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Who Attends Couples Counseling in the UK and Why?

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Abstract

In the UK, publicly-funded couples therapy is reserved for couples where one or both partners present with psychological disorders, rather than relationship distress, despite evidence of a bidirectional relationship between the two. Demographics and presenting issues for 14,726 couples who received counseling through a third-sector counseling organization in England and Wales were investigated. Clients were often white, aged 25-54 and presented with interpersonal issues. 'Mental health problems' were identified as an issue by about a quarter of all clients. This suggests that many couples seeking relationship counseling wish to address relational versus psychological distress, which has implications for publicly-funded services.

Keywords: psychological treatment, relationship factors, questionnaires

Introduction

Relationship distress is a common and growing problem which is known to have concerning implications for those involved, yet little is known about the people seeking relationship help and why. Evidence has shown that people in problematic relationships are more likely to suffer from anxiety and depression than those in satisfying relationships (Røsand, Slinning, Eberhard-Gran, Røysamb, & Tambs 2012; Whisman & Uebelacker, 2003). Other studies have reported that frequent and intense relationship conflict can harm the physical and mental health of children (Cowan & Cowan, 2002; Harold & Leve, 2012) - in some cases even causing behavioral or developmental problems (Tolan, Gorman-Smith, & Henry, 2002). It is therefore critical to understand the issues that lead to relationship distress to equip services to deliver effective interventions to alleviate them.

The relationship between dyadic relationship distress and negative individual mental health outcomes is bidirectional, with, for example, marital dissolution predicting mental health problems and mental health problems prospectively predicting marital dissolution (Mojtabai et al., 2017). In line with this, research suggests that relationship satisfaction moderates the adverse effects of emotional strain (Røsand *et al.*, 2012). This would suggest that interventions that address both individual diagnostic symptomology and dyadic relationship distress are needed. Furthermore, it could be argued that interventions which seek to address relationship issues may be an appropriate form of early or preventative intervention for mental health problems.

Couples therapy aims to provide a solution for relationship distress whilst also addressing individual mental health problems. In the United Kingdom (UK) there are arguably two main sectors that provide forms of couples therapy; the public sector (i.e. statutory services) and the third sector (voluntary and community services). Couple Therapy for

Depression is available in the UK through the statutorily-funded Improving Access to Psychological Therapies (IAPT) program which is offered by the National Health Service (NHS; a term which incorporates all statutory funded healthcare services across the UK). It is currently recommended by the National Institute for Health and Care Excellence ([NICE], 2009) for the treatment of mild to moderate depression. This is a manualized, integrative, behavior-based therapy which has been designed to treat both depression and relationship distress in couples (National Collaborating Centre for Mental Health [NCCMH], 2018). Couple Therapy for Depression in IAPT has been shown to improve individual mental health outcomes, reducing both depression and anxiety (NHS Digital, 2018: Table 7b). However, no data are available on the impact of this intervention for relationship distress because relationship functioning is not assessed in the IAPT dataset, despite it being designed to do so. This suggests that, whilst the intervention focuses on both relationship distress and depression, its effectiveness is considered (in the IAPT context at least) only in terms of depression. The current study aims to address whether this is the most appropriate indicator of successful therapy for couple therapy clients and what implications, if any, this has for funders.

Couples therapy is also widely accessible in the UK through private or voluntary/third sector settings which can be accessed via self-referral and paid for privately. In some circumstances, charitable services will provide low-cost or free relationship counseling for clients from particularly deprived backgrounds, however, this practice is inconsistent across the country as it largely depends on services receiving local grants or project funding. Historically this sector has focused on the alleviation of relationship distress over individual diagnostic symptomology. 'Relate' is the largest independent third-sector provider of what the organization terms 'relationship counseling', with 50 local centers and over 1,500 counselors working across more than 600 different sites to deliver online and face-to-face services across

England and Wales, including relationship counseling (Relate, 2017). All Relate therapists undergo a minimum of two years training before becoming fully qualified 'relationship counselors', who can work with adult individual and couples counseling clients. The training is based on a mix of diverse theoretical orientations, but most commonly psychodynamic and systemic theory. Prior to the present study, no nationwide evaluation of Relate service data has been undertaken, therefore posing the question whether this service is fit for purpose.

To improve suitability, services should be appropriately tailored towards the needs of clients. To achieve this, it is imperative to understand who attends services and their presenting issues, however available literature in this area is sparse. To date the largest evaluation of couples therapy in the UK analyzed data from only 877 clients (Hewison, Casey & Mwamba, 2016) which mostly consisted of a non-diverse (majority white, heterosexual, non-disabled) population and did not include any assessment of presenting issues. This study provides a strong argument for the efficacy of couples therapy however it does little to determine who, within a large community setting, is accessing couples therapy and why. Furthermore, a lack of diversity within the Hewison et al. study poses the question whether couples therapy services are both accessible and suitably tailored for effectively working with marginalized groups. This is pertinent given the benefits of adapting services for culturally modified populations, such as increased treatment efficacy (Griner & Smith, 2006). There is also little up-to-date research on why clients attend couples therapy, which is essential if services are to provide effective therapy. Though there is some research into client presenting issues, this is either outdated or deduced using small research samples (Doss, Simpson, & Christensen, 2004; Miller, Yorgason, Sandberg & White, 2003).

The large sample size of the present study (n=29,452) provides an opportunity to explore the following aims:

1. To understand who is accessing relationship counseling services and identify any under-represented groups.
2. To identify the most common self-reported presenting issues for couples therapy clients and examine differences in presenting issues across client demographics.
3. To determine key implications for funders, services and practitioners.

Method

Design

This was a retrospective naturalistic study which analyzed data from adults (aged 16 years and over) who accessed Relate relationship counseling services in England and Wales between 1 January 2015 and 31 December 2017. Clients can be seen with their partner, alone, or have a combination of couple and individual sessions. Clients in the present study had all received relationship counseling, which is predominantly offered face-to-face, although telephone and online relationship counseling is also available. For the purposes of the present study only clients seen as part of a couple, rather than those who attended without their partners, were included.

Sample characteristics

A total of 29,452 individual clients – representing 14,726 couples - from 42 Relate centers attended relationship counseling during the data collection period.

All counselors delivering relationship counseling in Relate are trained up to a minimum of a level 5 diploma in relationship counseling or equivalent and receive regular clinical supervision. A level 5 qualification in the UK is one which is delivered in Universities, Further Education Colleges and Alternative Providers, and other Private Training Providers and goes

beyond what is taught in secondary or high school, but is a level below a full undergraduate degree (Department for Education, 2018). In the UK, the British Association for Counseling and Psychotherapy (BACP) is the largest membership organization and professional body for counselors and psychotherapists, representing around 48,000 members (BACP, 2019a). To be eligible for individual BACP membership, you must have completed a minimum of one year full-time or two years' part-time classroom-based tuition, in addition to a supervised placement of at least 100 client contact hours (BACP, 2019b). This is often considered equivalent to a Higher National Certificate (HNC) or Higher National Diploma (HND), which are level 4 qualifications (Department for Education, 2018).

Measures

Demographics

Data were collected on client gender, age, ethnicity, disability, religion and sexual orientation. Socio-economic status (SES) of clients was determined inferentially by the Index of Multiple Deprivation (IMD) quintile of the geographical area where the Relate service was located. IMD is the official measure of relative deprivation of neighborhoods in England and is based on area indices for: income; employment; education, skills and training; health and disability; crime; housing and services; and the living environment (Department for Communities and Local Government [DCLG], 2016). Quintiles determine relative deprivation across five groups, from the 20% most deprived areas to the 20% least deprived areas. Due to centers in the present study serving a range of local areas, an 'average' IMD quintile was calculated for each service, causing data from the first and last quintiles (least and most deprived) to be 'lost' within the dataset. Whilst not an ideal measure of individual deprivation due to variability within areas (i.e. deprived individuals living within largely non-deprived

areas and vice versa; DCLG, 2015), it was the best indication of deprivation available for the current analysis.

Pre-counseling questionnaire

Presenting issues were captured using a bespoke tool (the ‘pre-counseling questionnaire’) developed by Relate which asked clients to identify whether they were experiencing issues across 25 pre-defined domains, such as ‘communication’, ‘my behavior’, ‘infidelity/having an affair’ and ‘money worries’. Clients were then asked to select one of three options: ‘yes – this is an issue/causing difficulty’, ‘possibly an issue/causing difficulty’ or ‘no – this isn’t an issue’. Clients also had the option to nominate their own (additional) presenting issues through a free text box; these data were not analyzed in the present study due to the possibility that personally identifiable information could be provided.

Procedure

Since 1 January 2015, demographic data about clients have been routinely collected by administrative staff at Relate services. For this same period, counselors have been encouraged to routinely collect paper copies of the pre-counseling questionnaire at the beginning of therapy. These data were then anonymized and stored in an online client management system before being extracted for the current analysis.

Informed consent to collect anonymized data for the purposes of service evaluation and audit was obtained from all clients during administrative processes prior to the start of counseling. Ethical approval for the present study was not sought due to the current analysis being a secondary analysis of anonymized, routinely collected data for the purposes of service evaluation; hence, according to UK standards, ethical review is not required (Department of Health, 2011).

Data analysis

In line with the aim to understand who is accessing Relate relationship counseling services, descriptive statistics were calculated for demographic data (gender, age, ethnicity, religion, disability, sexual orientation and social deprivation) and presenting issues. All percentages were calculated as a proportion of the known (i.e. not missing) responses.

To understand which demographic factors were associated with different reasons for seeking relationship counseling, chi-square analysis and two-way between-subject ANOVAS were used. Chi-square tests revealed whether certain types of groups were significantly more likely to identify particular presenting issues, while ANOVAs tested whether demographic variables were associated with the number of presenting issues identified by clients. For the purposes of these analyses, age data were further categorized into three groups: younger than 35 years, 35-54 years and 55 years and older. This allowed age data to distinguish between 'younger adults', 'middle-aged adults' and 'older adults'. Presenting issues were coded as dichotomous 'yes' or 'no' variables, with 'yes' responses including those who said that issues were 'possibly' causing difficulties.

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 24.0 (IBM Corp, 2016).

Results

Sample characteristics

Of the known data (i.e. not missing), just over half of the sample were female (51.5%), had an average age of 41.2 years ($SD = 10.2$, range 16-89 years) and were of White British/Irish/Welsh/White other ethnicity (88.1%). Levels of data completeness for gender and age were good (>99.9% and 96.3%, respectively) but poor for other demographic variables.

Ethnicity was unknown for over half (53.7%) of the sample. Similarly, sexual orientation data were missing for a large proportion of the sample (87.8%); where these data were known (12.2%) the majority of clients identified as heterosexual (95.9%). Clients identifying as bisexual accounted for 1.5% of the sample and those identifying as gay or lesbian each accounted for 1.4% and 1.0% . respectively. Religion was unknown for 75.1% of clients but of the remainder, just over half (51.5%) indicated that they were atheist or held no religious beliefs and 38.3% held Abrahamic beliefs (Christianity, Judaism and Islam). A small proportion held Dharmic (Buddhism, Hinduism or Sikhism) or ‘other’ religious beliefs (5.6% and 4.6%, respectively). Disability status was unknown for 42.5% of the sample; of the remainder less than half a percent of clients indicated that they had a disability, with very small proportions having a physical disability (0.3%), learning disability (<0.1%) or a sensory disability (0.1%).

Over half of the sample (55.9%) were indicated to be within the third quintile of social deprivation (e.g. average levels of social deprivation), 21.9% in the second quintile (e.g. 20-40% least deprived areas) and 22.1% in the fourth quintile (e.g. 60-80% most deprived areas). The level of data completeness for social deprivation status was good (92.1%).

[Insert Table 1 here]

Presenting issues

Table 1 provides an overview of the responses to the pre-counseling questionnaire. Data on presenting issues were available for 99.5% (n=29,306) of the sample.

On average, clients identified 11 presenting issues ($M = 11.3$, $SD = 3.9$), with females reporting significantly more issues ($M = 11.6$, $SD = 3.9$) than males ($M = 11.0$, $SD = 3.9$), $t(29287) = -12.2$, $p < .001$), although the effect size was trivial ($d = 0.14$). Age also had a statistically significant, but small, effect on the number of presenting issues identified ($F(2,$

28222) = 201.9, $p < .001$, $\eta^2 = 0.014$). Those aged under 35 identified the most presenting issues ($M = 11.6$, $SD = 3.9$), followed by those aged between 35 and 54 ($M = 11.4$, $SD = 3.9$). Clients aged 55 and over identified the fewest presenting issues ($M = 10.0$, $SD = 3.9$). Client ethnicity had no significant effect on the number of presenting issues when using Bonferroni adjusted alpha levels of .007 (.05/7), $F(6, 13577) = 2.5$, $p = .022$. Similarly, client sexuality did not have an effect on the number of presenting issues identified, $F(4, 3597) = 1.0$, $p = .429$.

The most commonly identified presenting issue across all clients was ‘communication’, with 79.7% reporting that ‘yes – this is an issue/causing difficulty’ and a further 13.6% reporting that it was ‘possibly an issue/causing difficulty’. Around two-thirds reported that ‘rows and arguments’ (68.9%), ‘managing conflict’ (67.8%), ‘worries about whether our relationship will end’ (65.1%) and ‘my partners behavior’ (63.8%) were also issues or causing difficulties, with 12.3%, 16.1%, 19.8% and 19.2% respectively indicating that these were ‘possible’ issues or difficulties. ‘Mental health problems’ were identified as an issue for 24.5% of clients, with an additional 19.6% saying they were ‘possibly’ an issue.

The least common presenting issues were ‘religion’, with 95.0% saying that this was not an issue or causing difficulty, followed by ‘unemployment’, ‘violence and/or abuse’, ‘bereavement’ and ‘physical health problems’, with 88.6%, 82.8%, 80.3% and 79.3% respectively indicating that these were not issues.

Whilst females were statistically significantly more likely than males to indicate that they were – or possibly were – experiencing most presenting issues ($p < .05$), effect sizes were negligible ($\phi < 0.1$) for all but one presenting issue: ‘my partner’s behavior’. Females were significantly more likely than males to identify ‘my partner’s behavior’ as an issue, $\chi^2(2) = 882.3$, $p < .001$, with gender having a small effect ($\phi = .177$).

Age was also found to have a statistically significant effect on most presenting issues, when using Bonferroni adjusted alpha levels of .0083 (.05/6), however, as with gender, effect sizes for age differences were trivial ($\phi_c < 0.1$) for most issues. The exceptions to this were that: younger clients (aged 54 and younger) were significantly more likely than older clients (aged 55 and over) to indicate that they were experiencing 'money worries', $\chi^2(2) = 347.8, p < .001, \phi_c = .115$ (small effect), with those aged 16-34 being proportionally the most likely to be experiencing this issue. Similarly, the youngest clients (16-34) were significantly more likely to be experiencing issues around 'having/whether to have a baby' than those aged 35-54, who in turn were significantly more likely to be experiencing this issue compared to over 55s, $\chi^2(2) = 1214.6, p < .001, \phi_c = .217$ (small effect). 'Middle aged' clients (i.e. those aged 35-54) were significantly more likely than those aged 16-34 or 55 and over to identify 'disagreements about parenting', $\chi^2(2) = 569.1, p < .001, \phi_c = .147$ (small effect), and 'problems with children' as issues, with those aged 16-34 being the least likely, $\chi^2(2) = 546.5, p < .001, \phi_c = .145$ (small effect). Conversely, those in the oldest age category (55 and over) were significantly more likely to identify this as an issue compared to those aged 35-54, who in turn were significantly more likely to identify it than those aged 16-34, $\chi^2(2) = 385.6, p < .001, \phi_c = .122$ (small effect).

Finally, whilst ethnicity was found to have a significant effect on some presenting issues, effect sizes were trivial ($\phi_c < 0.1$) for all but one issue: 'religion'. Those from Asian/Asian British, Black/Black British, Chinese, mixed ethnicity, White (other) and 'other' ethnic groups were proportionally more likely to identify religion as an issue than those from a White British/Irish/Welsh background, $\chi^2(6) = 137.8, p < .001, \phi_c = .105$ (small effect). Ethnicity had no significant effect on the multiple other presenting problem domains when Bonferroni-adjusted alpha levels of 0.003 (0.05/14) were used.

Discussion

This study has analyzed the largest naturalistic sample (almost 30,000 adults) of its kind to date to provide important information on the demographics and presenting problems of clients attending relationship counseling services in England and Wales. In line with study aims here we will consider: the demographic profile of relationship counseling clients and identify any under-represented groups, the most common presenting issues and how these differ across client demographics, and the key implications for funders and services. The clinical implications for practitioners are discussed throughout.

Demographic profile of relationship counseling clients

Demographic results for clients in the present study suggest a sample which is broadly reflective of the UK population, being roughly equal in terms of gender, majority heterosexual and white British (ONS, 2013; ONS, 2017). However, the high levels of missing data for ethnicity, disability, religion and sexuality make it difficult to draw strong conclusions about the extent to which relationship counseling, as offered by one national organization, is accessed by a diverse population.

It appears that couples therapy services more generally (as opposed to just Relate services) are severely under-accessed by older adults, even in comparison to individual psychological therapies. In line with data from statutorily-funded couple's therapy, such as IAPT's Couple Therapy for Depression (Perfect *et al.*, 2016), adults aged 65 years and over made up around 2.5-3% of clients in the present study. This is in stark contrast to the UK as a whole, where those aged 65 and over make up around 18% of the population (ONS, 2018). Services and funders should be particularly mindful of the under-representation of older adults accessing couples therapy services and consider options for outreach services and increasing the visibility of diversity in service publicity. This may help to overcome some of the common

barriers that older people face when accessing psychological therapy services, including the perception that they may not find it relevant or helpful, and practical barriers such as mobility or sensory issues (Mackenzie, Pagura, & Sareen, 2010).

In terms of social deprivation, Relate's relationship counseling appears to be more accessible to couples with a higher socio-economic status (SES) than those of a lower SES. When compared with clients entering NHS IAPT services (NHS Digital, 2018: Table 13a), Relate services had almost 17% fewer clients from the 60-80% most deprived areas and nearly a quarter more clients coming from areas of average levels of deprivation. This could possibly be due to the perception of the unaffordability of paid-for Relate services versus a free NHS service. However, the measure of SES in the present study was based on the IMD of the *service*, rather than the individual client, meaning it is possible that more clients from lower SES were accessing services, but it was not possible to identify them within the data. Hence, missing data from the highest and lowest SES brackets makes it difficult to draw definitive conclusions about the accessibility of services across individual economic groups.

Presenting issues

Investigation of the interactions between self-reported presenting problems and client demographics suggested important issues that have potential relevance for practice. Results from the present study indicated that females reported more presenting issues than men and were more likely to indicate '[their] partner's behavior' as a problem. It is important to acknowledge that males are less likely to initiate relationship counseling than females (Fleming & Córdova, 2012) and hence, it may be appropriate to suggest that the partner who initiates couples counseling is more likely to express a greater number of presenting issues by comparison.

However, previous research has suggested that men may find it difficult to open-up and engage with therapy due to feelings of ‘female collusion’ if working with a female therapist (Englar-Carlson & Shepard, 2005), which could be a relevant factor in Relate services that currently employ a majority female therapist workforce. Considerations to improve male engagement with therapy could be to adjust the initial ‘presenting problems’ survey and incorporate fewer latent/ emotional issues and more behavioral and physical issues that have been found to be more relatable for men (Seidler, Rice, Ogrodniczuk, Oliffe, and Dhillon, 2018).

Age was also found to have a small, yet significant, effect on some presenting issues, with younger clients generally identifying more relationship problems than older clients and different age groups reporting more issues in areas related to their life stage, e.g. older people experiencing more physical health problems than younger counterparts. There could be a variety of reasons for these findings including a difference in generational attitudes towards disclosure of issues (Corcoran, Brown, Davis, Pineda, Kadolph, & Bell, 2013).

Although the effects of gender and age on presenting issues tended to be small, with high levels of data completeness for these demographic factors, it can be assumed that these findings are robust and reliable, allowing for more definite conclusions to be drawn. Therefore, it is practical to suggest that practitioners working in relationship counseling services should expect some generational concerns among clients and for women to be more vocal in identifying couple presenting issues.

Implications for services and funders

Of paramount importance to funders and services, should be the finding that only around a quarter of clients are accessing relationship counseling for ‘mental health problems’.

Instead, the most common issues were of a communicative or interpersonal nature. Currently, statutorily-funded relationship counseling in the UK is often only available to those who meet the clinical thresholds for a mental health disorder, yet Relate counseling is available to *anyone* with relationship distress. Considering that the majority of clients entering relationship services do so for issues other than mental health reasons, it seems appropriate to suggest that services such as Relate should receive statutory funding to ensure that those who need the services are able to access them, irrespective of their clinical diagnoses or ability to pay.

Furthermore, given that the effectiveness of statutorily-funded couples interventions (e.g. IAPT Couple Therapy for Depression) is judged solely on the amelioration of mental health disorders such as anxiety and depression, it has to be asked whether mental health is indeed an appropriate, or realistic, measure of outcome. Instead, it is recommended that the focus of provision should be on problematic couple interactional patterns and that the measures used for client assessment should accommodate this focus.

It has been argued that it is important to identify who is seeking couples therapy and what clients perceive to be their major concerns to allow service users to feed into the development and evaluation of such services. However, there was a high proportion of missing data for demographic information, aside from age and gender, which makes it difficult to draw definitive conclusions about the accessibility of relationship counseling services and the impact that such factors may have on client presenting issues. From a service improvement perspective, counseling staff and administrators may benefit from training that creates a service context which places a high value on the collection of data, as well as practical advice on how to implement it into routine practice. Furthermore, to acquire a more accurate indication of client socio-economic status, it would be preferable to services to collect this data based on the IMD of the area where the client lives, rather than where the service is located.

Strengths, limitations and future research

A key strength of this study is the utilization of the largest naturalistic data set for relationship counseling yet analyzed, which has allowed for a detailed analysis of the types of clients attending relationship counseling and the issues that they bring to therapy. Due to the naturalistic study design, it can be assumed that the sample were broadly reflective of real-world relationship counseling clients in the UK as a whole.

As noted throughout, there were poor levels of data completeness for some client demographics, such as sexual orientation, religion and ethnicity. However, it should be noted that the study data were collected during the roll out phase of a national service evaluation project and subsequent revisions to the data protocol have substantially reduced demographic missing data. Thus, future research should repeat the current analysis to investigate presenting issues in a dataset with more complete demographic data.

A further limitation of the present study is that client presenting problems were collected through a bespoke form, which raises some questions about instrument validity. Future research to investigate the psychometric properties of the instrument is recommended, potentially alongside qualitative methods for eliciting client presenting concerns to ensure that the full spectrum of presenting issues are captured.

Conclusions

To conclude, this study has presented the largest dataset to date of demographic information and presenting issues for clients attending relationship counseling services at a third-sector relationship counselling service in England and Wales. The results provide an unprecedented understanding of who seeks couples therapy and why, suggesting that the majority seeking such support identify relational distress as their main concern rather than individual mental

health issues. Considering the research evidence for a bidirectional relationship between individual mental health difficulties and relationship distress, the study findings provide a strong argument for increased funding of relationship counseling for those who are relationally distressed even if neither individual are (yet) experiencing mental health concerns.

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