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BRIEF REPORT

Barriers and Facilitators of Relationship Help-Seeking Among
Low-Income CouplesHannah C. Williamson
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Despite being at elevated risk for relationship distress and dissolution, couples living with low incomes are less likely than their middle-class counterparts to participate in couple therapy. To increase treatment use among economically disadvantaged couples, information is needed on how they perceive barriers to treatment and on factors that might facilitate their help-seeking. The first aim of the present study was to identify the prevalence of attitudinal, structural, and relational barriers to seeking therapy for the relationship among individuals who perceived a need for help with their relationship. The second aim was to test whether having direct experience with a relationship intervention (through receipt of premarital education) or indirect experience (by having a social network member who has received couple therapy) is associated with reduced barriers and greater use of therapy for the relationship. Using self-report data from 231 ethnically diverse newlywed couples living in low-income neighborhoods, we find that men and women identify cost and uncertainty about where to go for help as their top two barriers to seeking therapy for the relationship, followed by the partner not wanting therapy (for women) and the belief that individual counseling would be more helpful than couple therapy (for men). Direct and indirect experiences with relationship interventions was associated with increased likelihood that couples sought therapy for the relationship. These results suggest specific directions that can be taken to improve the accessibility of interventions, thereby providing low income couples with resources that might enhance their relationship.

Keywords: barriers, couple therapy, help-seeking, premarital education, low-income

Distressed couples receiving empirically validated treatments commonly experience increases in relationship satisfaction and decreases in likelihood of divorce (e.g., Christensen, Atkins, Baucom, & Yi, 2010), whereas untreated distressed couples typically experience no improvement in relationship satisfaction (Baucom, Hahlweg, & Kuschel, 2003). Despite the potential benefits of couple therapy, many distressed couples either do not seek help at all or wait until their problems are very severe before doing so (e.g., Halford, Kelly, & Markman, 1997). Efforts to bridge the gap between needing and receiving couple therapy require an under-

standing of the reasons why couples are unable or unwilling to receive help as well as any experiences that may facilitate help-seeking. The present study focuses specifically on relationship help-seeking among couples living with low incomes, who are less likely to receive relationship interventions than middle-class couples (e.g., Halford, O'Donnell, Lizzio, & Wilson, 2006; Sullivan & Bradbury, 1997) despite being at greater risk for poor relationship outcomes (e.g., Lundberg, Pollak, & Stearns, 2016). In view of federal policy initiatives to disseminate relationship interventions among disadvantaged groups (Johnson, 2012), we aim to document barriers to seeking help for relationship distress, and test two possible mechanisms that may reduce these barriers and thereby facilitate help-seeking among underresourced couples.

Individuals seeking psychotherapeutic intervention face potential barriers that fall into two classes: attitudinal barriers and structural barriers (Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994). Attitudinal barriers stem from an individual's thoughts or beliefs about therapy, such as thoughts that therapy will not be helpful, that friends or family would be more helpful in solving the problem, or that he or she will be stigmatized for seeking therapy. In contrast, structural barriers are external obstacles to receiving therapy that must be overcome to gain access to treatment, including high cost, lack of knowledge about treatment options, and difficulty in securing childcare, time off of work, or

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transportation. Studies focusing on individuals in need of mental health services have found that attitudinal barriers were the top barriers for everyone, regardless of income, but mixed results indicate that structural barriers may or may not be greater for low-income individuals (Mojtabai et al., 2011; Sareen et al., 2007; Wells et al., 1994). In sum, attitudinal barriers appear to be the most common barrier to seeking individual therapy, and structural barriers may also play an important role for low-income individuals.

For couples considering therapy, the same attitudinal and structural barriers may not only be present but compounded by the fundamentally dyadic nature of couple therapy. Each structural barrier must be overcome by both spouses in order for them to be *able* attend couple therapy together. For example, couples with children must arrange childcare because one spouse cannot stay home with the kids. Alternatively, they could attend therapy during the day, but both spouses must be able to take time off of work, at the exact same time. Even if structural barriers are overcome, both spouses must also overcome attitudinal barriers and be *willing* to attend couple therapy. This “relational barrier” is a problem unique to individuals wishing to seek help for couple or family distress; their ability to engage in treatment hinges on the willingness of another person to overcome their own barriers and engage in treatment. Indeed, one of the top reasons that divorcing individuals report for not seeking couple therapy was that their spouse did not want to attend (Wolcott, 1986). Thus the barriers that prevent couples from seeking help for their relationship may differ from the barriers that prevent individuals from seeking therapy.

To increase the likelihood that couples in need of therapy receive it, it is not enough to determine the primary barriers to couple therapy; experiences that mitigate these barriers and facilitate help-seeking must also be identified. One promising facilitator of couple therapy is premarital education. Couples who experience premarital education are more likely to seek couple therapy later (Schumm, Silliman, & Bell, 2000; Williamson, Hammett, Ross, Karney, & Bradbury, 2018) and, importantly, this link is stronger among couples living with low incomes (Williamson, Trail, Bradbury, & Karney, 2014). However, the reason why premarital education might serve as a ‘gateway’ for eventual couple therapy is unclear. One possibility is that premarital education reduces the structural barrier of not knowing where to go to seek help, insofar as couples may return to the same provider or may have received referrals or guidance on how to find relationship interventions in the community. Another possibility is that couples who have participated in premarital education may have a better understanding of the experience of participating in a relationship-focused intervention, a more positive attitude toward it, or greater expectations that it will be useful, resulting in fewer attitudinal barriers. A third possibility is that couples who participate in premarital education are more religious than those who do not and religious engagement may make resources for relationship help-seeking more readily available.

In addition to personal experience with a relationship-focused intervention, having social network members who have participated in couple therapy may also serve to reduce barriers and facilitate receipt of couple therapy. Knowing someone who has sought professional help is associated with positive attitudes toward, and intentions to seek, mental health services (Vogel, Wade, Wester, Larson, & Hackler, 2007), and with increased likelihood

of making a mental health visit oneself (Alvidrez, 1999). To our knowledge, however, this association has not been explored in relationship-focused interventions. Knowing someone who has received couple therapy may reduce the structural barrier of not knowing where to go for help, if partners can seek therapy from the same source as their social network member. Pursuit of couple therapy by a social network member may also reduce attitudinal barriers by decreasing feelings of stigmatization about seeking help and by increasing confidence in the efficacy of relationship interventions.

The goals of the current study are, first, to identify the prevalence of structural, attitudinal, and relational barriers to seeking help for relationship distress, and second, to test whether personal experience (premarital education) and social network experience (knowing someone who has received couple therapy) are associated with a decreased likelihood that a barrier is reported and increased likelihood that a couple seeks therapy. We conduct these analyses in a sample of ethnically diverse low-income couples, many of whom experienced a treatment gap: they perceived a need for help in their relationship but did not ultimately receive treatment. We focus on this important segment of the population because enhancing relationships among people living with sociodemographic disadvantage can stabilize the financial status of people who, were they to divorce, would be subject to even more severe forms of poverty (e.g., Smock, Manning, & Gupta, 1999) and especially poor child outcomes (e.g., Amato, 2000). Understanding how to facilitate greater use of relationship interventions is therefore likely to have greater impact on vulnerable couples than on couples with more economic resources.

Method

Sampling

Procedures were designed to obtain a sample of newlywed couples living in high-poverty neighborhoods in Harris County, Texas. Recently married couples were identified through marriage license applications obtained from the Harris County Recorder’s Office between 2014 and 2015 (prior to the legalization of same-sex marriage, resulting in all different-sex couples). Addresses were matched with census data to identify applicants living in high-poverty communities, defined as census block groups with no less than 30% of the households categorized as living in poverty (U.S. Census Bureau, 2013). Couples were screened to ensure that they had married, neither partner had been previously married, both partners could speak English or Spanish, and neither partner was below 18. The study was approved by the RAND Corporation IRB (2013–0544-AM06; “A social network analysis of racial disparities in marital outcomes”).

Participants

The sample comprised 231 couples who were within 12 months of their wedding at baseline ($M = 5.5$ months, $SD = 2.0$). Wives ranged in age from 18 to 56 years ($M = 28.35$, $SD = 7.52$) and husbands ranged in age from 18 to 53 years ($M = 29.16$, $SD = 7.33$). Fifty-three percent of wives and 52% of husbands were Hispanic, 35% of wives and 32% of husbands were Black, 9% of wives and 10% of husbands were White, and 3% of wives and 6%

of husbands were Other/Multiracial. Approximately 65% of couples had children at baseline, with median age of 3.0 for the youngest child. Median household income was \$32,500. The majority of husbands (60%) and wives (54%) had less than or equal to a high school diploma/GED; 12% of husbands and 16% of wives had a college degree or higher. Thirty-three percent of husbands and 39% of wives reported attending religious services weekly or more, whereas 20% of husbands and 18% of wives never attend religious services.

Procedure

At baseline (T1), couples were visited in their homes by two interviewers who took spouses to separate areas to describe the IRB approved study, obtain informed consent, and orally administer self-report measures. Participants also completed other data collection procedures not relevant to the current study. Interviewers returned at 9 months (T2) and 18 months (T3), and administered the same interview protocol. Couples who reported that they had divorced or separated did not complete the interview. At T2, 84% ($n = 194$) of couples were still together and completed the interview with an additional 9% of couples indicating they had separated ($n = 15$) or divorced ($n = 5$) for a retention rate of 93%; data were not collected from 7% ($n = 17$) of couples because they refused or could not be located. The T3 field period was ended prematurely due to Hurricane Harvey which occurred in Harris County in August 2017, resulting in 17% ($n = 38$) of couples being unable to complete T3. At T3, 226 couples remained eligible for the study (the 5 couples who had divorced were no longer eligible), of whom data was collected from 74% ($n = 158$ couples and $n = 10$ individuals whose spouse refused), with an additional 3% of couples indicating that they had separated ($n = 6$) or divorced ($n = 1$), for a retention rate of 77%. In addition to missing data due to Hurricane Harvey, data was not collected from 3% ($n = 6$) of couples who were ineligible due to incarceration, military service, or death and 4% ($n = 7$) who refused or could not be located. Missing data was handled by using all available data for analysis. Thus, if a couple completed fewer than all three waves of assessment their cumulative variables (i.e., consideration of therapy for the relationship, receipt of therapy for the relationship) were calculated based upon data they had provided.

Measures

Premarital education. At T1 participants were asked “Did the two of you receive any sort of relationship education or classes before you got married?” Responses were coded as 0 = *no* and 1 = *yes*. Couples were coded as receiving premarital education if either spouse responded *yes*. In 91% of couples, partners agreed on whether they received premarital education. In 3% of couples only the husband reported that they received premarital education, and in 6% of couples only the wife reported that they received premarital education.

Consideration of therapy for the relationship. This was assessed by asking “Since you got married, have you ever considered seeking or receiving counseling/therapy for this relationship?” at T1 and “Since the last time we interviewed you, have you ever considered seeking or receiving counseling/therapy for this relationship?” at T2 and T3. Responses were coded 0 = *no* and

1 = *yes* at each time point and then collapsed across time points, such that individuals who responded *yes* at any time point were coded 1 and those who responded *no* at all time points were coded 0.

Receipt of therapy for the relationship. At T1 participants were asked “Since you got married, have you ever actually received counseling/therapy for this relationship?” At T2 and T3 participants were asked “Since the last time we interviewed you, have you ever actually received counseling/therapy for this relationship?” Responses were coded as 1 = *yes* and 0 = *no* at each time point and then collapsed across time points, such that individuals who responded *yes* at any time point were coded as 1 and individuals who responded *no* at all time points were coded as 0. Couples were coded as receiving therapy for the relationship if either spouse responded *yes*. In 90% of couples, partners agreed on whether or not they received therapy for the relationship. In 2% of couples only the husband reported that they received therapy, and in 8% of couples only the wife reported that they received therapy.

Social network experience with couple therapy. At T1-T3 participants were asked “As far as you know, have any of your close friends or family ever attended couples counseling/couples therapy?” Responses were coded as 0 = *no* and 1 = *yes* at each time point and then collapsed across time points, such that individuals who responded *yes* at any time point were coded as 1 and individuals who responded *no* at all time points were coded as 0.

Barriers to seeking therapy for the relationship. At T1-T3, participants who endorsed “consideration of therapy for the relationship” but did not endorse “receipt of therapy for the relationship” were read a list of 12 potential reasons why he or she may not have received those services, adapted from the RAND Deployment Life Study (Tanielian, Karney, Chandra, & Meadows, 2014), and asked if each reason applied to him/her. Only responses from the first time point at which individuals received these items were analyzed. Responses were coded as 0 = *no* and 1 = *yes*. See Table 1 for the list of potential barriers.

Results

Descriptive Statistics and Preliminary Analyses

Roughly 27% ($n = 63$) of couples received premarital education, which is comparable to other studies (e.g., 29% reported by Halford and colleagues [2006]). Over the course of their marriage, 32% ($n = 73$) of husbands and 47% ($n = 109$) of wives considered seeking therapy at some point; 15% ($n = 35$) of couples actually received therapy. Black individuals were significantly more likely to consider seeking therapy than were Hispanic individuals (husbands: 50% vs. 23%, Fisher’s exact test two-tailed $p < .001$; wives: 64% vs. 39%, Fisher’s exact test two-tailed $p < .001$), but there were no significant differences between any racial/ethnic groups in likelihood of receiving premarital education or therapy for the relationship.

The vast majority of the interventions (87% of premarital education and 80% of therapy) were received in religious settings. There were no significant differences between any racial/ethnic groups in likelihood of receiving treatment in a religious setting. In regards to social network exposure to help-seeking, 34% ($n = 78$) of husbands and 43% ($n = 99$) of wives reported that they knew someone who had received couple therapy. White husbands were

Table 1
Descriptive Statistics of Barriers to Seeking Couple Therapy

| Barriers | Husband | Wife |
|----------------------------------------------------------------------------|---------|------|
| Attitudinal Barriers | | |
| Individual counseling would be more helpful than couple therapy | 27% | 15% |
| Your family or friends would be more helpful than a counselor or therapist | 18% | 7% |
| You do not think the counseling would be kept confidential | 8% | 7% |
| The counseling or therapy services available are not very good | 8% | 4% |
| You do not believe that therapy would work | 6% | 3% |
| You were worried about what others might think if they found out | 4% | 4% |
| Structural Barriers | | |
| You would not know where to get help or who to see | 31% | 43% |
| You could not afford it | 35% | 42% |
| It would be difficult to get childcare or time off of work | 20% | 20% |
| It would take too much time to be in therapy | 14% | 11% |
| It would be difficult to arrange transportation to therapy | 6% | 5% |
| Relational Barrier | | |
| Your spouse or partner did not want to get therapy | 14% | 36% |

Note. Results for all individuals who considered but did not seek therapy: $n = 49$ husbands, $n = 75$ wives.

significantly more likely than Hispanic husbands to report that they knew someone who had received couple therapy (68% vs. 25%, Fisher's exact test two-tailed $p < .001$). There were no significant differences on this variable between any racial/ethnic groups for wives.

Barriers to Seeking Therapy for the Relationship

Of the 32% ($n = 73$) of husbands who considered seeking therapy for the relationship, 33% ($n = 24$) followed through and received therapy, whereas 67% ($n = 49$) did not. Of the 47% ($n = 109$) of wives who considered seeking therapy for the relationship, 29% ($n = 32$) followed through and received therapy, whereas 71% ($n = 77$) did not (data on barriers were missing for two of these women, leaving $n = 75$ for the following analyses).

Table 1 presents the percentage of individuals who considered therapy but did not seek it who endorsed each of the possible barriers to seeking help. Top barriers for women were structural and relational; "You would not know where to get help or who to see," "You could not afford it," and "Your spouse or partner did not want to get therapy." Top barriers for men were attitudinal and structural; "You could not afford it," "You would not know where to get help or who to see," and "Individual counseling would be more helpful than couples therapy." Women were significantly more likely than men to endorse the relational barrier "Your spouse or partner did not want to get therapy" (36% vs. 14%, Fisher's exact test two-sided $p = .008$).

Premarital Education as a Facilitator

Couples who received premarital education were significantly more likely to later receive therapy than those who did not receive premarital education (25% vs. 11%, $\chi^2(1) = 7.07$, $p = .008$). However, when husbands' and wives' religious attendance were entered simultaneously into a logistic regression with premarital education as predictors of receipt of therapy, only the wives' religious attendance was a significant predictor ($B = .380$, $p = .037$).

Wives who received premarital education and later considered seeking therapy were significantly less likely to endorse the structural barrier "You would not know where to get help or who to see" than wives who did not receive premarital education and considered seeking therapy (22% vs. 78%, Fisher's exact test two-sided $p = .031$). Receipt of premarital education was not significantly associated with a lower likelihood of endorsing any of the other barriers.

Social Network Experience as a Facilitator

Dummy codes for couples in which only the husband, only the wife, or both partners knew someone who received couple therapy were entered into a logistic regression predicting receipt of therapy. Couples in which both partners had social network experience with couple therapy were more likely to receive therapy ($B = .993$, $p = .031$), whereas couples in which only the husband ($B = .664$, $p = .26$) or only the wife ($B = .354$, $p = .495$) had social network experience with couple therapy were not significantly more likely to receive therapy. Social network experience with couple therapy was not significantly associated with a lower likelihood of endorsing any of the potential barriers.

Discussion

Despite evidence that empirically supported couple therapies improve relationship outcomes, few couples engage in therapy prior to divorce, suggesting that barriers prevent couples from seeking or receiving help. With data collected from couples living in low-income communities, we identify the most common barriers endorsed by couples who did not receive treatment when needed, and we demonstrate that direct and indirect experiences with relationship interventions can help bridge the gap and support help-seeking. As we outline below, these findings allow us to highlight some approaches that may help facilitate higher rates of treatment for low-income couples.

First, the top two barriers for all individuals who considered but did not receive therapy for their relationship were structural—cost

and uncertainty about where to go for help. This is consistent with literature on individual mental health services which indicates that cost is more likely to be a barrier for low-income people (Sareen et al., 2007; Wells et al., 1994). Financial barriers may also be an especially acute barrier to couple therapy because insurance companies often do not reimburse for couple or family interventions that are not focused on treatment of a mental health diagnosis (Doss, Feinberg, Rothman, Roddy, & Comer, 2017). In contrast, uncertainty about where to seek help has not been previously identified as a barrier to individual therapy; this may reflect a unique lack of clarity about relationship interventions. Relationship distress is neither a medical condition nor a mental health disorder, so the appropriate treatment providers may not be obvious to a lay person. Other structural barriers such as trouble finding childcare, difficulty arranging transportation, and therapy taking too much time were endorsed infrequently. It is possible that these structural barriers may only emerge later, based upon information received after a treatment provider can be identified.

Wives' third biggest barrier was relational: their husbands did not want therapy for the relationship. This is consistent with previous research indicating that women typically lead the help-seeking process, and men are more likely to be reluctant to engage in couple therapy (Bringle & Byers, 1997; Doss, Atkins, & Christensen, 2003). Indeed, for men their third most common barrier was attitudinal: they believed that individual counseling would be more helpful than couple therapy, and many also believed that their family or friends would be more helpful than a counselor or therapist.

Second, the vast majority of interventions were received in a religious setting, consistent with previous research showing that more religious couples are more likely to receive relationship interventions (Duncan, Holman, & Yang, 2007; Halford, O'Donnell, Lizzio, & Wilson, 2006). Additionally, receipt of premarital education was associated with higher likelihood of receiving therapy, but this effect was not significant after controlling for religious attendance. Furthermore, receipt of premarital education was associated with a lower level of uncertainty among wives about where to seek help. Taken together these results suggest that low-income couples may turn to readily available services, such as those associated with their religious organization, when seeking help for their relationship. Future research on help-seeking should document the provider and type of intervention received to better understand what couples are actually receiving, and to promote receipt of effective relationship interventions. Results of the current study also indicated that knowing someone who has received couple therapy is associated with an increased likelihood of receiving therapy, but only for couples in which both partners reported this social network experience. Future studies should explore this link further, including characteristics of the social network member and types of information about their therapy experience that are most facilitative.

Taken together, results of the current study suggest a few directions for reducing the treatment gap in couple therapy. First, low-cost, easily accessible alternatives to traditional couple therapy, such as online interventions, may reduce structural barriers. Efforts to develop these types of programs are already underway, most notably through the OurRelationship program (Doss et al., 2016). Second, focusing on barriers and facilitating experiences unique to husbands may reduce the dyadic barrier to treatment.

One promising approach may be to promote access to relationship-focused preventive interventions like the Marriage Checkup, a two-session informational assessment designed to facilitate couples' help-seeking (Cordova et al., 2014). Additionally, encouraging individuals who have had successful experiences in couple therapy to talk openly about this experience with friends and family could facilitate greater help-seeking among other couples.

Several factors limit the interpretation of these results. First, because the current study focused on different-sex newlywed couples sampled from low-income neighborhoods, results may not generalize to same-sex couples (who may have more concerns about discrimination) and more affluent couples (who may have more attitudinal barriers and fewer structural barriers). Second, although our sample is diverse in terms of race/ethnicity, we did not have enough data to test for moderation by race/ethnicity in our analyses. Compared to white couples, ethnic and racial minority couples likely experience different cultural norms about help-seeking and different barriers, such as finding a therapist who is competent in their language and culture. Future research on barriers to couple therapy should explore barriers that may uniquely affect different underrepresented groups. Third, we only assessed barriers to help-seeking for people who perceived a need for help in their relationship but did not end up receiving therapy. Barriers experienced by couples who successfully sought therapy and how they overcame them were not measured, but this is an important direction for future research. Fourth, barriers that prevent couples from engaging in relationship interventions may also prevent them from participating in research. Thus it is possible that our sample does not include couples with the highest levels of barriers, and that we have therefore underestimated these effects.

Notwithstanding these limitations, the present study documents the difficult structural barriers that prevent low-income couples from seeking help for their relationship and adds new perspective about facilitating the help-seeking process. Bridging the treatment gap for couples in need of intervention will take efforts across many domains, including reducing men's attitudinal barriers toward relationship interventions and reducing structural barriers by making couple therapy more affordable and accessible.

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