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PROGRAMS

Predicting Participation in Premarital Prevention Programs:  
The Health Belief Model and Social Norms

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## Abstract

The development of effective programs to prevent marital dysfunction has been a recent focus for marital researchers, but the effective dissemination of these programs to engaged couples has received relatively little attention. The purpose of this study is to determine which factors predict couples' participation in premarital counseling. Predictive factors were derived from the health prevention literature, with a particular focus on the health belief model (HBM). Couples' beliefs and attitudes about premarital counseling were assessed at least six months before their wedding and participation was assessed after their wedding. Results indicate that the strongest predictors of couples' participation were couples' perceptions of barriers to counseling and whether or not they had counseling recommended to them. These variables predicted participation even after controlling for important demographic variables. Recommendations for recruiting engaged couples for premarital counseling are made based on the findings.

## Predictors of Participation in Premarital Prevention Programs:

### The Health Belief Model and Social Norms

There are over a dozen research-based premarital prevention programs (Berger & Hannah, 1999) and numerous community-based programs (e.g., those offered by religious organizations) available to engaged couples to help them prepare for marriage. Outcome studies of research-based programs provide evidence that such programs can increase relationship skills and prevent marital distress and divorce (e.g., Hahlweg, Markman, Thurmaier, Engl, & Eckert, 1998).

Although important, the promise of these studies will not be realized unless couples in need of these interventions take part in them. The purpose of the present study is to clarify the factors that predict which couples participate in premarital counseling and which couples do not participate. It is hoped that a better understanding of what motivates couples to participate in premarital counseling will lead to the development of effective strategies for recruiting couples.

Couples getting married in the United States today have been estimated to have a 40% to 66% chance of divorcing (Norton & Miller, 1992; Martin & Bumpass, 1989) and there is clear evidence that marital distress and divorce have serious physical, emotional, and financial consequences for spouses and their

children (e.g, Bloom, Asher, & White, 1978; Emery & Coiro, 1995; Kiecolt-Glaser et al., 1988; Stroup & Pollack, 1994). Unfortunately, even the most effective therapeutic approaches for treating distressed couples have had limited success (Van Widenfelt, Markman, Guerney, Behrens, & Hosman, 1997). Furthermore, marital counseling is expensive (Albee, 1990) and most couples who experience distress do not seek help or do so after experiencing considerable distress (Halford & Behrens, 1996). Given the limitations of tertiary interventions, the significant problems caused by marital dysfunction, and the promising advances in prevention approaches, the need for involving couples in prevention interventions before they develop significant relationship distress becomes clear.

Recent studies indicate that the majority of engaged couples do not participate in premarital counseling despite growing popular interest in prevention approaches to relationship problems (Sullivan & Bradbury, 1997; Stanley & Markman, 1997; Silliman & Schumm, 2000; see Johnson et al., 2002 for an important exception). The low rates of participation in premarital counseling programs is especially troubling in light of research that indicates that couples at highest risk for marital problems are actually the least likely to participate in it (Sullivan & Bradbury, 1997).

One reason for low participation rates may be that couples who are not yet

experiencing significant distress are not motivated to change. Engaged couples generally high levels of relationship satisfaction may prevent them from being able to perceive themselves as susceptible to marital problems and divorce and thus feel no need for intervention (Floyd, Markman, Kelly, Blumberg, Stanley, 1995). Further, engaged couples may not perceive any benefits of participation (Guerney, Brock, & Coufal, 1986). Concern about getting couples to participate in premarital counseling has prompted researchers to suggest that premarital prevention programs incorporate . . . marketing strategies for reaching potential consumers of prevention (Floyd et al., 1995, p. 213).

#### *A Model for Predicting Participation in Prevention Programs*

To increase the numbers of couples making use of premarital prevention programs, we need to understand the factors that predict who participates and who does not. Conceptualizing participation in premarital counseling as a health-related preventive behavior, we employed a well-established, widely used theoretical model called the health belief model as a guide. The health belief model (HBM; for recent reviews see Strecher, Champion, & Rosenstock, 1997, and Sheeran & Abraham, 1996) posits that people are more likely to engage in preventive behaviors if 1) they perceive they are susceptible to the potential problem (perceived susceptibility), 2) they believe the problem has serious

consequences (perceived severity), 3) they perceive few barriers to taking the preventive action (perceived barriers), and 4) they believe the preventive action will be effective in minimizing the risk (perceived benefits). The HBM has been shown to predict many health-related behaviors including mammograms (Aiken, West, Woodward, & Reno, 1994) and condom use (e.g., Bakker, Buunk, Siero, & van Den Eijnden, 1997). Applying the HBM to premarital counseling, we posited that engaged individuals should be more motivated to attend premarital counseling if they believe that 1) they are likely to develop marital problems or to divorce, 2) marital distress and divorce would have very negative consequences, 3) participating in premarital counseling would not be difficult or problematic and 4) counseling would be helpful in preventing marital problems.

Decades of research on the HBM and competing models (e.g., the Theory of Reasoned Action; Azjen & Fishbein, 1980) in health literature have identified additional factors that motivate people to engage in preventive behaviors beyond those originally specified by the HBM. Many studies of diverse prevention behaviors have established that motivation to engage in preventive behavior is influenced by the attitudes and behaviors of important others. Perceptions about the attitude of important others toward the health behavior, or *social norms*, have been found to predict condom use (Morrison, Baker, & Gilmore, 2000), drunk

driving (Gastil, 2001), and medication compliance in mood disorders (Cohen, Parikh, & Kennedy, 2000), to name only a few.

In addition to social norms, other variables that have been shown to lead to engagement in preventive behaviors include knowledge about the problem and demographic variables such as age, ethnicity, income, and education (Strecher, Champion, & Rosenstock, 1997). Across many studies, the most direct predictor of behavior has often been found to be the intention to engage in the behavior (Ajzen & Fishbein, 2000); this is consistent with the theory of reasoned action.

Taking into account all these findings, a model is proposed to account for why couples do or do not participate in premarital counseling (see Figure 1). Couples will be more likely to intend to go to counseling and to actually go to counseling if they know something about the rates of marital dysfunction, if they believe that marital dysfunction is bad, if they believe marital problems could happen to them, if counseling appears easy to obtain and beneficial, and if the people around them have participated in and recommend premarital counseling. These predictors should be significant even after controlling for demographic variables. Further, couples' intentions to attend premarital counseling should be a strong predictor of actual participation. /Figure 1 above here/.

To evaluate the proposed model in predicting participation, engaged



couples' health beliefs, social norms, and intentions were assessed at least six months before their wedding (Time 1), and couples' participation in premarital counseling was assessed one month following their wedding (Time 2).

Premarital counseling is sometimes recommended or even required of couples by religious organizations. Therefore, religion was assessed at Time 1 and, at Time 2, the couples who had participated in counseling were asked whether participation had been required of them. To provide a rigorous test of the proposed model, the potential predictors were tested after controlling for religion at Time 1 and after controlling for whether or not counseling was required or recommended at Time 2.

## Method

### *Participants*

*Time 1.* Engaged couples were recruited via advertising in local newspapers or using a rental booth at three local bridal shows. Advertisements invited couples who were interested in participating in a study about engaged couples to call for more information. To be eligible, couples had to be engaged, could not have already attended premarital counseling (defined as more than 3 hours of contact with a clergy member, counselor, or leader with content that included discussion of relationship issues and not just wedding planning), and their

wedding date had to be at least six months away (to ensure sufficient time to attend counseling, if they chose to do so). Of ninety-five packets sent in the mail to eligible couples, 86 (91%) were completed and returned by both partners.

Male participants' average age was 27.5 years ( $SD = 6.16$ , range = 19 - 60), their average income was \$30,000 per year and, on average, they had received 15.5 ( $SD = 2.2$ ) years of education. Seventy-seven percent of male participants were Caucasian, 9.5% were Latino, 9.5% were Asian, and 3.6% were African American. Female participants' average age was 26.15 years ( $SD = 4.86$ , range = 19 - 53), their average income was \$20,000 per year and they had, on average, received 16 ( $SD = 1.8$ ) years of education. Sixty-one percent of female participants were Caucasian, 18.6% were Latina, 18.6% were Asian, and 2.3% were African American.<sup>1</sup>

### *Questionnaire*

Data were gathered with a 36-item questionnaire that assessed demographic information, couples' knowledge about divorce, their beliefs about marriage and premarital counseling (HBM factors), social norms regarding premarital counseling, and intentions to participate in premarital counseling. Participants provided information on age, ethnic identity, education level, income level, and religious affiliation. Knowledge items assessed knowledge of the current

divorce rate in the United States, the percent of couples who consider divorce, and the years and stages of marriage during which couples are at the highest risk for divorce (four items). Social norms were assessed by asking whether participants knew people who had gone to premarital counseling, whether those people found it useful, whether anyone had recommended it to them, and how important the recommenders' opinion was to them (four items). To assess intentions, participants were asked to rate the percentage chance (0% to 100%) they would participate using a six-point scale in response to the question, "Overall, what would you say is the chance that you will attend premarital counseling before your wedding?"

*HBM Scale Development.* Focus groups were conducted with newly married couples, some of whom had attended premarital counseling and some of whom had not.

Thirty-two newly married adults (16 couples) between the ages of 20 and 54 participated in one of four focus groups: 1) couples who had received counseling, 2) couples who had not received counseling, 3) women (including some who had received counseling and some who had not received counseling), and 4) men (the spouses of Group 3). Each group was asked to discuss the following key questions: "What were the reasons you did not receive premarital

counseling? (Groups 2-4), □What were the reasons you did receive premarital counseling? (Groups 1,3,4), □What do you think would attract engaged couples to come to premarital counseling?, □What do you think are the most important reasons couples attend or don't attend premarital counseling?, □Name one thing that would probably make you go to premarital counseling., □Name one thing that would probably make you not go to premarital counseling. □ The discussions were videotaped for later review and participants were then given \$50 compensation for their time (see Sullivan & Anderson, 2001 for a more detailed description of the focus groups).

Based on the content derived from the focus groups, and modeled after a questionnaire designed to test the HBM model in explaining mammography screening developed by Aiken et al. (1994), a 23-item scale was developed to assess the four HBM factors of susceptibility ( $n = 6$ ), severity ( $n = 5$ ), barriers ( $n = 8$ ), and benefits ( $n = 4$ ). See Table 1 for item content. All items were answered with 5-point Likert scales that were verbally anchored at each end. /Table 1 above here/.

### *Procedure*

*Time 1.* Eligible couples were sent packets in the mail. In addition to the

questionnaire described above, additional questionnaires were also included (e.g., questionnaires assessing marital satisfaction, personality, relationship skills, etc.), as this project was part of a larger study. This also served to minimize the potential influence of the study on participants' decisions to attend premarital counseling.

Each participant was sent his or her own packet to minimize sharing information between partners. Couples were instructed not to discuss answers with their partner until after they returned the packets. Couples were sent a check for \$25 for their participation.

*Time 2.* Each participant was telephoned for a follow-up interview one month following their wedding. Spouses were asked to complete the interview privately. One couple dropped out of the study and two couples could not be located. Of the 83 couples who were interviewed seven did not marry, resulting in complete follow-up data for 76 of the original couples. Spouses were asked whether they had participated in premarital counseling before their wedding and whether premarital counseling was required by the person(s) or institution performing the wedding ceremony. In cases when spouses disagreed about whether or not they had attended counseling ( $N = 2$  couples), a definition was provided (i.e., more than 3 hours with content that included more than just

wedding planning). In one case, the couple agreed after the definition was provided, in the other, the wife had attended premarital counseling but the husband had not.

To determine whether the Time 1 questionnaires functioned as a cue for couples to attend premarital counseling, couples who had attended counseling were asked whether participation in the study influenced their decision and, if so, how. Two wives answered "yes" (4% of those who attended counseling); both, however, were required or recommended to attend counseling by the church that performed the wedding ceremony. These wives stated that the study made them feel more positively about the counseling they knew they had to receive. Seven husbands (15% of those who attended counseling) answered "yes"; five of the seven were required or recommended by the church that performed the wedding ceremony to attend. Two husbands who did not have counseling required or recommended of them reported that being in the study influenced their decision to attend. One stated that the questionnaires "got me thinking about it and I talked to people who had been through it." The other stated that being in the study "gave them a guideline about what they should do." Neither spouse of these two husbands reported that being in the study influenced their decision to attend

counseling.

### *Scale Formation*

*Knowledge Scale.* A knowledge score was assigned to each participant based on the proportion of the items to which the participant responded correctly. Correct answers were based on the most current U.S. census data and the literature on divorce.

*Social Norm Scales.* A "peer benefits" score was assigned to each participant by assigning 0 points to those who knew no couples who had gone to premarital counseling, and, for those who did know couples who had gone, 1 point if the couple didn't benefit, 2 points if it was uncertain whether they benefitted, and 3 points if the couple benefitted. Space was provided for participants to list up to five people they knew who had been to premarital counseling, yielding a range of scores from 0 - 15.

A "respected recommenders" score was assigned to each participant by assigning 0 points to those who had not had premarital counseling recommended to them, and one to five points to those who had counseling recommended to them, based on their rating of how important the recommender's opinion was to the participant (on a scale of one to five, where 1 is "their opinion is not important

to me and 5 is [their opinion is important to me]). Space was provided for up to four recommenders, yielding a range of scores from 0 - 20.

*HBM Scales.* The extent to which the hypothesized four-factor HBM model accounted for the 23 items was examined with a confirmatory factor analysis using the LISREL 8.3 program (Jöreskog & Sörbom, 1999). Items were permitted to load only on the construct they theoretically represented; loadings of each item on factors other than the theoretically appropriate factor were constrained to zero. Modeling was based on a covariance matrix of the 23 items. For the initial four-factor model, *chi-square* estimates (326.12 for women, 279.51 for men) and the Bentler and Bonett (1980) non-normed fit index (*NNFI*; .75 for women, .84 for men) did not indicate a good fit (*NNFI*  $\geq$  .90 is considered indicative of good fit). Parameter estimates and standardized residuals indicated that items assessing couples' perceptions about marital distress represented a different construct than items assessing couples' perceptions about divorce for the susceptibility and severity factors. The model was therefore modified to include two susceptibility scales (susceptibility to marital problems and susceptibility to divorce). There was only one item assessing the perceived severity of divorce, therefore that item was analyzed individually and the severity scale was



represented by the remaining four items assessing the perceived severity of marital problems. The model was further modified by eliminating three items from the barriers scale which did not load significantly on that scale. These items were retained for individual analysis as they appeared to be potentially important, albeit conceptually different, barriers to receiving premarital counseling. For the modified five-factor model, *chi-square* (142) = 168.42 for men and 170.38 for women and the *NNFI* = .90 for men and .91 for women. See Table 1 for factor loadings. Perceived susceptibility to divorce and perceived susceptibility to marital problems were correlated ( $r = .63$  for men,  $r = .51$  for women) however, the correlation between susceptibility and perceived severity varied for men and women, with a significant correlation between susceptibility to divorce and severity for men ( $r = -.27$ ) and a significant correlation between susceptibility to marital problems and severity for women ( $r = -.24$ ). Perceived benefits were related to perceived susceptibility to divorce for men ( $r = .19$ ), perceived susceptibility to marital problems for women ( $r = .28$ ), and perceived barriers for men and women ( $r = -.77$  and  $-.79$  respectively). Perceived severity was related to perceived barriers for men ( $r = .25$ ) and women ( $r = .15$ ) as well.

Scale scores were calculated for each participant by summing the scores of the individual HBM items making up the scale for each construct. Cronbach's

(1951) alpha was adequate for the perceived susceptibility to marital problems scale (.84 for men and .87 for women; six items), the perceived severity of marital problems scale (.84 for men and .83 for women; four items), the perceived barriers scale (.82 for men and .76 for women; five items), and the perceived benefits scale (.82 for men and .77 for women; four items). Cronbach's alpha was somewhat weak for the perceived susceptibility to divorce scale (.59 for men and .63 for women), therefore analyses were conducted using both the individual susceptibility items and the scale score.

## Results

### *Time 1*

Means and standard deviations for all continuous variables (age, income, education ) and scales (knowledge scale, HBM factors, and social norm scales) can be found in Table 2. /Table 2 above here/.

### *Relationship of Predictors to Intentions.*

*Demographics.* Multiple regression analyses were used to determine whether the demographic variables, as a block, predicted intentions to attend premarital counseling. Significant overall prediction was found, with the demographic variables predicting about 25%-28% of the variance for women and 14%-18% of the variance for men (see Table 3). Of the individual demographic

predictors, age significantly predicted men's intentions to attend premarital counseling and religion significantly predicted intentions for women and men. Adding income, education, and ethnicity to the multiple regression equation did not add to the prediction. /Table 3 above here/.

*HBM and Social Norm Scales.* A series of hierarchical regression equations were used to determine whether the HBM and social norms predicted intentions over and above the contributions of demographic variables and one another (i.e., do the HBM factors contribute something unique to the prediction of intentions over and above social norms and demographic variables; do social norms make a unique contribution over and above the HBM and demographic variables?).

The HBM factors significantly predicted intentions after controlling for demographic variables (see Table 4). The HBM factors accounted for an additional 33% of the variance for women and 34% of the variance after controlling for age and religion. In the most stringent test, the HBM factors were added to an equation containing demographic variables and social norm scales. The inclusion of the HBM factors led to a 23% gain in prediction for women and a 19% gain in prediction for men. The significant individual factors varied between men and women. Susceptibility to marital problems and divorce, and barriers were

all significant predictors for women (benefits was marginally significant). For men, however, only the barriers factor and the concern about expense emerged as significant predictors after controlling for age, religion, and social norms.

Social norms were also significant predictors of intentions after controlling for age and religion. They led to a 13% gain in prediction for women and a 22% gain in prediction for the men after accounting for the demographic variables.

Both scales were significant for women, but only respected recommenders was a significant predictor for men. In the most stringent test, the addition of the social norm scales to an equation containing the demographic variables and the HBM factors led to a 3% gain in prediction for women and a 7% gain in prediction for men. The gain was significant for women and men. For women and men, having respected people recommend counseling was a significant individual predictor, but peer benefits was not.

### *Time 2*

Of the 76 couples who married and provided follow-up data, 46 husbands (60.5%) and 47 wives (61.8%) reported participating in premarital counseling. The premarital counseling received by these couples averaged 14 to 15 hours and cost couples an average of \$75 to \$80. Eighty-eight percent of husbands and 94% of wives reported that the counseling they received was church related.

The correlations between predictors and participation in premarital counseling can be found in Table 2, in the correlation with participation columns. Overall, the same individual predictors that were correlated with intentions were also correlated with participation (i.e., age for men, income for women, barriers, benefits, and recommendations for men and women). Thirty-seven husbands (80.4% of those who participated) and 36 wives (76.6% of those who participated) reported that premarital counseling was required or recommended by the person(s) or institution performing their wedding ceremony. The data analytic approach used in this study was to statistically control for counseling as a required or recommended, to determine whether the predictors of couple participation were significant after taking this factor into account.

#### *Relationship between intentions and participation*

Men's and women's earlier intentions to participate in premarital counseling were moderately correlated to their actual participation in premarital counseling. Point-biserial correlations were significant for men ( $r = .54, p < .001$ ) and women ( $r = .52, p < .001$ ). A more stringent test of whether couples' intentions to go to premarital counseling predict their actual participation was conducted by controlling whether counseling was required or recommended by the person(s) or institution performing the wedding ceremony. Logistic regression

equations were used to predict participation by intentions after controlling for whether counseling was required or recommended. Intentions significantly predicted participation after controlling for required or recommended participation for men (change in *chi-square* = 8.60,  $p < .01$ ) and for women (change in *chi-square* = 5.01,  $p < .05$ ).

*Prediction of Participation by HBM Factors.*

Logistic regression analyses were used to determine whether the HBM factors predicted participation in premarital counseling (see 5, Equation 1). The perceived barriers to premarital counseling significantly predicted whether or not couples went to premarital counseling for men (change in *chi-square* = 16.49,  $p < .01$ ) and for women (change in *chi-square* = 7.70,  $p < .01$ ). Addition of the HBM factors susceptibility, severity, and benefits did not add to the prediction. /Table 5 above here/.

A second logistic equation was run to determine whether perceived barriers would predict participation after controlling for whether or not participation was required or recommended (see Table 5, Equation 2). Required participation was a significant predictor for women (change in *chi-square* = 45.46,  $p < .01$ ). Required participation was not a significant predictor for men. Perceived barriers significantly predicted participation after controlling for whether counseling was

required was significant for men (change in *chi-square* = 8.71,  $p < .01$ ). For women, the addition of perceived barriers after accounting for required or recommended participation did not add to the prediction.

A third equation was run predicting participation from perceived barriers after controlling for required participation, demographic variables, and social norms (see Table 5, Equation 3). For men and women, the addition of perceived barriers after accounting for required participation, age, religion, and respected recommenders did not add to the prediction.

#### *Prediction of Participation by Social Norms.*

Logistic regression equations were run predicting participation from the social norm scales (see Table 6, Equation 1). For men and women, recommendations by respected people significantly predicted participation for men (change in *chi-square* = 13.81,  $p < .01$ ) and for women (change in *chi-square* = 8.09,  $p < .01$ ). The addition of the social norm scale peer benefits did not add to the prediction for men or women. /Table 6 above here/.

Next, logistic regression equations were run to determine whether recommendations would predict participation after controlling for whether or not participation was required or recommended (see Table 6, Equation 2). The addition of recommendations to the equation was significant for men (change in

*chi-square* = 12.65,  $p < .01$ ) and women (change in *chi-square* = 10.11,  $p < .01$ ), with recommendations accounting for an additional 15% and 9% of the variance respectively, after controlling for whether counseling was required.

Finally, logistic regression equations were run predicting participation from recommendations, required participation, demographic variables, and HBM factors (see Table 6, Equation 3). Recommendations was a significant predictor of participation after controlling for required participation, age, religion, and perceived barriers for men (change in *chi-square* = 6.56,  $p < .05$ ) and for women (change in *chi-square* = 6.46,  $p < .05$ ).

## Discussion

The purpose of the present study was to identify factors that motivate couples to participate in premarital counseling. Potential factors were identified by applying the health belief model (HBM), a model which has been used to explain participant motivation in a wide variety of health-related behaviors. Other important potential factors included social norms regarding the prevention intervention, intentions regarding participation, and knowledge about the potential problem. Demographic variables were also taken into account, as they have been shown to influence prevention behavior in the health literature and to influence participation in premarital counseling itself in previous studies (e.g., Sullivan &



Bradbury, 1997). Results from the current study confirm that certain demographic variables are significant predictors of couples' intentions and behavior, specifically age and religion for men and religion for women.

Several factors appear to be important in predicting engaged couples' intentions to participate in premarital counseling during their engagement, though they varied somewhat for women and men. For women, perceived susceptibility to marital problems and divorce, perceived severity of divorce, perceived barriers to counseling, and having a respected other recommend premarital counseling predicted intentions to participate in premarital counseling at Time 1. For men perceived barriers to counseling, perceived monetary expense, and having a respected other recommend premarital counseling predicted intentions to participate in premarital counseling at Time 1. These factors predicted intentions even after controlling for demographic variables and after controlling for other significant predictors. Thus these factors appear to make unique contributions in understanding what motivates engaged men and women to go to premarital counseling.

The factors that significantly predicted actual participation at follow-up were the same for men and women. Perceived barriers and having a respected other recommend counseling predicted participation. The relationship remained

significant even after controlling for demographic variables and whether or not counseling was required or recommended.

One strength of this study is that the sample is more ethnically and economically diverse compared to many samples used in this type of research (Cherlin, 1981; Martin & Bumpass, 1989). Nevertheless the sample is predominantly Caucasian, which leaves open the possibility that the explanatory factors presented here may not apply to more diverse populations. Continued efforts must be made in future research to obtain more ethnically diverse samples. The current sample is also relatively small, particularly for the number of analyses used. This concern is not too serious, given that the analyses are theory-driven. However, further research with larger samples would certainly strengthen our confidence in the current findings.

Another important difficulty is based on evidence that preventive behavior is sometimes triggered by a "cue to action" (Strecher, Champion, and Rosenstock, 1997). It is possible that a study of this kind might serve as a cue to action for engaged couples to participate in premarital counseling. Measures were taken to reduce the likelihood that this would happen, and the evidence suggests that this was not an important factor in the current study (see Methods section).

Finally, it is important to note that over 75% of the partners in this study

were required to attend premarital counseling, which limits the variance to be accounted for in the current study. In addition, the finding that the strongest predictor was if premarital counseling was recommended by someone the person respects is difficult to interpret in light of the number of couples for whom counseling was required.

### *Implications and Recommendations*

The importance of preventing marital problems is clear and many researchers and practitioners are working to develop effective prevention approaches for couples. Developing effective interventions, however, is only one of two key tasks in preventing adverse marital outcomes. The second key task is the effective dissemination of interventions for couples. Effective intervention without effective dissemination is no more useful than effective dissemination without effective interventions. The data presented here indicate that the factors that predict variability in access to services are identifiable and thus can inform dissemination efforts. What follows is an evaluation of potential recruitment strategies for couples based on the findings of the current study.

*Increasing Perceived Susceptibility and Perceived Severity.* Preventionists have sometimes engaged in "scare tactics" to motivate people to engaged in health behaviors. Examples of such tactics are include memorable television, magazine,

and billboard advertisements warning of the dangers of smoking or drug use (e.g., "this is your brain on drugs"). Scare tactics are used to increase people's sense of susceptibility and, more importantly, the severity of the problem that interventionists are trying to prevent. Though there is evidence that women's intentions to participate in premarital counseling are related to perceived susceptibility and severity of divorce, there is no evidence that these factors influence men's intentions, nor do they predict actual participation in premarital counseling for women or for men. Thus it seems likely that strategies based on increasing perceived susceptibility to and severity of distress and divorce, such as emphasizing the current high rates of divorce or the negative consequences of distress and divorce, will be of limited usefulness in motivating couples to participated in premarital prevention programs.

*Reducing Perceived Barriers.* Perceived barriers to participation in premarital counseling appear to be a strong predictor of intentions and participation for men and women, predicting couples' participation even after controlling for whether or not counseling was required or recommended. Given these findings, it appears that recruitment strategies that focus on reducing perceived barriers may be quite effective in increasing couples' motivations to

attend premarital counseling. Based on the items used to measure barriers in the current study, recommended strategies include efforts to provide low-cost counseling, efforts to make counseling as convenient as possible, and increasing couples' perceptions that the provider (whether therapist or minister) is competent and trustworthy.

*Increasing Perceived Benefits.* The current results indicate that couples' perceptions of the benefits of premarital counseling have little explanatory value for why couples do and do not participate. Thus providing information about the benefits of premarital counseling will probably not be useful for recruiting couples.

*Social Norms.* Couples' reports of whether they know people who had engaged in and benefitted from premarital counseling were not significantly related to intentions or participation for men or women. Therefore relying on methods such as "word of mouth" does not appear to be a good strategy in increasing the client base for premarital counseling interventions.

However, the strongest predictor in the current study was whether or not counseling was recommended by someone that the couple respects. Therefore, ensuring that community leaders regularly recommend counseling to engaged

couples may be the single most useful recruitment strategy. This may be especially important for couples who do not belong to a religious institution that requires counseling, given the finding that a recommendation accounts for additional variance above and beyond the variance accounted for by having counseling required. Clearly clergy are a very important group for this purpose as they hold respected positions in the community and are most likely to regularly encounter couples who wish to marry. Other potential recommenders may include mental health workers, doctors, politicians, or anyone who is respected in the community and who has regular access to engaged couples.

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## Footnotes

1 This sample is fairly representative of the population in the two cities from which it was drawn. Caucasians are over represented (by about 10 - 30%) and Latinos and Asians are under represented (by about 10% each). African-Americans are accurately represented. (US Bureau of the Census, 2000).

## Figure Captions

*Figure 1.* Proposed model for predicting participation in premarital counseling programs.

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