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Stages of change and engagement in a family intervention

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Abstract

Prochaska and DiClemente's stages of change model facilitate understanding of engagement difficulties in psychosocial intervention processes. We assessed the link between stages of family change and intervention dropout in a sample of 141 families with relational conflicts between parents and adolescent children. Each family member's stage of change was defined according to three criteria: seeing the conflict as a relational problem, assuming part of the responsibility for the dysfunctional relationship, and understanding one's own mental and emotional states and those of the other family members involved in the conflict (mentalization). Our dropout rate for the sample was 41.8% and was higher for immigrant families. We found a strong association between engagement and the contemplation stage of change, particularly the mother's. In family conflict interventions, participation of all the family members is essential so as raise awareness of the relational aspects of the conflict and the shared responsibility for the conflict and its resolution.

Keywords: adolescents; dropout; families; family conflict; stages of change

1 INTRODUCTION

Tensions may arise in any period of the lifecycle of families, but adolescence is a particularly fraught period. Although family bonds produce security and confidence, adolescents are also constructing their identity, promoting their autonomy, and developing peer relationships. If the family does not adjust to the changes in adolescents, its structure may be affected and previously hidden or suppressed conflicts may arise. If relationships in the family deteriorate, the adolescent's autonomy turns into distance and isolation (Elzo, Megías, Ballesteros, Rodríguez, & Sanmartín, 2014; Micucci, 2005).

The number of families with adolescent children needing help has grown to the point that, in many western societies, specific community services have been set up to facilitate conflict resolution, improve parenting skills, and promote family development and well-being (Bartau & De la Caba, 2009; Máiquez & Capote, 2001; Medlow, Klineberg, Jarrett, & Steinbeck, 2016; Morte & Lila, 2007). This research was carried out in such a service, conceived as a space for joint reflection and where professionals and families cooperate to solve relational and communication conflicts, to improve family bonds, and to develop family resources and capacities (Ruffolo, Kuhn, & Evans, 2006).

Intervention begins with an assessment process that aims to identify the difficulties, resources, and types of communication in a family and that thoroughly explores every person's (father, mother, and child) experience of their relationship with the others. Other key aspects of the early interviews are the construction of a helping

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alliance with the family, setting objectives, developing awareness of individual and family capacities, and creating empathy. After assessment, an intervention is decided on, typically mediation or psychoeducation or, in some cases, family therapy. The intervention's aim is to produce constructive changes in family interactions, contextualize the problem in the lifecycle of the family, promote the adolescent's autonomy, and develop the responsibility and thinking capacity of all the family members involved in the conflict. This capacity to consider one's own thoughts and feelings as well as those of others (referred to as the reflective function or mentalization) is necessary to regulate the intense feelings of loss, anger, sadness, resentment, etc. that are present in family conflicts (Benbassat & Priel, 2015; Fonagy & Target, 1997; Lebow & Rekart, 2007). As will be seen later, it is essential that the family members understand that their difficulties and conflicts have a relational basis and that change will be a result of modifying or regulating their relationships in order to reduce guilt, repair fractures, and promote the experience of synchrony and of sharing the meaning of what they are going through (Fearon et al., 2006; Molinari, Everri, & Fruggeri, 2010; Small, Jackson, Gopalan, & McKay, 2015; Tuttle, Knudson-Martin, & Kim, 2012).

To be able to work on all these aspects, it is obvious and unavoidable for the family members to attend sessions and to collaborate. Taking psychotherapy research as a reference (because it pays more attention to this issue), the standard definition of “dropout” is unilateral termination of consultation by a person or people (couple and family), despite the professional's recommendation that they continue and despite their problems continuing (Hopwood, Ambwani, & Morey, 2007; Swift & Greenberg, 2012). Recent studies propose the more complex concept of “engagement,” which points to attitudinal components linked to collaboration and emotional involvement with the treatment (Gopalan et al., 2010).

The emotional and care costs of the dropout are many: personal and community resources are wasted, there is an increased risk of chronification, and feelings of failure and frustration emerge in both the families and the professionals (Swift & Greenberg, 2012). In family intervention programmes reviewed by Ingoldsby (2010), dropout rates ranged from 20% to 80%. Dropout is more likely among those who need greater help, for instance, immigrant or ethnic minority families, teenage-parent families, single-parent families, families in poverty, and families under stress and experiencing especially chaotic or conflictive relationships or mental health problems (De Haan, Boon, De Jong, Hoeve, & Vermeiren, 2013; Gopalan et al., 2010; Ingoldsby, 2010; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012). The reasons for dropout are many and varied, with key roles played by the professional-user relationship, by where responsibilities are perceived to lie and by motivation and readiness to change (Niec, Barnett, Gering, Triemstra, & Solomon, 2015; Pereira & Barros, 2018).

The stages of change model by Prochaska and DiClemente (Norcross, Krebs, & Prochaska, 2011; Prochaska & DiClemente, 1983) are useful not only for evaluating the motivation and readiness to change, as referred to above, but also for understanding engagement difficulties in psychosocial intervention processes (Melchiorre & Vis, 2013). Prochaska and DiClemente understand change as a process that develops through five stages, with people in one stage or another depending on their awareness of a problem and their motivation and readiness to change. Thus, in the *precontemplation* stage, the person does not admit to having a problem or underestimates the inconveniencies, so that there is no readiness to change; in the *contemplation* stage, the person recognizes that they have a problem but is not yet ready or willing to take action to change; in the *preparation* stage, the person is aware of their difficulties, has a plan for action, and may even have started to change; in the *action* stage, the person invests time and energy in change and the results are evident; and finally, in the *maintenance* stage, the person focuses on consolidating their achievements and avoiding relapses.

For our purposes, we redefined those five stages of change for the family conflict domain so as to understand what it really means for the members of a family to be in a particular stage, most especially the precontemplation and contemplation stages. From our perspective, the fundamental issue was raising awareness that relational difficulties exist, that each family member contributes to those difficulties, and that change requires enhancing family members' capacity for reflection, that is, mentalization (Benbassat & Priel, 2015; Fonagy & Target, 1997).

Our research had the following objectives: (a) to assess the stages of change in fathers, mothers, and children in families with relational difficulties who attend a community support service and (b) to explore the relationship between stage of change and engagement, defined as attendance at scheduled interviews and agreed termination of the process.

The following hypotheses were established:

H1

Engagement will be greater in families in the contemplation stage (whether at an early or advanced stage) and lower in families in the precontemplation stage.

H2

Engagement will be less in immigrant families than in native families, given issues that hinder engagement (financial and social problems, low expectations about professional help, bonds eroded by separations associated with their migration process, different sociocultural values, etc.).

H3

Engagement will be less in single-parent families than in other family types, again given issues that hinder engagement (more demands on their time, less social support, financial difficulties, etc.).

We also assessed whether stages of change specific to the mother, father, or child had greater repercussions on the family's engagement in the intervention.

2 METHOD

2.1 Sample

Our study sample consisted of 141 families, users of a community support service for families for a period of 2 years, and who were appointed for a second interview. These families had varying problems related to a son (53.2%) or daughter (46.8%), including disobedience of house rules (29.8%), absenteeism and bad behaviour at school (19.9%), relational conflicts associated with a psychiatric condition (16.7%), or problems related to parental separation (14.2%), immigration (12.8%), or other causes (6.6%). The mean (*SD*) age of the children was 14.1 (3.3) years. Most families were native (85.1%), 37.6% were single-parent families, 34% were nuclear families, and 24.1% were blended families. The mother attended the first interview in 90% of the cases, whether on her own (23.4%), with the father (23.4%), with the child (20.6%), or with both father and child (19.1%).

After one or two interviews, 59 (41.8%) of the families dropped out (dropout subsample) without agreeing termination with the professional attending them. The remaining 82 (58.2%) families (engaged subsample) attended visits and completed the intervention (mediation, psychoeducation, or family therapy).

2.2 Procedure

The stages of family change categories were developed from the stages of change proposed by Prochaska and DiClemente (1983). The stage of change of each family member was considered according to three criteria: (a) recognizing the relational grounds for the family problems, (b) assuming responsibility for these problems, and (c) understanding one's own mental and emotional states and those of the other family members. The information on these criteria was obtained in the initial interview with the family, when each member was asked for their opinions regarding the reason for the conflict; in this way, we could determine if the conflict

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was relational and if responsibility was assumed—criteria (a) and (b). Criterion (c) was evaluated by exploring specific conflict situations with family members and asking about their own feelings and thoughts and those of other family members involved (mentalization). On the basis of this information, each family member (father, mother, and child) was categorized as in a precontemplation, early contemplation, or advanced contemplation stage (illustrative examples are given in Table 1), as follows:

1. Precontemplation stage: (a) they do not consider the family problem to have a relational base, (b) they do not admit to being part of the problem and place responsibility on other family members, and (c) they have difficulties to understand their own or the other's mental states.

2. Early contemplation stage: (a) they recognize the problem to be relational, but (b) they are not strongly committed to change, whether because they minimize the importance of their contribution to the problem or because they see difficulties in modifying attitudes or behaviours, and (c) their comprehension of their own or the other's mental states is partial or limited.

3. Advanced contemplation stage: (a) they recognize the problem to be relational, (b) they assume responsibility for change and for taking action, and (c) their comprehension of their own or the other's mental states is appropriate.

Table 1 Examples of stages of family change

Precontemplation stage
Juana is separated and has a daughter, María, aged 15. Two years ago, María started to get home late and miss school and became nasty and insulting. The family attended a public mental health consultation. María received psychotherapy and Juana participated in a parental support group. They were informed that their problem was relational, and then they stopped attending. Now, Juana assesses the help that they received negatively and also has a negative vision of her daughter, whom she blames for the problems between them.
Early contemplation stage
Elsa's arguments with her daughter Laura have increased. Shouting and insults are frequent, as well as banging doors and hitting furniture. Elsa separated 5 years ago and has had ongoing arguments with her ex-husband concerning child support and visits to his daughter. Elsa is now unemployed, and both mother and daughter have had to go and live with a relative. Laura is unable to accept this new situation. Elsa is aware of her responsibilities as a mother to Laura and partially understands what her daughter feels but says that she is personally going through difficulties and feels unable to get involved in a process of change.
Advanced contemplation stage
The Ferrer family consists of mother, father, and two children: Marta aged 14 and Eloy aged 8. The parents have problems with Marta, as she has started to be hostile and shouts and throws things to the floor when told no. Marta has always been a very good student, but not in recent months. She has changed friends and breaks house rules and disobeys timetables set by her parents. Both Marta and her parents would like to improve their relationship and get back their previous dialogue and respect. They recognize their own feelings and those of the others and accept that their life together would improve if attitudes changed.

The other categories in the Prochaska and DiClemente (1983) stages of change model (action, maintenance, and termination) were not defined because our aim was to assess the situation of the family at consultation, when the process of change was at an early stage.

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The stage of family change was categorized from information in our records, which included the explanations of each family member regarding the conflict and its causes, whether it had a relational basis and whether they assumed part of the responsibility and their mentalization capacity.

Once the system of categories was designed and tested, the members of the 141 families in the sample were categorized by the three coinvestigators. Each categorized their own cases and, for cases that were doubtful, obtained a second opinion from another coinvestigator. These tasks were specifically designed in such a way that they would not impose any overload on the service or the professionals.

From the information collected for each family, a number of variables were coded for further statistical analysis: age and sex of the child triggering the consultation; attendees at the first two interviews (child, mother, father, and other); family type (nuclear, single-parent, blended, and extended); family/child problems; family origin (native and immigrant): occupational status of the parents (employed, unemployed, and retired); and stage of change for each family member (precontemplation, early contemplation, and advanced contemplation). Finally recorded was the kind of termination for the intervention, based on distinguishing between engagement (agreed termination of the process) and dropout (interruption of the process despite the professional's recommendation to continue).

On the basis of the aforementioned variables, the differences between engaged and dropout families were analysed. Means were compared for quantitative variables, and Pearson's chi-squared (χ^2) test was used for categorical variables. Variables with statistical significance in the bivariate analysis were included in the stepwise logistic regression model, with dropout as the dependent variable. The Hosmer–Lemeshow test was used to check the significance of the logistic model ($p > .05$). Statistical analyses were performed using SPSS v22.

3 RESULTS

As can be seen in Table 2, in terms of stage of change, 41.7% of mothers and 46.8% of fathers were in precontemplation, 27.3% and 25.8% in early contemplation, and 31.1% and 27.4% in advanced contemplation, respectively. The corresponding percentages for children were 29.7%, 32.8%, and 37.5%.

Table 2 Engagement and dropout associations with study variables

	Total sample	**Engagement**	**Dropout**	
	***N* = 141**	***N* = 82 (58.2%)**	***N* = 59 (41.8%)**	**Statistics (sig)**
Family origin				
Native	120 (85.1%)	77 (64.2%)	43 (35.8%)	$V = .291$ (.001)
Immigrant	21 (14.9%)	5 (23.8%)	16 (76.2%)	
Requested by	139	81	58	
Mother	71 (51.1%)	46 (56.8%)	25 (43.1%)	$\chi^2 = 41.2$ (.001)
Father	14 (10.1%)	9 (11.1%)	5 (8.6%)	
Child	23 (16.5%)	20 (24.7%)	3 (5.2%)	
Mother + Father	15 (10.8%)	1 (1.2%)	14 (24.1%)	
Others	16 (11.5%)	5 (6.2%)	11 (19.0%)	
Interview attendance	132	76	56	

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	Total sample	Engagement	Dropout	
	N = 141	*N* = 82 (58.2%)	*N* = 59 (41.8%)	Statistics (sig)
Child yes	60 (45.5%)	47 (61.8%)	13 (23.2%)	χ^2 = 19.4 (.001)
Child no	72 (54.5%)	29 (38.2%)	43 (76.8%)	
Mother's stage of change	132	77	55	χ^2 = 38.7 (.001)
Precontemplation	55 (41.7%)	20 (26%)	35 (63.6%)	*V* = .542 (.001)
Early contemplation	36 (27.3%)	17 (22.1%)	19 (34.5%)	
Advanced contemplation	41 (31.1%)	40 (51.9%)	1 (1.8%)	
Father's stage of change	62	44	18	
Precontemplation	29 (46.8%)	18 (40.9%)	11 (61.1%)	χ^2 = 6.1 (.048)
Early contemplation	16 (25.8%)	10 (22.7%)	6 (33.3%)	*V* = .313 (.048)
Advanced contemplation	17 (27.4%)	16 (36.4%)	1 (5.6%)	
Child's stage of change	64	52	12	
Precontemplation	19 (29.7%)	12 (23.1%)	7 (58.3%)	χ^2 = 9.974 (.007)
Early contemplation	21 (32.8%)	16 (30.8%)	5 (41.7%)	*V* = .395 (.007)
Advanced contemplation	24 (37.5%)	24 (46.2%)	0 (0%)	

Note. For some variables, information for all the families in our sample (*N* = 141) is not available, either because this information was not in their record or (for the stage of change) because the mother, father, or child did not take part in the intervention.

Abbreviation: *V*, Cramér's *V*.

Families made a mean (*SD*) of 3.4 (2.2) visits (range, 1–9). Over half (58.2%) of the families completed the intervention, leaving 41.8% who dropped out. As Table 2 shows, chi-squared tests point to statistically significant relationships between dropout and mothers in the precontemplation stage and between engagement and mothers, fathers, and children in the advanced contemplation stage. Likewise, the probability of engagement increased when the child attended the first interview. The association between type of termination and family origin was statistically significant, with native and immigrant families tending more towards engagement and towards dropout, respectively.

There was no significant relationship between type of termination and the child's sex, family problems, type of family, and parental occupational status. Regarding the relationship between stages of change and other variables, the mother in the advanced contemplation stage of change was significantly associated with the presence of the child at the first interview (χ^2 = 7.2; *p* = .028). Also significant was the relationship between the mother in the advanced contemplation stage and the family being native (χ^2 = 6.5; *p* = .039). There was no statistically significant relationship between the stage of change of either the father or child and the other variables.

Of the variables that were significant in the bivariate analysis, predictive variables in the logistic regression model were family origin, child attendance at the first interview, and the stage of change of the family members. The results of the logistic regression show that the intervention tended to be completed by families

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(a) that were native, (b) whose child attended the first interview, and (c) whose mother was in the advanced contemplation stage. The percentage of families with a satisfactory engagement/dropout classification was 85.8%, with an explained variance of 64.5% (Hosmer–Lemeshow; $p = .761$).

4 DISCUSSION

We designed a system of stages of family change (based on the model of Prochaska and DiClemente) in order to study the relationship between stages of change and engagement versus dropout for a community family support service (where interventions are usually short, around six sessions) and used it to analyse a sample of 141 families with relational conflicts between a parent or both parents and a teenager.

The stage of family change—precontemplation, early contemplation, or advanced contemplation—was defined on the basis of three criteria: understanding the conflict as a problem in relations among family members, assuming part of the responsibility for the dysfunctional relationship, and the ability to understand one's own mental state and that of others (the reflective function or mentalization). Failure to meet any of these criteria indicated the person to be in the precontemplation stage, meeting all three criteria reflected an advanced contemplation stage, while recognizing the relational aspect of the conflict but failing to progress further reflected the partial contemplation stage.

Our results show that almost half of the mothers and fathers in our sample were in the precontemplation stage, which would suggest that they hold their children responsible for the family's problems, whereas over half the children had advanced to the contemplation stage, indicating that they assumed partial responsibility for their family's problems. The fact that adolescents tend to reflect relational problems in their behaviour may help them admit their difficulties and so arrive to the contemplation stage of change. It is difficult, after all, to deny disobedience, school absenteeism, challenging attitudes, etc. From the parents' perspective, this visibility of adolescent behaviour may lead them to shirk their own responsibilities, given that it is the child who is evidently "behaving badly."

Although raising parental awareness of the relational dimension of their children's attitudes and behaviours is not easy, it is essential to recovering family homeostasis. While working on parenting skills, affective relationships and appropriate control–supervision are key elements in psychosocial interventions with families (Dekovic, Asscher, Manders, Prins, & Van der Laan, 2012; Henggeler, 2012), the responsibility for problems and their resolution has to be equitably shared. Thus, adolescents also have to take on their share of responsibility and become involved in the process of change. Children, after all, are not passive receivers of particular styles of upbringing. Bearing in mind sociocultural influences, the close emotional bonds established among family members make mutual influence very powerful (Tuttle et al., 2012). Interventions with conflictive families requires raising the capacity for awareness of each family member as a key element in the regulation of emotions (Fearon et al., 2006; Lebow & Rekart, 2007; Shemmings, Shemmings, & Cook, 2012).

Of the 141 families in the sample, 41.8% dropped out of the study. As far as we are aware, no studies exist that quantify such data for family-oriented community services, so we were not able to draw any comparisons. Increasing the engagement percentage, however, is a real challenge but worth tackling, as data from our study show a significant relationship between engagement and family members reaching the advanced contemplation stage (thus confirming H1).

Our study indicates that the probability of dropout is higher when the mother is in the precontemplation stage, indicating that the mother is the lynchpin to working with a family. Not only is the mother the family member most likely to attend (nine out of 10 consultations in our study), when she is in the advanced contemplation stage the intervention is more likely to be completed.

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The mother's greater involvement in trying to solve family problems contrasts with the lower involvement of fathers. Previous studies indicate that mothers are more predisposed to change than fathers, who tend to be more defensive and to feel less capable of modifying their relationship with their children (Niec et al., 2015). In a study of involvement in family interventions by immigrant parents (of Mexican origin), Wong, Roubinov, Gonzales, Dumka, and Millsap (2013) reported paternal participation to be 66%, with fathers' involvement higher in families with fewer interparental conflicts, fewer financial problems, and higher maternal education levels. Partnership conflicts tend to lead men to abandon their responsibilities as parents (Wong et al., 2013), particularly when women more actively assume the task of taking care of family issues. Financial problems seem to have an important impact on the father's role (Wong et al., 2013), as being the main breadwinner continues to be broadly perceived as the most important contribution of men to their families. As for higher maternal education levels and its association with greater participation by fathers (Wong et al., 2013), this may be because better educated mothers may be more influential in encouraging the father's participation or may be associated with more equalitarian families. However, when (as was apparent in our study) families have not achieved parity in terms of involvement in family issues, mothers are likely to become overwhelmed by family demands, both at the practical and emotional levels (Arranz, Oliva, Martín, & Parra, 2010). Any attachment figure (mother, father, or both) experiencing overload is clearly less likely to be sensitive to their children's needs, which, in turn, increases the risk of conflict and of developmental difficulties (Bowlby, 1988; Hopkins, Gouze, & Lavigne, 2013).

Almost half of the children involved in family conflicts attended the sessions and our results show that the child's attendance promotes engagement and completion of the intervention. Our results also show that the child is less likely to attend sessions when the mother is at the precontemplation stage, with the resulting increased risk of dropout. It seems essential to invest efforts in raising awareness among all family members regarding their responsibility for the problem, but most especially in families where the mother is at the precontemplation stage. Because the participation of family members, particularly of parents, is associated with better outcomes in family interventions, spaces should be created for dyadic, triadic, and full family participation, so that all members are involved in assessing and resolving the problem; this approach avoids placing the focus on a “problem child” or on the mothers who, generally, are more willing to participate (Molinari et al., 2010).

The native families in our sample were more engaged than the families of immigrant origin (thereby confirming H2). While immigrant families perceive the need for support services (Ayón, 2014), the higher dropout rate may be attributed to the professionals' difficulty in understanding their concept of family relationships (hierarchy, rules, power distribution, etc.) and in responding appropriately to their expectations (Tuttle et al., 2012). Also, requiring consideration is a situation in which lengthy separation periods have eroded bonds between the couple and with the children (Fresneda, 2001). Immigrant families may also have financial problems, housing and employment issues, adaptation problems, etc. Stressors of this nature leave little energy or mental space for the dedication and emotional effort required to reflect on family problems (Wong et al., 2013).

The fact that there was no significant relationship between the two main study variables (type of termination and stage of change) and child's age, child's sex, referral type, family problem, number of problems and family type would suggest that dropout rates for single-parent families were no higher than for other family types (thereby rejecting H3). Our finding was that the most significant aspect of engagement was not family type or even problem, but the stage of change at which family members were located. When family members were at the advanced contemplation stage, the intervention was very likely to develop successfully.

Assuming partial responsibility for the family difficulties promotes listening and consensus on the basis of understanding others and empathizing with their feelings, while promoting mentalization processes (Fearon et al., 2006; Lebow & Rekart, 2007). It is important for the family to realize that the problem is not the adolescent but that what every member does or does not do influences the others. Because everyone perceives the self in relation to others, all members of a family experience difficulties in adapting to the adolescent period in the family life cycle (Micucci, 2005; Tuttle et al., 2012).

Given the impact of psychosocial interventions on families, it is necessary to consider how to promote the transition from the precontemplation to contemplation stages. As recommended in some studies, it may be useful to discuss any possible external obstacles (timetables and journeys) and internal obstacles (fear of being criticized or questioned) with the family and also expectations of change, as this would clarify the sense of the intervention and its benefits for the family (Gopalan et al., 2010; Small et al., 2015; Sterrett, Jones, Zalot, & Shook, 2010). Encouraging participation by all family members would also reduce the dropout risk. An initial interview with the family is essential to assessing members' stages of change and to placing the work in the correct context. If precontemplation is predominant, the first change needed is to raise awareness about the relational roots of the family problem. The focus of the intervention is reflection, understanding the mental states underlying attitudes and behaviours associated with conflicts and developing the capacity to understand oneself and others (Benbassat & Priel, 2015). Other strategies that foster involvement are to more openly emphasize family strengths, resources, and capacities, to revisit the issue of blame, and to set achievable objectives aimed at laying the groundwork for change (Isaacs, Roman, Savahl, & Cheng Sui, 2017; Pereira & Barros, 2018). Due attention should be paid to absences from sessions, which should also be discussed, and consideration could be given to short interventions with a pre-established duration to facilitate the family's commitment. The possibility of making visits to the family home should also be considered in the case of particularly vulnerable families (Goh, 2015; Henggeler, 2012; Ingoldsby, 2010; Swift & Greenberg, 2012). With immigrant families, more effort is needed to understand cultural influences, the impact of migration processes and concepts of family relationships and hierarchies. Beyond their origin, however, whether native or immigrant, family support services should aim to enhance bonds that promote well-being and growth in all the family members.

Some of the limitations of this study are its retrospective and correlational character, which did not allow us to establish causal relationships between variables. Although the professionals who designed and applied the system of categories based on Prochaska and DiClemente's model established a procedure to resolve doubts and agree on categorizations, no reliability or validity tests were run for the system of categories. We also considered it important for the research not to involve work overload or modification of the usual work routines. Future research should consider the issue of reliability and should allow for prospective data collection so as to enlarge the number of variables studied. For instance, it may be useful to study the relationship between stages of change and the quality of the couple's relationship, the quality of the relationships between children and their mothers and fathers, and the kind of attachment. The concept of engagement with the intervention could also be expanded; whereas in our case it was restricted to attendance at sessions, other aspects could be included, such as adherence to the intervention, the emotional bond established between the family and professionals, agreement regarding objectives and tasks to be developed, etc. (Friedlander et al., 2006).

As far as we are aware, this is the first study that uses Prochaska and DiClemente's model to analyse family engagement with a community family support service. Our results point to the importance of family members being at the contemplation stage, to the significance of the mother's role in family change processes, and to the need to work towards achieving higher levels of engagement by fathers. Part of our task is to get each family member to understand the complexity of the family problems and to understand and assume responsibility for the relational grounds of conflicts.

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