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RESEARCH ARTICLE

‘We argue a lot and don’t talk with each other’:

How distressed are families when seeking Relate family counselling?

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Abstract

Aims: Family counselling, with its preventative and supportive focus, could offer an important addition to higher-intensity family therapy services, improving functioning for families in need. However a basic question is whether families presenting to such services are, as assumed, less distressed than those presenting to NHS services. This study therefore examined the levels of distress (child and family functioning) of families seeking help at a national voluntary sector family counselling service (Relate). In addition the study explored how parents and children describe their families and understand the difficulties that brought them into family counselling. *Method:* A total of 55 families (61 adults, 9 children) from one local Relate centre completed the ‘Systemic Clinical Outcome and Routine Evaluation’ Scale (SCORE-15), the ‘Family Adaptability and Cohesion

Evaluation Scale III' (FACES-III) and the 'Strengths and Difficulties Questionnaire' (SDQ) before counselling. The answers to three open SCORE questions (family and problem description) were analysed with a combination of thematic and content analysis. *Results:* The quantitative results indicate moderate to high levels of distress reported by families when seeking Relate family counselling, comparable with NHS secondary service contexts (CAMHS). The qualitative data shows a broad range of problems at different levels (child related issues, family conflicts, marital break-down, external pressures). *Discussion:* The results indicate a potential mismatch between the preventative and low-intensive focus of this kind of intervention and the levels of distress and problem severity in the help-seeking population. Possible implications from these results for further research and therapeutic practice are explored.

Keywords: Family counselling, family therapy, child functioning, family functioning, prevention

Introduction

With its accessibility and preventative orientation low-intensity family counselling has the potential to play a key role in a flexible 'stepped care' model of service delivery for families (with high-intensity NHS treatment options alongside low-intensity interventions for less severe problems). Such a model is currently used by the 'Improving Access to Psychological Therapies' (IAPT) programme in the provision of psychological therapy for adult individuals (IAPT programme, DoH, 2010; DoH 2007). The IAPT model of care offers an important model for family interventions because political initiatives to promote wellbeing and functioning on a family level are shifting 'the focus from dealing with the consequences of problems to preventing problems occurring in the first place' (BMA, 2006, p21).

Government policies have also shifted in the last decade away from a focus on children ('Every Child Matters'; DfES, 2004) to a focus on parent-child relationships ('Every Parent Matters'; DfES, 2007) and the relationships in the family (including adult couple relationships; Klett-Davies, 2012). The current coalition government continues to provide dedicated funding for relationship support, with £30 million allocated to 12 different relationship support providers from the voluntary and community sector (among them Relate) in the Spending Review period 2011 to 2015 (Spielhofer et al., 2014). A recent evaluation study focusing on three specific kinds of interventions (marriage and relationship education, relationship education for new parents, and couple counselling) found couple counselling and marriage education beneficial for clients and cost-effective

(with cost-savings for society substantially bigger than costs to deliver the services; Spielhofer et al., 2014). However, questions remain about the best way to provide such preventative and support-focused aid for families in need.

In the UK, family counselling and psychotherapy is provided in a wide range of settings, including National Health Service (NHS), voluntary organisations and privately (by individual practitioners). Currently, much of the therapeutic family interventions are set up as high-intensity services provided by highly trained practitioners in the NHS context for families experiencing considerable distress and difficulty (Cottrell & Kraam, 2005). NHS family therapy is typically offered in Child and Adolescent Mental Health (CAMHS) clinics by a multidisciplinary team including psychiatrists, social workers and child and family psychotherapists. Family therapists working in CAMHS clinics will have completed four years of specialist family therapy training which equips them to work with these complex presentations (AFT, 2012). The CAMHS Outcomes Research Consortium (CORC) is routinely evaluating outcomes across the full range of Child and Adolescent Mental Health Services with both standardised and idiographic child-, parent- and clinician-rated outcome measures, on a session-by-session basis and at review (e.g. Wolpert et al., 2012). The CORC research group has just started to published findings on the basis of the collected data (CORC, 2013), with the most common presenting problems among children and adolescents categorised as emotional (55%), conduct (18%), autism (18%) and hyperkinesia (12%; Wolpert et al., 2012; based on 16,115 episodes of care submitted by 41 CAMHS). Lower-intensity services in child and family as well as couple therapy are

beginning to rolled-out through the IAPT initiative, however as yet there is little data available to support the efficacy of this intervention. Initial evidence from the Newham pilot site provides evidence of the efficacy of systemic therapy in a primary care context (though the systemic service in question was based at and managed within the Tier 2 service), with recovery rates over 50% (Kuhn, 2011) and most individual clients suffering from depression (70%) and anxiety (50%) also identifying 'relationship difficulties in their lives' (2011, p. 402).

Family counselling outside the NHS is often less intensive and provided by less trained practitioners. However, it has the advantage that it is potentially more accessible for families in need due to shorter or no waiting times, and the fact that the service does not involve any diagnosis or clinical assessment (unlike NHS-provided family therapy). The biggest national provider of preventative, low-intensity family counselling is Relate, the national federated charity offering relationship support through a network of Relate centres. Relate family counselling has been conceptualised as 'largely preventative, dealing with life issues before they become serious problems requiring specialist interventions' (Relate, 2009a, p3). It has a clear relational focus and commitment to exploring communication problems between people in family systems, and most families seek help at Relate of their own free will, indicated by high rate of self referrals (Relate, 2010). Relate began to offer family counselling in 2002 and the service has grown rapidly since then with an estimated 9000 families using the service annually (Relate, 2009b). To date 52 (out of 74) Relate centres offer family counselling in centres and a range of other

locations including GP surgeries, Children's or Sure Start Centres and schools (Relate 2010). Service audits 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). Relate historically trains its own counsellors and Relate family counsellors are required to have at least one year of part-time training in addition to a Relate qualification in relationship counselling. Around 300 Relate counsellors have been trained in family counselling since 2002 (Relate, 2009a). In contrast, family therapy training requires a four-year part-time training on top of an existing professional qualification. The Relate family counselling training incorporates a core of systemic counselling approaches with integrated psychodynamic and CBT elements (Relate, 2008). Relate practitioners are provided with in-house supervision in individual and group setting (at least once a month).

Accessible and lower-intensity family counselling services with a flexible and preventative focus have the long-term potential to be more cost-effective than high-intensity approaches on their own, as they aim to reduce risk factors as well as symptoms and onset of problems by strengthening protective factors (WHO in NIMHE, 2005). However, unlike family therapy provided in the NHS, there is currently no evaluation system in place to monitor provision and outcome of Relate family counselling systematically. It is also not possible to simplistically apply the body of family intervention research (e.g. Carr, 2010; Carr, 2014a; Carr, 2014b; Stratton, 2011; Shadish & Baldwin, 2003) to this service form due to the conceptual and practical differences between family therapy and family

counselling as provided by Relate, as described above (i.e. preventative focus, low-intensity, no diagnostic classification). This means that at present there is a lack of evidence regarding whether Relate family counselling indeed has a preventative potential in terms of a 'stepped care' model of working with families with less severe difficulties and lower levels of distress (compared to CAMHS clinics). In order to begin answering this, one basic question must be asked: are families presenting for family counselling - as assumed in a stepped model of care - less distressed than families presenting for higher intensity family therapy settings? The current study thus provides a first-step evaluation of low-intensity family counselling by examining the profile of families presenting to one Relate centre. The specific objectives were:

1. to obtain information about the demographic profile of families that seek family counselling as well as the levels of distress they report at service entry along two dimensions, family and child functioning; and
2. to explore how parents and children describe their families and understand the difficulties that brought them into family counselling.

Method

Participants

Data was collected from families seeking family counselling at a Relate centre in southern England over a nine-month period. Family counsellors at the Relate centre introduced the evaluation project at the first session with the families, and went through the consent processes for the project. The counsellors supported their families in completing the study questionnaires if necessary. A voucher (£10) was paid to each family as a small compensation for their involvement in the project. Demographic data for the included families was collected from service records at the Relate centre.

The sample consisted of 54 families, with 60 adult respondents (46 mothers, nine fathers and one grandmother) and 15 child respondents aged between 11 and 14 years (nine boys and six girls). Forty-three of the adult respondents had children in the range of 4 to 16 years, 17 had children outside that range. Not all the parents stated how many children they had but of those that did, 12 had one child, 20 two children, 14 three children, four had four children and one each had five and six children respectively. The age range of the adult respondents was 17 to 63, with a mean age of 31.46 years. In terms of self-reported ethnicity, of those who provided an answer, 20 adult respondents reported themselves as 'white British' or 'white English'; 14 as British or English, two as Black African, one as British Pakistani; one as Brazilian. The sample consisted of 20 adults who self-reported themselves to be employed, the same number who described themselves as 'mothers' or 'housewives' and 12 parents who described themselves as 'unemployed;' the rest of the sample did not complete this item.

Instruments

Three questionnaires were administered at or just before the start of the first family counselling session, two questionnaires being used to evaluate family functioning and one child functioning. Study participants aged 11 and up were given both family functioning scales; children between 11 and 16 and adults with children aged four to 16 completed the child functioning scale (the SDQ), the children providing a self-report and parents a rating of the child they identified as experiencing most problems in the family.

The Systemic Clinical Outcome and Routine Evaluation scale (SCORE-15; Stratton, Bland, Janes & Lask, 2010; Stratton et al., 2014) is a relatively new instrument which was developed to provide a broad-based assessment of family functioning suitable for use in routine clinical practice in Britain. The SCORE is a 15-item Likert instrument with three sub-scales 1. 'Strengths and Adaptability', 2. 'Overwhelmed by difficulties' and 3. 'Disrupted communication'. The potential range for the total score is 15-75 (a mean score (1-5) can also be calculated); higher scores are indicative of higher distress. The SCORE also includes three open qualitative questions about 1) the words that would best describe the family, 2) the problems and challenges that brought the family into counselling and 3) the main problem in the family. The SCORE-15 has been reviewed by the CAMHS Outcome Research Consortium (CORC) and included in the list of family completed patient report outcome and experience measures supported and recommended by CORC. Evidence of validity has been found with sizeable correlations between a 28-item version of the SCORE and the General Functioning Scale of the McMaster Family Assessment Device ($r = .82$; Ryan, Epstein, Keitner, Miller & Bishop, 2005), as well as moderate correlation with other relevant scales, including the total

problems SDQ scale ($r = .45, p < 0.01$; Cahill, O'Reilly, Carr, Dooley & Stratton, 2010).

Coefficient alpha for the SCORE-15 is .89 and research with 239 families (584 individuals) suggests typical start-of-therapy scores of 39 (Stratton et al., 2014).

The Family Adaptability and Cohesion Evaluation Scale III (FACES-III; Olson, 1986) is a widely used and empirically supported American measure of family functioning that was used in this study in order to both ensure a strong measure of family functioning and, given the newness of SCORE, to provide evidence of the convergent validity of the two instruments. The FACES-III is a 20-item Likert scale assessing family functioning along two dimensions of Adaptability and Cohesion. For each sub-scale, the potential score range is 10-50, with higher scores indicating more positive family functioning (higher adaptability and cohesion). Instrument norms are available for various populations; for the FACES-III, American norming data for parents with small children and parents with adolescents have found mean Cohesion scores of 41.6 and 37.1, and Adaptability scores of 26.1 and 24.3 respectively (Olson, Portner, & Lavee, 1985). Olson's (1986) original study yielded alpha coefficients of .68 for the entire scale and .77 and .62 for the Cohesion and Adaptability Scales, respectively. More recently, Ide, Dingmann, Cuevas and Meehan (2010) reported higher coefficients (.86 for entire scale) but a similar pattern, with higher alpha values for Cohesion (.89) than for Adaptability (.70).

The Strengths and Difficulties Questionnaire' (SDQ, Goodman, 2001) is a well-validated measure of child functioning which is widely used in CAMHS settings in Britain, as well as internationally, and for which British norms are available (Meltzer, Gatward, Goodman & Ford, 2000). It is a 30-item Likert-type scale rating positive and negative aspects of

children's behaviour as well as perceived impact of problems. Five dimensions of behaviour are assessed and, as indicated above, both parent and child self-report versions were utilised in the current study. For the SDQ, the potential range is 0-10 for the six sub-scales and all but the 'prosocial' scale are negatively orientated, with a higher score indicating higher reported difficulties. A total SDQ score is also available, which is an aggregate of the totals the four negative behavior dimensions and which has a potential range of 0-40. Psychometric properties of the instrument are good, with mean Cronbach alpha scores of 0.73 (Goodman, 2001). SDQ scores over the 90th centile substantially increase the probability of independently assessed psychiatric disorders (Meltzer et al., 2000). As shown in Table 2, instrument developers provide a series of cut-off scores for categorising SDQ scores as 'normal', 'borderline' and 'abnormal' (www.sdqinfo.com).

Qualitative analysis

The qualitative analysis of the answers to the three open SCORE questions employed a combination of thematic analysis (TA, Braun & Clarke, 2006) with some content analysis (Neuendorf, 2002) since data counts seemed useful and informative in this context. The analysis focused on the way participants see their families and on their understanding of where the problems are located (e.g. within the child vs. on a family level), since both can have an impact on the experience and perception of distress.

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. The material was first explored and analysed by the first researcher to identify categories

using open coding. The resulting analysis was then reviewed and amended by the second researcher and discussed between both researchers in order to develop a shared understanding of the data and the emerging categories. This analysis process helped to maximise the reliability of the analysis and to ensure that the analysis is grounded in the data.

Ethical considerations

The study was conducted in accordance with the frameworks of the British Psychological Society and the British Association for Counselling and Psychotherapy. It also complied with Relate's own ethics policy, and ethical approval was formally granted by Relate. Particular care was taken to ensure informed consent, with informed consent processes being considered separately for child and adolescent participants. The consent process stated explicitly that a decision not to participate in the research would not in any way affect the family's entitlement to family counselling.

Results

Quantitative results

Table 1 provides the instrument mean scores and range for participants at their entry into the Relate family counselling service. For the SCORE, the results show participants reporting levels of family distress which are clearly comparable with those reported in

clinical samples with families who had been referred for family therapy in the NHS context and completed the SCORE before their first session (Stratton et al., 2010; 2014). However the ranges also suggest that some participants are reporting very little and others maximal difficulty in family functioning.

For FACES, comparison with the US non-clinical samples, suggests that the Adaptability score reported by the British participants of this study is on par with US norms and mid-range. This indicates that parents and children perceive their families to have adequately flexible functioning, with a moderate ability to adapt to changing circumstances. In contrast, the average Cohesion score is noticeably lower than that reported by the non-clinical US families, suggesting that both children and adults in the study perceived a lack of emotional connectedness within the family.

[INSERT TABLE 1 ABOUT HERE]

For the SDQ, the availability of British norms allows a clear and relevant comparison point for the current study. The results displayed in Table 2 for the SDQ total difficulty score (which aggregates the four negative behavior dimensions of emotional, conduct and peer problems and hyperactivity-inattention) show that both child and adult respondents see children as being in the 'abnormal range'. Parents also see their children's problems as having 'abnormal' impact. The small sample of children acknowledge emotional and conduct problems and the means for hyperactivity and peer problems are only 0.1 point

off being in the 'borderline' range. The only dimension which neither children nor parents perceive problems is the prosocial dimension. Further, comparison of the parent SDQ mean scores derived from this study directly with the 90th centile scores derived from a British sample of over 10,000 individuals (Meltzer et al., 2000; sample drawn from Child Benefit records; data weighted and adjusted to improve representativeness) suggests that only the prosocial and hyperactivity scores for this study sample fall outside that range, indicating that sample parents perceived a high and serious level of dysfunction in their children which is predictive of psychiatric disorders being diagnosable in those children (Meltzer et al., 2000).

[INSERT TABLE 2 ABOUT HERE]

In order to explore the patterns of association between the instruments, Pearson correlations were run (see Table 3). This showed statistically significant correlations between 'Cohesion' (FACES sub-scale) and the SCORE total scale ($r = -.587, p < .001$), indicating that higher family distress is associated with lower family cohesion, and providing evidence of convergent validity between the family functioning instruments. In order to explore associations between reported family and child problems, a correlation was also run between the SDQ total score and the family functioning instruments. There were no significant correlations.

[INSERT TABLE 3 ABOUT HERE]

Qualitative data

The shortest response to the first open question in the SCORE questionnaire (*'What words would best describe your family?'*) was a single word, the longest was 22-words; there were 62 responses in the data set from both children and adults. Examining the words that participants used to describe their families, there were 71 words that were negatively toned and 86 that were positively toned. Negative words included words related to anger, such as 'angry,' 'bitchy,' 'argumentative,' 'annoying,' and 'conflict;' as well as words that hinted at underlying anger in the respondent, such as when the family was labelled 'nasty,' 'rude,' 'ignorant,' 'immature,' 'stupid,' 'liars,' 'selfish,' 'unpleasant,' 'lazy' and 'spoilt.' Some negative family descriptors suggested that the family was experienced as a place of sadness, with descriptors including: 'anguish,' 'depression,' 'unhappy,' 'quite sad;' others suggested anxiety – 'stressy,' 'stressful' – or fear, with one participant describing their family as: 'chaotic, frightening at times.' There were also words that hinted at perceptions of the family as significantly damaged: 'broken,' 'messed up.'

Positive descriptors included frequently stated words such as 'happy,' 'loving,' 'caring,' 'fun,' 'close' and 'helpful.' Less often mentioned words included: 'kind,' 'friendly,' 'generous' and 'supportive.' In some cases the positive descriptors were combined with words that depicted the family as teetering on being out-of-control, but in a fun way: 'hectic,' 'crazy,' 'challenging,' 'excited,' 'loud,' 'chaotic,' 'adventurous,' 'reactive,' 'emotional.'

Notably a number of the family descriptors were mixed positive and negative, with the families being described as 'broken but happy' or 'caring, loving, funny, ignorant, nasty, rude, disrespectful, happy.' These descriptors seem to imply an experience of family which was undifferentiated or chaotic to the extent that a stable evaluation of family state was not easy to articulate. A much smaller number of the family state descriptors suggested a change in family status, either from positive to negative ('happy, now sad') or negative to positive ('relationship with daughter is improving').

The second open SCORE question, '*What is the problem/challenge that brought you to family counselling?*,' and the third item, '*The main problem is....*,' were analysed together due to their focus on family identification of the presenting issues. These items had answers ranging from one word (e.g. 'husband', or 'men') to 28 words long, with 66 responses in total for each item.

A number of problem statements located the family difficulty in the child/children.

Children were identified as problematic in terms of illnesses and special needs as well as diagnoses and disorders such as ADHD, sleep disorders and behaviour disorders. They were identified additionally as problematic in terms of behaviours such as being verbally and physically abusive, and due to engaging in self-harming behaviours and criminal behaviours such as aggravated bodily harm (ABH). Children were also described in less formal ways as problematic, as: 'very naughty,' 'very angry,' 'hurting others,' 'difficulty managing temper,' 'bickering.' Children were described as problematic both globally as individuals and globally in terms of their behaviour; thus parents and children alike

identified that the 'behaviour' of the child generally was problematic (children identified both self and sibling behaviour this way). Specific problematic behaviours that were named included: 'wetting self,' 'thumb sucking,' 'emotional outbursts,' 'punching others,' 'running away,' 'throwing stuff around,' 'swearing' and behaviour generally at school. In some descriptions it appeared as if all the children in a family were seen as problematic while in others it was clear that one child in particular was identified as the difficulty. By contrast, the family problem was solidly located by some participants in the (sometimes ex-)partner, who was identified as creating problems in terms of domestic violence, infidelity, conflict and arguments, and marital break-down. Lack of engagement with the family and adult intimacy problems were also cited. This focus led to participants sometimes simply identifying the problem as: 'ex-partner,' 'husband,' or 'past and current relationship'. Participants also however sometimes clearly identified the family problem as residing in themselves. Thus certain parents perceived their own histories to be the issue, for example past sexual abuse and 'old problems and memories haunting me', as well as childhood and own relationships with parents more generally. Others identified their own behaviours (spending, infidelity, 'appalling' behaviour) or emotional states ('getting upset and crying,' 'depression,' 'lack of energy,' 'being stressed') as being the family problem.

Some participants identified family problems also in terms of external agents (social services, legal system) or external pressures on the family in terms of debt or money problems. Others additionally located the family difficulty in the broader family system (grandparent death, (grand)parental illness, 'extended family issues', step-family issues).

However, across all of the responses very few of the problem descriptions suggest a systemic view of the family problem in which there was an understanding that all family members have a role to play in family difficulties. Exceptions included: 'We argue a lot and don't talk with each other'; 'We argue too much, miss family life', 'Forgetting what family is about.'

Discussion

The aim with this research was to explore how distressed families are when seeking the low-intensity family counselling offered by Relate, and how their level of functioning compares to that of families presenting in higher-intensity family therapy settings (such as in the NHS context). The answers to these questions can help to clarify the role of low-intensity family counselling in terms of a stepped care type model and within the UK's provision of family-based therapeutic interventions.

The results of this study indicate comparatively high levels of self-reported family distress (SCORE) and child dysfunction (SDQ) at the onset of Relate family counselling. This picture is underpinned and illustrated by the answers to the open SCORE questions, with many respondents reporting a broad range of problems at different levels (child related issues, family conflicts, marital break-down, external pressures) which contribute to the perceived severity of problems. A comparison with data collected at 41 CAMHS in the UK

(Wolpert et al., 2012) shows that the reported levels of child distress in this study (mean total SDQ difficulty score: 20.3 for parents, 18.1 for children) are similar or slightly higher than the reported problem severity in NHS secondary service contexts. For CAMHS parents at treatment outset, the mean total SDQ difficulty score was 18.7 (for cases with data available at six-month follow-up; mean of 19.7 for cases with missing data at follow-up), with child-rated SDQ means at a similar level (17.2 with follow-up data, 18.1 without). Similarly, the results for the SCORE (parent mean total score 42.7, child mean 36.7) were highly comparable with scores gained from a national sample of 247 individuals engaged in systemic family or couple therapy (mean total score at intake 39.39; Stratton et al., 2014). These findings might surprise, given the significant difference in intensity and practitioner training between family interventions in NHS secondary care and in the low-intensity Relate context. The remainder of this section will discuss questions and implications that can be drawn from the results of this study for further research and therapeutic practice.

Implications for future research

The study results seem to suggest a mismatch between problem severity in the help seeking population and the preventative and low-intensive focus of Relate family counselling. There is some evidence that adult individual clients presenting for voluntary sector counselling agencies similarly report problem severity at intake on a par with that in NHS primary care settings (Moore, 2006) and the same holds true for university students matched with similar age clients presenting in NHS primary care (Connell,

Barkham & Mellor-Clark, 2006). It may be that the assumption that lower intensity wellbeing focused counselling services attract lower-severity clients – a key assumption in any stepped care model – needs to be re-evaluated. However, the current findings are based on data collected at one Relate centre only, and the sample of child respondents was very small. Future research should aim to include a larger sample of centres and families to see whether the findings can be generalised for the wider Relate context.

Some of the answers to the open SCORE questions suggest that parent mental health issues or parental concerns are contributing to family problems (Carr, 2014b). This suggests that future studies investigating the levels of distress in family counselling should therefore also include an instrument to assess adult mental health functioning (not only child and family functioning). This would also allow a comparison of the mental health functioning of children and parents.

Further research should also focus on the outcomes of low-intensity family counselling to investigate whether problem severity at the beginning of the counselling process impacts on the efficacy of the service provided (e.g. does family counselling with less severe cases lead to better outcomes? Are families with more complex and severe problems more likely to drop out?). A clearer definition of the family intervention in future outcome studies (e.g. manualised treatment) would also help to identify which sort of intervention is most efficient at which level of distress. Qualitative studies would also be useful to explore the experiences of family counsellors (Do they feel equipped to work with

families presenting with high levels of distress and a wide range of problems?) and clients in both low-intensity family counselling and family therapy in the NHS contexts (How do they experience the services in terms of access, service culture and treatment received?).

Implications for practice

The study findings raise several important questions for the practice of family counselling – especially if they are confirmed by future research, including outcome studies (as outlined above). First, it is questionable whether a population with such a high level of distress is best served with a low-intensive primary care service with a preventative focus. In making this point it is acknowledged that this is a problem not confined to the family counselling context but potentially valid across a range of counselling contexts. The study findings also suggest that service providers may want to evaluate and if necessary change and improve the training of their family counsellors so that they have the skillset to work with severe family problems and distress levels similar to those found in NHS primary and secondary care settings. The findings also suggest that for family counselling to be an effective and preventative intervention, carefully developed screening procedures might be needed to ensure that the severity of presenting problems is appropriate for the service on offer. A closer local collaboration and established referral system between low intensive family counselling and CAMHS would help to establish an effective stepped care system. Better cooperation would require increased openness, institutionalised knowledge and information transfer between both services (e.g. regarding criteria for referrals and the treatment offered by each service).

A final implication of the study is that the participants' lack of a systemic understanding of their family problems, as illustrated in the qualitative data of this study, confirms that a systemic approach can be a useful intervention for families in this context. Seeing the problems as caused mainly by one person or external agents often contributes to processes of blaming and problem-saturated conversations. The introduction of a systemic problem understanding can help in this situation to broaden a family's understanding of their difficulties and their context in the family and open possibilities for alternative views and new narratives to emerge (Vossler, 2010).

Conclusion

This study found significant levels of distress in families seeking help at Relate family counselling, a preventative and low-intensity family intervention in the voluntary sector. The findings highlight the potential value of an improved cooperation between low-intensity family counselling and family interventions in the NHS context in establishing an effective stepped care system for families in need.

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Table 1: Adult and child mean scores on SCORE and FACES-III

	Parents		Children	
	Range	Mean	Range	Mean
SCORE				
Strengths and adaptability	0 - 22	13.2	5 - 17	11.0

Overwhelmed by difficulties	5 - 30	15.4	8 – 21	12.6
Disrupted communication	5 – 30	14.1	8 – 19	13.1
Score Total	15 - 61	42.7	30 - 57	36.7
FACES-III				
Adaptability	14 - 38	25.4	14 – 30	26.9
Cohesion	13 - 46	33.1	19 – 46	32.9

Notes: SCORE is the *Systemic Clinical Outcome and Routine Evaluation*; FACES-III is the *Family Adaptability and Cohesion Evaluation Scale III*. The N was 60 for parents and seven for children.

Table 2: Adult and child mean scores alongside norms for SDQ subscales.

SDQ-scales	SDQ norms			Study data	
	Normal	Borderline	Abnormal	Parents	Children
Emotional problems	0-3	4	5-10	5.5** [0-10]	4.0* [3-7]
Conduct problems	0-2	3	4-10	4.7** [0-10]	5.4** [3-7]
Hyperactivity - inattention	0-5	6	7-10	6.4* [1-10]	5.9 [4-10]
Peer problems	0-2	3	4-10	3.7* [0-8]	2.9 [0-5]
Prosocial behaviour	6-10	5	0-4	7.1 [2-10]	6.3 [4-7]
Impact of problems	0	1	2-10	3.6** [0-8]	2.7 [2-6]

Total difficulty score	0-13	14-16	17-40	20.3** [9-30]	18.1** [13-22]
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Notes: SDQ is the *Strengths and Difficulties Questionnaire*. The N was seven for children and 36 for adults since only adults with children aged 4-16 completed the instrument. ** is used to indicate where parent or child reports fell into the 'abnormal' range and * for when parent or child reports fall into the 'borderline' range. Ranges are in parenthesis under each mean.

Table 3: *Correlations between the family functioning instruments and the SDQ scales*

	<i>SCORE total</i>	<i>FACES Cohesion</i>	<i>FACES Adaptability</i>
SCORE total	--	-.587**	.218
SDQ total	.271	-.236	.125

Note: ** = $p < .001$

Biographical outline

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