

Family therapy ‘lite’?

How family counsellors conceptualise their primary care family work

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Abstract

A number of current developments in the field potentially provide opportunities for preventative relationship and family interventions to be integrated into primary care. In this context it is important to understand what family counselling is and how it might differ from family therapy. Thus, this paper investigates how the service of one low-intensity family counselling provider, Relate, is conceptualised and practised by counsellors on the ground. Questions about practice were posed to five focus groups of family counsellors and these were analysed using thematic analysis. The findings suggest that Relate family counselling is seen as ‘family therapy lite’, with a flexible, eclectic and integrative use of concepts and techniques within a systemic framework. Implications of this conceptualisation of family counselling for training, practice and research are discussed.

Keywords: Family counselling, family therapy, family interventions, Any Qualified Provider, Relate

Introduction

Family therapy in Britain has traditionally largely been practiced in secondary care settings within the National Health Service (NHS) or in private practice, with little apparent provision in primary care (Shepherd, 2014). One survey found that fewer than twenty percent of primary care services offered some sort of systemic/family intervention (Barnes, Hall & Evans, 2008). However, limited evidence exists that relationship problems are a significant presenting issue in primary care. For example, one study found that counsellors in primary care reported that 20% of their clients presented with relationship difficulties, and that relationship difficulties were the second most frequent presenting problem after depression (Cape & Parham, 2001). Another found audit evidence that 20-25% of primary care presenting problems were interpersonal (Shepherd, 2014). The lack of systemic/family interventions in primary care, together with the scant research base on relationship issues as presenting problems, suggests that in the past interpersonal presenting complaints may have been overlooked in the one-to-one, individual-focused world of primary care.

However, there are signs that the field could become more open for relationship or family interventions in future. Many of the problems for which systemic family therapy has been shown to be effective are also found in primary care (AFT, 2011; Carver & Jones, 2013), and NICE recommends family therapy as a treatment option for of a variety of adult and childhood problems (such as depression, drug misuse, PTSD and anti-social behaviour disorder; AFT, 2011). Added to this is a growing emphasis on the importance of patient choice within the National Health Service (NHS, 2014) which would argue for offering family therapy at primary care level. At the same time, there is an increasing understanding of the role poor interpersonal functioning can play in triggering and maintaining anxiety and

depression (Carr, 2014b). Furthermore, increasing the availability of a range of psychological therapies in primary care has been the driving force behind the Department of Health's Increasing Access to Psychological Therapies (IAPT) scheme (IAPT programme, Department of Health (DoH), 2010). Currently the model is expanding, embracing a number of other therapeutic modalities including couple therapy for depression alongside its core approach of offering CBT for individual adults (Kuhn, 2011). A recent initiative to incorporate IAPT into existing Child and Adolescent Mental Health services (children and young person's IAPT, CYP-IAPT) is starting to include systemic family therapy (Stratton & Lask, 2013). An additional reason to include family based interventions into adult IAPT services could be the fact that these services will now be commissioned through the new 'Any Qualified Provider' (AQP) process (DoH, 2011). The AQP process allows non-NHS organisations (such as charities, not-for-profits and even individual therapists) to bid for NHS work. It also allows commissioners to consider and accredit therapies where there is a sound evidence base of efficacy and positive patient outcome (including those that are 'best-evidenced' even when NICE guidelines are pending), thus widening the therapeutic modalities that can be commissioned.

Hence, it seems that the field is now more open for non-statutory organisations to potentially offer the delivery of preventative and low-intensity interventions for families at the primary care level. In this context the aim of this paper is to explore and discuss how family counselling can be employed as a low-intensive service by investigating the already existing practice of Britain's current biggest family counselling service provider – the Relate Federation. Although Relate family counselling currently sits outside the NHS, the way in which it is defined places the service within a low intensity model.

Relate is the oldest and most well-established nation-wide relationship counselling organisation in Britain (59 centres nationally licensed under the Relate brand and operating through a membership agreement). According to Relate service statistics (Relate, 2009) the family counselling service offered by Relate centres in the UK has grown rapidly since it was established in 2002, with an estimated 9000 families using the service annually. The family counselling service is offered in Relate centres and a range of other locations including GP surgeries, Children's or Sure Start Centres and schools (Mills-Powell, 2010). The service is targeted at people who self-refer or are referred via their GP or other agencies (such as Sure-Start or Parent-Line plus). Service audits seem to suggest that as a 'frontline service' in local communities Relate family counselling is successfully reaching disadvantaged families presenting with a wide range of adult and child difficulties (Relate, 2010).

The Relate organisation (Relate, 2008) posits a conceptual and practical definitional distinction between their family counselling service and 'Family and Systemic Psychotherapy' as conceptualised by the Association for Family Therapy and Systemic Practice in the UK (AFT, 2016) and practiced in a wide range of settings, from private practice to social care and mental health services. Whilst using a systemic approach that aims to 'be relational and look at communication problems between people', Relate family counselling has been conceptualised as 'largely preventative, dealing with life issues before they become serious problems requiring specialist interventions' (Relate, 2009, p3). Unlike NHS-provided family therapy offered in Child and Adolescent Mental Health (CAMHS) Clinics, the relevant point of comparison for primary care family services, Relate family counselling is not provided by a multi-disciplinary team but by 'certificated and experienced counsellors'.

As a lower-intensity and preventative-focused service, Relate's family counsellors have a different and shorter training than family therapists, who typically complete a 4-year part-time training on top of an existing professional qualification (AFT, 2016). Relate are historically training its own counsellors and Relate family counsellors are required to have at least one year in-house training in Systemic Therapy in addition to a Relate qualification in relationship counselling. The training incorporates a core of systemic counselling approaches with integrated psychodynamic and CBT elements (Relate, 2008). The systemic competencies taught in this training are equivalent with the foundation level of systemic training (first of three levels) as defined in the framework for accrediting courses in family and systemic practice provided by the Association for Family Therapy and Systemic Practice in the UK (AFT, 2016). Relate centres also accept family counsellors with different systemic trainings pathways above the foundation level, which means in practice there is some diversity of systemic training backgrounds among Relate family counsellors.

Relate's family counselling service is an example of an organisation that could bid to provide NHS primary care psychological services to families. However, in contrast to family therapy provided in the NHS, there is currently no evaluation system in place to systematically monitor provision and outcome of Relate family counselling nationally. More broadly also the evidence base for family counselling is lacking. Moreover, due to the conceptual and practical differences between family therapy and family counselling as provided by Relate, it is not possible to simply apply the growing evidence base for family therapy interventions (e.g. Carr, 2010; Carr, 2014a; Carr, 2014b; Stratton, 2011; Shadish & Baldwin, 2003) to the lower-intensity service offered by Relate. This means that the efficacy of these family counselling services is as yet not empirically established.

A key first step when attempting to establish the efficacy of any therapeutic approach is to seek to clearly identify or define the intervention under study. Relate family counselling has been defined by organizational policy documents, as described above, however it needs to be established whether low-intensity family counselling is operationalised by Relate family counsellors on the ground in similar ways. For although Relate family counsellors are trained in systemic counselling, it is not clear how they conceptualise their practice, and what they actually do with families (e.g. what concepts and techniques they use).

Research which aims to reduce definitional and conceptual uncertainty around an intervention is similar to efforts in the field of systemic family therapy to manualise the approach (Pote et al., 2003) and to generate and disseminating core competencies required by systemic therapist (Stratton et al., 2011). Investigating the practice of family counselling and how it is conceptualised by Relate family counselling practitioners is not only important for Relate. Understanding the conceptual and methodological overlap between systemic family therapy and this model of family counselling would aid in locating this type of primary care, preventative family service within a stepped care model (NICE, 2011). In addition, study results would enhance the sparse systemic research base on how family practitioners conceptualise their work (Pote et al., 2003). Additionally, the study could help to clarify the extent to which benchmark systemic competencies (Stratton et al., 2011) are applicable in the training and employment of primary-care family practitioners.

The aim of this qualitative pilot study then, is to investigate how Relate family counselling is conceptualised by Relate counsellors and how Relate family counselling can be located within the broader field of systemic family counselling and psychotherapy.

Method

Approach to the research

The epistemological stance taken in this study was a form of tempered realism. Whilst assuming a broadly uncomplicated relationship between language and reality, the authors were aware that researchers and participants would impact on one another, and that the authors' values and assumptions would contribute to both the questions asked and the reading of the data. It was therefore important throughout the research to reflect on the authors' subjectivity and how it impacted on the collection and perception of the data. For transparency, two of the authors (first and third author) work for Relate (as a couple counsellor and family counsellor respectively), and the third member of the research team has worked therapeutically with families and couples but has never worked for Relate. The analysis was conducted using an inductive 'bottom up' approach in which there was no attempt to fit the data into an existing theory (Braun & Clarke, 2006).

Participants

In order to elicit counsellors' own understanding of their practice, focus groups were used. The participants were recruited via Relate National Office, who emailed centres offering family counselling. Any centres interested in taking part contacted the research team. Five centres took part from various locations within England (north, south west and central) and the five focus groups conducted ranged in size from 2 to 13 participants. All participants were Relate family counsellors with varying levels of experience from newly qualified to those participants who were also family counselling supervisors. The groups were of mixed gender and age, although the majority of Relate's family counsellors were female. Ethical consent

was obtained from both Relate central office and the University of the West of England ethics committees. Participants were informed that they could withdraw their data from the study at any point prior to write-up and data was anonymised before analysis.

Source of data

The focus group methodology was chosen because group dynamics can generate excitement and interest in a topic as well as allow participants freedom to be spontaneous (by not having to answer every question) and thus the method has the potential to generate a rich account of counsellors' practice (Brotherson, 1994; Vaughn et al., 1996). Additionally, one of the strengths of focus group interviews as a research tool is that participants are actively encouraged to participate in a forum which seeks to capture diverse views and outlooks (Krueger, 1994). A focus group question schedule was drawn up according to the guidelines outlined by Brotherson (1994). The schedule contained open ended questions about how family counsellors viewed their practice and the facilitators encouraged interaction within the group. All groups were facilitated by two members of the research team (the first author facilitated all five groups with either the second or third author as co-facilitator). The questions posed in the focus group discussion can be found in the appendix.

Data Analysis

The focus groups were recorded and the resulting audio tapes transcribed and analysed using thematic analysis (TA; Braun & Clarke, 2006). The first author became immersed in the data through multiple readings of transcripts and by noting down of initial responses and ideas. Each transcript was then coded and sorted into potential themes. Emerging themes and sub-themes were then discussed with the rest of the research team to make sure they were representative of the data. Through this process of revision, which included going back to the

data and checking for confirmatory and disconfirmatory evidence, the final thematic structure, representing a coherent and consistent story about the data, was achieved. In keeping with the guidelines for TA (Braun & Clarke, 2012), the quality and rigor of the analysis was considered and enforced throughout the whole data analysis process. It was important for the researchers to throughout the research reflect on the ways in which their own knowledge of the Relate organisation (first and third author) and its family counselling service (third author) may have impacted on the collection and perception of the data. For example, the researchers sought to identify through a group discussion prior to data analysis any pre-existing assumptions (both negative and positive) about family counselling in general and Relate family counselling. During the analysis, the researchers worked to bracket off these assumptions; they also rigorously reviewed the evidence for emerging themes to ensure that they were thoroughly grounded in the data.

Results

The analysis focused on how participants understood themselves as doing family counselling, noting both the distinctions made by participants between family counselling and family therapy and the commonalities claimed. Understanding the participants' responses as an understandable attempt to justify and legitimize their way of working, the analysis also sought to engage critically with the participants' accounts in order to arrive at a potential understanding of the ways in which family counselling is family therapy 'lite'. In the following, each participant is identified with a pseudonym and a focus group number.

How family counselling differs from family therapy

The participants were clear that the work that they were doing differed from Family Therapy. One counsellor for example distinguished their work from Family Therapy on the basis that it did not typically involve reflecting teams, two-way mirrors and the use of counselling teams for each family. As Carol, who was in Focus group four, stated,

I would say that it's the same work that we're doing, but we are doing it 'lite', we are doing it with one person or two people (counsellors) in the room at most. And without the benefit of the reflecting team that a family therapy setup might have.

Some counsellors commented that more utilization of reflecting teams in both practice and training would be “incredibly useful” but conceded that this was not financially possible, not: “*practical, because we are reliant on client contributions.*”

Counsellors also distinguished between their work and the work of Family Therapists on the basis of problem severity of their clients:

So anorexic, or people with very serious sexual abuse histories, or people with more serious mental health problems, we would have referred them to family therapy. For a little bit more support.

As Roberta (focus group one) stated, “*mental health problems in their, or alcohol or drug problems, we wouldn't work with that.*” Concurrently this meant not working with those carrying formal diagnoses. As John (focus group five) stated: “*There is a cut-off around diagnosis. And that's consistent with all the work that we do so...We don't diagnose.*” This stance is partly reflective of organisational policy that Relate family counselling service should not be offered to people where drug addiction is the main issue or to those with

diagnosed and severe mental health problems (Relate, 2008). However the practice of excluding families struggling with more severe difficulties also accords with the notion of 'family therapy lite' which is 'lite' in the sense of being only resourced to cope with 'lighter' problems.

How family counselling is similar to family therapy

While clearly distinguishing the work of family counselling from that of family therapy, the participants also explicitly claimed a strong connection between the two approaches that can be perhaps be understood as a way of claiming the authority of family therapy as a longer established and empirically well supported therapeutic approach. One way that this was done was that the majority of participants described their work as 'systemic' or having a 'systemic approach'. Some participants went even further, being keen to explicitly classify themselves as 'systemic'. For example, Linda a counsellor from focus group five explained her approach to the work in the following way:

You know I am always saying to myself this is family work, this is systemic. What I am saying is that the family work that we do within Relate is systemic counselling, it's not family counselling or whatever, it is systemic work.

The dismissive tone of "family counselling or whatever" rhetorically suggests that "systemic work" is a more credible thing to be doing.

Although participants consistently described themselves and their work as systemic, when asked to detail what this looked like they tended to list specific systemic techniques, such as reflecting teams, sculpting, the use of genograms, circular questioning and hypothesising.

They also named broader ideas about communication that have had influence in systemic thinking such as coordinated management of meaning (Pearce, 2007) and appreciative inquiry (Whitney & Trosten-Bloom, 2010) as well as third wave therapeutic approaches such as narrative (White & Epson, 1990) and solution focused (de Shazer, 2005). And they cited emphases in Family Therapy, such as the focus on a multi-perspective view, or the value of a social constructionist perspective. In justifying their claim to being systemic the participants thus utilized the vocabulary of the systemic approach. This was not always convincing, as in the case of one participant who included a technique typically associated with Cognitive Behavioural Therapy **when asked to** describe systemic techniques **used**: *“lots of specific techniques, including using genograms and forms of questioning and Socratic kind of interventions.”*

In addition to using lists, the responses of some counsellors suggested an attempt to incorporate an understanding of the role of certain techniques within a systemic approach. For example Jane from focus group one described her understanding of the benefits of using genograms as being a way to both involve and invoke the whole system or family:

I do use a genogram. I think in the family work, genograms are pretty invaluable in some ways. Because you are talking about this wider system, so genograms are really useful for that. And that's quite good in engaging the younger people to help you do those, so that's quite good.

While it is obvious that systemic practitioners would be expected to draw on a systemic vocabulary to justify their status as ‘systemic,’ overall the analysis suggests that many participants tended to claim their systemic credentials simply by listing systemic techniques

or theories that they used or liked. The relative absence of more in-depth or conceptually rich illustrations suggests that perhaps one way that family counselling is 'family therapy lite' is that it is theoretically 'lite'. In the case of Relate, this perhaps is inevitable in that many of the participants had experienced an in-house Relate family training which integrated systemic ideas and approaches with other theoretical approaches and that for most their family training typically followed a core and non-systemic training as an individual and/or couple therapist. Thus for the Relate participants family therapy and systemic understandings might not be expected to be as fully articulated as might be the case for those whose core training is a longer and 'purer' systemic/family therapy training. Nonetheless this notion of family counselling as theoretically 'lite' begs questions more broadly. For example, is the mixed training background of the Relate participants, with its potential implications in terms of shallower understandings of family and systemic therapies, typical of family counsellors? Alternatively there is perhaps a question about whether family counselling, as an approach distinct from family therapy, has – as yet – a firm theoretical and conceptual base.

Eclecticism and Integration in family counselling

While some of the participants were keen to claim that the systemic approach was the core driver of the work with families, in line with their typically diverse training, not all participants appeared to position the systemic approach so centrally. For instance Neil from focus group one stated:

I suppose theoretically,...I suppose what you are doing is various aspects of the systemic approach. You're picking out the people who have probably written extensively on their experience of working with family groups and you pick or align yourself with those things that best fit how you think you can work and that can fit your skill set.

Neil's statement positions Family Therapy as a pick-and-mix box which he can select from based on his own personal preference. Other counsellors described systemic ways of working as "a useful tool", "a really effective strategy", and an additional framework through which to listen to clients, implying that family was just part of their repertoire.

In addition to positioning systemic ideas and approaches as only part of their repertoire, nearly all the participants made a point to acknowledge other well-known therapeutic modalities which they draw on in their work, often naming theories or techniques that they found influential or useful. Many also went further than merely acknowledging other theoretical influences with an explicit apparent need by a number of participants not to be labelled as purely systemic in their approach. This led many to use such words as "integrative" or "eclectic" in their description of themselves. Here for example is Mary from focus group three describing the work:

I don't know whether it's a pendulum swing, we create ourselves, you know we're family therapists and we're systemic and there is a movement back towards the way other people have worked in the therapy world. But umm, there has been a return of attachment, big-time. And I have found that really useful. Because I found that I couldn't be as systemic as I was on my training. So I wanted to bring in some other ideas, so I found the return of attachment to be really useful. And I found that I bring in eclectically anything that I feel works for me. I don't know whether it's right, but that's what I do.

In this statement Mary appears to acknowledge that a purely pragmatic eclectic approach might be criticized for being 'not right' (and indeed this reflects part of the theoretical debate

about eclecticism, see: Lazarus, 2005). However the quote also illustrates the strategy of many of the participants of claiming the legitimacy of their ‘family therapy lite’ approach to working with families through reference to other well known theories. The quote also provides an example of how participants may at times contradict themselves in the discussion and mantel their work as family therapy (*‘we’re family therapists’*) although they were generally clear of the difference between their work and that of Family Therapy.

In justifying an eclectic stance towards systemic ideas and ways of working, participants often cited experiences with clients as a key rationale for a more pragmatic, less ‘pure,’ approach to their work. There was a sense from some counsellors that what they were trying to do was use theory responsively and offer techniques according to clients’ need. As Maggie from focus group four stated:

Because what I think it does, we need diversity, because the families that we get in, are quite diverse. So we need all sorts of backgrounds and experience to bring it to life almost. One certain way is not always the right way. So I think it's good to have multi-tasking, rather than just one way. Because one way doesn't work for everybody, it's the way I look at it. It's what they're bringing to the room as well isn't it?

Maggie illustrates very clearly here the belief that many counsellors expressed regarding the validity of their approach – in other words that eclecticism was accepted because it worked. However it should be noted that in their descriptions of their work, participants used the words ‘eclectic’ somewhat interchangeably with the word ‘integrative’. Given the history of the integration and eclecticism movement in counselling this can be seen as a reflection of both current and historic debates (Norcross, Karpiak, & Lister, 2005). However, there was

also some indication that at least some of the participants were trying to describe a form of theoretical integration; a synthesis of theories and ideas from different models into a systemic based meta-theory. Thus a number of participants stated that they used systemic theories more loosely, as a framework to guide how they worked with families, and to inform what they actually did in the room. This is exemplified in the following quote in which Carol from focus group four, calls the model eclectic but sees systemic ideas as providing nonetheless an integrative ‘overarching’ theory.

So I don't think that Relate family work is purely systemic. I think it uses ever...a level of systemic, quite a high level, but that is underpinned highly by psychodynamic hypotheses. By attachment, all the other theories. I think it's quite an eclectic model. I think still over arched by their systemic idea of inclusivity and neutrality and transparency, that's really useful.

In discussing the value of utilizing systemic ideas and theories in this way, Kate from focus group two, stated:

It's a way of really extending the work, by means of a different range of skills, it's kind of building on core skills, but it's a systemic, essentially a systemic way of working.

Kate here is referencing the way in which the systemic approach has allowed Relate to extend its work with individuals and couples to families, thus reaching a broader group, however she is also making an interesting claim that a systemic way of working is simultaneously both an add-on to the “core skills” of a Relate practitioner and as “essential” to the whole way that they work. What Kate seems to be describing is an approach to family counselling in which family therapy is used both integratively, as a meta-theory, and eclectically, as a set of

techniques and approaches. The promise of this construction of what ‘family therapy lite’ might look like in family counselling and training is discussed next.

Discussion

The analysis was focussed on how participants saw and understood the family service they are providing and revealed three major themes (‘How family counselling differs from family therapy’, ‘how family counselling is similar to family therapy’, ‘Eclecticism and integration in family counselling’). The participants drew a clear line between the work they were doing in the Relate centres and the work of family therapists (e.g. in the NHS context), both in terms of available resources and the severity of presented problems, leading to the notion of Relate family counselling being a lighter version of Family Therapy. They stressed at the same time the similarities between both approaches by describing family counselling as ‘systemic work’ and by referring to specific systemic techniques and concepts they were employing. However, most participants did not provide a coherent systemic conceptualisation or theoretical basis of their work, and showed a rather eclectic stance towards systemic concepts and ways of working. The participants in this study seem to see themselves as both pragmatic and integrated – whilst approaching family counselling with a systemic perspective and employing systemic techniques, they also draw on techniques and theories from other approaches.

What seems to emerge from this focus group study is a tentative conceptualisation of family counselling as ‘family therapy lite’ - encompassing three different conceptual levels. At the first level is the notion of family counselling as a service that is lightly resourced and only appropriate for clients with less severe problems, which therefore works without diagnosis or

formal clinical assessment. On a second and theoretical level, the difficulty with articulating a coherent theoretical foundation for the approach potentially suggests that family counselling is currently not only practically but also theoretically 'lite' - because it is both a relatively new approach and because, by their nature, family counsellors usually do not have in-depth training as Family and Systemic Psychotherapists (AFT, 2016). Finally, family counselling as conceptualised by the participants in this study has a 'light touch' relationship with Family Therapy - it seems at the same time potentially *both* eclectic, with a flexible and pragmatic use of systemic techniques and ideas alongside those from other theoretical schools, *and* integrative, using the systemic perspective as a general framework for the therapeutic work with families.

The therapeutic potential of this construction of family counselling can be seen in the way it draws on family therapy 'lightly', utilizing both broad and general systemic understandings to inform all therapeutic work and flexibly using specific ideas and approaches in ways that suit the individual practitioner and/or their client without worrying about theoretical purity. Such a 'light' approach can in times of limited resources not only help to service more families in need of support, it also has the potential to accommodate the fact that family therapy generally encapsulates a wide range of theoretical approaches (Dallos & Draper, 2015; Vossler, 2010) which are difficult to integrate into one theoretical model (Pote et al, 2003; Carr, 2006). In using a flexible systemic framework in an integrative and pragmatic manner it seems family counsellors are also not overly reliant on the 'mid-range theories' which are arguably lacking in family therapy (Heatherington, Friedlander & Greenberg, 2005) – theories linking understandings of how overall change might happen to defined therapy tasks/therapeutic interventions and specific moments in therapy. However, to be able

to harness the potential of family counselling as ‘family therapy lite’ it will be necessary to consider the implications of this approach for training, practice and research.

Implications for training and practice

In its own description of family counselling, Relate does not claim to provide one particular ‘pure’ or manualised model (Relate, 2008). In line with this, the organisation has recognised a number of different training routes that can lead to qualification as a Relate family counsellor. There is some overlap between the conceptualisation of family counselling as ‘family therapy lite’ provided by the participants of this study and the service description of the Relate Federation (‘systemic approach’, ‘relational’, ‘preventative focus’; see introduction). Hence, to a certain degree there seems to be a shared understanding of the service provided despite the variety of backgrounds and trainings Relate family counsellors have and the fact that Relate itself is a federation (with individual centres being open to contract differently).

However, the challenge in training and practice is to elaborate and sharpen the conceptual profile of family counselling and its location within the primary care landscape. Following the concept of family counselling as ‘family therapy lite’, training courses would need first to provide a broad introduction into key ideas and concepts essential to develop a systemic framework, and then a clearly identified set of systemically informed skills and techniques (a systemic ‘tool box’) for the therapeutic work with families. Part of this challenge is to establish adequate systemic competencies required for practitioners working at this level. The question whether these competencies should equal the intermediate level of systemic training (‘developed understanding of systemic family practice in at least one area of work’, AFT, 2016, p36) rather than the foundation level ~~can~~ cannot however be answered on the basis of

our explorative study. In the light of recent research findings showing significant levels of distress in families seeking help at Relate family counselling (Vossler & Moller, 2015), service providers should also monitor and evaluate the provision of family counselling to make sure that the severity of problems is appropriate for the training and skillset of their practitioners. Finally, in order to establish an effective stepped care system for families (similar to IAPT) it would be necessary to develop a closer local collaboration and referral system between low-intensive family counselling and CAMHS service within the NHS. All these are critical steps in order to build a coherent, evidence-based model for family counselling within primary care as a low-intensive ‘frontline service’ in local communities that can complement more widely accessible one-to-one therapies (such as those provided by IAPT services).

Limitations of research and implications for future research

Despite the various benefits of using focus groups as research tool, the specific circumstances surrounding the data collection for this study might have had some limiting effects. The five focus groups conducted had varying group sizes and group processes unfolding during the sessions, both of which can impact on the group interaction (Hollander, 2004). For example, some of the focus groups were attended by the supervisor to the other participants, and their powerful position could have influenced what and how their supervisees contributed to the discussion (Krueger, 1994). In addition, the decision to use TA (and not e.g. discursive analysis) to analyse the focus group data meant the focus of the analysis was inevitably more on the content of what was said than on the social interaction that might have impacted on the discussion (Wilkinson, 2008).

Based on the conceptualisation of Relate family counselling as ‘family therapy lite’ that has emerged in this pilot study, a logical next step would also be to seek empirical evidence for this form of low-intensity family intervention. There is no manual for the provision of family counselling which makes it difficult to build a robust evidence-base for the service using controlled trials. However, quantitative research with appropriate instruments for therapeutic work with families (e.g. SCORE, Stratton et al. 2014) could be used to establish outcomes on different levels. This could be combined with qualitative studies (e.g. semi-structured interviews) to explore client and practitioner experiences of the service provision. These kind of research activities could help to locate and establish preventative family counselling within a stepped primary care model and develop a body of research evidence for this service.

Conclusion

This study has provided insight into the ways how practitioners conceptualise their work as family counsellors as ‘family therapy lite’, working both integratively and eclectically on the basis of a systemic framework. The findings provide a useful starting point for further research and can help service providers to make a case for family counselling at primary care level aimed at low intensity presenting problems.

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Appendix: Focus group questions

- ‘How would you describe the aim of Relate family counselling?’
- ‘How long have you been a Relate family counsellor?’

- 'What approaches do you find most useful in working with families?'
- 'What techniques did you learn in training that you find useful in your work?'
- 'What skills/techniques do you use the most?'
- 'What are the typical Relate family counselling clients?'
- 'What could be done to improve the Relate family counselling service?'