious, a mediator can help. It strengthens relationships to work out problems.

Needs to be severe.

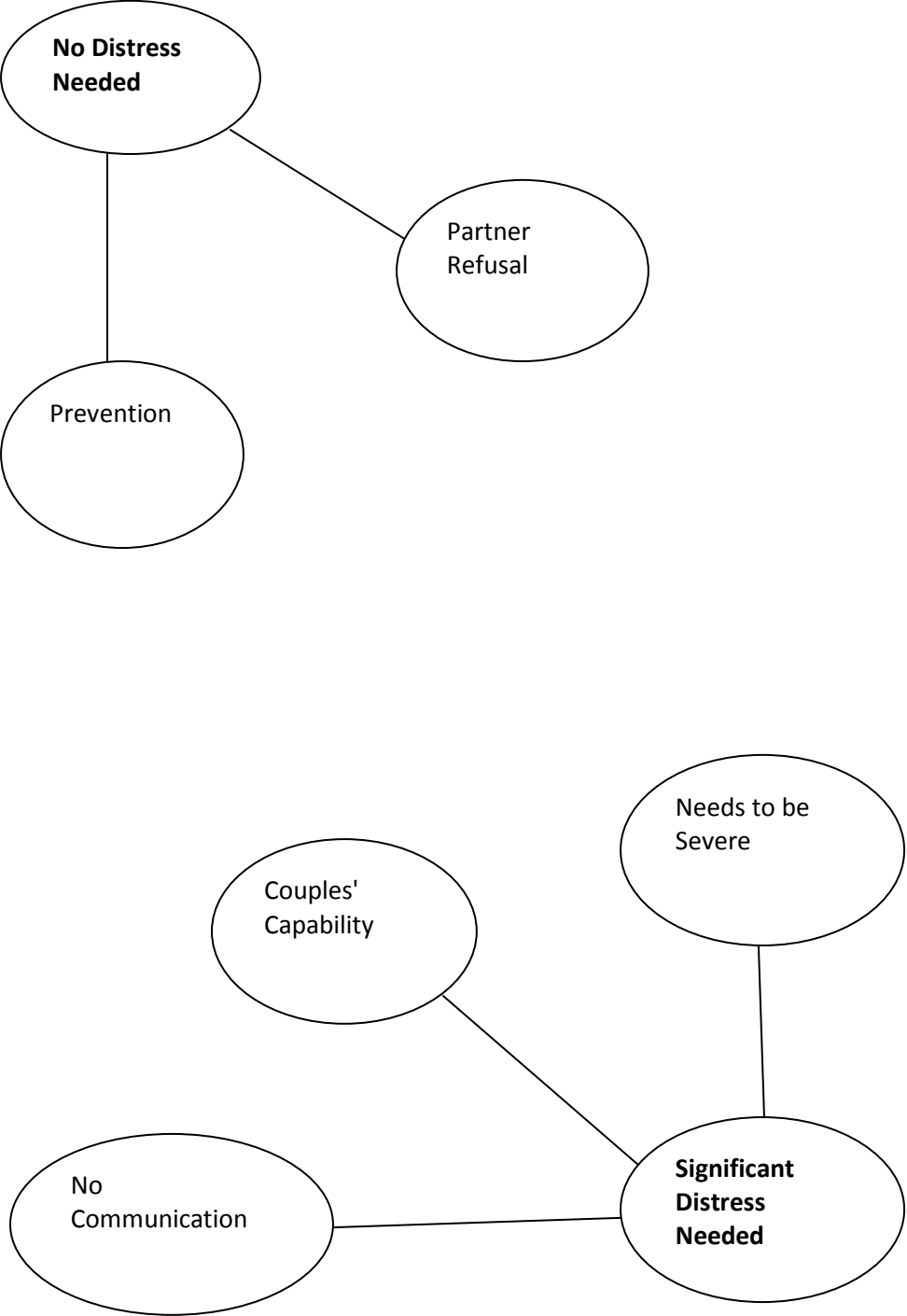
This theme represents responses that indicated that couple therapy should be prefaced by severe distress.

P: I think there needs to be significant concerns about the state of the relationship for an extended period of time.

P: I feel you need to have severe conflict to be seeking couple therapy. I think the couples would need to have a serious problem like infidelity to be seeking counselling.

Overall, these themes demonstrate that there is a perception that attending couple therapy should be sought once a couple has exhausted personal resources and should be prefaced with significant distress. The following is the thematic map that was generated to demonstrate the themes for this item visually, shown below in Figure 15.

Figure 15. Distress Scale Item Thematic Map



Hypotheses Results

Hypothesis 1.

Hypothesis one that willingness to seek help will be positively related to attitudes toward marital therapy (ASSPH-MT scale and subscales). The second part of this hypothesis is that there is support that a negative stigma of couple therapy will be present and that stigma is related to a person's willingness to seek help.

To examine this hypothesis, a Pearson's R correlation was performed examining willingness to seek help in relation to the ASSPH-MT overall score, 4 subscales and the 3 individual items examined in the previous section (Item 3, Item 20 and Item 23). Each subscale and item was also examined using an independent samples t-test. The results from the Pearson's R and t-test for each subscale and individual item will be discussed individually. To perform the independent t-tests, participants' willingness scores were divided into two groups (low and high scores) using Visual Binning. The low scores represent those who had reported a lower willingness to seek help if they were in a distressed relationship, and high scores indicated a greater willingness to seek help.

Overall attitudes.

The overall attitude score was significantly related to willingness to seek couple therapy ($r = .58, p < .000$). This result indicated a strong positive relationship between overall attitude toward help seeking and willingness. For the 'overall attitudes' score, the Levene's test for equality of variances indicated that these two groups' variability could not be assumed ($F = 4.3, p = .04$). The second line of output (equal variances not assumed) was examined for the 'overall attitudes' score to examine if there was a difference present between the two means. There was a significant difference between the low willingness ($M = 3.47, SD = .49$) and high willingness groups ($M = 4, SD = .4$) in terms of overall attitudes scores ($t = -6.44, df = 111.15, p < .000$). This

indicated that there was a significant difference of overall attitudes toward marital therapy among those who indicated a high likelihood of attending couple therapy in comparison to those who indicated that they were less likely to attend. Overall, this result shows that individuals in this study who had more positive attitudes also indicated that they would be more willing to attend couple therapy.

Subscale confidence in help

The subscale confidence in help was found to be significantly related to willingness to seek couple therapy ($r = .6, p < .000$), demonstrating a strong relationship. The independent samples t-test was performed, and a significant difference was found between low willingness ($M = 3.6, SD = .47$) and high willingness ($M = 4.1, SD = .46$), ($t = -5.89, df = 115, p < .000$). These results demonstrate that those with more confidence in marital therapy reported higher willingness to seek help. Overall, this shows that those who believe in the value of couple therapy are more willing to seek it out if they felt they needed help.

Subscale interpersonal openness.

The subscale 'interpersonal openness' is also found to be significantly related to willingness to seek help ($r = .53, p < .000$), showing a strong relationship in a positive direction. The independent t-test found that there was a significant difference between the low willingness group ($M = 3.48, SD = .62$) and high willingness group ($M = 4.01, SD = .48$), ($t = -5.17, df = 115, p < .000$). This indicates that a significant difference is present between the high and low groups in terms of interpersonal openness. Those who rated lower likelihood of seeking help also had lower levels of interpersonal openness.

Subscale Recognition of Need

The subscale 'recognition of need' is also related to willingness to seek help ($r = .47$, $p < .000$), showing a strong relationship in a positive direction. It is evident from these correlations that the overall attitude toward marital therapy, recognition of need, interpersonal openness, confidence in help, and stigma tolerance are all significantly related to willingness to seek help. Of the 3 stigma related items, 2 were significantly related to willingness to seek help. The independent t-test showed that the Levene's test for equal variances indicated that equal variability could not be assumed ($F = 4.22$, $p = .04$). The second line of output (equal variances not assumed) was used to examine these results. A significant difference was found between low willingness ($M = 3.52$, $SD = .61$) and high willingness ($M = 4.01$, $SD = .49$) for the recognition of need subscale ($t = -4.89$, $df = 110.51$, $p < .000$). This indicates that there is a significant difference between these groups in terms of recognition of need scores. Overall, this shows that those who are more willing and able to recognize the value of marital therapy for certain difficulties also indicated that they are more willing to seek couple therapy.

Stigma subscale.

This section will discuss the stigma subscale, individual items and the qualitative data pertaining to stigma. The next subscale examined is stigma tolerance, the subscale 'stigma tolerance' was also significantly related to willingness to seek couple therapy ($r = .38$, $p < .000$). The independent samples t-test found a significant difference between the low willingness group ($M = 3.16$, $SD = .74$) and high willingness ($M = 3.79$, $SD = .55$), ($t = -5.23$, $df = 115$, $p < .000$). This demonstrates that there is a significant difference present between participants who had low willingness to attend couple therapy and those who had higher levels of willingness in terms of

stigma tolerance. Overall, those with higher stigma tolerance are more willing to seek help if needed.

Individual items.

Item 3 "I would feel uneasy going to a marriage counselor because of what others might think"

Item 3 scores were found to be modestly correlated to willingness to seek help in a negative direction ($r = -.32, p < .000$). The independent t-test found that the Levene's test for equality indicated that equal variances could not be assumed ($F = 7.78, p = .006$), the second line of output was used for interpretation. There was a significant difference found between the low willingness group ($M = 2.56, SD = 1.15$) and high willingness group ($M = 1.74, SD = .89$) for this item ($t = 4.3, df = 115, p < .000$). Overall, this demonstrates that those who agreed they would feel uneasy because of what others thought would also be less willing to get help if needed.

Item 20 - 'There are aspects of my relationship that I would not share with anyone'

The Pearson's R correlation found that this item is mildly related to willingness to seek help in a negative direction ($r = -.27$). The independent t-test found that there was a significant difference between the low willingness ($M = 3.1, SD = 1.16$) and high willingness ($M = 2.52, SD = 1.11$), ($t = 2.79, df = 115, p = .006$). These results show that those who agreed that there are secretive aspects of relationships also indicated that they would be less willing to seek help if needed. This finding is important, as privacy about relationship concerns was also present in the qualitative data. It could be speculated that this privacy may be a personal preference and not necessarily be related to seeking couple therapy, however this finding provides evidence that it

related to willingness to seek help. This finding demonstrates that these privacy concerns are related to whether a person would be willing to seek help for their relationship.

Item 23 - 'There is something admirable in the attitude of a person with marital problems who is willing to cope with marital problems without resorting to professional help'

Item 23 was found to be significantly related to willingness to seek help ($r = -.41, p < .000$), which shows a strong relationship in a negative direction. The independent t-test found a significant difference was evident between the low willingness group ($M = 3.56, SD = .84$) and high willingness ($M = 2.95, SD = .93$), ($t = 3.75, df = 115, p < .000$). These results indicate that those who agreed that a person is admirable for not seeking help, is also less willing to seek help if it was needed. These results are noteworthy, as they are in accordance with the qualitative findings regarding the perception that couples who seek help are less capable. These connections will be discussed further in the discussion section.

Qualitative Evidence for Hypothesis 1

In addition to these quantitative findings, the qualitative data also provides evidence supporting the second part of this hypothesis that a negative stigma of couple therapy attendance exists. As discussed in the 'couple therapy perspectives item', stigma was prevalent throughout the data. Stigma was a theme (and motivation) for both participants who indicated they would share attendance with others and those who would not be willing to share. Stigma specific themes were generated from the analysis, and stigma was also noted in non-stigma specific themes such as 'not family'. In the theme 'not family', most responses indicated family would be judgmental and would assume the relationship is ending, which speaks to the general assumptions of couple therapy attendance. Themes such as 'relationship viewed negatively' further support the hypothesis that a stigma of couple therapy exists, as this theme described the

assumption that the couple would be judged as being incapable if they were to admit to attending therapy. These findings do not indicate whether seeking help behaviours would be directly influenced by these perceptions. For example, these responses do not say 'I would never seek help because people would view our relationship differently'. The findings do show, however, that there are certain assumptions that exist about couple therapy attendance in general.

Summary of Hypothesis 1

The first part of this hypothesis is supported as there are significant differences between attitudes toward marital therapy and willingness to seek help. The second part of this hypothesis is supported as it was found that stigma tolerance and willingness to seek help are significantly related and significant differences were found. Two of the specific items from the ASSPH-MT score that address stigma were also found to be significantly related to willingness to seek help. The qualitative data further supports that there is a general perspective that there is a negative stigma associated with couple therapy attendance, and is noted as reason to keep attendance secretive.

Hypothesis 2

The second hypothesis indicated that there would be gender differences present in the data specifically that men would be less willing to seek help and would have less positive attitudes toward marital therapy than women.

An independent t-test was performed to examine whether there was a significant difference between gender and two variables: willingness to seek help and attitudes toward marital therapy. The Levene's test indicated that equal variance could be assumed for the overall attitudes score ($F = 1.73, p = .19$), and the t-test demonstrated that there is no significant

difference between male and female participants in terms of attitudes toward marital therapy ($t = -.05, df = 114, p = .98$).

The Levene's test for equality of variance indicated that equal assumption could be assumed for willingness to seek help ($F = .13, p = .72$). There was no significant difference present between male and female participants in terms of willingness to seek help ($t = .26, df = 114, p = .79$).

This evidence indicates that this hypothesis is not supported. The lack of a difference may be a reflection of the number of males in the study ($n = 20$ of $N = 117$), and these 20 men may have differing views from the general population. The lack of a difference may also be a reflection of the nature of the sample, as the majority of the males in the sample are in helping profession programs ($n = 17$ of $n = 20$) and may have less negative views of couple therapy (Jorm et al., 1997).

In summary, the hypothesis that women would have more positive attitudes toward marital therapy and would be more willing to seek help was not supported in this study.

Hypothesis 3

The third is that relationship satisfaction would be negatively related to willingness to seek help. To examine this hypothesis, a Pearson's R correlation was performed. There was a significant difference found between willingness to seek help and relationship satisfaction in a positive direction ($r = .3, p = .002, n = 102$). This demonstrates that a modest relationship exists between higher relationship satisfaction and willingness to seek couple therapy. An independent samples t-test was performed and a difference was found between low willingness ($M = 4.35, SD = .57$) and high willingness ($M = 4.59, SD = .42$), ($t = -2.5, df = 96.28, p = .01$). This further demonstrates that those with higher satisfaction would be more willing to seek help if needed.

In spite of these significant findings, they cannot be taken to be an accurate depiction of the relationship between relationship satisfaction and willingness to seek help due to lack of variability in the relationship satisfaction of this sample. Nearly the entire sample reported excellent relationship quality, which means this analysis is demonstrating the difference between those who have great relationships and those who have excellent relationships. This hypothesis is in reference to low satisfaction, and in this sample only 7 of the 102 participants in relationships indicated relationship satisfaction scores below 3.5.

In summary, it was found that higher relationship satisfaction was positively related to willingness to seek help. The hypothesis that low relationship satisfaction would be related to greater willingness to seek help is not supported by these data.

Hypothesis 4

The fourth hypothesis is that more participants will indicate that above moderate to severe distress is necessary before seeking couple therapy as opposed to participants who indicated that mild or no distress is necessary for seeking help. As demonstrated in the descriptive analysis, it appears that significantly more participants indicated that above moderate to severe distress is necessary for help seeking. To verify this trend, a Chi-Square test was performed. Scores were divided into two categories, mild (scores 1, 2 and 3) and above moderate to severe group (5, 6 and 7), scores in the middle were omitted (scores of 4, $n=8$ omitted). The Chi-Square test results indicated that there was a significant difference between the mild group (observed $N=14$, expected $N=53$, residual= -39) and above moderate to severe group (observed $N=92$, expected $N=53$, residual= 39), ($\chi^2(1, N = 106) = 77.396, p <.001$). Table 1 shows the tables from the Chi-Square test with observed and expected frequencies, and Table 2 shows the statistics table.

Table 1. Chi-Square Results, Observed and Expect N for Distress Scale Item (1=mild, 2=above moderate to severe)

Distress			
	Observed N	Expected N	Residual
1 (low)	13.2%	50%	-36.8%
2 (high)	86.8%	50%	36.8%
Total	106		

Table 2. Chi-Square Statistics Table

Test Statistics	
	Distress
Chi-Square	57.396 ^a
df	1
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 53.0.

In summary, this hypothesis is supported as there were significantly more people who indicated that couple therapy should be prefaced by above moderate to severe distress. This demonstrates that among these participants, there is a perception that a couple ought to be in significant distress before they see a couple therapist.

Discussion

The initial intent of this study was to examine attitudes toward couple therapy among the general population, however, due to limitations of this study the sample was fairly specific to graduate students in helping profession programs. The nature of the sample is noteworthy for a couple of reasons, the first being that it reflects a limitation to the interpretation of the findings.

Due to the specific nature of the sample, the findings can not be interpreted to general perceptions of couple therapy. The second reason the nature of the sample is noteworthy is that it reflects that these perceptions exist in spite of the population consisting of future therapy providers.

This section will first discuss the connections between these findings and the literature discussed earlier in this thesis, and a general discussion and summary of the results will follow.

Literature connections

The findings from this study support the findings of Bringle & Byers (1997), which found that attitudes toward marital therapy are positively related to intentions to seek help if needed. Bringle & Byers (1997) suggested that the decision to seek couple therapy may not be a private decision, and that couples may have reservations about the possibility of being stigmatized. The Bringle & Byers (1997) study examined subjective norms, however, did not measure stigma specifically. The findings from this study support the speculations made by Bringle & Byers (1997) that intentions to seek help are related to stigma. Sirey et al. (2001) and Sibicky & Dovidio's (1986) articles demonstrated how stigma can influence a person's willingness to seek help for their mental health concerns. Although this study does not demonstrate causality, it does show a relationship between stigma tolerance and willingness to seek help if relationship issues arose. This study provides evidence that the potential costs of stigmatization are not isolated to individual therapy, but are also attached to couple therapy. Furthermore, the qualitative findings suggest that for participants, there is a perception that couple therapy attendance is stigmatized.

In spite of having generally very positive attitudes toward marital therapy, this sample still indicated certain negative perceptions of help seeking. A moderate portion of this sample

indicated that working through relationship issues without help is admirable, that these issues should be secretive, couples who seek help are less capable and a large portion indicated that significant levels of distress should be reached before help is sought. These findings demonstrate that even though this sample has positive attitudes about couple therapy, there are still certain negative beliefs regarding couple therapy attendance.

Delays in Seeking Couple Therapy

Doss et al. (2003), examined what contributes to the delay in help-seeking behaviours, and found that women were quicker to recognize need, consider treatment, and to seek treatment. The findings from this study do not provide support for these findings as no gender differences were found. However, as mentioned earlier this is likely a reflection of the nature of the sample in this study. Doss et al. (2003) also found that relationship satisfaction was predictive of seeking help, specifically that women with low satisfaction were more likely to seek help. The findings from this study cannot extend this finding because of the lack of relationship satisfaction variability.

Gottman & Gottman (1999) cited Buongiorno & Notarius, (1992) that couples experience distress for an average of 6 years prior to seeking professional help. The findings from this study are in accordance with this research, as participants indicated that help seeking should be prefaced by significant distress. This finding is in accordance with this research as it demonstrates that beliefs are in congruence with actual help seeking. In this study, it was found that participants believed help should only be sought once the couple is in significant distress, and research shows couples are distressed for 6 years before help is sought.

Wolcott (1986) found that the most common reason noted for not attending therapy among divorced couples was that it was "too late", and that when it was sought it was a "last resort" and that the relationship was already deteriorated beyond repair or one partner was

already severely distressed (p164). These findings are in congruence with this study as participants presented beliefs that couple therapy should be utilized once other resources are exhausted and that if couples are capable, they will not need help. These beliefs provide a possible explanation as to why many couples wait to seek help. Unfortunately, this then impedes the potential for therapy to be effective (Dunn & Schwebel, 1995; Snyder, 1997; Whisman & Johnson, 1990). Research has shown that severely distressed relationships are less likely to be helped by couple therapy (Snyder, 1997; Snyder, Mangrum & Wills, 1993), and this distress level accounts for marital satisfaction variability at follow-up (Whisman & Jacobson, 1990). The findings from this study bridge an important connection between actual therapy seeking and assumptions about when therapy should be sought. Research has shown the following: couples often wait extensive periods of distress prior to seeking help (Buongiorno & Notarius, 1992 as cited in Gottman & Gottman, 1999), couples often surpass the period of when both partners are invested in fixing the problems (Wolcott, 1986), and severe distress reduces the possibility that couple therapy will be effective (Whisman & Jacobson, 1990). The findings from this study demonstrate that there is a perception that couple therapy is a resource to be sought once above moderate to severe distress levels are perceived.

These findings provide a possible explanation to the aforementioned research and present a significant barrier to couples if this perception is widely held. The nature of this sample indicates that this perception may be a widely held belief, as this finding was found even in a sample which also holds highly positive attitudes about marital therapy and indicates willingness to seek help if needed.

In concluding this part of the discussion, I wish to forward a couple of speculations related to the research findings. The findings from this study provide important clarifications

regarding perceptions and attitudes toward couple therapy, including that there is a stigma associated with couple therapy, specifically that one's relationship may be viewed negatively and couples who seek help are assumed to be less capable and that seeking couple therapy is considered to be an action reserved for above moderate to severe distress levels. I speculate that these perceptions represent significant barriers to help seeking and contribute to the documented delay among distressed couples. I speculate that these negative perceptions could likely be wide spread, and thus many couples may be deterred from seeking help (Bringle & Byers, 1997). Causality could not be identified in this study, however, I speculate that the negative beliefs exposed are likely representative of general perceptions of seeking couple therapy, as demonstrated by the documented delay in help seeking (average distress time of six years).

Implications and Future Directions for Research

These study findings have implications for both future practices of couple therapy and research on relationships. The results of this study show a relationship between stigma tolerance and willingness to seek help. An implication of this finding is that it provides support for future research to explore alternative marketing approaches for ways to reduce the stigma associated with couple therapy. Future research could incorporate a more in-depth aspect of the connection between relationship problems and stigma. As mentioned in the speculations discussion, there were negative beliefs about the couples who seek therapy in the qualitative findings. This may be a rich area for future exploration and insight into the negative perceptions associated with having relationship problems as noted among this sample. Although this study does not demonstrate causality, it does show that many people would be hesitant to tell others about couple therapy attendance because of this concern.

These beliefs may also address potential barriers that exist for couples seeking help, which could also be addressed in raising awareness by reframing couple therapy as a positive activity by awareness of how challenging relationships can be, and by emphasizing the connection of relationship quality to health and well-being. For example, it is regularly advertised and encouraged to reduce stress and exercise and these activities are viewed very positively. Couple therapy, on the other hand, is not viewed quite as positively and it is not encouraged for relationship quality to be maintained. If couple therapy was reframed positively as a proactive and preventive measure used to maintain relationship quality, this may help to reduce barriers to seeking help. In spite of the emphasis we place on relationships in our society, we are taught very little about how to manage our intimate relationships.

In our society, we are generally encouraged to allow romance to be our guide and to believe that 'love is all we need'. Unfortunately, the many divorced people in the world would likely indicate that this is untrue. Another future area may be advocating for there to be greater education on relationships. Part of this education could include information on healthy relationships and how to recognize when a relationship may be struggling. Providing education on relationship health could help to reduce stigma of relationship problems and provide information as to how couple counselling can be beneficial at times.

Another implication could be increasing the awareness of 'when' couple therapy is most beneficial in our society. As this study found, most people indicated couple therapy should not be sought until significant distress is present. If these individuals were aware of the research that shows that waiting until distress is severe can be damaging, these perceptions may be altered. Furthermore, increasing the awareness that couple therapy is most helpful when used before

distress is severe may help to minimize the delay and stigma. Although it may be challenging to accomplish, increasing awareness that intimate relationships are challenging and that seeking help is not representative of a lack of ability would be helpful in reducing the barriers uncovered in this study. This awareness could be raised in many ways, such as advertising and increasing awareness of research findings, articles, and potentially educating clients who express relationship concerns in individual therapy.

The results of this study also have implications for couple therapy practice, as the connection between relationship issues and stigma could provide insight into the therapy process. These implications may also extend to how a couple therapist approaches seeking clients. For example, speaking to the concerns people have about seeking help (stigma and/or shame) on a webpage or discussing this with individual therapy clients could relieve some potential clients' concerns and encourage them that seeking help earlier is beneficial.

Limitations to the Study

This study is limited in certain ways, such as having a minimal budget of \$150.00 making more extensive survey options and participant recruitment challenging. For example, it would have been ideal to talk with couples who had sought out couple therapy and divorced, to gain insight on this topic from couples who have experienced this situation directly. Another minor limitation of this study is that it can only illustrate associations between variables and cannot distinguish causality. It would strengthen this study and the literature on this topic if the study was able to demonstrate causality between stigma and therapy attendance. Another limitation is that study participants were mainly from social work and seminary studies. As expected this group elicited positive attitudes toward couple therapy, and this may not be indicative of a

general population. It could have strengthened this study to have had a greater variability of demographics and have a greater representation of groups who are less likely to seek couple therapy (educated, middle-class, Caucasian, heterosexual individuals are the most common demographic that seek couple therapy). It is also possible that the perceptions could be vastly different among these groups, as these groups are underrepresented in couple therapy practice.

Study Strengths

This study had several strengths, such as incorporating qualitative components into a survey methodology to complement the quantitative survey measures. This approach facilitated the opportunity to collect both quantitative evidence to support the hypotheses as well as gain a more in-depth understanding of what the quantitative data might have meant to the participants. By recognizing the overlapping findings between the quantitative and qualitative data, it also strengthens the inferences that can be made.

The nature of the sample represented in this study could also be considered a strength as it is possible to speculate that this group would not elicit the hypothesized stigma of couple therapy given that they are likely working toward careers in the helping professions and thus would have more positive thoughts about couple therapy and the people who utilize such services. This could be considered a strength as in spite of the nature of this group, the stigma and negative perceptions were still elicited in the data. It strengthens the findings as the negative perceptions still emerged, in spite of overall positivity toward couple therapy. This demonstrates that these perceptions may be deeply ingrained. Another strength of this study is the large sample size. Statistically having a group of over 30 is considered to be the minimum needed before inferences can be made and this study had a sample of 117 people. In addition to the large sample size, another strength of this study was the amount of qualitative data participants

provided. As a study with a minimal incentive, it was speculated that participants might not invest a great deal of time on the qualitative sections. Surprisingly, the majority of participants responded to the narrative components and enough data was collected to effectively conduct qualitative analyses.

Conclusions

Considering the importance placed on intimate relationships, the prevalence of marital discord (Lederer & Jackson, 1986; Snyder, Castellani & Whisman, 2006), and the influence that marital quality can have on well-being (Whisman & Ubelacker, 2006), it is surprising that seeking professional help is not viewed more positively as demonstrated by the findings from this study and shown in Bringle & Byers (1997), Doss et al. (2003), and Wolcott (1986).

Couples will experience distress at certain points throughout their relationships, however, the effects of this distress could be mitigated with the help of couple therapy (Johnson, 2000; Lederer & Jackson, 1968). Couple therapy may not be suitable or beneficial for all couples, however, research has illustrated that couples can resolve conflict effectively, especially when they seek help early (Cordova, 2007). Although marital conflict is common, the results of this study demonstrate that there is a perception that only weak and significantly distressed relationships should seek help. This represents a negative perception of couple therapy attendance, and these perceptions are part of the noted stigma of attending. Researchers and clinicians actively advocate that the stigma associated with mental health and its associated treatments needs to be diminished (Kessler et al., 2005; Kohn et al., 2004) and this study provides support that couple therapy should be included in this movement.

The important elements that have emerged from the findings of this study are that there are certain perceptions and attitudes about both couple therapy and relationships. The findings of this study highlight barriers to couples in accessing help. It is unsurprising that there is an aversion to couple therapy in consideration of the negative perceptions that emerged in this study. Although couple therapy may not be an ideal or possible option for all couples, it is an empirically supported resource for helping couples through distress if sought early, and if negative perceptions are delaying distressed couples from using this resource it should be addressed. Relationships are challenging, and the quality of relationships appears from the literature to be closely connected to well-being. Addressing and combating the negative perceptions could lead to more positive and supportive perceptions of seeking professional help for relationship concerns.

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WILFRID LAURIER UNIVERSITY
SOCIAL WORK DEPARTMENT
INFORMED CONSENT STATEMENT

Attitudes Toward Couple Therapy
Student Researcher: Laura Demoe, Master's of Social Work
Supervisor: Dr. Marshall Fine, Associate Dean, Faculty of Social Work

INFORMATION

You are invited to participate in a research project being conducted by Laura Demoe under the supervision of Dr. Marshall Fine. This project is being completed in partial fulfillment of Laura Demoe's Master's thesis course. In this study, I am interested in learning more about general perspectives and attitudes toward couple therapy and counselling.

The study takes place completely online and consists of responding to survey type questions and one short answer question, the survey should take between 8 to 15 minutes to complete. You will also be asked to provide basic demographic information, such as age, gender, relationship status and program of study. Please know that you are free to skip any question or procedure and/or withdraw from the study at any time.

RISKS

It is possible that responding to questions about your relationship could lead to feelings of sadness or stress. These feelings are normal and should be temporary. If any negative feelings persist or worsen after the study, we encourage you to contact the researchers and/or Counselling Services (2nd floor of the Student Services Building, 519-884-0710 ext. 2338, counselling@wlu.ca).

BENEFITS

As a participant in this study, you will contribute to the development of knowledge about how couple therapy is perceived and what leads couples to choose (or not choose) to seek help. You may also learn about what decisions couples may consider prior to seeking counselling.

CONFIDENTIALITY

Participants' data will be confidential, which means no one other than Laura Demoe, Dr. Fine and Dr. Cameron (Committee member) will see and/or have access to the anonymous amassed data. Your specific data will be disconnected from your name/email address and combined with all the data from other participants. Written answers will be coded and themes will be discussed in final write-up. Direct quotations will not be used to order to ensure that confidentiality is maintained. In addition, if you enter your email address at the end of the survey in order to be eligible to receive the prize, your email address will not be associated with your responses. Note that while in transmission on the internet, confidentiality of data cannot be guaranteed. All data will be stored on Laura Demoe's password protected computer. Your personal information will be stored in a separate file on the same computer and will be deleted by Laura Demoe by November 30th, 2015. The anonymous data file will be maintained until September, 2015. Data

will be presented in aggregate (e.g., means) in any publications resulting from this study.

COMPENSATION

For your participation, you will have a chance to win one prize of \$100. At the end of the survey there will be a link to enter your email into the draw for this prize. the winner will be notified by january 31st, 2015 and will receive an email e-transfer for the amount of \$100. I will then ask for your name and provide you with a password to access the prize. if the winning participant is unable to receive an email transfer, she or he can email Laura Demoe and alternate arrangements will be made to have a cheque mailed to you.

CONTACT

If you have questions at any time about the study or the procedures (or you experience adverse effects as a result of participating in this study), you may contact the student researcher, Laura Demoe, (647) 629 6726, demo3600@mylaurier.ca or the supervisor, Dr. Fine (519) 884-0710 ext. 5223, mfine@wlu.ca. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Rob

- 1) What is your gender? Options: Female, Male, or Other (please specify)
- 2) What is your age?
- 3) Program and year of study?
 - Are you a student?
 - What program?
 - What year?
- 4) Which of the following best describes your current relationship status?
 - Married
 - In a dating relationship
 - Widowed
 - Divorced and currently single
 - Separated
 - In a domestic partnership or civil union
 - Single, never married
 - Other (Please describe)
- 5) If you are currently in a relationship, please answer the following:
 - Is your partner of the opposite or same sex as yourself?
 - What is the length of your current relationship?
- 6) What is the length of your longest relationship?
- 7) What is your ethnicity?
 - Aboriginal
 - Asian
 - Black or African American
 - Hispanic or Latino
 - White/Caucasian
 - Prefer not to answer
 - Other (please specify)
- 8) Previous counselling experience:
 - Have you ever attended counselling?
 - If yes, what type (individual, couple, family)?
 - If yes, for how long?

Appendix C - Variable List

V1 - Gender (1- Female, 2 - Male, 3- Genderqueer)

V2 - Age (Scale from 22 - 51+ in years)

V3 - Program (Social work, Theology and other)

V4 - Year of Study

V5 - Relationship type (1- Divorced, 2 - in dating relationship, 3 - domestic partnership, 4 - married, 5 - other, 6- seperated)

V6 - Relationship length (in years, scale - 1- relationship length less than 1 year, 2- between 2-3 years, 3 - between 4-5 years, etc)

V7 - Relationship (Yes or No) - (1 - Single, 2- In relationship)

V8 - Sexual orientation (1- Heterosexual, 2- Homosexual, 3- Bisexual)

V9 - Counselling (Yes or No) (1- No, 2- Yes)

V10 - Length of Counselling history (1- Minimal, ie. Less than 6 sessions or 1 month, 2- Between minimal - moderate, more than 6 sessions, between 1 month - 5 months, 3 - moderate, 6 months to 1 year, 4 - lengthy, more than 1 year)

V11 - Ethnicity (1- White/Caucasian, 2- Other)

V12 - Individual therapy attended (0 - Did not attend, 1- Attended)

V13 - Couple therapy attended (0- Did not attend, 1 - Attended)

V14 - Family therapy attended (0- Did not attend, 1 - Attended)

V15 - Likelihood of attending couple therapy (1 - Highly unlikely - 7 Highly likely)

V16 - Attitudes scale composite - Recognition of Need

V17 - composite - Stigma tolerance

V18 - composite - Openness

V19 - composite - Confidence in therapy

V20 - Overall attitude (higher #s = more positive attitude)

V21 - V48 (Items 1- 28 of attitudes scale)

V49 - Relationship assessment scale (RAS) item 1 (1-5, 1 = less satisfied)

V50 - RAS item 2

V51 - RAS item 3

V52 - RAS item 4

V53 - RAS item 5

V54 - RAS item 6

V55 - RAS item 7

V56 - Overall RAS score (higher # = more satisfied)

V57 - Distress scale (1-7, 1= no distress, 7 = severe distress)

V58 - Number of therapy types attended (0 - no types attended, 1- 1 type attended, 2- 2 types attended, 3 - 3 types attended)

Appendix D

ASPPH-MT – The Attitudes Toward Seeking Professional Help – Marital Therapy (Cordova, 2007)

Directions: Using the scale below, please use the blank provided to write the number which best represents your views on the following statements:

1 – Strongly Disagree 2 – Disagree 3- Neither Agree Nor Disagree 4 – Agree 5- Strongly Agree

1. Although there are many different places to seek counseling or professional help for my marriage, I would not have much faith in them.
2. If a good friend asks my advice about a problem they are having in their marriage, I might recommend that he or she seek marital counseling.
3. I would feel uneasy going to a marriage counselor because of what people would think.
4. A person with a strong character can find ways to deal with marital problems by him or herself, and would have little need for a professional.
5. There have been times when I have felt completely at a loss to deal with a problem in my marriage and would have welcomed professional advice.
6. Considering the time and expense involved in marital therapy, it would have doubtful value for me and my partner.
7. I would willingly confide intimate matters to an appropriate person if I thought it might help my relationship.
8. I would rather live with certain problems in my marriage than go through the ordeal of getting professional assistance.
9. Marital problems, like many difficulties, tend to sort themselves out over time.
10. There are certain problems which should not be discussed outside of one's marriage.
11. If I believed my marriage was on the verge of breaking up, my first inclination would be to get professional help.
12. Focusing on a job helps me to avoid worries and concerns about my relationship.
13. Having seen a marriage counselor is an indication of some failure in a person's relationship.
14. I would rather be advised by a close friend than by a professional, even for a serious problem in my marriage.
15. A couple with problems in their relationship is not likely to solve them by themselves; they are more likely to solve them with professional help.
16. I resent a person—professionally trained or not—who wants to know about the difficulties in my relationship.
17. I would want to seek professional advice if I was unhappy in my marriage for a long period of time.
18. The idea of talking about problems with a marriage counselor strikes me as a poor way to resolve relationship conflicts.
19. Having problems with one's marriage carries with it a burden of shame.
20. There are aspects of my relationship that I would not discuss with anyone.
21. It is probably best not to think about everything in my relationship.
22. If I were experiencing an acute problem in my marriage, I would be confident that

I could find some relief in professional counseling.

23. There is something admirable in the attitude of a person who is willing to cope with his or her marital problems without resorting to professional help.

24. At some future time, I might want to have marital therapy or counseling.

25. A couple should work out their own problems; getting professional assistance would be a last resort.

26. If my partner and I received marital therapy or counseling, I would not feel that it should be kept secret.

27. If I thought I needed professional assistance for my marriage, I would get it no matter who knew about it.

28. It is difficult for people to talk about their personal relationships with highly educated people such as doctors, teachers, and clergy.

Appendix E

RELATIONSHIP ASSESSMENT SCALE

Please mark on the answer sheet the letter for each item which best answers that item for you.

How well does your partner meet your needs?

A	B	C	D	E
Poorly		Average		Extremely well

In general, how satisfied are you with your relationship?

A	B	C	D	E
Unsatisfied		Average		Extremely satisfied

How good is your relationship compared to most?

A	B	C	D	E
Poor		Average		Excellent

How often do you wish you hadn't gotten in this relationship?

A	B	C	D	E
Never		Average		Very often

To what extent has your relationship met your original expectations:

A	B	C	D	E
Hardly at all		Average		Completely

How much do you love your partner?

A	B	C	D	E
Not much		Average		Very much

How many problems are there in your relationship?

A	B	C	D	E
Very few		Average		Very many

Items 4 and 7 are reverse scored. A=1, B=2, C=3, D=4, E=5. You add up the items and divide by 7 to get a mean score.

Appendix F - Word Counts (Therapy Attendance Item)

Themes from Thematic Analysis

Yes I would share

Honesty/openness is important (8x)

Belief in counselling (10x)

Helpful to share/ or beneficial to process then yes... (5x)

Helpful to reduce stigma (14x)

Want support from others (17x)

‘nothing to be ashamed of’ (7x)

Talk to partner about decision (8x)

Show I am working on relationship (7x)

Maybe category

Would only tell people I trust and am very close to (27x)

Wouldn’t tell “everyone” (5x)

If it was appropriate/or came up in conversation (4x)

If others had also been to counselling/ To gain insight on counselling (8x)

If advised to share by therapist (4x)

No I would not share

No, it would be private, not their ‘business’, its personal (23x)

Wouldn’t share details of problems (5x)

Family (specifically) would not understand and would judge (10x)

Stigma/criticized/judged/embarrassed (29x)

No, Shame (5x)

Others would view my partner differently (4x)

People would judge my relationship to be weak or should end/ embarrassed that we couldn't do it on our own (21x)

Appendix H - Coding for Distress Item

Different/depends on couple - 12

Has to be hurting, lots of conflict - 2

Threatens stability -2

Personal - 1

Should try and work it out on their - 1

Prevention - 5

Big movements or engaged - 1

No threshold - 1

Partner doesnt want to go - 6

Can grow - 4

If in the budget - 2

Check-in - 1

Hard to say - 2

Arguing no reason - 1

Significant concern of state of relationship, extend period - 1

Try to resolve it yourself - 8

Should be able to resolve it yourselves - 8

Break down in communication or stuck - 4

Ongoing issue - 1

Learn about each other - 2

Trauma - 1

Right before severe distress - 6

Anytime - 1

Learn about each other - 1

Major unresolved conflict - 1

Would go on own first - 1

Moderate distress - 1

If coping mechanisms overwhelmed - 1

More severe problems such as infidelity - 2

Severe distress too late - 4

Severe - 3

Themes

It depends on the couple/situation

Try to resolve it on your own as way to strengthen problem-solving skills

Couples should be able to fix it on their own

Go when you've stopped communicating

Needs to be significant, relationship at stake

Need significant distress, but not too severe because it will be too late

Can be preventative

Distress level is irrelevant because partner won't attend

Appedix I - Research Ethics Approval



November 10, 2014

Dear Laura Demoe

REB # 4201

Project, "Attitudes Toward Couple Therapy"

REB Clearance Issued: November 10, 2014

REB Expiry / End Date: December 31, 2014

The Research Ethics Board of Wilfrid Laurier University has reviewed the above proposal and determined that the proposal is ethically sound. If the research plan and methods should change in a way that may bring into question the project's adherence to acceptable ethical norms, please submit a "Request for Ethics Clearance of a Revision or Modification" form for approval before the changes are put into place. This form can also be used to extend protocols past their expiry date, except in cases where the project is more than two years old. Those projects require a new REB application.

Please note that you are responsible for obtaining any further approvals that might be required to complete your project.

If any participants in your research project have a negative experience (either physical, psychological or emotional) you are required to submit an "Adverse Events Form" within 24 hours of the event.

You must complete the online "Annual/Final Progress Report on Human Research Projects" form annually and upon completion of the project. ROMEO will automatically keep track of these annual reports for you. When you have a report due within 30 days (and/or an overdue report) it will be listed under the 'My Reminders' quick link on your ROMEO home screen; the number in brackets next to 'My Reminders' will tell you how many reports need to be submitted.

All the best for the successful completion of your project.

(Useful links: [ROMEO Login Screen](#) ; [ROMEO Quick Reference Guide](#) ; [REB webpage](#))

Yours sincerely,

A handwritten signature in black ink that reads "Robert Basso". The signature is written in a cursive style with a large, prominent 'R' at the beginning.

Robert Basso, PhD
Chair, University Research Ethics Board
Wilfrid Laurier University

Table 3. ANOVA (By programs) & Post Hoc Table

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Attitude	Between Groups	397.407	2	198.704	.947	.391
	Within Groups	23907.823	114	209.718		
	Total	24305.231	116			
Confidence in Help	Between Groups	.866	2	.433	1.566	.213
	Within Groups	31.525	114	.277		
	Total	32.391	116			
Openness	Between Groups	.075	2	.037	.099	.906
	Within Groups	43.286	114	.380		
	Total	43.361	116			
Stigma Tolerance	Between Groups	1.087	2	.544	1.043	.356
	Within Groups	59.406	114	.521		
	Total	60.493	116			
What is the likelihood that you would be willing to attend couple counselling if you were in a relationship that was experiencing distress	Between Groups	9.658	2	4.829	2.159	.120
	Within Groups	254.923	114	2.236		
	Total	264.581	116			
Relationship Satisfaction	Between Groups	13.762	2	6.881	.523	.595
	Within Groups	1290.000	98	13.163		
	Total	1303.762	100			
Distress scale	Between Groups	.693	2	.346	.126	.882
	Within Groups	314.196	114	2.756		

Total	314.889	116			
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Multiple Comparisons

Bonferroni

Dependent Variable	(I) Program	(J) Program	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Attitude	Social Work	Seminary	-1.685	3.570	1.000	-10.36	6.99
		Other	4.234	3.639	.741	-4.61	13.08
	Seminary	Social Work	1.685	3.570	1.000	-6.99	10.36
		Other	5.919	4.525	.580	-5.08	16.91
	Other	Social Work	-4.234	3.639	.741	-13.08	4.61
		Seminary	-5.919	4.525	.580	-16.91	5.08
Confidence in Help	Social Work	Seminary	-.128	.130	.977	-.44	.19
		Other	.162	.132	.668	-.16	.48
	Seminary	Social Work	.128	.130	.977	-.19	.44
		Other	.290	.164	.241	-.11	.69
	Other	Social Work	-.162	.132	.668	-.48	.16
		Seminary	-.290	.164	.241	-.69	.11
Openness	Social Work	Seminary	.029	.152	1.000	-.34	.40
		Other	.067	.155	1.000	-.31	.44
	Seminary	Social Work	-.029	.152	1.000	-.40	.34
		Other	.038	.193	1.000	-.43	.51
	Other	Social Work	-.067	.155	1.000	-.44	.31
		Seminary	-.038	.193	1.000	-.51	.43
Stigma Tolerance	Social Work	Seminary	-.091	.178	1.000	-.52	.34
		Other	.219	.181	.687	-.22	.66
	Seminary	Social Work	.091	.178	1.000	-.34	.52
		Other	.311	.226	.512	-.24	.86

	Other	Social Work	-.219	.181	.687	-.66	.22
		Seminary	-.311	.226	.512	-.86	.24
What is the likelihood that you would be willing to attend couple counselling if you were in a relationship that was experiencing distress	Social	Seminary	-.435	.369	.722	-1.33	.46
	Work	Other	.534	.376	.474	-.38	1.45
	Seminary	Social Work	.435	.369	.722	-.46	1.33
		Other	.969	.467	.121	-.17	2.10
	Other	Social Work	-.534	.376	.474	-1.45	.38
		Seminary	-.969	.467	.121	-2.10	.17
Relationship Satisfaction	Social	Seminary	-1.000	.987	.940	-3.40	1.40
	Work	Other	-.333	.965	1.000	-2.68	2.02
	Seminary	Social Work	1.000	.987	.940	-1.40	3.40
		Other	.667	1.227	1.000	-2.32	3.66
	Other	Social Work	.333	.965	1.000	-2.02	2.68
		Seminary	-.667	1.227	1.000	-3.66	2.32
Distress scale	Social	Seminary	-.081	.409	1.000	-1.08	.91
	Work	Other	-.205	.417	1.000	-1.22	.81
	Seminary	Social Work	.081	.409	1.000	-.91	1.08
		Other	-.124	.519	1.000	-1.38	1.14
	Other	Social Work	.205	.417	1.000	-.81	1.22
		Seminary	.124	.519	1.000	-1.14	1.38