



2809443566

**Unheard Voices: Parents' and Adolescents' Experiences of
Multisystemic Therapy for Young Offenders**

LUCY CASDAGLI

D.Clin.Psy. thesis (Volume 1), 2007

University College London

UMI Number: U592670

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI U592670

Published by ProQuest LLC 2013. Copyright in the Dissertation held by the Author.
Microform Edition © ProQuest LLC.

All rights reserved. This work is protected against
unauthorized copying under Title 17, United States Code.



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

OVERVIEW

This thesis is in three parts.

The literature review examines what is known from the adolescent's perspective in research investigating the outcome of psychological therapies. The literature in three mental health domains that are particularly relevant to adolescence is focussed on: anorexia nervosa, depression and antisocial behaviour. Both quantitative and qualitative studies are examined and what has been asked of adolescents is explored. This review highlights what can be learnt from eliciting adolescents' views and considers how these views can better inform treatment.

The empirical paper presents the results from a qualitative study exploring ten parent-adolescent pairs' experiences of Multisystemic Therapy (MST). The findings emphasised the value of the therapeutic relationship, with the experience of MST being very much dependent on this relationship as well as the improved relationship between parents and adolescents. Furthermore, the importance of involving adolescents in MST was underscored.

The critical appraisal provides an in-depth discussion of the process of the research. The challenges and dilemmas posed during the project, as well as the rewards gained, are reflected upon. It examines the reasons behind conducting the research, the recruitment of the families, the interviews themselves and the analysis. The wider implications for future research are also considered.

TABLE OF CONTENTS

	Page Number
ACKNOWLEDGEMENTS	7
LITERATURE REVIEW	8
Abstract	9
Introduction	10
Anorexia Nervosa	11
Quantitative studies	12
Qualitative studies	18
Summary	24
Depression	25
Quantitative studies	26
Qualitative studies	38
Summary	41
Antisocial Behaviour	42
Quantitative studies	43
Qualitative studies	51
Summary	55
Discussion	56
References	59

	Page number
EMPIRICAL PAPER	74
Abstract	75
Introduction	76
Method	81
Results	87
Discussion	106
References	114
CRITICAL APPRAISAL	119
Introduction	120
Personal reflections	120
Engaging and Interviewing the Families	121
Methodological Issues:	124
Challenges of Qualitative Research	
Conclusions:	127
The Importance of Hearing Service User Voices	
References	128
APPENDICES	129
Appendix A Ethical Approval	130
Appendix B Information and Consent Forms	134
Appendix C Interview Schedules	143
Appendix D Steps in Framework Analysis	148

TABLES**Literature Review**

Table 1a: 13

Summary of findings of quantitative studies for adolescent AN

Table 1b: 17

Measures given to adolescents in AN studies

Table 1c: 19

Summary of findings of qualitative data for AN

Table 2a: 27

Summary of findings of quantitative studies for adolescent depression

Table 2b: 34

Measures given to adolescents in depression studies

Table 2c: 39

Summary of findings of qualitative data for depression

Table 3a: 44

Summary of findings of quantitative studies for adolescent ASB

Table 3b: 49

Measures given to adolescents in ASB studies

Table 3c: 52

Summary of findings of qualitative data for ASB

Empirical Paper

Table 1: 78

Nine core principles of Multisystemic therapy

Table 2: 83

Description of participants

Table 3: 88

'Outcomes' of MST

Table 4: 88

'Process' of MST

ACKNOWLEDGEMENTS

I would like to thank the team at the MST trial; the administrator, the therapists and the project manager, without whom this project would not have been possible.

The parents and adolescents who took part in the study were always open and friendly and made me feel welcome in their homes. Their open and heart-felt narratives made the interview process enjoyable as well as providing rich material. I hope I have captured their experiences in a meaningful way.

A big thank you to my supervisors, Nancy Pistrang and Stephen Butler, whose wise words, encouragement and enthusiasm have been a constant support to me throughout this project.

Finally I want to thank those who have supported me personally. To my parents and close friends, I couldn't have done this without you.

Part 1: Literature Review

Adolescents' Perspectives in Outcome Research of Psychological Therapies

Adolescents' Perspectives in Outcome Research of Psychological Therapies.

ABSTRACT

Government guidelines for mental health interventions emphasise the importance of taking young people's views into account. This review examines what is known from the adolescent's perspective in research investigating the outcome of psychological therapies. The literature in three mental health domains that are particularly relevant to adolescence is focussed on: anorexia nervosa, depression and antisocial behaviour. Both quantitative and qualitative studies are examined and what has been asked of adolescents is explored. This review highlights what can be learnt from eliciting adolescents' views and considers how these views can better inform treatment.

INTRODUCTION

The importance of taking the young person's views into account has been recognised in the National Service Framework guidelines for children and young people (Department of Health, 2004). However despite the importance of drawing upon service user feedback to inform service development having been highlighted (e.g. Buston, 2002; Street & Svanberg, 2003), much of the existing literature fails to tap into adolescents' views, with only a small number of outcome studies exploring young people's experiences and views of treatment.

The aim of this review is to investigate what is known from the adolescent's perspective in relation to research on the outcome of psychological therapies for three types of problem; anorexia nervosa, depression and antisocial behaviour. These areas were chosen as they are all common in adolescence and reflect a range of mental health problems. Outcome studies for evidence-based psychological treatments for adolescents are examined in each of the problem areas, with a focus on self report measures as well as qualitative interviews. The review does not intend to provide a comprehensive review of all the literature in this field but to concentrate specifically on what has been elicited from the adolescents themselves.

Search strategy

'PsycINFO' and 'Google scholar' were used to search for relevant articles.

Various combinations of words were used for each domain:

All: 'adolescent', 'childhood', 'treatment', 'therapy', 'CBT', 'family therapy'.

Individual domain: 'anorexia nervosa', 'eating disorder', 'depression', 'delinquency', 'antisocial behaviour'.

Quantitative: 'outcome', 'research', 'review', 'meta-analysis'.

Qualitative: 'qualitative', 'views', 'voices', 'being heard'.

Recent reviews of evidence-based treatments for each domain were also consulted. This review is only concerned with evidence-based psychological therapy outcome studies; therefore studies that have included drugs or non-evidenced based therapies have been excluded. Only studies focussing on the specific problem areas have been included; therefore studies incorporating other problems such as substance abuse have also been excluded. The age range for most of the studies included has focussed on adolescents; however the child and young adult literature has been cited when relevant.

Structure of review

Each of the problem areas are reviewed in turn. Firstly a brief overview of the problem is given. The quantitative literature is explored, focussing on the scales given to the adolescents and the strengths and limitations of what as been elicited from the adolescent's point of view. The qualitative studies are then reviewed, also looking at strengths and limitations. The findings from each problem area are summarised in a final section.

ANOREXIA NERVOSA

Anorexia nervosa (AN) generally arises in early to middle adolescence and affects up to 2% of young women and 1% of males (Hoek & van Hoeken, 2003). This is a major adolescent disorder since young people with eating disorders occupy more adolescent inpatient beds than any other diagnosis (O'Herlihy et al, 2004).

Outcomes for AN patients are not optimistic with mortality rates between 6-15% (Le Grange & Lock, 2005). Considering these psychological and medical consequences, it is surprising that there are only limited psychosocial treatments for AN (Le Grange & Lock, 2005) and only a quarter of studies in the area of eating disorders are devoted to adolescents (Steinhausen, 1997).

National Institute for Clinical Excellence (NICE; 2004) guidelines on treatment of AN currently recommend that family interventions which directly address the eating disorder should be offered to children and adolescents, but highlight that the research base to guide treatment is limited.

Quantitative studies

Overview of outcome studies

Table 1a presents a summary of findings of the quantitative studies for adolescent AN. Eight quantitative studies have looked specifically at outcome of interventions for AN in adolescents, with six being Randomised Controlled Trials (RCTs). The majority of these studies investigate only one form of family therapy, “family-based therapy” (FBT; Dare & Eisler, 1997). This focuses on familial management of the symptoms of AN and the consequences for the patient and family rather than pathologising the young person or family.

Only two studies with adolescents have examined any form of individual therapy, despite individual therapy also being a commonly recommended intervention for adolescents with AN (American Psychiatric Association, 2000).

Overall outcomes of the studies have yielded positive results and found when family therapy is compared to individual therapy the former is more effective. One representative study in the field is Eisler et al. (2000). This study compared two forms of family based therapy: conjoint and separate (separate family therapy involved separate parent and adolescent sessions). A significant improvement was found in both groups, with no overall differences in effectiveness. However, separate family therapy was more effective with families with a high level of parental criticism, whereas there were greater changes on individual psychological and family

Table 1a. Summary of findings of quantitative studies for adolescent AN.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Russell, Szmukler, Dare, & Eisler (1987)	Family based Therapy (FBT) vs individual therapy (IT)	21	At discharge and 1 year follow up (FU)	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Family therapy more effective than individual in young patients, where illness not chronic. • IT valued in older patients. • Eisler et al (1997) 5 yr FU, FT more effective.
Le Grange, Eisler, Dare & Russell. (1992)	Conjoint FBT vs separate FBT	18	Pre and post treatment	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • No difference between treatment groups, both proved to be effective.
Robin et al (1999)	FBT vs ego-oriented IT	37	Pre and post treatment and 1 year FU	<ul style="list-style-type: none"> • Eating Attitudes Test (EAT) • Eating disorders inventory (EDI) • Beck depression inventory (BDI) • Internalising behaviour score from youth self report • Parent adolescent relationship questionnaire (PARQ) 	<ul style="list-style-type: none"> • FBT produced greater weight gain. • Both proved to be effective treatment, FBT produced faster return to health.
Geist, Heinmaa, Stephens, Davis, & Katzman (2000)	Family Therapy and Family Group Psycho Education	25	Pre and post treatment	<ul style="list-style-type: none"> • Eating Disorder Inventory (EDI-2) • Children's Depression inventory (CDI) • Brief symptom inventory (BSI) • Family Assessment measure (FAM- III) 	<ul style="list-style-type: none"> • Weight restoration achieved in both but no significant change in psychological functioning

Table 1a contd. Summary of findings of quantitative studies for adolescent AN.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Eisler et al (2000), Eisler, Le Grange & Asen (2003).	Conjoint Family Based Therapy (FBT) vs separate FBT	40	Pre-treatment, 3 months, 6 months, and post treatment	<ul style="list-style-type: none"> • Short mood and feeling Q (SMFQ) • Rosenberg Self esteem inventory (RSI) • Maudsley obsessive compulsive index (MOCI) • Eating disorders inventory (EDI) • Eating Attitudes Test (EAT) • Family adaptability and cohesion evaluation scale (FACES III) 	<ul style="list-style-type: none"> • Overall no difference in groups. • High maternal criticism; SFT better. • Symptomatic change; SFT better. • Psychological change, CFT better. • Continued improvement at FU.
Wallinn & Kronwall (2002)	Outpatient family therapy	26	2 yr FU	<ul style="list-style-type: none"> • Family relation scale (FARS) • The family climate 	<ul style="list-style-type: none"> • Observer rating: family changed towards more functional pattern. • Family rating: more expressive.
Lock, Agras, Bryson, & Kraemer (2005)	Long term FBT (12mth) vs short term FBT (6mth)	86	Post treatment	<ul style="list-style-type: none"> • Yale-Brown-Cornell eating disorder scale (YBC-ED) • Family environment scale • Youth self report (YSR) 	<ul style="list-style-type: none"> • Shorter course as effective as LT. • Suggestion those with more severe obsessional thinking and non intact families benefit from longer treatment
Le Grange, Binford & Loeb (2005)	Outpatient FBT	45	Post treatment	<ul style="list-style-type: none"> • Beck Depression Inventory • RSI 	<ul style="list-style-type: none"> • Findings provide preliminary support for feasibility of an outpatient approach with active parent involvement for adolescent AN.

functioning in the conjoint family therapy. Long-term follow up data found patients continued to improve after treatment ended, irrespective of the type of treatment (Eisler, Le Grange & Asen, 2003).

However the consensus in the literature is that despite these positive findings, the superiority of FBT over other types of interventions has not been sufficiently established due to the empirical base being small as well as the limitations of the studies (Lock & Gowers, 2005). For example many studies have been conducted at the same site, with small sample sizes and only two studies employed manualised treatments (Lock & Le Grange, 2005).

Primary outcome measures

Restoration of body weight is the primary outcome variable in all of the studies, measured by body mass index (BMI) and/or Morgan Russell scales (M-R scales). M-R scales measure nutritional status, menstrual functioning, mental state, psychosexual adjustment and socio-economic status (Morgan & Haywood, 1988). This makes sense in terms of weight being a primary medical concern and the main diagnostic criteria for AN, but does not necessarily come in conjunction with psychological change in the adolescent (Gowers, Weetman, Shore, Hossain, & Elvins, 2000). Some studies have exclusively used these measures as indices of outcome and therefore contain no information from the adolescents themselves.

Scales completed by adolescents

Recent studies have also included adolescent self report scales as outcome measures. As with most self report measures these scales mainly consist of a checklist which measures the presence or absence of a problem and to what degree, using a Likert scale. The scales used across the studies can be categorised as studying change in terms

of three main domains of functioning: the specific problem, individuals' general adjustment and family measures (see Table 1b).

Firstly scales that are specific to the eating disorder itself have been used, which cover areas such as eating disturbance, habits and attitudes. A common scale used is Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy 1983), which measures eating disturbance. Secondly scales have been used that focus on the adolescent's general adjustment, such as mood, depression and obsessional phenomena as well as more global problems of interpersonal functioning. A specific measure for self esteem, the Rosenberg Self esteem inventory (RSI; Rosenberg, 1965), is looked at in two studies. Finally there are a range of self report measures centred on family functioning, including conflict, cohesion and the emotional atmosphere. An example is the Parent-Adolescent Relationship Questionnaire (PARQ; Robin, Koepke, & Moye, 1990) which measures family conflict in terms of overt conflict, belief systems and family structure.

Strengths and limitations of the measures used

The majority of studies use scales from more than one domain of functioning, thus providing information from the adolescent in more areas than just the eating disorder itself. This recognises the multi-determined nature of AN; that is, a range of family, physical and personality variables lead to overvaluing the importance of weight and restraint (Gowers & Shore, 2001). Fonagy and Kurtz (2002) suggest that 'outcome measures should cover more domains than just symptomatology and diagnosis; a treatment in the long run may be more effective if it has a beneficial impact across other domains of functioning, even if the effect on symptoms is no greater' (p.105).

Table 1b. Measures given to adolescents in AN studies^a.

Domain	Scale	Reference	Description
Eating Disorder	<ul style="list-style-type: none"> Eating attitudes test (EAT) Eating disorders inventory (EDI) Eating disorder Inventory (EDI-2) Yale-Brown-Cornell eating disorder scale (YBC-ED) 	<ul style="list-style-type: none"> Garner & Garfinkel, 1979 Garner et al., 1983 Garner, 1991 Mazure et al., 1994 	<ul style="list-style-type: none"> Measures eating attitudes and habits Eating disturbance Eating disturbance Severity of obsessiveness and compulsiveness about eating behaviours weight and exercise
Individual adjustment	<ul style="list-style-type: none"> Beck depression inventory (BDI) Youth self report (YSR) Children's depression inventory (CDI) Brief symptom inventory (BSI) Short mood and feeling Q (SMFQ) Rosenberg self esteem inventory (RSI) Maudsley obsessive compulsive index (MOCI) 	<ul style="list-style-type: none"> Beck, 1976 Achenbach, 1991 Kovacs, 1992 Derogatis, 1992 Angold et al., 1995 Rosenberg, 1965 Hodgson & Rachman, 1977 	<ul style="list-style-type: none"> Depression: low mood, suicidality, disturbances in sleep, eating and cognitive functioning Global problems of interpersonal functioning Depression Mood Mood Self esteem Obsessive phenomena
Family functioning	<ul style="list-style-type: none"> Parent adolescent relationship questionnaire (PARQ) Family assessment measure (FAM- III) Family adaptability and cohesion evaluation scale (FACES III) Family relation scale (FARS) The family climate Family environment scale 	<ul style="list-style-type: none"> Robin et al., 1990 Skinner et al., 1991 Olsen et al., 1979 Cederbald & Hook, 1992 Hansson et al., 1994 Moos, 1974 	<ul style="list-style-type: none"> Family conflict: overt conflict, belief systems and family structure Family functioning Perception of closeness and rigidity; provides measure of family dissatisfaction Family functioning : attribution, interests, isolation, chaos, cohesion. Modified from the FACES Emotional atmosphere: closeness, distance, expressive, chaos Family functioning

^a References for the individual measures in this table have not been included in reference section; please refer to relevant studies.

The measures provide an important insight into the view of adolescents but still leave some neglected areas, which these scales do not evaluate. For example, the scales used in the studies focus exclusively on problems and do not consider positive aspects of adaptation or resilience. Therefore the research does not identify participants' strengths, just whether or not they have symptoms. An exception is the measure of self-esteem. However this is used in only two studies which is surprising considering the theory which regards self esteem and self worth as exclusively dependent on weight and shape (Fairburn & Harrison, 2003).

An important area to consider when treating adolescents with AN is their motivation for change (Ward, Troop, Todd, & Treasure, 1996), especially as it may not be their wish to be in therapy and therefore they may be resistant to change. This is likely to inform outcome of therapy but again has not been included in the studies.

Qualitative studies

Overview of qualitative studies

Table 1c presents a summary of findings from the qualitative studies for AN. There are only five qualitative research studies in this area which focussed exclusively on adolescents' accounts. Therefore some qualitative studies of young adults with AN are also reviewed, particularly as some were retrospective accounts of adolescent experiences of treatment.

Most of the studies have focused on the experience of inpatient treatment for AN. The risk of mortality alongside concern from parents means that many adolescents will experience a period of inpatient care (Gowers et al., 2000). This is an important

Table 1c. Summary of findings of qualitative studies for AN.

Author	Type of intervention	Sample Size	Method/design	Summary of Findings
Colton & Pistrang (2004)	Inpatient treatment	19	Qualitative semi structured interview	5 themes: what is this illness that I have?; Do I want to get well?; being with others: support vs distress; being an individual vs just another anorexic; collaborating in treatment vs being treated.
Offord, Turner & Cooper (2006)	Inpatient treatment	7	Qualitative interview, retrospective study	Themes: removal from normality vs connecting with outside world; treated as another anorexic vs a unique individual in distress; control and collaboration; the importance of peer relationships.
Cockett (1992)	Inpatient treatment	10	Qualitative interview	In relation to treatment components, adolescent inpatients valued individual psychotherapy and exercise most highly and family therapy least highly.
Krautter & Lock, (2004)	Family Based Therapy (FBT)	34	Satisfaction survey- 2 part outpatient effectiveness survey (scale and questionnaire)	Treatment highly acceptable, but individual therapy, more FT and focusing on other issues than AN would improve treatment.
Paulson-Karlsson, Nevonon & Engstrom, (2006)	FBT	32 patients, 41 parents	Questionnaire	Majority felt individual patient sessions and parental sessions helpful. Patients valued FT as less helpful than parents.
Le Grange & Gelman, (1998)	Family counselling and Cognitive Behaviour Therapy (CBT)	21	Interviews at 1yr FU	Helpful components: psycho education, supportive environment, challenging of dysfunctional beliefs, behavioural strategies. Unhelpful: significant minority felt causes of illness dealt with inadequately, behavioural strategies insufficient when symptoms too overpowering; lack of focus on cause of illness and neglect of other personal problems.

Table 1c contd. Summary of findings of qualitative studies for AN.

Author	Type of intervention	Sample Size	Method/design	Summary of Findings
Pettersen & Rosenvinge, (2002)	Improvement and recovery from eating disorders: Patient organisations and university eating disorder unit	47	Standard questionnaire and qualitative interview	Important recovery factors: wish to change, professional treatment, non-professional care, important persons in patients' lives. Recovery included: improved acceptance of oneself, interpersonal relations, problem solving, body satisfaction not entirely dependent on symptom absence.

area to study as admission to hospital can have a huge impact on adolescents, disrupting their school, social and family life (Lock & Gowers, 2005).

Colton and Pistrang (2004) interviewed adolescents with AN about their experiences of inpatient treatment. They found patients expressed both positive and negative views of treatment as well as ambivalent feelings about wanting to get well versus staying anorexic. The study highlighted the importance of patients' readiness to change, with those who felt more willing to change tending to find treatment more helpful. The importance of not just focusing on weight restoration but also on individuals' psychological needs was emphasised alongside balancing restrictions with flexibility in an inpatient setting.

Offord, Turner and Cooper (2006) interviewed young people about their experiences of general adolescent inpatient wards and discharge during their adolescence. This was a retrospective study as it was felt that the passage of time would potentially yield important new information. They found similar themes emerged. Young people reported more positive views of treatment when they felt considered as individuals, whose eating disorder was a symptom of more fundamental problems. When problem behaviours were prioritised over emotional needs and needs of other family members ignored, treatment was seen as unhelpful. It also emerged that authoritarian approaches left patients feeling ineffective, worthless and isolated, highlighting the importance of collaboration. Cockett (1992) found that in relation to treatment components, adolescent inpatients valued individual psychotherapy and exercise more than family therapy.

Two studies focussed on adolescents' satisfaction with family-based treatment. Krautter and Lock (2004) developed a satisfaction scale to evaluate specific treatment components, which included both rating scales as well as

descriptive written responses of the treatment process. Treatment was generally viewed as highly effective and acceptable. The most useful aspects of treatment for parents included a focus on the whole family as well as the re-feeding process, whereas adolescents highlighted the value of 'separating the patient from the illness', as well as individual therapy. It was felt that treatment could be improved by offering more family therapy alongside focusing on issues other than the AN. Paulson-Karlsson, Nevonon and Engstrom (2006) used questionnaires focusing on expectations and experiences of treatment, and found that patients valued family therapy as less helpful than did the parents, whereas they valued individual therapy more.

Two further studies with young adults looked at the patients' perspectives of treatment and recovery. Le Grange and Gelman (1998) looked at what was helpful as well as harmful about treatment (either CBT or FT) after one year of completion. They found most patients reported improvements. Helpful components were psycho-education, a supportive environment, challenging of dysfunctional beliefs, and behavioural strategies. Unhelpful components were a lack of focus on the cause of illness and neglect of other personal problems. Patients found behavioural strategies were also insufficient when symptoms were too overpowering. Pettersen and Rosenvinge (2002) found important perceived recovery factors were a wish to change, receiving professional treatment and support from important people in patients' lives. Recovery included self acceptance, improved interpersonal relations, with body satisfaction not entirely dependent on absence of symptoms.

Strengths and limitations of the qualitative studies

The studies reviewed above underscored the importance of particular treatment components that were valued by adolescents and young adults with AN.

These included not just focusing on illness or weight restoration but examining the cause of the eating disorder, as well as the importance of separating adolescents from their illness and looking at other factors in their lives. The importance of flexibility of treatment and being treated as an individual as well as considering adolescents' motivation for change seemed vital in whether treatment would be acceptable to them. This highlights the significance of collaborative approaches.

Recovery encompassed more than just weight restoration to young people; it included an improved acceptance of oneself and interpersonal relationships, with body satisfaction not entirely dependent on symptom absence. This suggests that the meaning of positive outcomes to clinicians and patients are likely to be different.

An interesting finding generally was that family therapy was seen as less helpful by adolescents but was valued by parents. The importance of individual therapy was highlighted by adolescents. This would be an important area to explore further.

These studies show that gaining patients' perspective of therapy can provide helpful feedback to improve treatment, in considering what components are valued by patients as well as which approaches are preferred by some patients and why. The importance of individualising care is emphasised in clinical work. Weisz and Hawley (2002) stress that individualising treatment for adolescents is essential, emphasising the importance of being flexible.

It is also important to emphasize the limitations of these qualitative studies. As with most qualitative research there were small sample sizes in the studies; therefore there is a problem with generalising the findings, particularly as associations with other variables were not considered (e.g. family background, social class). Most studies relied on retrospective accounts and therefore this could yield

less accurate reports of experience. However qualitative research is less concerned with an objective reality and instead aims to gain an understanding of individuals' perceptions and feelings.

Despite these limitations the studies do seem to look at different aspects of treatment outcome than quantitative research and elicit different information from adolescents. The focus in qualitative research is not so much on outcome but on the process of therapy, therefore bringing something different to the literature.

Summary

AN is a serious disorder and despite the positive findings of studies, the empirical base is small and has limitations. There is a need for larger, better controlled, systematic research in the area of therapy for AN in adolescence (Agras et al., 2004). For example there are no studies comparing different types of family therapy.

Recent quantitative studies include self report measures of the specific problem, the individual's general adjustment and family functioning. This shows positive developments in terms of current research being informed by theoretical developments, such as recognising the multi-determined nature of AN. However the primary outcome in quantitative research still focuses on weight restoration. A common finding amongst clinicians is that after re-feeding adolescents say that all that has changed is their weight, with little accompanying psychological change (Gowers et al., 2000). This highlights what can be learnt from in-depth accounts of adolescents' experiences. In qualitative studies, adolescents have emphasised the importance of not putting on weight too fast but the need to feel in control of the process, through collaborative treatment (e.g. Colton & Pistrang, 2004).

Nothing is known from the quantitative studies in terms of what has helped to make the change or the 'active' ingredients of therapy. Thinking more about the process of therapy rather than just the outcome may help understand what is specifically useful about treatment and why it works for some people and not others. For example, nothing about the therapeutic relationship is asked of adolescents in the quantitative studies, although the importance of this is recognised in the literature. The quality of therapeutic relationship is recognised across all models of therapy as fundamental and has been found to be a powerful predictor of treatment outcome (Horvath & Symonds, 1991).

The importance of listening and taking into account adolescents' views is highlighted in the qualitative literature; the significance of collaborative work where the young person's motivation to change is a crucial factor in how treatment is received, as well as the importance of examining the cause of the illness and including other areas of their life in therapy. Further studies looking at the relationship between patients' experiences of treatment and linking this to eventual outcome would be useful.

DEPRESSION

Depression is one of the most prevalent mental health problems among adolescents with rates between 2-5% (Birmaher, Ryan, Williamson, Brent, & Kaufman, 1996), with the critical age for the emergence around the onset of puberty (Nolen-Hoeksema, Girgus & Seligman, 1992). Adolescent depression has an impact on most aspects of functioning including a decrease in school performance, withdrawal from social relationships, increase in family conflict and a heightened risk of suicide (Brent et al., 1988; Stark, 1990).

The importance of focusing on recurrence of depression has been highlighted by researchers, suggesting it should be treated as a chronic illness (Andrews, 2001) and therefore underscoring the importance of follow-up studies in the literature.

NICE (2004) guidelines suggest CBT to be an effective treatment for depressed adolescents. However the evidence base that underpins the guidelines is sparse, with far fewer treatment studies of depression in children than adults. Hammen et al. (1999) reflect that interventions have been based on extensions of treatments for adult depression, which focus on the individual, thus neglecting important developmental considerations, such as adolescents being dependent and embedded in a family system.

Quantitative studies

Overview of outcome studies

Table 2a presents a summary of the findings of the quantitative studies for adolescent depression. The majority of the studies focus on individual therapies, which are the main type of interventions recommended for adolescent depression. Two types of individual therapy have been researched: cognitive behavioural therapy (CBT) and interpersonal therapy for adolescents (IPT-A). CBT is an active, problem-oriented treatment which seeks to change maladaptive beliefs, attitudes and behaviours that contribute to emotional distress (Freeman & Reinecke, 1995). IPT-A is a short term psychological intervention which has been adapted for use with adolescents, being originally developed for treatment with adults, and has the capacity to deal with salient issues such as single parent families (Mufson, Moreau, Weissman & Klerman, 1993).

The vast majority of the studies focus on CBT. General outcomes from these studies show there is efficacy of CBT but only for mild to moderate depression

Table 2a. Summary of findings of quantitative studies for adolescent depression.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Reynolds & Coates (1986)	Cognitive behaviour therapy (CBT) vs relaxation vs wait list	30	Pre and post treatment and 5 wk FU	<ul style="list-style-type: none"> • Beck Depression Inventory (BDI) • Reynolds adolescent depression scale (RADS) • Rosenberg self esteem inventory (RSI) • Academic Self-Concept Scale (ASCS-HS) • State-Trait Anxiety Inventory (STAI) 	<ul style="list-style-type: none"> • Both active treatments groups superior to waitlist in reducing depressive symptoms; maintained at FU. • No significant differences between active treatment groups.
Stark, Reynolds, & Kaslow (1987)	Self-control therapy vs behaviour problem solving therapy	28	Pre and post treatment and 8 wk FU	<ul style="list-style-type: none"> • Children's depression inventory (CDI) • Child depression scale (CDS) • Coopersmith Self-Esteem Inventory (CSEI) • Revised childrens manifest anxiety scale (RCMAS) 	<ul style="list-style-type: none"> • Subjects in both active treatments reported significant improvement on self-report and interview measures of depression while subjects in the waiting list condition reported minimal change. • Results were maintained at FU.
Lewinsohn, Clarke, Hops & Andrews (1990); Lewinsohn Clarke, Seeley & Rohde (1994)	CBT Group sessions vs CBT Group sessions + parent group vs wait list	59	Pre and post treatment and 1, 6, 12 and 24 month FU	<ul style="list-style-type: none"> • BDI • Centre for epidemiologic studies depression scale (CESD) • Subjective probability Q (SPQ) • Dysfunctional attitude scale (DAS) • Personal beliefs inventory (PBI) • Pleasant events schedule (PES) • State Anxiety Q (SAQ) • Issues checklist (IC) 	<ul style="list-style-type: none"> • Both active Treatments significantly improve compared to wait list, no significant differences between active treatment groups; strong trend for results to favour adolescent-parent condition. • Gains maintained at two years post treatment.

Table 2a contd.. Summary of findings of quantitative studies for adolescent depression.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Mufson et al (1994); Mufson Weissman, Moreau & Garfinkel (1999)	Interpersonal therapy for adolescents (IPT-A) vs treatment as usual (TAU)	32	Pre and post treatment	<ul style="list-style-type: none"> • Beck Depression Inventory (BDI) • Social adjustment scale self report (SAS-SR) • Social problem solving inventory- revised 	<ul style="list-style-type: none"> • IPT-A group reported greater decrease in depressive symptoms and greater improvement in overall social functioning. • IPT-A reduced depressive symptoms and improved social functioning and interpersonal problem solving skills.
Wood, Harrington & Moore (1996); Jayson, Wood, Kroll, Fraser & Harrington (1998)	Cognitive Behaviour Therapy (CBT) vs relaxation training	48	Pre and post treatment	<ul style="list-style-type: none"> • Mood Feeling Questionnaire (MFQ) 	<ul style="list-style-type: none"> • CBT was associated with significantly more improvement across multiple outcome. • Depressed children who respond better to CBT tend to be younger and less severely impaired.
Vostanis, Feehan, Gaatan & Bickerton (1996)	CBT vs attention placebo (non focussed intervention)	57	Pre and post treatment, 9 month FU	<ul style="list-style-type: none"> • MFQ • RCMAS • Self esteem inventory • Aggression scale • Expectancy/impression of treatment 	<ul style="list-style-type: none"> • Both treatments significant improvement, although MFQ showed trend favouring CBT condition, no significance between group in outcome. • Both treatments maintained significant improvements on all psychosocial measures.
Weisz, Thurber, Sweeney, Proffitt & LeGagnoux (1997)	primary vs secondary control enhancement training	48	Pre and post treatment, 9 month FU	<ul style="list-style-type: none"> • Children's depression inventory (CDI) 	<ul style="list-style-type: none"> • Children in active treatment group reported significantly fewer symptoms of depression.

Table 2a contd. Summary of findings of quantitative studies for adolescent depression.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Brent et al (1997); Brent et al (1998)	Cognitive Behaviour Therapy (CBT) vs systemic behaviour family therapy (SBFT) vs non directive support (NST)	78	Pre and post treatment	<ul style="list-style-type: none"> Beck Depression inventory (BDI) 	<ul style="list-style-type: none"> CBT more efficacious than others, resulting in more rapid and complete treatment response. No difference on suicidal or functional status outcomes.
Clarke, Rohde, Lewinsohn, Hops & Seeley (1999)	CBT vs CBT+ parent group vs wait list. FU: CBT group booster sessions.	96	Pre and post treatment. FU: CBT booster 4 and 12 monthly	<ul style="list-style-type: none"> BDI 	<ul style="list-style-type: none"> Both active treatment groups showed significant improvement across multiple outcomes relative to wait list. No differences between active treatment groups. Booster sessions did not reduce rate of recurrence in FU but accelerated recovery in still depressed patients after acute phase.
Rossello & Bernal (1999)	CBT vs Interpersonal therapy for adolescents (IPT-A) vs waitlist for ethnic minority group	58	Pre and post treatment	<ul style="list-style-type: none"> Children's depression inventory (CDI) Piers-harris childrens self concept scale (PHSCS) Social adjustment scale for children and adolescents (SASCA) Family involvement and criticism scale (FEICS) YSR 	<ul style="list-style-type: none"> Both active treatment groups positive benefit relative to wait list; no significant difference in outcome between active treatment groups. Results show treatment useful for ethnic minority groups.

Table 2a contd. Summary of findings of quantitative studies for adolescent depression.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Birmaher et al (2000)	Cognitive Behaviour Therapy (CBT) vs systemic behaviour family therapy (SBFT) vs non directive support (NST)	78	2yr FU to Brent (1997)	<ul style="list-style-type: none"> • Beck Depression inventory (BDI) • Beck Hopelessness Scale (BHS) • Childrens negativie cognitive error questionnaire (CNCEQ) • Conflict behaviour Q (CBQ) • Areas of change Q (ACQ) • Family assessment device 	<ul style="list-style-type: none"> • No significant differences in LT outcome among 3 groups over FU period. • Descriptive data favoured CBT. • SBFT seemed to impact more on family conflict and CBT and NST tended to show greater reduction in anxiety symptoms.
Diamond, Reis, Diamond, Siqueland & Isaacs (2002)	Attachment based family therapy (ABFT) vs waitlist	32	Pre, mid and post treatment, 6 month FU	<ul style="list-style-type: none"> • BDI • State-Trait Anxiety Inventory for Children • Peer-adolescent parent and peer attachment • Suicidal ideation Q (SIQ) • BHS • Youth Self Report • Family functioning self report 	<ul style="list-style-type: none"> • ABFT showed a significantly greater reduction in both depressive and anxiety symptoms and family conflict. • Results continued at 6 mth FU.

Table 2a contd. Summary of findings for quantitative studies for adolescent depression.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Asarnow, Scott & Mintz (2002)	Cognitive behaviour therapy (CBT) family education programme vs waitlist	23	Pre and post treatment	<ul style="list-style-type: none"> • Children's depression inventory (CDI) • Automatic Thoughts Questionnaire-Revised • Self report coping scale • Client satisfaction 	<ul style="list-style-type: none"> • Active treatment groups showed improvements in depressive symptoms, reductions in negative automatic thoughts and less internalising coping. • Children and parents reported high satisfaction with intervention- educational component useful and number of sessions adequate.
Mufson et al (2004)	Interpersonal therapy for adolescents (IPT-A) vs school based mental health clinic	63	Pre treatment, every 4 weeks, post treatment	<ul style="list-style-type: none"> • Beck Depression inventory (BDI) • SAS-SR 	<ul style="list-style-type: none"> • IPT-A greater symptom reduction and improvement in overall functioning. • IPT-A delivered in school based health clinics is effective for adolescent depression.
Weersing, Iyengar, Kolko, Birmaher & Brent (2006)	'Gold standard' CBT research benchmark vs CBT outpatient depression speciality clinic (STAR)	80 from STAR (and 37 from Brent (1997) study)	Pre and post treatment	<ul style="list-style-type: none"> • BDI 	<ul style="list-style-type: none"> • CBT in real world setting produced improvement and achieved significant symptom change. • On average STAR treatment group experienced significantly slower symptom improvement than in CBT research benchmark. • However referral source may have accounted for differences.

(Harrington, 1998) with younger depressed patients responding better to CBT than adolescents (Jayson, Wood, Kroll, Fraser & Harrington, 1998). A well regarded study in the field is Brent et al. (1998) who found CBT to be more effective than family therapy or supportive therapy in terms of symptomatic improvement and rapid response to treatment but found no differences on suicidal or functional outcomes. However long term follow up data suggests CBT and IPT-A are superior to no treatment or treatment as usual but show little or no differences when compared to alternative treatments.

There has been a limited amount of research in adolescent depression focusing on the family. Only a small number of the studies have involved parents in the therapy, with only two distinct forms of family therapy having been investigated: systemic behaviour family therapy (SBFT) and Attachment based family therapy (ABFT). The lack of development and testing of family based treatments for adolescent depression is also striking considering the wealth of research acknowledging that family environmental factors underpin the disorder (e.g. Asarnow, Goldstein, Tompson, & Guthrie, 1993). This shows future advancements in this area are needed.

Many adolescents have been excluded from the studies due to co-morbid conditions, which are frequently present in clinical practice (Curry, 2001). Two of the studies have addressed these issues by testing the application of research therapy to community settings, recognising the important gap between research settings and real environments and therefore whether clinicians can benefit from findings of outcome research (Weisz, 1995).

Primary outcome Measures

The primary outcome measures used in most of the studies are the School age Schedule for Affective Disorders and Schizophrenia (K-SADS: Puigantich & Ryan, 1986) and Beck Depression Inventory (BDI). The K-SADS is rated by the clinician and is a diagnostic tool looking at onset, course and severity of depression. The BDI is a self report scale which focuses on depressive symptoms. All studies have included a self report depression scale as a measure of outcome: some have used a self report depression scale and the K-SADS as the only outcome measures.

Scales given to adolescent

The scales used across the studies can be categorised, as before, by studying change in terms of three main domains of functioning: the specific problem, individuals' general adjustment and family measures (see Table 2b).

Firstly scales that are specific to measuring depressive symptoms have been used in all types of study. These measure a range of symptoms, including physical symptoms, mood, as well as cognitive distortions and negative automatic thoughts, which are central to CBT. The most commonly used measure is the BDI which measures a range of depressive symptoms including low mood, suicidality, disturbances in sleep, eating and cognitive functioning. Several studies focusing exclusively on CBT have only included scales focusing on depression.

Secondly scales have been used that focus on the adolescent's general overall adjustment. IPT studies focus mainly on two areas: the individual's self concept and social adjustment which take into account interpersonal and school functioning. For example the Social Adjustment Scale Self Report (SAS-SR: Weissman & Bothwell, 1976) measures social functioning across four areas of school, friends, family and

Table 2b. Measures given to adolescents in depression studies^a.

Domain	Scale	Reference	Description
Depression	<ul style="list-style-type: none"> • Beck Depression Inventory • Reynolds adolescent depression scale (RADS) • Children Depression Inventory (CDI) • Child depression scale (CDS) • Centre for epidemiologic studies dep. scale • Mood Feeling Questionnaire • Beck hopelessness scale (BHS) • Suicidal ideation Q (SIQ) • Automatic thoughts Q (ATQ) • Dysfunctional attitude scale (DAS) • Childrens negativie cognitive error questionnaire (CNCEQ) 	<ul style="list-style-type: none"> Beck, 1961 Reynolds, 1986 Kovacs, 1983 Reynolds, 1989 Radloff, 1977 Angold et al., 1995 Beck et al., 1974 Reynolds, 1988 Hollon & Kendall, 1980 Weissman & Beck, 1978 Leitenberg et al., 1986 	<ul style="list-style-type: none"> • Depressive symptoms, dysphoria, anhedonia, suicidality, disturbances in sleep, eating, cognitive functioning • Depressive symptoms • Depressive symptoms • Depressive symptoms • depressive symptoms • Mood • Pessimism, suicidal intent • Suicidal intent • Frequency of occurrence of NATs • Depressive cognitions • Cognitive distortions: catastrophisation, overgeneralisation, personalisation, selective abstraction in 3 domains: athletic, scholastic, social

Table 2b contd. Measures given to adolescents in depression studies^a.

Domain	Scale	Reference	Description
Individual adjustment	• Social adjustment scale self report (SAS-SR)	Weissman & Bothwell, 1976	<ul style="list-style-type: none"> • 4 categories: school, friends, family, dating • Level of social adjustment: interpersonal and school functioning • Positive, negative, rational, impulsive problem solving, avoidant coping style • Self concept, behaviour, intellectual and school status, physical appearance, anxiety, popularity, happiness • Academic self concept • Measure of general self concept • Social abilities and behaviour problems • Anxiety • Manifest anxiety • Anxiety • Self esteem • Individual's personal evaluation of his or her own worth • Positive and negative items of self esteem • Personal beliefs • 5 scales: 2 approach (social support, problem solving) 3 avoidant (distancing, internalising, externalising) • Pleasant events • Conflict resolution • Aggression
	• Social adjustment scale for children and adolescents (SASCA)	Beiser, 1990	
	• Social problem solving inventory- revised	D'Zurilla & Nezu, 1990	
	• Piers-harris childrens self concept scale (PHCSCS)	Piers & Harris, 1984	
	• Academic self-concept scale (ASCS-HS)	Reynolds, 1981	
	• Subjective probability Q (SPQ)	Munoz & Lewinsohn, 1976	
	• Youth Self Report	Achenbach, 1991	
	• State-trait anxiety inventory for children	Spielberger, 1973	
	• Revised children's manifest anxiety scale	Reynolds & Richmond, 1978	
	• State anxiety Q (SAQ)	Spielberger, 1979	
	• Coopersmith self-esteem inventory (CSEI)	Coopersmith, 1967	
	• Rosenberg Self esteem Inventory	Rosenberg, 1965	
	• Self esteem inventory	Warr & Jackson, 1983	
	• Personal beliefs inventory (PBI)	Munoz & Lewinsohn, 1976	
	• Self report coping scale	Causey & Dubow, 1992	
	• Pleasant events schedule (PES)	MacPhilamy & Lewinsohn, 1982	
	• Issues checklist (IC)	Robin & Weiss, 1980	
	• Aggression scale	Olweus, 1978	

Table 2b contd. Measures given to adolescents in depression studies^a.

Domain	Scale	Reference	Description
Family functioning	• Family involvement and criticism scale (FEICS)	Shields et al., 1992	• Emotional expression of family- 2 scales: emotional involvement, perceived criticism
	• Conflict behaviour Q (CBQ)	Robin & Foster, 1989	• Family environment: conflict and negative communication
	• Areas of change Q (ACQ)	Jacob & Seilhammer, 1985	• Family environment
	• Family assessment device	Epstein et al., 1983	• Family functioning: general functioning, problem solving, communication, roles, affective responsiveness and involvement, behavioural control
	• Peer-adolescent parent and peer attachment	Armsden & Greenberg, 1987	• Positive and negative affective and cognitive dimension of report on mother
	• Family functioning self report	Bloom, 1985	• Cohesion, expression, conflict
Other	• Satisfaction scale	Asarnow et al., 2002	• How helpful the group, whether like more sessions, parents noticing if children using skills taught
	• Expectancy/impression of treatment	Vostanis et al., 1996	• Expectancy of clinical improvement at start of treatment and evaluation of treatment at end

^a References for the individual measures in this table have not been included in reference section; please refer to relevant studies.

dating. In the family studies one study examines global problems of functioning and another study looks at coping. In some of the CBT studies anxiety and self esteem have also been examined.

Finally there is a range of self report measures centred on family functioning examining conflict, criticism, communication and intensity of emotional involvement of family members. An example is the Conflict Behaviour Questionnaire (CBQ; Robin & Foster, 1989) which measures conflict and negative communication within the family environment. However family measures are only used in more recent family therapy studies and one study comparing CBT and IPT.

A satisfaction scale is used in one study (Asarnow, Scott & Mintz, 2002). The importance of interventions being acceptable and credible to parents and young people is underscored in most therapies; the impact of satisfaction on outcome is an important area to explore further.

Strengths and limitations of the measures used

Each study has elicited information from adolescents as a primary measure, focussing on depressive symptoms (sometimes the only outcome measure). This is positive in terms of including information from the adolescent when considering outcome and makes sense considering these symptoms are central to disorder. However there is a lack of focus on the impact of depression on other areas of functioning, particularly in some of the CBT studies which only use scales focusing on the symptoms of depression itself. This has been recognised in the literature; Hammen et al. (1999) emphasise the neglect of other areas of functioning such as academic, family, social relationships, and that these should be included in outcome studies as they not only play a critical role in the development of depression but are also likely to contribute to future depression. One recent family therapy study has

taken these different areas into consideration. No studies have focused on positive factors or resilience in the young people.

One study involved satisfaction scales where parents highlighted how family sessions met their needs. The importance of tailoring family needs and preferences to interventions is crucial for engagement and satisfaction (Cottrell, 2003) and therefore more focus on satisfaction with services is needed to be considered in relation to outcome.

One study looked at expectancy and impressions of treatment. However nothing is known from these studies about the active components of change of the therapies and no published investigations compared components of treatment (Compton, Burns, Robertson & Egger, 2004). Preventing recurrence appears to be the critical aspect in management of depression in young people therefore the importance of knowing what works is crucial. This is an area in which qualitative research is often used to gather information.

There are several studies which look at the effect of therapist training on outcome. However specific therapist variables are not considered nor adolescents' views of their therapists. It would also be useful to also ask adolescents what they think is important in terms of therapist characteristics.

Qualitative studies

Overview of studies

Table 2c presents a summary of the findings from the qualitative studies. There is a very limited amount of qualitative research in the area of depression and none which focuses exclusively on experiences of depressed adolescents. One case study looking at childhood depression is reviewed and one study of adolescents' experiences of non-clinical depression.

Table 2c. Summary of findings of qualitative studies for adolescent depression.

Author	Type of intervention	Sample Size	Method/design	Summary of Findings
Stegall & Nangle (2005)	Case study: manualised Cognitive Behaviour Therapy (CBT)	1	Case study	Several issues arose in the course of therapy which had implications for the application of individual treatment in general, such as difficulty of conducting individual treatment adequately without involvement of the parent.
Snyman, Poggenpoel & Myburgh (2003)	Experience of non clinical depression	Not reported	Qualitative interviews	There was a clear relationship between dysfunctional interpersonal interactions and the low feelings experienced by the adolescents. Themes of powerlessness and perceived lack of control over their lives emerged, often leading to feelings of helplessness.

Stegall and Nangle (2005) analysed a case study looking at the process of implementing a manualised treatment (CBT) for childhood depression. They found a positive outcome of treatment yet emphasised the need of therapy being flexible and the importance of including parents. They concluded that although CBT focuses on working with the child, remembering and applying skills outside of therapy may not occur without parental reinforcement of both skills and homework completion. Therefore strictly adhering to manuals may not always adequately address a client's needs.

Snyman, Poggenpoel and Myburgh (2003) investigated adolescent girls' experience of non-clinical depression. There was a clear relationship between dysfunctional social relationships and the low feelings experienced by the adolescents. Themes of powerlessness and perceived lack of control over their lives emerged, often leading to feelings of helplessness. Peer involvement was highlighted as a high priority in the study since the adolescents tended to discuss their feelings with their friends rather than with adults.

Strengths and limitation of qualitative studies

The importance of thinking about the child being part of a wider system, and particularly as a drawback of manualised individual treatment, was highlighted in one case study (Stegall & Nangle, 2005). However this is based on a single case study and cannot therefore be generalised. Wilson (1996) warned that manualised treatments are often not sensitive to unique needs of the individual and can interfere in the development of the therapeutic relationship. This seems an important area that should be explored further by qualitative research.

The significance of peer relationships and social interactions was highlighted in one study as having a significant impact on low mood and therefore the

importance of involving peers in the prevention of depression in young people was recommended.

However it is important to place these findings into context; there is a very limited amount of research upon which to base any conclusions, and no studies from depressed adolescent's perspectives. This is clearly an area to be developed further.

Summary

Considering that adolescent depression occurs frequently, is recurrent and associated with significant functional impairment and mortality, there is surprisingly little research in this area, particularly in terms of family interventions. There are some positive results of CBT and IPT-A studies, showing efficacy for mild to moderate depression, however follow up data suggests this is mainly when compared to treatment as usual.

The quantitative literature contains self reports looking at depressive symptoms in individual studies; the BDI is used as a primary outcome measure which involves adolescents but is limited to symptom changes in depression and doesn't provide an account of why changes may have taken place or changes occurring in other aspects of adolescents' lives. Despite the wealth of research suggesting family environmental factors, such as high parental criticism, marital discord and poor parent-child communication, play a critical role in the development, maintenance and relapse of adolescent depression (Asarnow et al, 1993) only a few studies have taken these areas into account. There is no qualitative research exclusively focusing on adolescents with depression. One study of non-clinical adolescent's perspectives highlighted problematic social relationships as having a strong impact on mood, leading to feelings of powerlessness with regard to depressive symptoms. This suggests it may be valuable to assess both of these

factors (social relationships, locus of control) in the quantitative literature, in terms of outcome.

Michael, Huelsman and Crowley (2005) suggest research into treatments for adolescent depression should focus on a systematic analysis of therapist variables due to their potential contribution to outcome. One way of achieving this is to research adolescents' views of important therapeutic variables, such as the therapeutic alliance, particularly since clients who have a negative view of their therapists are far more likely to drop out of therapy prematurely (Garcia & Weisz, 2002).

Ethnic and cultural considerations were looked at in one study (Rossello & Bernal, 1999), which focussed exclusively on Puerto Rican adolescents. The importance of culturally relevant therapies is a neglected but crucial area and one which lends itself well to being explored by qualitative design.

Due to the recurring nature of depression and the potential negative consequences alongside a lack of efficacious studies for severe depression, further research involving adolescents seem crucial for treatments to improve.

ANTISOCIAL BEHAVIOUR

Serious and repeated antisocial behaviour (ASB) during childhood and adolescence can have significant negative, long term consequences for individuals, their families and society (Farrington, 1995). For instance, serious young offenders are at high risk of mental and physical health problems, substance abuse, low educational and occupational achievement, and interpersonal difficulties (Laub & Sampson, 1994; Lyons, Baerger, Quigley, Erlich, & Griffin, 2001). Criminal activity also has damaging emotional, physical and economic effects on victims and

communities (Britt, 2000). Such outcomes highlight the importance of effective treatments for antisocial behaviour.

It is well recognised that there are various causes of ASB, strongly supporting a socio-ecological view (Bronfenbrenner, 1979). Therefore family interventions which target different aspects of the adolescents' lives, addressing the multiple determinants, are recommended treatments for ASB (Henggeler, Schoenwald & Pickrel, 1995).

Quantitative studies

Overview of studies

Table 3a presents a summary of the findings of the quantitative studies for adolescent ASB. The main evidence-based psychosocial treatments for adolescents incorporate a family approach: functional family therapy (FFT) and multi-systemic therapy (MST).

FFT is an integrated treatment approach combining aspects of CBT, systemic and behavioural therapies, which understands the problem behaviour as providing a function within the family (Alexander & Parsons, 1982). MST (Henggeler & Borduin, 1990) is an intensive family and community based treatment that addresses the multiple determinants of serious antisocial behaviour in young offenders.

FFT is considered an effective treatment for ASB and has been shown to reduce re-offending in adolescents who have repeatedly offended (Fonagy & Kurtz, 2002). However relatively few research trials have been carried out (Kazdin, 1997). There have been a number of randomised controlled trials and quasi-experimental designs investigating the effectiveness of MST (Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996; Henggeler, Melton & Smith, 1992; Henggeler et al., 1986) which suggest that it has the strongest evidence for effectiveness amongst

Table 3a. Summary of findings of quantitative studies for adolescent ASB.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Barton, Alexander, Waldron, Turner & Warburton (1985)	Functional Family Therapy (FFT) vs adolescent group homes	74	Pre and post treatment	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • FFT efficacious in improving family interaction and reducing recidivism compared to other group.
Henggeler et al (1986)	Multisystemic Therapy (MST) vs alternative treatment vs normal controls	57	Pre and post treatment	<ul style="list-style-type: none"> • Eysenck Personality Inventory (EPI) • Family relationship Q (FRQ) 	<ul style="list-style-type: none"> • MST significantly decreased conduct problems, anxious behaviour, immaturity and association with deviant peers. • Mother-adolescent and marital relationship warmer. • Alternative treatment associated with deterioration.
Gordon, Arbuthnot, Gustafson, & McGreen (1988)	FFT vs probation service only	54	28 month FU	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • FFT group much lower recidivism rates, cost of treatment also much lower.
Henggeler, Melton & Smith (1992)	MST vs Treatment as usual	84	Pre and post treatment	<ul style="list-style-type: none"> • Self report delinquency scale (SRD) • Family adaptability and cohesion evaluation scale (FACES III) • Missouri peer relations inventory (MPRI) 	<ul style="list-style-type: none"> • MST group fewer arrests and offences; less incarceration compared to TAU group. • Families in MST group reported increased cohesion and decreased youth aggression in peer relations.

Table 3a contd. Summary of findings of quantitative studies for adolescent ASB.

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Borduin et al. (1995)	Multisystemic Therapy (MST) vs individual therapy (IT)	176	Pre and post treatment. 4 yr FU (arrest data only)	<ul style="list-style-type: none"> • Brief symptom inventory (BSI) • Family adaptability and cohesion evaluation scale (FACES II) 	<ul style="list-style-type: none"> • MST more effective than IT in improving family correlates of ASB and ameliorating adjustment problems in individual family members. • 4 yr FU; MST more effective in preventing future (violent) criminal behaviour
Henggeler, Melton, Brondino, Scherer & Hanley (1997)	MST vs usual juvenile justice service	155	Pre and post treatment. 1.7 yr FU (arrest data only).	<ul style="list-style-type: none"> • BSI • Self report delinquency scale (SRD) • FACES III • Family assessment measure (FAM-III) • Missouri peer relations inventory (MPRI) • Parent peer conformity inventory (PPCI) • MST adherence measure 	<ul style="list-style-type: none"> • Outcomes better where treatment adherence ratings high. • Highlights importance of maintaining treatment fidelity. • At FU incarceration substantially decreased.
Ogden & Halliday-Boykins (2004)	MST vs usual child welfare service	100	Pre treatment and 6 months FU	<ul style="list-style-type: none"> • Youth Self Report • SRD • Social competence with peers questionnaire (SCPQ) • Social skills rating system (SSRS) • FACES III 	<ul style="list-style-type: none"> • MST was more effective than CWS at reducing youth internalising and externalising behaviours and out of home placements, as well as increasing youth social competence and family satisfaction with treatment. • Treatment outcomes differed across sites.

Table 3a contd. Summary of findings of quantitative studies for adolescent ASB

Author	Type of intervention	Sample Size	Assessment points	Measures given to Adolescents	Summary of Findings
Halliday-Boykins, Schoenwald & Letourneau (2005)	Multisystemic Therapy (MST): ethnically matched vs ethnically not matched participants and therapists	1711 youths and families and 405 therapists	Pre and post treatment and 6mths FU	<ul style="list-style-type: none"> Vanderbilt functioning index (VFI) 	<ul style="list-style-type: none"> Youths whose care givers were ethnically matched with therapists showed decreases in symptoms, longer time in treatment and increased likelihood for discharge having reached goals. Ethnic match effects on treatment length and successful discharge partially mediated by therapist adherence to MST.
Schaeffer & Borduin (2005)	MST vs Individual therapy	165	10 yr FU (to Borduin et al. 1995)	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> MST group had significantly lower recidivism rates at follow up, fewer arrests, fewer days of confinement. Longest FU study to date.
Ogden & Hagen (2006)	MST vs usual child welfare service	69	2 yr FU (to Ogden et al. 2004)	<ul style="list-style-type: none"> Youth Self Report Self report delinquency scale (SRD) 	<ul style="list-style-type: none"> Sustainability of treatment effects; MST still more effective in reducing out of home placements and behavioural problems.

current treatments. The results showed a distinct reduction in offending and incarceration as well as an improvement in family functioning. An important finding was that the severity of antisocial behaviour did not predict either dropping out of treatment or outcome, indicating treatment was useful for even the most severe cases. Borduin et al. (1995), a well regarded study in the field, found a reduction in arrests for violent crime as well as a reduction in psychological symptoms in both parents and adolescents. Results from a four year follow up of re-arrest data showed MST was more effective than individual therapy in preventing future criminal behaviour. However the implications of the findings from the MST studies are limited by small sample sizes and relatively high drop out rates (Fonagy & Kurtz, 2002).

There has been some controversy in the MST literature; despite the positive findings, recent meta-analyses by independent research groups suggest that MST may not be as effective as previous reviews have suggested (Littell, 2005). There is also evidence to suggest implementation issues affect treatment outcome, and that very little is known about the factors that may moderate the impact of treatment (Fonagy & Kurtz, 2002, Huey, Henggler, Brondino, & Pickrel, 2000).

Primary outcome measures

Primary outcome measures in MST studies focus on the reduction of criminal behaviour, measured either by a self report delinquency scale (SRD: Elliott, Ageton, Huizinga Knowles & Canter, 1983) or re-arrest rates. FFT literature contains no measures from the adolescents themselves, only focusing on re-arrest rates as evidence of outcome.

Scales completed by adolescent

The scales used across the MST studies can be categorised, as before, as studying change in terms of three main domains of functioning: the specific problem,

individuals' general adjustment and family measures (see Table 3b). Henggeler et al. (1997) emphasise the importance of measuring constructs from multiple perspectives i.e. parent, adolescent, therapist and sometimes teacher, and incorporating measures of adolescents emotional-behavioural functioning.

Firstly a scale that is specific to measuring ASB has been used in all of the studies. This scale is the primary outcome scale: self report delinquency scale (SRD). It measures reports of criminal behaviour, including violent offending and general delinquency. Secondly scales have been used that focus on the adolescent's general overall adjustment, including peer relations, social skills and competence. An example is Missouri Peer Relations Inventory (MPRI: Borduin, Blaske, Cone, Mann & Hazelrigg, 1989) which measures perceptions of youth friendships in terms of emotional bonding, aggression and social maturity. Finally there is a range of self report measures centred on family functioning, covering areas such as cohesion, conflict and family relationships. A commonly used scale is the Family Adaptability and Cohesion Evaluation Scale (FACES III: Olson, Portner & Lavee, 1985) which focuses on family perceptions of closeness and rigidity, providing a measure of family dissatisfaction. There are also measures of therapist adherence to MST. In one study this is asked of adolescents but in most studies this is only asked of parents.

Strengths and limitations of measures

The MST studies have rigorously measured a wide range of areas of functioning through adolescent self report measures, recognising the impact of ASB on most areas of functioning and targeting empirically demonstrated risk factors, as emphasised in the literature. For example, it is recognised that peer relations are a

Table 3b. Measures given to adolescents in ASB studies^a.

Domain	Scale	Reference	Description
ASB	<ul style="list-style-type: none"> Self report delinquency scale (SRD) 	Elliott et al., 1983	<ul style="list-style-type: none"> Reports of criminal behaviour: covert, overt ASB, violent offending, general delinquency, status offences.
Individual adjustment	<ul style="list-style-type: none"> Missouri peer relations inventory (MPRI) Brief symptom inventory (BSI) Youth Self Report Social competence with peers Q (SCPQ) Social skills rating system (SSRS) Eysenck personality inventory (EPI) Vanderbilt functioning index (VFI) 	<ul style="list-style-type: none"> Borduin et al., 1989 Derogatis, 1993 Archenbach, 1991 Spence, 1995 Gresham & Elliott, 1990 Eysenck, 1963 Bickman et al., 1998 	<ul style="list-style-type: none"> Perceptions of youth friendships: three dimensions; emotional bonding, aggression, social maturity Symptomatology, psychiatric functioning Behaviour; internalising, externalising Assesses consequences of social interactions with peers Social skills, problem behaviours and academic performance; cooperation, assertion, responsibility and self control Extraversion, neuroticism, social desirability Functioning at home, school, peers and ASB, self harm.
Family functioning	<ul style="list-style-type: none"> Family adaptability and cohesion evaluation scale (FACES II/III) Family assessment measure (FAM-III) Parent peer conformity inventory (PPCI) Family relationship Q (FRQ) 	<ul style="list-style-type: none"> Olson et al., 1985 Skinner et al., 1983 Berndt, 1979 Henggler & Tavormina, 1980 	<ul style="list-style-type: none"> Family cohesion and adaptability Task accomplishment, role performance, communication, affective involvement and control Pro-social and antisocial peer conformity Perception of affect, conflict, dominance
Other	<ul style="list-style-type: none"> MST adherence measure 	Henggler & Borduin, 1992	<ul style="list-style-type: none"> Family and therapist behaviours specific to practice of MST

^aReferences for the individual measures in this table have not been included in reference section; please refer to relevant studies.

major risk factor for ASB (Loeber & Farrington, 2000) and parents of adolescents with behaviour problems tend show a more coercive parenting style, a known factor in the genesis of antisocial behaviour in children (Patterson, 1982). This is positive in terms of involving the adolescents' point of view on different areas of functioning as measurement of outcomes. In contrast, the FFT studies and a long-term follow up study of MST contained no information from the adolescents themselves but instead measured outcome of criminal activity on the basis of re-arrest rates.

There are limitations to the self report measures used in MST studies. For example, they do not identify participants' strengths or protective factors, and instead just focus on the presence or absence of symptoms. This is at odds with therapies such as MST which focus on strengths and often utilise these strengths to inform treatment.

In most studies certain questionnaires are only given to caregivers: such as the therapist adherence measure (TAM) and satisfaction measures. One reason for this could be that the adolescents themselves do not have to be actively involved in the therapy. However asking adolescents about their views on satisfaction with treatment could provide useful information about how to engage them better in treatment.

In FFT despite no information being elicited directly from the adolescent, there have been several studies looking at the process of therapy, such as the influence of the therapeutic process on outcome (Fonagy & Kurtz, 2002). For example Robbins, Alexander and Turner (2000) studied the immediate impact of therapist reframing interventions and found this had a specific impact in reducing family members' defensive statements as well as generating favourable responses from adolescents. Mas, Alexander and Barton (1985) examined the impact of

therapist gender on verbalisations in first sessions of family therapy. These studies provide useful information and highlight the importance of looking at the process of therapy; they could be advanced further by asking participants themselves.

The importance of considering ethnicity is highlighted in one study which found that when care givers were ethnically matched with therapists this resulted in more positive outcomes for therapy, such as a decrease in symptoms, a longer time in treatment and increased likelihood for discharge having reached goals. This could be explored through qualitative research, which would facilitate a further understanding of the significance of ethnicity.

Qualitative studies

Overview of studies

Table 3c presents a summary of the findings from the qualitative studies of ASB. There is a very limited amount of qualitative research in the area of antisocial behaviour, with only three studies which take into account experiences of adolescent offenders. One study looks at parents and adolescents views of MST and two studies focus on adolescents in residential treatment. Due to the small number of studies, one study of young adults' experiences of a police probation initiative is also reviewed, as similar themes emerged.

Lawrie (2005) interviewed parents and a small number of adolescents who had received MST. Parents emphasised the importance of the therapeutic relationship, which included a space to talk and be listened to, enabling a collaborative relationship to develop. The 'struggles of being a parent' was another emerging theme, which included reflecting on parenting a difficult teenager and the therapeutic relationship helping parents to feel 'backed up'. The themes from the

Table 3c. Summary of findings of qualitative studies for ASB

Author	Type of intervention	Sample Size	Method/design	Summary of Findings
Chui et al (2003)	Police probation initiative	11	Qualitative interviews	Views of probation experience and usefulness of crime reduction project. Themes: offenders attitude to offending; self-explanations for their criminality; views of peer associations; usefulness of project intervention.
Lawrie et al (2005)	Multisystemic Therapy (MST)	12 (9 parents, 3 adolescents)	Qualitative interviews	Themes: Parents: A person centred approach: a space to talk and be listened to, a collaborative effort. Struggles of being a parent: reflection on parenting; being 'backed up'. Adolescents: Not being listened to; betrayal; playing the game of therapy.
Abrams & Aguilar (2005)	Residential treatment	10	Qualitative interviews (each participant interviewed at least 3 times)	Many able to identify negative trends in their lives that led to criminal behaviour. Although able to envisage hoped for selves most had only vague strategies for achieving this.
Abrams (2006)	2 different residential treatments	19	Qualitative interviews	Concepts: youth offenders in treatment often feel confused as they grapple with therapeutic or 'adult' understanding of their delinquent conduct. Secure confinement may not have a significant deterrence effect, particularly for offenders who are accustomed to chaotic lives or institutional living. Youth offenders remain uncertain about their ability to change until they are able to apply their new skills and training to real-world situations.

adolescents' experiences of MST were less positive. They reported a sense of disappointment and feeling let down by the therapy; they didn't feel listened to or that any efforts were made to include them in the therapy which resulted in them 'playing the game of therapy'. They also voiced feelings of betrayal, conveying feelings of broken trust in the therapist and therapy.

Abrams and Aguilar (2005) and Abrams (2006) interviewed adolescent offenders in residential treatment. The studies focused on how young offenders reacted to their time in residential care and the effects of this on their motivations to stop anti social behaviour. Some residents expressed that it was the time to reflect on their lives which was important, rather than the treatment activities in themselves. They found that there was a lack of understanding amongst the adolescents as to the purpose of the treatment and a confusion of the therapeutic or 'adult' understanding of their delinquent behaviour. Secure confinement did not have a significant deterrent effect, particularly for the offenders who were accustomed to chaotic lives or institutional living. The study highlighted the disconnection between real world and institution as the most significant barrier to change, and suggested the need for concrete ways to translate what has been learned to the 'real world' and thus the importance of aftercare services. One study compared two different types of residential treatment and found that the more relaxed programme allowed more positive relationships with staff to develop: however this also provided the opportunity for a 'faking it' culture to emerge. In contrast, the stricter individualistic programme offered less room for faking but failed to help offenders develop a sense of their own purpose.

Chui, Tupman, and Farlow (2003) interviewed young adult offenders about their views of the probation experience and usefulness of a crime reduction project.

They found that individual attention to offenders personal and social problems resulted in positive changes. Immediate issues such as drug abuse and motivation to change were highlighted as important issues to be focused on initially. Other important factors were a trusting relationship with their supervisor, self motivation to stop offending and an understanding of the causes of their repeated offending behaviour. The impact of family support as the major motivation for change was highlighted.

Strengths and limitations of qualitative studies

The studies highlighted the importance and value of gaining the young offenders' perspectives. Recurring themes emerged across the studies. Firstly adolescents voiced a lack of understanding of treatment as well as a lack of involvement in the therapy, highlighting a discord between youth culture and therapeutic culture, which led to a culture of 'faking it'. The importance of the therapeutic relationship was also highlighted in the studies, particularly in relation to trust. For example when a trusting relationship occurred this led to positive changes. However when adolescents felt let down by the therapist and unengaged, this often led to the adolescents 'playing the game of therapy'. Understanding the rationale behind treatment as well as feeling listened to seem vital factors to consider when attempting to engage adolescents in treatment.

In the studies of institutional care, contrary to what might be thought, secure confinement was not considered a deterrent to future criminal behaviour. The importance of applying the skills learnt to real world settings was emphasised, highlighting the important role of community-based treatments.

Specific components of the therapy itself were also highlighted. For example, drug abuse and motivation for change were considered factors which

needed to be focussed on first, as well as young people gaining an understanding of the causes of their behaviour. The importance of family support was particularly highlighted in one study.

The limitations of these studies need to be taken into consideration when interpreting the results. The numbers of people involved in each of the studies was small, for example only three adolescents in MST data and therefore these findings are difficult to generalise.

However this preliminary qualitative data suggests that interviews with adolescents provide important relevant data concerning implementation issues and factors that they perceive are relevant to successful and unsuccessful treatment. This is an area which is lacking in empirically supported treatments such as MST. Therefore further qualitative research investigating these issues is needed.

Summary

ASB is an important area considering the impact both emotionally as well as financially on society. There have been several RCTs in the area with positive and promising results; however there are limitations to the evidence base and much is still not known as to the components which facilitate change.

The self reports used in MST studies rigorously measure different aspects of functioning and recognise more than just the problem behaviour itself. This is positive in terms of including adolescents' point of views on different aspects of their lives, recognising the multi-determined nature of ASB. However, the scales do not measure more positive aspects of experience, such as adolescents' strengths. The FFT literature has looked at the therapeutic process, with useful findings but has not included adolescents' views.

From the qualitative literature the importance of the therapeutic relationship as well as being involved in the therapy and an understanding of the treatment itself were emphasised; the consequence of a 'faking it' culture if these things were not taken into account was also underscored.

MST has the strongest evidence for effectiveness amongst current treatments, impacting on processes critical to the generation of delinquent behaviour (Henggeler et al., 1992). However there is dispute about the effectiveness and what it is that facilitates change specifically.

Talking to the adolescents themselves would facilitate a further understanding of the processes and outcomes involved in MST and FFT, potentially highlighting previously undiscovered factors, thus providing a different perspective to current research. By exploring these views of therapy a fuller perspective of what are the helpful and unhelpful aspects of therapy can be gained, contributing to the discussion of effective treatment components and thus the knowledge base.

DISCUSSION

The results of this review demonstrate that there has been a limited amount of outcome research, over a range of different mental health problems, which has taken into account the adolescent's perspective. The importance of actively involving young people in research, in order to help progress our knowledge about treatment effectiveness is therefore highlighted.

The focus in quantitative research on psychological therapies for adolescents is on measuring outcome. Information has generally been gathered in the form of self report measures covering three main areas: the specific problem, general overall adjustment and family functioning. More recent studies, particularly in the areas of AN and ASB, have incorporated all these areas, highlighting the multi-determined

nature of these problems. This shows positive developments of viewing adolescents as part of a wider system as well as in the context of their surroundings. However some studies, (such as those more individually focused e.g. CBT) particularly in the area of depression, only contain measures relating to the problem itself, despite recognition in the literature that other areas of functioning are clearly affected.

Little is known about the 'active' components of therapy and how young people actually understand and experience treatment strategies as well as the therapeutic process itself. Therapies such as CBT focus on tailoring the therapy to the needs of the individual and rely on feedback from the client in order to facilitate this, yet there are few studies which incorporate the adolescents' views of treatment when considering outcome.

The focus in qualitative research is on understanding the experiences of therapy from the participants' view point. There have been a very limited number of qualitative studies examining this in the areas of AN and ASB; in depression there are no studies that focus exclusively on adolescents' experiences. However preliminary studies have elicited important information and highlight the value of gaining adolescents' perspectives through in depth interviews.

Across the three mental health areas covered in this review the importance of pan-therapeutic factors were highlighted: a collaborative therapeutic relationship, and developing an understanding of the causes of behaviour as well as considering motivational factors and the importance of peer relationships. Adolescents highlighted particular factors which affected their engagement in therapy; in AN this concerned their motivation for change whereas in ASB this was centred around the adolescents' understanding of the treatment and a feeling of being involved in the therapy. This highlights that what therapists may think important is likely to be

different to the adolescents themselves, which seems vital to consider when attempting to engage adolescents in treatment.

Another important finding from qualitative studies in the AN literature was the importance adolescents placed on being seen as separate from the 'illness' and recovery encompassing more than just symptom reduction. This underscores the importance of thinking about outcome as more than just an improvement in the problem area itself.

There are, of course, limitations to these qualitative studies, such as small sample sizes and therefore the difficulty of generalisability. However, the studies do show that adolescents can provide valuable information about how they use treatment and what they find helpful.

In terms of outcome it seems that both quantitative and qualitative studies have added in different ways to the research base. This emphasises the importance of taking a multi-method approach to research or 'methodological pluralism' (Barker, Pistrang & Elliott, 2002). It is important to integrate the literature in both fields and use the findings to gain fuller understanding; however this still poses difficulties as qualitative research is not seen as evidenced based. Further research asking adolescents about their experiences of treatment and linking this to eventual outcome would yield valuable information, informing and improving psychological interventions for adolescents.

REFERENCES

- Abrams, L.S. (2006). Listening to Juvenile Offenders: Can Residential Treatment Prevent Recidivism? *Child and Adolescent Social Work Journal*, 23, 61-85.
- Abrams, L. S., & Aguilar, J. P. (2005). Negative trends, possible selves, and behaviour change: A qualitative study of juvenile offenders in residential treatment. *Qualitative Social Work*, 4, 175-196.
- Agras, W. S., Brandt, H., Bulik, C. M., Dolan-Sewell, R., Fairburn, C. G., Halmi, C. A., et al. (2004). Report of the National Institutes of Health Workshop on Overcoming barriers to treatment research in anorexia nervosa. *International Journal of Eating Disorders*, 35, 509 – 521.
- Alexander, J.F., & Parsons, B.V. (1982). *Functional Family Therapy*. Monterey, CA: Brooks/Cole.
- American Psychiatric Association. (2000). Practice guideline for the treatment of patients with eating disorders (revision). *American Journal of Psychiatry*, 157.
- Andrews, G. (2001). Should depression be managed as a chronic disease? *British Medical Journal*, 322, 419-421
- Asarnow, J.R., Goldstein, M.J., Tompson, M., & Guthrie, D. (1993). One year outcomes of depressive disorders in child psychiatric inpatients: evaluation of the prognostic power of a brief measure of expressed emotion. *Journal of Child psychology and Psychiatry*, 34, 129-137.
- Asarnow, J.R., Scott, C.V., & Mintz, J. (2002). A combined cognitive behavioural family education intervention for depression in children: A treatment development study. *Cognitive Therapy and Research*, 26, 221-229.
- Barton, C., Alexander, J.F., Waldron, H., Turner, C.W., & Warburton, J. (1985).

- Generalising treatment effects of Functional Family Therapy: three replications. *American Journal of Family Therapy*, 13, 16-26.
- Birmaher, B., Brent, D. A., Kolko, D., Baugher, M., Bridge, J., Holder, D., Iyengar, S., & Ulloa, R.E. (2000). Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Archives of General Psychiatry*, 57, 29–36.
- Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A., & Kaufman, J. (1996). Childhood and adolescent depression: A review of the past 10 years. Part II. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1575–1583.
- Borduin, C.M., Blaske, D.M., Cone, L., Mann, B.J., & Hazelrigg, M.D. (1989). *Development and validation of a measure of peer relations: The Missouri Peer Relations Inventory*. Unpublished manuscript, Department of Psychology, University of Missouri--Columbia.
- Borduin, C.M., Mann, B.J., Cone, L.T., Henggeler, S.W., Fucci, B.R., Blaske, D.M., & Williams, R.A. (1995). Multisystemic treatment of serious juvenile offenders: Long term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, 63, 569-578.
- Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., & Johnson, B. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive treatments. *Archives of General Psychiatry*, 54, 877–885.
- Brent, D. A., Kolko, D., Birmaher, B., Baugher, M., Bridge, J., Roth, C., & Holder,

- D.(1998). Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 906-914.
- Brent, D.A., Perper, J. A. Goldstein, C. E. Kolko, D. J. Allan, M. J. Allman C. J. & Zelenak J. P. (1988). Risk factors for adolescent suicide. A comparison of adolescent suicide victims with suicidal inpatients. *Archives of General Psychiatry*, 45, 581-588.
- Britt, C.L. (2000). Health consequences of criminal victimisation. *International Review of Victimology*, 8, 63-73.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiences by nature and design*. Cambridge, MA, Harvard University Press.
- Buston, K (2002). "Adolescents with mental health problems: What do they say about health services?" *Journal of Adolescence*, 25, 231-242.
- Chui, W.H., Tupman, P., & Farlow, C. (2003). Listening to young adult offenders: views on the effect of a police probation initiative on reducing crime. *The Howard Journal*, 3, 263-281.
- Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-behavioural treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 272-279.
- Cockett, A. (1992). Logical re-feeding: An adolescent specific approach to the inpatient treatment of anorexia nervosa. *British Review of Bulimia and Anorexia*, 6, 22.
- Colton, A., & Pistrang, N. (2004). Adolescents' experiences of inpatient treatment for Anorexia Nervosa. *European Eating disorders Review*, 12, 307-316.

- Cottrell, D. (2003). Outcome studies of family therapy in child and adolescent depression. *Journal of Family Therapy*, 25, 406-416.
- Compton, S.N., Burns, B.J., Robertson, E., & Egger, H.L. (2004). Review of the Evidence Base for Treatment of Childhood Psychopathology: Internalizing Disorders. *Journal of Consulting and Clinical Psychology*, 70, 1240–1266.
- Curry, J.F. (2001). Specific Psychotherapies for Childhood and Adolescent Depression, *Biological Psychiatry*, 49, 1091–1100.
- Dare, C., & Eisler, I. (1997). Family therapy for anorexia nervosa. In D. M. Garner & P. Garfinkel (Eds), *Handbook of treatment for eating disorders* (pp. 307 – 324). New York: Guilford Press.
- Department of Health. (2004). *National Service Framework for Children*. The Stationary Office.
- Diamond, G. S., Reis, B., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment based family therapy for depressed adolescents: A treatment development study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 1190–1196.
- Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., & Le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: the results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry*, 41, 727-736.
- Eisler, I., Dare, C., Russell, G. F. M., Szumukler, G. I., Le Grange, D., & Dodge, E. (1997). Family and individual therapy in anorexia nervosa: A five-year follow-up. *Archives of General Psychiatry*, 54, 1025 – 1030.
- Eisler, I., Le Grange, D., & Asen, K.E. (2003). Family interventions. In J. Treasure,

- U. Schmidt, & E. van Furth (Eds.), *Handbook of eating disorders* (2nd ed., pp. 291–310). Chichester: Wiley.
- Elliott, D. S., Ageton, S. S., Huizinga, D., Knowles, B. A., & Canter, R. J. (1983). *The prevalence and incidence of delinquent behavior: 1976-1980* (National Youth Survey Project Report No. 26). Boulder, CO: Behavioural Research Institute.
- Fairburn, C., & Harrison, P.J. (2003). Eating disorders. *The Lancet*, *361*, 407–416.
- Farrington, D.P. (1995). The Twelfth Jack Tizard Memorial Lecture: The development of offending and antisocial behaviour from childhood: Key findings from the Cambridge study in delinquent development. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *36*, 929-964.
- Fonagy, P., & Kurtz, A. (2002). Disturbance of Conduct. In P. Fonagy, M. Target, D. Cottrell, J. Phillips & Z. Kurtz (Eds.), *What works for whom? A critical review of treatments for children and adolescents*. New York: Guilford Press.
- Freeman, A., & Reinecke, M. (1995). Cognitive therapy. In A. Gurman, & S. Messer (Eds.), *Essential psychotherapies*. New York: Guilford Press.
- Garcia, J.A., & Weisz, J.R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology*, *70*, 439-443.
- Garner, D.M., Olmstead, M.P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of eating disorders*, *2*, 15-34.
- Geist, R., Heinmaa, M., Stephens, D., Davis, R., & Katzman, D.K. (2000).

- Comparison of family therapy and family group psycho education in adolescents with anorexia nervosa. *Canadian Journal of Psychiatry*, 45, 173-178.
- Gordon, D.A., Arbuthnot, J., Gustafson, K.E., & McGreen, P. (1988). Home-based behavioural-systems family therapy with disadvantaged juvenile delinquents. *American journal of Family Therapy*, 16, 243-255.
- Gowers, S.G., & Shore, A. (2001). Weight and shape concerns in the development of adolescent anorexia nervosa. *British Journal of Psychiatry*, 179, 236–242.
- Gowers, S. G., Weetman, J., Shore, A., Hossain, F., & Elvins, R. (2000). Impact of hospitalisation on the outcome of adolescent anorexia nervosa. *British Journal of Psychiatry*, 176, 138–141.
- Halliday-Boykins, C.A., Schoenwald, S.K., & Letourneau, E.J. (2005). Caregiver–Therapist Ethnic Similarity Predicts Youth Outcomes From an Empirically Based Treatment. *Journal of Consulting and Clinical Psychology*, 73, 808–818.
- Hammen, C., Rudolph, K., Weisz, J., Rao, U., & Burge, D. (1999). The context of depression in clinic-referred youth: neglected areas in treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 64–71.
- Harrington, R., Whittaker, J., Shoebridge, P., & Campbell, F. (1998). Systematic review of efficacy of cognitive behaviour therapies in childhood and adolescent depressive disorder. *British Medical Journal*, 316, 1559-1563.
- Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65, 821–833.

- Henggeler, S.W., & Borduin, C.M. (1990). *Family therapy and beyond: A Multisystemic approach to treating the behaviour problems of children and adolescents*. Pacific Grove, CA: Brooks/Cole.
- Henggeler, S.W., Cunningham, P.B., Pickrel, S.G., Schoenwald, S.K., & Brondino, M.J. (1996). Multisystemic Therapy: an effective violence prevention approach for serious juvenile offenders. *Journal of Adolescence*, 65, 47-61.
- Henggeler, S.W., Melton, G.B., & Smith, L.A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60, 953-961.
- Henggeler, S.W., Rodick, J.D., Borduin, C.M., Hanson, C.L., Watson, S.M., & Urey, J.R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behaviour and family interactions. *Developmental Psychology*, 22, 132-141.
- Henggeler, S.W., Schoenwald, S.K., & Pickrel, S.G. (1995). Multisystemic Therapy: Bridging the gap between university- and community-based treatment. *Journal of Consulting and Clinical Psychology*, 63, 709-717.
- Hoek, H.W., & van Hoeken, D. (2003). Review of the prevalence and incidence of eating disorders. *International Journal of Eating Disorders*, 34, 383-396.
- Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology*, 38, 139-149.
- Huey, S.J., Henggeler, S.W., Brondino, M.J., & Pickrel, S.G. (2000). Mechanisms of

- change in multisystemic therapy: Reducing delinquent behaviour through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology*, 68, 451-467.
- Jayson, D., Wood, A., Kroll, L., Fraser, J., & Harrington, R. (1998). Which depressed patients respond better to cognitive-behavioural treatment? *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 35-39.
- Kazdin, A.E. (1997). Practitioner review: psychosocial treatments for conduct disorder in children. *Journal of Clinical Psychology and Psychiatry*, 38, 161-178.
- Krautter, T., & Lock, J. (2004). Is manualised family-based treatment for adolescent anorexia nervosa acceptable to patients? Patient satisfaction at end of treatment. *Journal of Family Therapy*, 26, 66-82.
- Laub, J.H., & Sampson, R.J. (1994). Unemployment, marital discord, and deviant behaviour: The long-term correlates of childhood misbehaviour. In T. Hirschi & M.R. Gottfredson (Eds.), *The generality of deviance* (pp. 235-252). New Brunswick, NJ: Transaction.
- Lawrie, S. (2005). Multisystemic therapy for serious juvenile offenders: A qualitative study of services users' perspectives. D.Clin.Psy.thesis. University College London.
- Le Grange, D., Binford, R., & Loeb, K. L. (2004). Manualised family-based treatment for anorexia nervosa: A case series. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 41 – 46.
- Le Grange, D., Eisler, I., Dare, C., & Russell, G. (1992). Evaluation of family treatments in adolescent anorexia nervosa: A pilot study. *International Journal of Eating Disorders*, 12, 347 – 357.

- Le Grange, D., & Gelman, T. (1998). Patients' perspective of treatment in eating disorders: A preliminary study. *South African Journal of Psychology*, 28, 182–186.
- Le Grange, D., & Lock, J. (2005). The dearth of psychological treatment studies for anorexia nervosa. *International Journal of Eating Disorders*, 37, 79 – 81.
- Lewinsohn, P. M., Clarke, G. N., Hops, H., & Andrews, J. (1990). Cognitive-behavioural group treatment of depression in adolescents. *Behaviour Therapy*, 21, 385-401.
- Lewinsohn, P., Clarke, G., Seeley, J. & Rohde, P. (1994) Major depression in community adolescents: age at onset, episode duration, and time to recurrence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 809-818.
- Littell, J.H. (2005). Lessons from a systematic review of effects of multisystemic therapy. *Children and Youth Services review*, 27, 445-463.
- Lock, J., Agras, W. S., Bryson, S., & Kraemer, H. (2005). A comparison of short- and long-term family therapy for adolescent anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 632 – 939.
- Lock, J., & Gowers, S. (2005). Effective interventions for adolescents with anorexia nervosa. *Journal of Mental Health*, 14, 599 – 610.
- Lock, J., & Le Grange, D. (2005). Family-based treatment of eating disorders. *International Journal of Eating Disorders*, 37, 64 – 67.
- Lyons, J.S., Baerger, D.R., Quigley, P., Erlich, J., & Griffin, E. (2001). Mental health service needs of juvenile offenders: A comparison of detention, incarceration, and treatment settings. *Children's services: Social Policy, Research, and Practice*, 4, 69-85.

- Mas, C. H., Alexander, J. F., & Barton, C. W. (1985). Modes of expression in family therapy: A process study of roles and gender. *Journal of Marital and Family Therapy, 11*, 411-415.
- Michael, K.D., Huelsman, T.J., & Crowley, S.L. (2005). Interventions for child and adolescent depression: Do professional therapists produce better results? *Journal of Child and Family Studies, 14*, 223-236.
- Morgan, H.G., & Hayward, A.E. (1988). Clinical assessment of anorexia nervosa: The Morgan-Russell Outcome Assessment Schedule. *British Journal of Psychiatry, 152*, 367–371.
- Mufson, L., Moreau, D., Weissman, M.M., & Klerman, G.L. (1993) *Interpersonal psychotherapy for depressed adolescents*. New York: Guilford Press.
- Mufson, L., Moreau, D., Weissman, M. M., Wickramaratne, P., Martin, J., & Samoilov, A. (1994). Modification of interpersonal psychotherapy with depressed adolescents (IPT-A): Phase I and II studies. *Journal of the American Academy of Child and Adolescents Psychiatry, 33*, 695–705.
- Mufson, L., Weissman, M. M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry, 57*, 573–579.
- National Institute for Clinical Excellence (2004). *Depression: management of depression in primary and secondary care. A clinical guideline*. London.
- NICE (2004). *Treatment of anorexia nervosa, bulimia nervosa and related eating disorders: A clinical guideline*. London: National Institute for Clinical Excellence.
- Nolen-Hoeksema, S., Girgus, J., & Seligman, M. (1992). Predictors and

- consequences of childhood depressive symptoms: a 5-year longitudinal study. *Journal of Abnormal Psychology*, 3, 405–422.
- North, C., & Gowers, S. (1999). Anorexia nervosa, psychopathology, and outcome. *International Journal of Eating Disorders*, 26, 386-391.
- Offord, A., Turner, H., & Cooper, M. (2006). Adolescent Inpatient Treatment for Anorexia Nervosa: A Qualitative Study Exploring Young Adults' Retrospective Views of Treatment and Discharge. *European Eating Disorders Review*, 14, 377–387.
- Ogden, T., & Halliday-Boykins, C.A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. *Child and Adolescent Mental Health*, 9, 77-83.
- Ogden, T., & Hagen, K.A. (2006). Multisystemic Treatment of Serious Behaviour Problems in Youth: Sustainability of Effectiveness Two Years after Intake. *Child and Adolescent Mental Health*, 11, 142–149.
- O'Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Mears, A., Banerjee, S., & Hill, P. (2004). Characteristics of the Residents of In-Patient Child and Adolescent Mental Health Services in England and Wales. *Clinical Child Psychology and Psychiatry*, 9, 579-588.
- Olson, D. H., Portner, J., & Lavee, Y. (1985). *FACES-III*. St Paul: Department of Family Social Science, University of Minnesota.
- Patterson, G.R. (1982). *Coercive family process*. Eugene, OR: Castalia.
- Paulson-Karlsson, G., Nevenon, L., & Engstrom, I. (2006). Anorexia nervosa: treatment satisfaction. *Journal of Family Therapy*, 28, 293–306.
- Petterson, G., & Rosenvinge, J. H. (2002). Improvement and recovery from eating

disorders: A patient perspective. *Eating Disorders: The Journal of Treatment and Prevention*, 10, 61–71.

Puig-Antich, J. H., & Ryan, N. (1986). *Schedule for Affective Disorders and Schizophrenia for School-Age Children*. Pittsburgh, PA: Western.

Reynolds, W. M., & Coates, K. I. (1986). A comparison of cognitive– behavioural therapy and relaxation training for the treatment of depression in adolescents. *Journal of Consulting and Clinical Psychology*, 54, 653–660.

Robbins, M., Alexander, J.F., & Turner, C.W. (2000). Disrupting Defensive Family Interactions in Family Therapy with Delinquent Adolescents. *Journal of Family Psychology*, 14, 688-701.

Robin, A.L., & Foster, S.L. (1989). *Negotiating parent-Adolescent Conflict: A Behavioural- Family Systems Approach*. New York: Guilford.

Robin, A.L., Koepke, T., & Moye, A. (1990). Multidimensional assessment of parent-adolescent relations. *Psychological Assessment for Journal of Consulting and Clinical Psychology*, 2, 451-459.

Robin, A.L., Siegel, P.T., Moye, A.W., Gilroy, M., Baker-Dennis, A., & Sikard, A. (1999). A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 1482-1489.

Rosenberg, M. (1965). *Society and the adolescent self image*. Princeton, NJ: Princeton University press.

Rossello, J., & Bernal, G. (1999). The efficacy of cognitive– behavioural and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology*, 67, 734–745.

Russell, G. F., Szmukler, G. I., Dare, C., & Eisler, I. (1987). An evaluation of family

- therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry*, *44*, 1047 – 1056.
- Schaeffer, C.M., & Borduin, C.M. (2005). Long-Term Follow-Up to a Randomized Clinical Trial of Multisystemic Therapy With Serious and Violent Juvenile Offenders, *Journal of Consulting and Clinical Psychology*, *73*, 445–453.
- Snyman, M. V., Phil, M., Poggenpoel, M., & Myburgh, C. P. H. (2003). Young adolescent girls' experience of non-clinical depression. *Education*, *124*, 269-288.
- Stark, K. D. (1990). *Childhood depression: School-based intervention*. New York: Guilford Press.
- Stark, K.D., Reynolds, W.M., & Kaslow, N.J. (1987). A Comparison of the Relative Efficacy of Self-Control Therapy and a Behavioural Problem-Solving Therapy for Depression in Children, *Journal of Abnormal Child Psychology*, *15*, 91-113.
- Stegall, S.D., & Nangle, D. (2005) Successes and Failures in the Implementation of a Manualized Treatment for Childhood Depression in an Outpatient Setting. *Clinical Case Series*, *4*, 227-245.
- Steinhausen, H.C. (1997). Annotation: Outcome of anorexia nervosa in the younger patient. *Journal of Child psychology and Psychiatry*, *38*, 271-276.
- Steinhausen, H.C., Sedel,R., & Metzke, C-W. (2000). Evaluation of treatment and intermediate and long-term outcome of adolescent eating disorders. *Psychological medicine*, *30*, 1089-1098.
- Street, C., & Svanberg, J. (2003). Listening to young people. *Mental Health Today*, *64*, 28–30.

- Vostanis, P., Feehan, C., Gaatan, E., & Bickerton, W-L. (1996). A randomised controlled out-patient trial of cognitive-behavioural treatment for children and adolescents with depression: 9-month follow-up. *Journal of Affective Disorders, 40*, 105- 116.
- Wallin, U., & Kronwall, P. (2002). Anorexia nervosa in teenagers: Change in family function after family therapy at 2-year follow up. *Nordic Journal of Psychiatry, 56*, 363–369.
- Ward, A., Troop, N., Todd, G., & Treasure, J. (1996). To change or not to change- ‘how’ is the question? *British Journal of Medical Psychology, 69*, 139-146.
- Weersing, V.W., Iyengar, S., Kolko, D.J., Birmaher, B., & Brent, D.A. (2006). Effectiveness of Cognitive-Behavioural Therapy for Adolescent Depression: A Benchmarking Investigation, *Behaviour Therapy 37*, 36–48.
- Weissman, M.M., & Bothwell, M. (1976). Assessment of social adjustment by patient self report. *Archives of General Psychiatry, 33*, 1111-1115.
- Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 688- 701.
- Weisz, J.R., & Hawley, K.M. (2002). Developmental factors in the treatment of Adolescents. *Journal of Consulting and Clinical Psychology, 70*, 21-43.
- Weisz, J. R., Thurber, C. A., Sweeney, L., Proffitt, V. D., & LeGagnoux, G. L. (1997). Brief treatment of mild-to-moderate child depression using primary and secondary control enhancement training. *Journal of Consulting and Clinical Psychology, 65*, 703–707.
- Wood, A., Harrington, R., & Moore, A. (1996). Controlled trial of a brief cognitive-

behavioural intervention in adolescent patients with depressive disorders.

Journal of Child Psychology and Psychiatry, 37, 737–746.

Wilson, G.T. (1996). Manual-based treatments: The Clinical application of research findings, *Behaviour Research and Therapy*, 34, 295-314.

Part 2: Empirical Paper

Unheard Voices: Parents' and Adolescents' Experiences of Multisystemic Therapy for Young Offenders

Unheard Voices: Parents' and Adolescents' Experiences of Multisystemic Therapy for Young Offenders

ABSTRACT

Multisystemic Therapy (MST), an intensive family and community based treatment for young offenders, has been shown to be effective in reducing criminal activity and improving family functioning. However little is known about how MST is received by families or the specific aspects which promote change. This qualitative study explored parents' and adolescents' experiences of MST. Ten parent-adolescent pairs were interviewed separately; framework analysis was used to analyse the interviews, focussing on the 'process' and 'outcomes' of MST. Parents expressed positive views about the value of the therapeutic relationship and their experience of MST was very much dependent on this relationship. However they held mixed feelings about adolescent behavioural outcomes. Adolescents highlighted an improved relationship with their parents as well as the importance of being heard. The findings emphasised the importance of involving adolescents in MST and the value of obtaining parents' and adolescents' views in order to inform treatment.

INTRODUCTION

Serious and repeated antisocial behaviour during childhood and adolescence can have significant negative, long term consequences for the individuals, for those connected with them and for society (Farrington, 1995). For instance, serious young offenders are at high risk of mental and physical health problems, substance abuse, low educational achievement, and interpersonal difficulties (Laub & Sampson, 1994; Lyons, Baerger, Quigley, Erlich, & Griffin, 2001). Additionally, criminal activity has extreme detrimental emotional, physical and economic effects on victims and communities (Britt, 2000). Such outcomes highlight the importance of effective treatments for antisocial behaviour.

Multi-Systemic Therapy (MST; Henggeler & Borduin, 1990) is an intensive family and community based treatment that addresses the multiple determinants of serious antisocial behaviour in young offenders. It adopts a socio-ecological approach to understanding anti-social behaviour, considering the adolescent's roles in various systems (e.g. peer, school and neighbourhood) and focuses on the inter-relationship between these systems.

MST targets families with chronic, violent or substance-abusing juvenile offenders at high risk of out of home placement. The main goal of MST is to reduce criminal offending through empowering parents with the skills and resources they need to address their difficulties in raising teenagers as well as empowering adolescents to cope with familial and extra-familial problems. Serious antisocial behaviour is multi-determined and therefore lends itself to this socio-ecological view (Bronfenbrenner, 1979). The capacity of MST to address the multiple determinants is one of the key components in its success (Henggeler, Schoenwald & Pickrel, 1995).

MST is based on a family preservation model of service delivery and therefore interventions are home-based, pragmatic and time limited. Individualised goals are developed within the context of the family's values, beliefs and culture and the family is considered to be a valuable treatment resource. The design and implementation of treatment is guided by nine core principles of MST (see Table 1) and treatment strategies are based on techniques from other evidence-based therapies, such as parent management training and functional family therapy.

A number of randomised controlled trials and studies using quasi-experimental designs have evaluated the effectiveness of MST (Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996; Henggeler, Melton & Smith, 1992; Henggeler et al., 1986). The results have shown a reduction in rates of criminal activity and incarceration as well as improved family functioning. An important finding was that severity of antisocial behaviour did not affect either dropping out of treatment or outcome, indicating treatment was useful for even the most severe cases. Borduin et al. (1995) found a reduction in arrests for violent crime as well as a reduction in psychiatric symptomatology in both parents and adolescents. Results from a four-year follow up of re-arrest data showed MST was more effective than individual therapy in preventing future criminal behaviour. MST has the strongest evidence for effectiveness amongst current treatments, impacting on processes critical to the generation of anti-social behaviour (Henggeler et al., 1992). However the implications of the findings from these studies are limited by small sample sizes and relatively high drop out rates (Fonagy & Kurtz, 2002).

Despite this strong evidence base, recent meta-analyses by independent research groups suggest that MST may not be as effective as previous reviews have suggested (Littell, 2005), leading to growing controversy in the MST literature.

Table 1. Nine core principles of Multisystemic therapy^a

Principle	Statement
1	The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
2	Therapeutic contacts emphasise the positive and use systemic strengths as levers for change.
3	Interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
4	Interventions are present focused and action oriented, targeting specific and well-defined problems.
5	Interventions target sequences of behaviour within and between multiple systems that maintain the identified problems.
6	Interventions are developmentally appropriate and fit the developmental needs of the youth.
7	Interventions are designed to require daily or weekly effort by family members.
8	Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful treatment.
9	Interventions are designed to promote generalisation and long term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

^a From Henggeler, Schoenwald, Borduin, Rowland & Cunningham (1998).

There is also evidence to suggest implementation issues affect treatment outcome, and very little is known about the factors that may moderate the impact of treatment (Fonagy & Kurtz, 2002; Huey, Henggler, Brondino, & Pickrel, 2000).

The focus in MST research has been on outcome factors, with little emphasis on which parts of this multi-system approach help to facilitate change. For example it is uncertain to what degree working directly with the family, the school or linking with the peer group specifically have an effect on outcome. Considering that little is known about the 'active' components of therapy and how families actually understand and experience these treatment strategies, this is an important area to explore. Qualitative research lends itself well to exploring the important psychological processes within therapy from the perspective of the service users, such as which aspects of therapy are useful, allowing their voices to be heard (Barker, Pistrang & Elliott, 2002) and thus providing a different perspective to current research.

Qualitative research looking at adolescents' experiences of psychological therapies in other areas, such as anorexia nervosa, has elicited important information and highlighted the value of gaining the adolescents' perspectives through in depth interviews. For example, in a study of adolescents' views of inpatient treatment for anorexia nervosa, the importance of not putting on weight too fast and the need to feel in control of the process through collaborative treatment was emphasised (Colton & Pistrang, 2004). This was in contrast to most treatments for anorexia which focus on re-feeding and increase weight gain in the first instance.

In a qualitative study of MST, focusing primarily on parents' views of receiving the therapy, Lawrie (2005) found that interviews with parents provided important information concerning implementation issues and factors that parents

perceived as relevant to successful and unsuccessful treatment. For example, parents described the central importance and value of the therapeutic relationship, where they felt listened to and understood as well as 'backed up' by the therapist. This enabled parents to gain confidence in their parenting ability.

The aim of the present study was to extend these findings, using a qualitative approach to investigate both adolescents' and parents' experiences of MST. The focus was on understanding what specific aspects of MST promoted change from the perspectives of adolescents and parents themselves. The study thus aimed to examine the processes (e.g. the helpful and unhelpful aspects of the therapy) as well as the outcomes of MST. The similarities and differences between adolescents' and parents' accounts were also explored, recognising that MST is likely to be experienced differently by parents and adolescents.

A fundamental underlying assumption of the study was that an understanding of adolescents' views of MST is essential as adolescents are at the heart of the system: it is their behaviour that is being looked at and successful outcome of therapy is ultimately determined by an improvement in their behaviour. The importance of taking the young person's views into account has been recently emphasised in the NSF guidelines for children and young people (Department of Health, 2004).

The study addressed the following research questions:

- 1) What do adolescents and parents perceive as helpful and unhelpful components of MST?
- 2) What do adolescents and parents perceive as major changes as a result of MST?

METHOD

Setting

Participants were recruited from a North London charity that provided independent (non-NHS) psychotherapy and counselling services for local young people. At the time of the study, MST was being delivered at this centre. In order to receive MST young people had to have at least three convictions and be aged between 13-17 yrs old at the time of referral. The involvement of a parent or primary carer was also necessary for MST to be administered since the focus of treatment is on the primary caregiver; adolescent participation is not required for MST to be delivered. MST was delivered over a period of 3-6 months. The centre, together with the North London Youth Offending Service, was supporting an ongoing randomised clinical trial of MST as well as accepting referrals for MST from other sources.

Five therapists administered MST from June 2005 to April 2007. They had no previous experience of administering MST but qualified as MST therapists prior to working with the families. All the therapists were female; three counselling psychologists, one social worker and one from a youth and community work background.

Participants

A series of families who had participated in MST for at least 20 sessions during the period of the study were all invited to take part, from June 2005 to April 2007. The families were all contacted between one and four months after their last session of MST. During this time 24 families had received MST: 15 were part of the clinical trial and nine from other sources. In order to be included in the study, both the parent and the adolescent from each family had to agree to participate. Four

parents declined and neither they nor their adolescents took part. Six parents agreed to be interviewed but were excluded from the study because their adolescents were not interested in participating. Four families were not contactable by phone. Ten parent-adolescent pairs agreed to take part and were interviewed.

Characteristics of the participants are shown in Table 2. Seven boys and three girls took part. They ranged in age from 13-17 yrs old (mean age of 14.6) and came from a range of ethnic backgrounds: five were White British, two Afro-Caribbean and three mixed White and Black Caribbean. Their offences included both violent and non-violent crimes.

Nine mothers and one father took part. Demographic data for all of the parents were not available. However most were unemployed, with a low level of educational attainment. Most were single parent families who lived in deprived neighbourhoods. Five of the families were part of the trial and the mean length of treatment for these families was 19.2 weeks. For the five non-trial families the mean length was 20.6 weeks.

Ethics

Ethical approval was provided by Camden and Islington Community Local Research Ethics Committee, who has also given ethical approval for the clinical trial of MST (see Appendix A).

Procedure

Each family was contacted after ending the MST treatment, initially by letter (see Appendix B1). It was recognised that the adolescents might be difficult to recruit, as experienced in the previous study. Recruitment procedures were therefore modified and the adolescents were sent a separate letter from their parents so as to be

Table 2. Description of participants ^a

Family	Participants	Length of MST (wks)	Total number of sessions	Age of adolescent at start of MST	Single parent family
1	Mother, son	17	37	13	Yes
2	Mother, son	20	36	16	Yes
3	Mother, son	24	51	14	Yes
4	Mother, daughter	28	33	14	New partner
5	Mother, son	17	20	15	Yes
6	Mother, son	22	34	13	Yes
7	Father, daughter	18	52	13	Yes
8	Mother, son	12	20	16	Separated during MST
9	Mother, daughter	19	25	15	Yes
10	Mother, son	22	36	17	No

^a Ethnicity not included for the purpose of confidentiality.

more approachable and to involve them more fully in the process; the letter also offered a financial incentive of music vouchers (see Appendix B2).

The letters explained the purpose of the study and were accompanied by an information sheet, which gave a fuller summary of the aims (see Appendices B3 & B4). This was then followed up by a phone call to find out whether the parents were interested in taking part, to answer any further questions and if in agreement to arrange a convenient time for interview. Parents were asked if they were happy for their son or daughter to take part and how best to contact them for their consent. The adolescent interviews were arranged through the parents, with one exception in which the adolescent was contacted directly.

Consent was sought from each of the participants before taking part (see Appendices B5 & B6). Each parent received £10 for their participation in the study. Each young person was given the choice of £10 cash or £15 music voucher as payment for their participation.

Interviews

The interviews took place in families' homes and were tape-recorded. The main parent and adolescent were interviewed separately in order to allow each to voice their point of view; parent interviews lasted approximately 1 hour and the adolescent interviews about 40 minutes.

A semi-structured interview schedule was used, which covered areas such as participants hopes and expectations of MST and what they found both helpful and unhelpful about treatment. The schedule was shortened for the adolescents, but covered similar areas (see Appendices C1 & C2). These schedules were designed to facilitate the exploration of certain areas as well as being flexible in order to allow the participants to explore areas they felt important (Smith, 1995).

The interview schedule was a modified version of that used in the previous study (Lawrie, 2005). This was modified for parents to include some questions covering their views of their child's experience of MST in order to compare and contrast them to the adolescents' viewpoint. The interview schedules were piloted at the beginning of the study to establish the most useful line of questioning. The schedule for adolescents was modified after two interviews to focus on engaging the adolescents at the beginning of the interview process, in order to help them to feel more comfortable in expressing their views.

Researcher's perspective

The importance of transparency and stating the perspective of the researcher is recognised as being important within qualitative research (Elliott, Fischer & Rennie, 1999). I had few preconceptions or knowledge of MST and was not involved in the employment of MST or in the clinical trial but had a strong interest in working with adolescents and families. I came from a systemic perspective, understanding problems as occurring within a context, thus locating them within the complex systems and networks surrounding an individual rather than within the individuals themselves. From working in an adolescent inpatient unit I particularly valued the importance of maintaining this non-pathologising approach and addressing issues of stigma as well as the need to give adolescents a voice within this medical setting.

Analysis

All the interviews were transcribed verbatim. (In one interview the tape failed to record and detailed notes were made after the interview). Each transcript was analysed using framework analysis (Ritchie & Spencer, 1994), a method of thematic analysis which aims to explore the data systematically and in detail,

involving a number of distinct but connected stages. This method was chosen to facilitate comparison both between and within families as well as enabling each theme to be examined in depth.

The first step, familiarisation with the data, involved reading the transcripts several times, listing key ideas and identifying meanings and tentative themes. Secondly a thematic framework was constructed, drawn from a priori concepts and recurrent themes which emerged from the participants' accounts; this was applied to a few transcripts and then refined. It was decided to organise the data by process and outcome factors and to separate parents' and adolescents' views within each of these (see Tables 2 and 3 in Results section for final versions). Thirdly the process of 'indexing' was employed, where the thematic framework was systematically applied to the transcripts in order to label data into manageable 'bites' for subsequent retrieval (see Appendices D1 & D2). The fourth stage of analysis involved 'charting' the data (see Appendices D3 & D4), for parents and adolescents separately. Finally the fifth stage involved 'mapping' and interpretation of the data set as a whole, where adolescents' and parents' views were compared and contrasted. The refined thematic framework was then checked against original transcripts in order to make sure the essence of participants' experiences of MST was captured.

The credibility of the results was checked by discussing the themes with supervisors at various stages of the analysis, which resulted in several refinements of the thematic framework. The themes were also checked for correspondence to the data at each stage. These processes are in accordance with 'good practice' in qualitative research (Elliott et al., 1999).

RESULTS

Both adolescents and parents had strong opinions about their involvement in MST. Tables 3 and 4 present the themes resulting from the framework analysis; these were organised into ‘outcomes’ of MST and the ‘process’ of MST, each from the parents’ and adolescents’ points of view. In the sections below, the ‘outcomes’ themes are presented first (the parents’ views followed by the adolescents’ views) and then the ‘process’ themes are presented (again, from these two view points). The accounts both across and within the parent-adolescent pairs are then compared and contrasted.

Ellipses (...) indicate material edited for brevity. Parent quotes are indicated by (P) and adolescent quotes by (A). The identification number for each family is presented in Table 2 (Method section).

Outcomes: Parents’ views

Most parents reported favourable outcomes, particularly for themselves and their relationship with their child. Several felt that they had gained more from the therapy for themselves than had their child. Some parents initially voiced that little had changed with regard to their child’s behaviour but through the process of the interview realised there had been significant improvements. However two parents reported no positive outcomes; they did not feel they personally gained anything nor did their child.

The parents’ views of ‘outcomes’ were divided into three parts: ‘for me’ referring to themselves, ‘for our relationship’ describing their relationship with their adolescent and ‘for other’ referring to their adolescent.

Table 3. 'Outcomes' of MST

Themes	Parent view	Adolescent view
Outcome: For me	p1.1: Opening my eyes to the problem p1.2: Becoming a more confident parent	a1.1: Starting to think and changing behaviour
Outcome: For our relationship	p2.1: A closer relationship p2.2: Applying parenting skills	a2.1: A closer relationship a2.2: Thinking about Mum/Dad
Outcome: For other	p3.1: Son/daughter behaviour change- a mixed outcome	a3.1: Mum/Dad becoming more of a parent

Table 4. 'Process' of MST

Themes	Parent view	Adolescent view
Process: The therapy itself	p4.1: Hurdles of Engagement p4.2: Mixed feelings about components of therapy	a4.1: Hurdles of Engagement
Process: The therapeutic relationship	p5.1: Therapist as source of support p5.2: A trusting relationship, in contrast to other professionals p5.3: Engaging my son/daughter	a5.1: Therapist as support for Mum and go-between a5.2: My relationship with therapist, in contrast to other professionals

Outcome for me

Parent theme 1.1: Opening my eyes to the problem

Most parents emphasised that as a result of MST they were now able to see their situation more clearly, realising what had been going on between them and their child and the change which was needed in their own approach. They described how they had gained the capacity to step back from a situation, helping them to achieve a sense of perspective.

It just opened my eyes it was so unbelievable, like how could you not see that, but when you're in it you don't see it... she's controlling me, [daughter] is controlling me, I wasn't controlling her (P4).

Several parents reported that part of seeing things more clearly included the realisation that they needed to change as much as their children.

I realised that not only did [son] have to change but I had to change as well... "You've got to speak to them with respect"... if I want him to do something I don't demand, "Do it now", I need to speak properly (P6).

While the majority spoke positively about this experience, there was one exception.

This parent felt that MST was not useful and did not help things to change.

In one sense it sort of opened my eyes and gave me a hell of a lot of experience, do I need the experience? Probably not as it is not going to do me any good (P7).

Parent theme 1.2: Becoming a more confident parent

Most parents described an increase in their self-confidence which resulted in feeling "stronger" in relation to their ability to parent. Their new found self-esteem led to a feeling of being more in control and able to stand up for themselves.

I'm a lot stronger than what I used to be, you know, my confidence has gone up... I just feel like I can cope with things better. With [son], I don't let him take the mickey out of me like he used to ... I won't stand like for what he used to do (P1).

Several parents voiced the importance of MST in helping them not to blame themselves for their child's behaviour, which seemed a crucial aspect in feeling better about themselves as a parent.

It was helpful for me. Because you do think when your children get into trouble... you automatically think it has got to be something you're doing wrong... but I don't really think you can turn it in on yourself too much (P5).

For other parents gaining confidence allowed them to "wake up" from what seemed to be a depressed state and realise the importance of looking after and doing things for themselves.

I gained that how I cope with things... before I was crying a lot... because I can't cope... Now I start to go out with my friends... it is very necessary to look after myself because I have another kid to look after... Now I comb my hair, I change my clothes (P3).

Outcome for our relationship

Parent theme 2.1: A closer relationship

Parents talked about how their relationship with their child had changed significantly. They described how communication had built up with their child which now involved a two way dialogue and a willingness to talk and listen in contrast to previous arguments. They described how their child was now prepared to sit and talk to them.

Like if something keeps bothering him ... you know he would say to me instead of keeping it in... Yeah, we communicate more now... he would say things to me like, which he wouldn't say before (P8).

Instead of arguing we ended up laughing instead. I ended up tickling him or something and that was the end of it, instead of it turning into a full scale "I can't stand this anymore." (P5).

Parents also expressed a change in how they felt about their child, which facilitated a closer relationship. Two parents realised their previous angry feelings towards their child had been getting in the way of talking with them and how working through these feelings allowed their children to open up.

I talk to him when he comes in from school every day about his day. Before I couldn't be bothered cos I just used to feel so angry with him all the time (P1).

He still came to me the other day and talked to me, like he's never talked to me before and it was like, "Gosh," you know, "He's never done that in 17 years."... I seem a bit more approachable, cos probably I was just always angry (P2).

Parent theme 2.2: Applying parenting Skills

Most parents described learning specific parenting skills, which they now felt able to put into practice and helped them to feel more able to deal with their child's behaviour. They felt they had learnt the importance of being consistent and standing by their decisions, thus establishing clear boundaries, which their child understood better and respected.

Well it worked for me but it has to be consistent. You have to keep the same boundaries all the time.... I mean I've laid down boundaries before but I've never stuck to them... I'd say your grounded and then I wouldn't repeat the same thing but with this it's almost like an everyday thing now, it's part of my life (P6).

For several parents, an important improvement in their parenting skills involved no longer being drawn into 'teenage' arguments but instead remaining calm and walking away, which was much more effective than shouting.

It's letting her get you into that argument. So that you say something and she'll say, "Oh but"... which then ends up into a slanging match. But now I'm more in control and say, "That's it, I ain't gonna talk about it, go away" (P9).

Outcome for other

Parent theme 3.1: Son daughter behaviour change- a mixed outcome

Parents' accounts varied a great deal in relation to their child's behaviour. Most parents reported improvements in some areas but little change in others. Significantly most parents reported that a distinct improvement was that their child no longer got into trouble with the police, although one reported this still to be a problem.

It was really bad... every minute it's like, you know, phone calls and at police stations... that's all gone. There's just no... he hasn't been in trouble since (P2).

Some parents also reported decreases in other delinquent behaviour, such as no longer being aggressive and not “hanging out” with the previous peer group. One parent described a previous obsession with knives which was no longer evident.

He used to have massive problem with knives... but that has completely gone, the fascination with knives it's just gone which, you know, looking back I was like I forgot all about that. He was obsessed with it for years (P2).

Parents also reported an increase in positive behaviour, such as going to school and helping around the house. This helped some to feel positively about the future.

I think that he's on the right road now to a good future. I feel positive about that. He's going back to school (P6).

Parents partly attributed these changes to their child starting to think about their actions and realising their behaviour had consequences.

He did stop stealing for a certain time ... I think when they said to take items out of his room ... it was kind of making him see you know if it was done to him how would he feel... he was starting to make that connection, “I wouldn't very well like my things all being taken”... it made him sit up and think (P10).

However, despite these positive outcomes, several parents voiced their disappointments and concerns that certain behaviours had not changed, such as not going to school or getting a job and still “hanging out” with the same friends.

I hoped is like that some miracle was going to happen and suddenly he was going to stop... he's back to standing on the street and seeing the same friends... or getting out, get a job and nothing like that has changed (P2).

One parent felt his daughter's behaviour had got worse directly as a result of the therapy.

Her behaviour got progressively worse instead of better... not only was she not going to school, by the time the end of it came she hadn't been to school at all... we triggered something but it was the negative rather than the positive (P7).

Other parents felt that the lack of behaviour change in certain areas was due to their child's low self esteem and lack of motivation.

[Daughter] wants to do a lot, but it's getting her motivated to actually do it... so she's sort of saying all these things, coming up with all these ideas... and not putting anything in place (P9).

Outcomes: Adolescents' views

All the adolescents reported some favourable outcomes, which they mostly attributed to significant improvements in their relationship with their parents. There was no mention of a lack of change or any negative changes taking place in any of their accounts. This seemed linked to a genuine surprise and satisfaction that MST helped their relationship with their parent improve, this being the most important thing they wanted to change.

The adolescents views of 'outcomes' were again divided into three parts: 'for me' referring to themselves, 'for our relationship' describing the relationship with their parent and 'for other' referring to their parent.

Outcome for me

Adolescent theme 1.1: Starting to think and changing behaviour

Most adolescents described the experience of beginning to think about and reflect on their previous behaviour. They felt that the therapy had made them see things in a different way and realise the impact of their behaviour on their own life.

It does make you think that you don't want to start 'cause you will get stuck in a pattern 'cause I think when I was getting in trouble at school I got stuck into a pattern with that, it was just like a routine, go in, be naughty, get excluded (A9).

I used to be out, not do as I'm told, be naughty, don't go to school. But now I've had the time to think about it, I'm mucking up my own life, not no one else's (A7).

For several adolescents, starting to think also led to a shift in attitude towards consideration for other people. This change in attitude resulted in less delinquent

behaviour: coming home on time, keeping their anger under control and no longer associating with their previous peer group.

I don't get into fights anymore... I don't torment people... Because I think to myself 'one day there is going to be a person out there that's going to be stronger than me and they might turn round and give me a smack in the mouth'... Probably because I never used to think... if I was bored I used to just do it (A1).

Just the way I see things has changed... like my friends I started to realise they're not clever... before I'd do what they'd say... I hang round with more sensible people than before... sometimes I'm silly but not enough to get myself involved with the police (A4).

Outcome for our relationship

Adolescent theme 2.1: A closer relationship

All the adolescents spoke about the positive outcome of getting on better with their parents and spending more time together. The main reason for this change was that they could now communicate with their parent, having more time for discussion rather than arguments as well as being open and honest with each other.

The most important thing was the communication with my mum, because that's all I really wanted to do, communicate with my mum more. So that instead of sneaking behind her back, I could actually tell her I'm going to this place, I'll be back at this time (A8).

For others a closer relationship involved being able to talk to their parent and laugh instead of arguing.

It's a much more happy environment, everyone gets on with everyone now... there used to be arguments upon arguments with everyone, and now it's just... we'll laugh it off, like, just get it off our backs straightaway (A7).

Some adolescents expressed that being listened to and feeling respected brought them closer to their parents.

Before she used to be hard and if I used to ask her a question she said 'what?' (angry tone of voice). Now it's like 'yes love' rather than stuff like that (A1).

She'll talk to me more... she's just easier to chat to and like she listens and that's it... that was the only problem... Me and her didn't talk (A2).

Adolescent theme 2.2: Thinking about Mum Dad

The majority of adolescents spoke about starting to think about their parents' point of view and becoming more aware of their parents' feelings. The realisation of what was important to their parents seemed to be the main motivation behind changing their behaviour. Some voiced that they hadn't realised how their parents felt, and once they did, strived to change.

I started going to school... it was just the fact that my Mum would like me to go to school... because she likes to tell people that she made that achievement (A1).

I didn't know she wanted me to listen so much, well now I realise so I thought "yeah I should listen"... all of the suffering my mum's gone through... I thought "I shouldn't make it worse" so I realised that I should be good (A3).

Several adolescents realised the negative impact that their behaviour had been having on their parents, which now motivated them to be more considerate.

She used to try and go college but cos of me like she didn't – she'd be too tired, she'd wait up all night waiting for me till half four, I realised like she needs to go to college so I'd just started coming in on time (A3).

You... look how worried your dad is. And like, now I'm... in the house more often, I ring my dad when I'm out and like I haven't been to school in ages, but I'm going to start going back... after half term (A7).

Outcome for other

Adolescent theme 3.1: Mum Dad becoming more of a parent

Some of the adolescents felt that their parents had become more confident in themselves. They described their parents as being more in control, setting boundaries and meaning what they said. This led to their parents appearing calmer in themselves.

I think he just got more confidence... he used to shout at anything, but now he's more laid back, he can just sit there... and just be like, leave it alone (A7).

One adolescent described a significant change in her mother, from almost having given up to becoming more of a parent to her.

I think my mum was on the verge of giving up, she couldn't really be bothered and we'd just argue and I'd explode but now its much better.... I'd say that my Mums got more confidence... Sometimes I get like kind of pissed off about it, but when you think about it its what a parent needs to do (A4).

Another adolescent talked about his mother being happier in herself.

My mum and my dad – that was the main issue, their arguments, 'cause I don't think my mum was happy. But now he's gone, everything's much better... 'cause before, she'll be a bit miserable, but now, you can see her running up and down the road, skipping and singing (A8).

Process: Parents' views

Most parents had low expectations of therapy and initially felt that they would try anything, grateful for any help but once involved in the MST seemed to have high hopes for change. The main aspect of the process of therapy that parents highlighted as being particularly significant was the importance of the therapeutic relationship. Parents' views of the 'process' were divided into two parts: the therapy itself and the therapeutic relationship.

The process of the therapy itself

Parent theme 4.1 Hurdles of engagement

Most parents described some initial difficulties in adjusting to MST, which included their struggles to absorb the intensity of three times weekly therapy. Some found it to be too stressful while others had difficulty finding the time to fit in with work commitments. However most soon realised they needed this intensity to begin to put things in place.

The first time really, I don't like it... it feels a bit like hassle ... they come three times a week... I have a lot of pressure off my son and then again when they come and they talk to me (P3).

Parents also described some initial negative effects that MST brought about in their child's behaviour. This included their child hating the changes that MST imposed at first, particularly reacting against the process of putting the contract in place (The 'contract' was a behavioural agreement, devised by parents and the therapist and usually agreed with the adolescent, to target a desired behaviour change, detailing specific rewards and consequences).

He hated me being around her, hated anything that would have sounded like [therapist] that was coming from my mouth... like when he saw changes in me (P2).

[Daughter] started to threaten, threaten... like hold knives to her neck saying she was going to kill herself if I didn't give her what she wanted (P4).

Parents also described the discipline needed to implement and adhere to the contract and begin to put things in place, particularly as some were sceptical about it. For some this was overcome, by seeing changes taking place through the process of MST; parents with older children felt this process would have been easier if their child had been younger.

I fought it in the first few weeks. I thought to myself, "Oh god, it's not going to work, it's not going to work,"...but it's over months... you start seeing maybe little changes and then a bigger change... I think what encouraged me to carry on with it was the fact that it was working for me (P6).

Parent theme 4.2: Mixed feelings about components of therapy

There were certain components of therapy that the parents highlighted as being pertinent within the treatment. There was a difference in opinion in the effectiveness and value of these; some parents found them useful whilst others found them ineffective.

Most parents described that once the contract was in place, the importance of having a structured plan enabled them not to get into arguments and helped them to lay down boundaries.

Because by having that contract in place it did improve things within the home because once that was there, it give me the ammunition then to say, "Right no you're not getting this"... so when it comes to her coming back and saying, "Ah hello mum", you just refer to the contract (P9).

The main factors in helping the contract to work and overcoming the initial barriers were involving the child through incorporating their point of view as well as the importance of rewards rather than punishment, so their child could benefit.

I done a contract as well to say that I would stop shouting at him... because [therapist] asked him what he would want me to change and he said for me to stop shouting at him and speak to him properly... he realised that himself (P6).

He'd write down his own rules what he'd like you know... they were taken into consideration... I think he liked that he was being involved (P10).

However some parents felt that the contract didn't work as it was too rigid and their child was not involved or interested in the rewards. Money did not work as an incentive as their child was already stealing it.

The contracts... there were lots of things that could be positive but [daughter] wasn't into positive, she didn't care about the money... she was stealing it anyway so it didn't really make any odds. She didn't care about giving me, doing things with the family or going anywhere (P7).

Watching the video (a parenting skills video showing parenting strategies in action) helped some parents to see themselves and how they reacted and become more detached from the situation.

We watched a film.... It was actually because I related to it, "That's [son], and that's me," (laughs)... because you do think that you're the only one that's really crap at parenting (P2).

Nearly all the parents felt that it was beneficial that the therapy took place in their home; this helped with both the convenience as well as feeling more comfortable on their own ground. However one parent felt her son would have listened more if it hadn't been in the home.

It was easy for me because I didn't have to go to the person... They're coming into my home; it's my territory. I feel happy; I'm safe (P8).

[Son]'d have to listen, he couldn't storm out the room... he wouldn't be rude in anybody else's place ... but this is his home, he can do what he likes (P10).

For two parents MST didn't seem to last long enough. This left them with a sense of feeling let down and frustrated.

So much frustration in it ... but I found you know they'd lots of good ideas you know but putting them in place; you can't put things in place within weeks... it does take time when there's been so much going on here for so long (P10).

The therapeutic relationship

Parent theme 5.1; Therapist as source of support

Parents talked about the valuable experience of having someone there for them as support, since many were single parents who felt isolated, with no one else to talk to. They described the therapist as "on my side" which led to increased confidence and strength.

I just felt like I had somebody on my side, she really was on my side and like if I had meetings to go to, she'd be there to support me (P1).

It was the support mechanism for me... I was finding it very difficult, with [daughter]... and having [therapist] there was someone to talk to as well, not just to sort out ways forward (P9).

Several parents talked about the therapist being a 'motivator', who gave them a push and supported them to do things they wouldn't do normally.

She wouldn't have forgotten and she would say, "Right what happened when you did that?" and that would keep me on my toes because I'm ... you know what if I feel that there's a way to sort of, "No I don't have to do that," I'm terrible (P2).

Although the majority felt very supported, one parent talked about feeling let down by the therapist, who was not there to support him on one occasion when his daughter got arrested.

Well to tell you the truth because I had no-one else, I was gutted ... I then had to take the [other] children with me to the police station... it was the only thing I could do (P7).

Parent theme 5.2: A trusting relationship, in contrast to other professionals

Parents emphasised the importance of building up a trusting relationship with the therapist through being heard, which enabled them to open up and feel understood. The therapist being easy to talk to and non judgmental facilitated this process.

I was totally honest with [therapist] because I trusted her and I could talk to her and if I lost it I'd tell her I lost it and then she'd sort of make me aware of where I went wrong so I'd just correct that (P6).

Some parents described feeling very attached to the therapist, who became a friend to them, and whom they felt sad losing when the therapy came to an end.

She kind of became a friend... we used to just like go out and have a coffee and just talk about things in general really, cos I was having problems with my partner and she would sort of talk to me about that as well...I really miss her (P1).

Many described the friendly nature of the therapist herself, which allowed this relationship to develop.

She's just very jolly, she's always got a smile on her face... she just comes across a really happy person and I think when you're depressed it's nice to see happy people (P1).

For the majority of parents this trusting relationship was in stark contrast to their experiences of other professionals, when they had been made to feel guilty and blamed.

I really opened up to people and I was really honest and I felt like it all backfired on me, I felt like I was getting stabbed in the back because everybody I was honest to, they were just going back and when they put out a report it come across so much worse than it was (P1).

One parent described that the impact of the positive experience with the therapist had made her consider trying to work with other professionals.

If you can, as a parent, as an adult, stop being negative towards everybody and you know trying to work with people rather than against them, you get a much better result. It makes me feel stronger in myself (P6).

For two parents the therapist changed due to unforeseen circumstances. These parents highlighted the importance of the continuity of the same therapist and the difficult experience when someone else came in to take their place.

There was no continuity; I kept getting a different person; the first week the girl came... then she said she was going on holiday so this next girl come... it wasn't the same person constant so I found that very difficult (P10).

Parent theme 5.3: Engaging my son daughter

Several parents described how the therapist was able creatively to engage their child, which other professionals had been unable to do. The therapist's sensitive and relaxed approach enabled their child to open up.

[Therapist] was pretty good because she knew how far to take it... she knew what would make him too upset. And she knew what was enough to start things moving in the right direction (P5).

[Son] didn't feel that [therapist] made him feel like he was mad... Normally he wouldn't want nothing to do with therapists... but it wasn't like that with [therapist].... He didn't feel threatened... she was very easy to talk to (P6).

The 'objectivity' of the therapist facilitated this engagement and allowed their child to listen to the therapist.

It wasn't the two of us sort of ganging up on him, it was the fact it came from another source completely independent of any of my thoughts so that was helpful (P5).

Other parents felt that the therapist was either too aligned with them, against the child, or unable to relate to the child, which led to a lack of engagement.

[Therapist]'s just not clued up... and [son]'s terrible with things like that... I just think he can probably only deal or talk to or communicate with somebody that he probably feels on the same level... he couldn't relate to her (P2).

It was us against [daughter] again and it's ... that is how it came across... I think it seems that we were actually ganging up on her... it is really hard to change that actual first impression (P7).

Process: Adolescents' views

Most adolescents had negative expectations about the potential value of MST before it started and initially reacted against it. However the process of becoming closer to their parent allowed them subsequently to value MST. Several described it as “great” and thought it should be recommended to other young people. The therapeutic relationship was highlighted as crucial in this process. Adolescents' views of the ‘process’ were divided into two parts: the therapy itself and the therapeutic relationship.

The process of the therapy itself

Adolescent theme 4.1: Hurdles of engagement

Most of the adolescents described not wanting to be involved in MST at first due to their initial negative feelings; some had low expectations of it helping them whilst others had more negative preconceptions that it would involve something punitive.

I didn't think it was going to do anything....I thought it was going to be a waste of time (A2).

I thought it would have been something like a boot camp! (A8).

Most reported that initially they “hated” the contract, thinking it was a “stupid” idea and refused to sign it. However most realised that it was going to go ahead and on reflection some felt that it had been useful.

I used to get angry about it and say ‘[therapist], I hate her and the dumb contract’ but when I think about it its much better, I earned a lot of money...it helped a lot, for my mum as well... it's a smart contract when I think about it (laughs) before I just hated it (A4).

Adolescents felt that being involved and listened to in the process of re-working the contract was important in helping them to accept it. Subsequently getting something out of the contract was also beneficial.

It just brung me and my mum kind of closer... [therapist] got to know both of us before she made the contract, so she knew what both of us were expecting, she made it easy for both of us (A2).

However, some adolescents stated that some of the rewards and tokens in the contract did not work.

They made the rewards up but I, you know I just couldn't be bothered. I was just too tired to go to school, I come home too late (A3).

The therapeutic relationship

Adolescent theme 5.1: Therapist as support for mum and go-between

Several adolescents spoke positively about the therapist being there as a support for their mothers.

I think my mum really needed someone to talk to, as well ... With [therapist] coming here, because she's a different person and it's like a counsellor, she helped a lot. So she spoke to my mum for a lot of things which made my mum feel better (A8).

Most adolescents also described the therapist as a 'messenger' between them and their parents: someone who understood their point of view and expressed this to their parent. This also helped them to hear what their parents had to say.

When I used to come in late, my mum used to take my PS2 [play station]. Say if I come in on a normal time like she could leave my PS2... [therapist] would talk to my mum and tell her... and then it'll make me come in on time, so like [therapist] would understand that (A3).

For one adolescent, being with his mother and the therapist made him more aware of how he came across to other people.

I kind of felt like an idiot because I was sitting here in front of my mum and this other person and... I looked like a little kind of like a thug isn't it, so I just thought, I want to change my appearance kind of thing (A5).

Adolescent theme 5.2: My relationship with therapist, in contrast to other professionals

Adolescents talked about the experience of feeling listened to and understood by the therapist, which enabled them in turn to listen and build up a trusting relationship. Several adolescents described the therapist as able to relate to them and being easy to talk to, which facilitated this process.

I don't think they judge a book by its cover... they'll listen to what you say... they give a nicer approach (A5).

[Therapist]'s like an open person. If she's got something to tell you... She's like one of those people who'll be like "I tried my best but I ain't promising" and like I reckon in ways I trusted her (A9).

Several adolescents talked about how this relationship enabled them to open up and talk about personal things, whilst others appreciated that the therapist was not too intrusive.

Having someone to talk to about personal things... I thought it was brilliant, I just, I loved it, rather than having to talk to six different people a week (A7).

You have your own personal friend. So you can share secrets... 'Cause then, you know that [therapist]'s not going to tell your mum if you don't want her to let your mum know about your business or something (A8).

All the adolescents talked about the importance of the therapist having a sense of humour and being able to "have a laugh" together. This created a relaxed atmosphere.

A nice, funny lady. She's always chatting... She could chat for England that one!... She'd just laugh about stuff... I was cracking a bit of joke too (A10).

This relationship was in contrast to their experience with other professionals and many adolescents highlighted the importance of being spoken to as an equal rather than being told what to do or punished. This enabled the adolescents to feel that the therapist was there to help them.

The ease of talking to her just made me think, if there's someone like this that can be telling me and I feel this easy to talk to, rather than someone shouting in my ear and telling me I've got to do this... she talked to me like, not as a younger person but as someone of her own age... so it was easier for me to take it all in (A7).

Comparison of parents' and adolescents' accounts

The accounts of parents and adolescents showed similarities with regard to some themes but differences in others. Parents' accounts were more mixed and seemed to focus on outcome in terms of their child's behaviour. Parents also voiced hopes for big changes with regard to their child's behaviour, and therefore disappointments that certain things hadn't changed. However adolescents were much more positive about MST; they started with negative expectations but all voiced that what was most important to them to change was their relationship with their parent, which significantly improved.

Within parent-adolescent pairs, half were broadly in agreement and voiced similar views, and half contained some disparities. Most were in agreement about the outcome of getting on with each other and having a closer relationship.

It's easier to chat with each other. I know what my mum thinks, so I can approach her and chat to her. About me, yeah. And life in general. I don't know, it's just good to know how someone feels (A2).

He talks to me now... and that's like really massive for me because when he's talking to me like crap I just... I can't ignore it. So it's helped, I mean it hasn't completely gone but he's definitely got more respect for me (P2).

For some pairs, the disparity in accounts seemed to be due to a difference in focus: parents expanded on the process of MST and their adolescent disliking the therapy, whereas the adolescents focussed on the positive outcome of their relationship with their parent, and how this was facilitated by the therapist. There was also a slight difference in emphasis on adolescent outcome; parents seemed more sceptical about changes in behaviour being maintained in the longer term, whereas adolescents

voiced more positive changes within themselves which they felt were going to be kept up.

He's become good boy now, he come into the house, if I ask him to wash his body, he wash his body, but I don't believe it will be kept up... even before he did the same, he listened to me but after a while he will return back late again (P3).

I'll try and keep going school, come in on time and just listen to my mum and I'll be alright, she'll be happy... Keep coming in on time, that's a good one (A3).

In one family the accounts seemed in stark contrast to one other; the father talked about the therapy as a 'disaster' and having a negative impact, whilst the daughter talked about how 'brilliant' it was and the positive outcome on their relationship as well as her behaviour.

That's what's helped me... because since [therapist]'s gone, I've had all this time to think about what she said to me, and it sort of hit me when I got a letter about a meeting [about school]... usually I just don't go to them... but I felt that I should, just to prove that I can, to all the people that said I can't (A7).

I just think they lost [daughter]. I think we are having real problems now, trying to get that child back. I have real belief that ... well at the moment she has actually slowed down but I have been in contact with the police when she has been shoplifting, she has robbed somebody (P7).

DISCUSSION

The adolescents and parents interviewed gave personal and rich accounts of their experiences of MST. For parents these were characterised mainly by positive feelings about the therapeutic relationship but more mixed feelings about adolescent behavioural outcomes. In slight contrast, adolescents' accounts were all favourable, highlighting the positive outcome of an improved relationship with their parents as well as the importance of being listened to and involved in the therapy.

In terms of the process of MST, a central theme highlighted by both parents and adolescents was the importance of the therapeutic relationship. This included being listened to and the therapists' warmth and trust which facilitated a feeling of

being understood: all recognised as vital factors in building a relationship. Lawrie (2005) also found parents emphasised the relationship with the therapist as a crucial aspect of MST. The quality of the therapeutic relationship is recognised across all models of therapy as fundamental and has been found to be a powerful predictor of treatment outcome (Horvath & Symonds, 1991), with clients' subjective evaluation of the relationship having the most impact on outcome (Horvath, 2000).

The importance of therapeutic relationship seemed particularly pertinent to the isolated single parents that predominated in this sample, many of whom also described the therapist as a friend. Several of the mothers described being brought out of a depressive state by this relationship, linking to the finding that maternal depression is associated with conduct problems in children (Loeber & Farrington, 2000). The therapeutic relationship seemed a vital factor which enabled most parents as well as adolescents to overcome the initial hurdles of engagement experienced at the start of MST. Parents who described negative feelings towards MST also emphasised feelings of being let down and unsupported by the therapist, suggesting the experience of MST was very much dependent on the relationship with the therapist.

Creatively engaging the adolescents was also recognised as important by both adolescents and parents. The difficulty of engaging adolescents in therapy is common place in clinical practice; many adolescents are not self-referred but pressured by their families into seeking help. Therefore the importance of being flexible and tailoring treatment for adolescents is essential (Weisz & Hawley, 2002). Moreover, findings suggest that adolescents who have a negative view of their therapists are far more likely to drop out of therapy prematurely (Garcia & Weisz, 2002).

The parents and adolescents repeatedly described previous negative experiences with other professionals. This is likely to have informed their 'relationship to help' (Reder & Fredman, 1996) that is, people's feelings towards seeking help and the beliefs that clients hold about the helping process, which they bring to therapy. In general, many adolescents with antisocial behaviour come into contact with mental health services through the criminal justice system and therefore their main experience of 'help' has been of a coercive nature. These negative experiences were described by the adolescents. Parents described previous experiences of feeling blamed for their child's behaviour, with a sense that services were working against them rather than with them. These experiences led to many parents and adolescents having little or even negative expectations of MST. Many described the relationship with the therapist as providing a contrast to these experiences, thus giving them a more positive view of professionals, impacting on their relationship to help. Since serious young offenders are at high risk of mental and physical health problems, the importance of providing a positive experience both to engage adolescents in treatment as well as facilitate future engagement with services seems important to consider with these families and individuals.

The involvement of adolescents in MST was another part of the process of therapy which was highlighted during interviews with parents and adolescents. MST focuses on working with parents and does not require the adolescent to be directly involved in the therapy. However, most parents thought this was necessary and those whose adolescents were engaged in the therapy felt this to be a positive experience. Parents who had a negative experience of MST felt the lack of adolescent involvement to be a significant problem. All adolescents emphasised the importance of being heard and involved in MST. This was facilitated by the therapist as a go-

between, both hearing what they had to say as well as supporting the parent. Similar findings have been shown in research looking at adolescents' views of family therapy which highlighted the importance of being heard, included and accepted in decisions, as well as feelings of frustration if kept from participation in therapy (Stith, Rosen, McCollum, Coleman, & Herman, 1996; Strickland-Clark, Campbell, & Dallos, 2000). In her small sample of adolescents, Lawrie (2005) found adolescents voiced feelings of betrayal and broken trust in the therapist and MST itself; they did not feel listened to or that any efforts were made to include them in the therapy, which resulted in them 'playing the game' of therapy. In light of these findings it seems important to consider and further explore the effects and long term outcomes of adolescent involvement in MST: whether this facilitates changes in other areas or is an active component of change in itself.

In terms of outcomes, a central theme in both parents 'and adolescents' accounts was an improvement in their relationship and being able to communicate with each other; this was especially important to adolescents. Beyers, Loeber, Wikstrom, and Stouthamer-Loeber (2001) found that in families from low socio-economic status neighbourhoods, poor parent-adolescent communication was a predictor of antisocial behaviour in adolescents. This highlights the importance of the parent-adolescent relationship as a long term protective factor in the lives of these families. These findings also complement a systemic model of thinking about problems being located within systems and between people rather than within the individuals themselves.

The main outcome of MST for parents seemed to be the development of an authoritative parenting style: they described feeling more confident and less guilty about their ability to parent. This was facilitated by the therapist being a motivator,

enabling specific aspects of therapy such as the contract to be put in place, which helped the parent to lay down boundaries. It is widely recognised that being a single parent is associated with increased stresses which negatively affect the ability to provide authoritative parenting (Hinshaw & Lee, 2003). Authoritative parenting contrasts to a more coercive parenting style, which is characterised by patterns of harsh, unsuccessful interchanges, which negatively reinforce their child's aggressive behaviour; this is a known factor in the genesis of antisocial behaviour in children (Patterson, 1982).

A significant outcome of MST for adolescents included increased empathy and beginning to think about others, particularly their parent. Cohen and Strayer (1996) found lower empathy in adolescents with conduct disorder. Youths that engage in antisocial behaviour are at an increased risk of difficulties in close interpersonal relationships in the future (Farrington, 1991); therefore increasing capacity for empathy may be an important protective factor to be further explored.

It is important to consider the differences between accounts of parents and those of adolescents. Parents' main focus was on a decrease in antisocial behaviour and they described mixed outcomes in adolescent behaviour change. Adolescents voiced the importance of the relationship with their parent improving as the most significant outcome. One reason for the disparity in their accounts seems to be a difference in what was important to each and therefore how they evaluated MST, as well as their hopes and expectations. This difference in focus seems important to take into account and recognise when engaging the adolescents in therapy. However it is also possible that the adolescents were more acquiescent in the interviews, saying what they thought they should. It is recognised in family work that different things are held important by parents and children (Day, Carey, & Surgenor, 2006).

This suggests that in terms of evaluation of treatments for anti-social behaviour a shift to considering what is important to both parents and adolescents rather than a focus on decreasing offending behaviour would be beneficial.

Several methodological issues should be taken into account in relation to the findings. Like many qualitative studies, the findings are based on a small, self-selected sample and therefore may not be representative of others' experiences. For example it is possible that those who had more positive experiences were those who agreed to take part. Therefore it is difficult to generalise the findings, particularly as associations with other variables were not considered (e.g. family background, age of onset of offending). In terms of the quality and validity of accounts, participants appeared to be open and honest, which was facilitated by the interviewer being independent from the MST team. However, it could be argued that asking people about their experiences retrospectively could yield less accurate reports of experience. However qualitative research is less concerned with an objective reality, indeed many approaches argue that this does not exist and instead aim to gain an understanding of individuals' perceptions and feelings.

It is also important to be clear about the distinction between the participants' comments and the researcher's interpretations of these comments (Smith, 1996). My interest in working with families led me to conduct the research and ask certain questions which took the analytical process in a particular direction. The analysis itself also imposed a certain structure on the data, focusing on the 'process' and 'outcomes' of MST. Therefore the themes reported are not claimed to be objective, but quotations have been included in the results in order to be as transparent as possible. Additional credibility checks, such as testimony validity (Elliott et al., 1999), could have been used to check these themes with the participants themselves.

Despite these limitations the accounts from parents and adolescents suggest that most participants had positive experiences of MST, which not only changed their behaviour and view of themselves but also their relationship with each other. This suggests that MST has beneficial effects in more areas than adolescent re-offending behaviour, reinforcing its capacity to address the multiple determinants of antisocial behaviour. In particular the findings have a number of implications for the therapy itself as well as areas for future research.

The components which families highlighted as facilitating change were the therapeutic relationship which enabled engagement of both parents and adolescents; for parents this supported them in developing a more authoritative parenting style, whilst for adolescents the involvement and being listened to promoted empathy and a better relationship with the parent. Huey et al. (2000) highlighted the importance of identifying the central change mechanisms in order to understand how complex treatments like MST contribute to outcomes

The findings highlight the importance of hearing adolescents' voices and what can be learnt from listening to their views. Further research with adolescents, investigating other factors which affect engagement would be useful in order to gain a fuller understanding of their experiences of MST and thus contributing to how they could be further involved in the therapy. As mentioned, this is particularly relevant given that these adolescents have been involved in the juvenile justice system, which is non-negotiable and may be construed as coercive, and often reported previous negative experiences with mental health services. The importance of empowerment is emphasised in MST: by taking into account adolescents' views and experiences when thinking about evaluation this process is enhanced.

Although there is a clear logic to studies in this field focusing on the reduction of antisocial behaviour, the findings of this study suggest that long term outcomes should also focus on areas such as parent-child communication, increased empathy in the adolescent and an authoritative parenting style, which may serve as important protective factors in the future; this is particularly important given the multi-determined nature of antisocial behaviour. Further research is needed to address the effects of promoting the protective factors identified on future risk of adolescents with antisocial behaviour and how these may moderate long term outcomes.

REFERENCES

- Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical and counselling psychology, Second Edition*. New York: Wiley.
- Beyers, J.M., Loeber, R., Wikstrom, P.H., & Stouthamer-Loeber, M. (2001). What predicts violent delinquency in better-off neighbourhoods? *Journal of Abnormal Child Psychology*, 29, 369-381.
- Borduin, C.M., Mann, B.J., Cone, L.T., Henggeler, S.W., Fucci, B.R., Blaske, D.M., & Williams, R.A. (1995). Multisystemic treatment of serious juvenile offenders: Long term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, 63, 569-578.
- Britt, C.L. (2000). Health consequences of criminal victimisation. *International Review of Victimology*, 8, 63-73.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiences by nature and design*. Cambridge, MA, Harvard University Press.
- Cohen, D., & Strayer, J. (1996). Empathy in conduct-disordered and comparison youth. *Developmental Psychology*, 32, 988-998.
- Colton, A., & Pistrang, N. (2004). Adolescents' experiences of inpatient treatment for Anorexia Nervosa. *European Eating disorders Review*, 12, 307-316.
- Day, C., Carey, M., & Surgenor, T. (2006). Children's Key Concerns: Piloting a Qualitative Approach to Understanding Their Experience of Mental Health Care. *Clinical Child Psychology and Psychiatry*, 11, 139-155.
- Department of Health. (2004). *National Service Framework for Children*. The Stationary Office.
- Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publications

- of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Farrington, D.P. (1991). Childhood aggression and adult violence: Early precursors and later-life outcomes. In D.J. Pepler & K.H. Rubin (Eds.) *The development and treatment of childhood aggression* (pp. 5-29). Hillsdale, NJ: Erlbaum.
- Farrington, D.P. (1995). The Twelfth Jack Tizard Memorial Lecture: The development of offending and antisocial behaviour from childhood: Key findings from the Cambridge study in delinquent development. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 36, 929-964.
- Fonagy, P., & Kurtz, A. (2002). Disturbance of Conduct. In P. Fonagy, M. Target, D. Cottrell, J. Phillips & Z. Kurtz (Eds.), *What works for whom? A critical review of treatments for children and adolescents*. New York: Guilford Press.
- Garcia, J.A., & Weisz, J.R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology*, 70, 439-443.
- Henggeler, S.W., & Borduin, C.M. (1990). *Family therapy and beyond: A Multisystemic approach to treating the behaviour problems of children and adolescents*. Pacific Grove, CA: Brooks/Cole.
- Henggeler, S.W., Cunningham, P.B., Pickrel, S.G., Schoenwald, S.K., & Brondino, M.J. (1996). Multisystemic Therapy: an effective violence prevention approach for serious juvenile offenders. *Journal of Adolescence*, 65, 47-61.
- Henggeler, S.W., Melton, G.B., & Smith, L.A. (1992). Family preservation using

- multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60, 953-961.
- Henggeler, S.W., Rodick, J.D., Borduin, C.M., Hanson, C.L., Watson, S.M., & Urey, J.R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behaviour and family interactions. *Developmental Psychology*, 22, 132-141.
- Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (1998). *Multisystemic treatment of antisocial behaviour in children and adolescents* (Ch.9. pp. 237-257). New York: Guilford Press.
- Henggeler, S.W., Schoenwald, S.K., & Pickrel, S.G. (1995). Multisystemic Therapy: Bridging the gap between university- and community-based treatment. *Journal of Consulting and Clinical Psychology*, 63, 709-717.
- Hinshaw, S.P., & Lee, S.S. (2003). Conduct and oppositional defiant disorders. In R.A. Barkley & R.J. Mash (Eds.), *Child Psychopathology, Second Edition* (pp. 144-198). New York: Guilford Press.
- Horvath, (2000). The therapeutic relationship: from transference to alliance. *Journal of Clinical Psychology: In session psychotherapy in practice*, 56, 163-173.
- Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology*, 38, 139-149.
- Huey, S.J., Henggler, S.W., Brondino, M.J., & Pickrel, S.G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behaviour through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology*, 68, 451-467.

- Laub, J.H., & Sampson, R.J. (1994). Unemployment, marital discord, and deviant behaviour: The long-term correlates of childhood misbehaviour. In T. Hirschi & M.R. Gottfredson (Eds.), *The generality of deviance* (pp. 235-252). New Brunswick, NJ: Transaction.
- Lawrie, S. (2005). Multisystemic therapy for serious juvenile offenders: A qualitative study of services users' perspectives. D.Clin.Psy.thesis. University College London.
- Littell, J.H. (2005). Lessons from a systematic review of effects of multisystemic therapy. *Children and Youth Services review*, 27, 445-463.
- Loeber, R., & Farrington, D.P. (2000). Young children who commit crime: Epidemiology, developmental origins, risk factors, early interventions, and policy implications. *Development and Psychopathology*, 12, 737-762.
- Lyons, J.S., Baerger, D.R., Quigley, P., Erlich, J., & Griffin, E. (2001). Mental health service needs of juvenile offenders: A comparison of detention, incarceration, and treatment settings. *Children's services: Social Policy, Research, and Practice*, 4, 69-85.
- Patterson, G.R. (1982). *Coercive family process*. Eugene, OR: Castalia.
- Reder, P. & Fredman, G. (1996) The Relationship to Help: Interacting beliefs about the treatment process. *Clinical Child Psychology and Psychiatry*, 1, 457-467.
- Ritchie., J & Spencer., L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analysing qualitative data*. London: Routledge.
- Smith, J. A. (1995). Semi-structured interviewing and qualitative data analysis. In J. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology*. London: Sage.

- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*, 261–271.
- Stith, S.M., Rosen, K.H., McCollum, E.E., Coleman, J.U., & Herman, S.A. (1996). The voices of children: preadolescent children's experience in family therapy. *Journal of Marital and Family Therapy, 22*, 69-86.
- Strickland-Clark, L., Campbell, D., & Dallos, R. (2000). Children's and adolescents' views on family therapy. *Journal of Family Therapy, 22*, 324-341.
- Weisz, J.R., & Hawley, K.M. (2002). Developmental factors in the treatment of adolescents. *Journal of Consulting and Clinical Psychology, 70*, 21-43.

Part 3: Critical Appraisal

CRITICAL APPRAISAL

Introduction

This review critically examines the process of the research which investigated both adolescents' and parents' experiences of Multisystemic therapy (MST). The challenges and dilemmas posed during the project, as well as the rewards gained, are reflected upon. It examines the reasons behind conducting the research, the recruitment of the families, the interviews themselves and the analysis. The wider implications for future research are also considered.

Personal reflections

My strong interest in working with adolescents and families motivated me to conduct this research. I came from a systemic perspective, understanding problems as occurring within a context, thus locating them within the complex systems and networks surrounding an individual rather than within the individuals themselves. I felt that seeking to locate problems in the system around an individual was non-stigmatising and preferable to giving a diagnosis which might not only be unhelpful but also could be disabling. Therefore although I had little knowledge of MST, I was particularly interested in its ecological and non-pathologising approach.

My placement on an adolescent inpatient unit also informed my decision to take on this project. I chose a qualitative project as I wanted to hear service users' voices, particularly those of adolescents, as from my experience they frequently went unheard. Within this medical inpatient unit I particularly valued the importance of maintaining a non-pathologising approach, at times finding it a challenging experience to provide an alternative explanation to the medical model. I often found myself in an advocacy role for the adolescents, since their voices seemed not to be

heard, due to their ‘one down’ position, as many were on a section, having been placed in this unit against their will. The main focus of my work therefore, was mainly around helping adolescents manage their relationship with the system, by addressing issues of power and stigma, as well as the need to give the adolescents a voice within this medical setting. From my perspective, helping adolescents consider these issues was crucial to their recovery.

Completing the research has reinforced my view that much can be learnt by talking to service users. I had some concerns that it might be hard to elicit experiences from some of the adolescents and that therefore the interviews might not yield ‘rich’ enough data, due to my preconceived idea of the ‘young offender’ being potentially difficult to engage, particularly in emotional talk. However I found this not to be the case; in fact once the adolescents felt comfortable and were helped to tell their stories, they were both open and thoughtful about their experiences. This taught me that by actually listening to what adolescents have to say, we can learn something about why they might not be engaged in services and how to try and further facilitate this in the future.

In terms of my clinical skills, I have learnt the value of ‘unpacking’ individuals’ experiences and not assuming that I know what someone means, but facilitating them to be able to explain in their own words.

Engaging and interviewing the families

The interviews themselves posed both challenges and rewards, not only in setting up the interviews but also in conducting them.

Recruitment

It was recognised and experienced in the previous project (Lawrie, 2005), which interviewed parents and a small number of adolescents who had received

MST, that the adolescent population was difficult to recruit. I tackled this from the outset, sending adolescents a separate letter to their parents, in order to be more approachable and to involve them fully in the process. The incentive for taking part was also increased, from £10 to the option of receiving a £15 music voucher instead.

I felt it was still important to have the parent's agreement for their child to take part and so the adolescent interviews were arranged through parents, on all but one occasion. On this occasion the adolescent was contacted separately but with the consent of the parent. Therefore no adolescent interviews took place without the parent interview also taking place, as parents who declined to take part did not want their adolescent to be interviewed. This reflects the process of the MST itself, which focussed on engaging the primary caregiver and did not require the adolescent to be involved.

In terms of implications for the sample it is therefore possible that the adolescents who were interviewed were more likely to have had better relationships with their parents, which was one of the main themes to emerge, than those where parents agreed to take part but the adolescent was not interested. Despite the difficulties in the recruitment, ten pairs agreed to take part, who voiced both positive and negative experiences.

Engaging and interviewing adolescents

The main challenge in interviewing the adolescents was establishing engagement. Although they agreed to take part, initially they were not always forthcoming about their experiences. I felt that a number of factors affected this: previous negative experience of services, feeling uncomfortable opening up to a stranger, being unsure and suspicious about my intentions, particularly if they had experienced other services in the past as coercive, as well as generally being unused

to being asked their opinion. Thus after my experiences of the first couple of interviews, my focus shifted onto engaging the adolescents, in order to help them feel more comfortable and to explore ways of expressing their experiences.

The adolescent interview schedule was adapted to start with more concrete questions, anchoring them in the interview. I was careful to learn the balance between engaging them in their story and following the interview schedule. In terms of my interviewing skills, I concentrated on creating a relaxed and informal atmosphere, where I would actively listen to their opinion with a genuine interest in what they said; indeed, these were the qualities that they said they valued from the therapeutic relationship.

Most of the adolescents were surprised that I was interested in hearing their view-point, with one adolescent stating that no one had been interested in his opinion before. The interview process seemed to give them a positive experience, which is pertinent particularly for these adolescents who are likely to have experienced services in the past as coercive, and thus unlikely to have had the experience of being heard.

Interviewing parents

Once parents agreed to take part, they were quick to engage, being thoughtful and open about their experiences. The interviews took place in their homes, which is likely to have added to their sense of comfort.

At times during the interviews it became apparent that many of the parents were still isolated and had no one to talk to about their current difficulties. This seemed to be highlighted by the interview bringing up and reminding them of the trusting relationship which they had built with the therapist, whom many still missed. This posed a dilemma of my wanting to be empathic and let them tell their story but

also being clear that I was not offering a therapeutic space. It seemed important to be transparent about what the interview would entail and to bring parents back to the purpose of the interview alongside being understanding and validating their experiences.

Their stories also had an emotional impact on me, at times leaving me feeling sad and helpless. The opportunity provided by my supervisor to de-brief after the interviews was an important part of the process in enabling me to deal with these difficult feelings. This helped me to separate the parents' feelings from my own feelings and concerns. In one instance this enabled me to feed back my concerns regarding a family to the MST team.

For the majority of parents, despite being emotional, the interview seemed therapeutic in itself, as it helped them to talk through and consolidate in their minds what had changed and remember what life was like before MST.

Methodological issues: challenges of qualitative research

Quality and validity of accounts

In terms of the quality and validity of the participants' accounts, all the adolescents voiced positive views of therapy. This made me question whether I was getting their honest opinions or if instead they were telling me what they thought I wanted to hear, which could have been due to their concerns about issues of confidentiality and worries that they might get in to trouble. However from the adolescents' accounts their positive views seemed more linked to a disparity between their preconceptions of MST and the positive outcome they experienced. Most adolescents had negative expectations about the potential value of MST before it started but the process of becoming closer to their parent allowed them subsequently to value MST.

There were also differences in opinion within some parent-adolescent pairs; in one instance the accounts of a father and his daughter seemed polar opposites. Again, this made me question the validity of the adolescents' accounts, but I also considered this difference in terms of their differing expectations of MST. It is recognised in the literature that different things are held important by children and their parents. For example, Day, Carey and Surgenor (2006) found children had different preoccupations to adults, when evaluating services. It is also well known that parents and adolescents report different levels of disorder when given a questionnaire to complete (Cantwell, Lewinsohn, Rohde, & Seeley, 1997).

My impact on the interview process

During the interviews I became aware of my own impact on the interview process, with relation to my gender, age and ethnicity. Several parents commented on my similarity to the therapists as well as the importance of my being casually dressed in helping them to feel more relaxed. Several adolescents voiced that, due to my age, they perceived me as 'more in touch' and thus felt more comfortable in talking with me. However, I was also aware of being a different ethnicity and culture to some of the families and wondered whether this initially made them less comfortable with me

It was also important for me to recognise my assumptions and not let these unduly influence the questions I asked, particularly due to the potential power dynamic with the adolescents. I therefore adopted a not-knowing approach: being curious and wanting to hear their experiences, careful not to put words in their mouths. This is a central aspect of a systemic approach, where therapists' assumptions are made explicit to prevent them from becoming 'married' to their hypotheses (Cecchin, Lane, & Ray, 1992).

This process made me realise the challenges and skills of being a good interviewer. I became more confident through the experience of interviewing whilst maintaining an awareness that each person's experiences were different and that it was necessary to help them tell their own individual story.

Qualitative Analysis

Framework analysis took the research in a particular direction. This structural approach did impose a certain rigidity on the data through a construction of themes, based on both the research questions as well as the interpretation of participants' comments. Therefore certain experiences could have been emphasised differently or even missed out through this analysis. However this type of analysis did have advantages for this particular data set, in allowing the interviews to be analysed both between and within parent-adolescent pairs as well as allowing each theme to be examined in depth.

Different methods could have been employed to improve the validity of the themes which emerged. For example 'testimony validity' (Elliott, Fischer & Rennie, 1999), involves checking the credibility of the themes with participants themselves. Additionally the research could have incorporated the therapist's views on the engagement of adolescents and how they thought families experienced MST, thus getting a third perspective; a process called triangulation.

Throughout the analysis I realised the importance of rechecking themes with original transcripts to make sure I was staying close to the data and capturing participants' experiences. I also greatly valued the experience of discussing themes with my supervisors and having to explain my thought process. The importance of multiple researchers when conducting qualitative research in order to increase validity was made clear to me (Elliott et al., 1999).

Another difficulty with qualitative research is that it relies on language to capture experience (Willig, 2001). It seemed that at times some adolescents had difficulty putting into words their experience, although their attitudes and behaviour had clearly been affected. Another type of analysis, focusing more on the language used by participants, could have been conducted on the data. For example, discourse analysis could have been used, which focuses on how people construct their experience through language (Potter & Wetherell, 1987).

Conclusions: the importance of hearing service user voices

Throughout the project I experienced both the challenges of engaging adolescents and listening to emotive parent interviews, and the rewards of hearing important and valuable opinions. This highlighted the importance of listening to service users and what they can offer in terms of the evaluation of therapies.

Both the adolescents and parents appreciated someone taking them seriously, and generally had positive experiences of being interviewed as well as of MST itself. Future research into understanding how better to engage young people in therapy seems vital, particularly with this adolescent client group, who are often hard to engage.

The current culture views young offenders as a nuisance, and has moved beyond listening and understanding to using more punitive approaches. However this research highlighted the importance of adolescents being heard and listened to; maybe one way of understanding their behaviour is that their actions seem to speak louder than their words. MST is a viable alternative approach to incarceration, and further research into both the impact of involving adolescents fully in the therapy and the factors which stop them engaging, will enable them to feel involved, heard and be part of the process, thus having an impact on their behaviour.

REFERENCES

- Cantwell, D., Lewinsohn, P.M., Rohde, P., & Seeley, J.R. (1997). Correspondence between Adolescent Report and Parent Report of Psychiatric Diagnostic Data. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, 610-619.
- Cecchin, G., Lane, G., & Ray, W.A. (1992). *Irreverence: A Strategy for Therapists' Survival*. London: Karnac Books.
- Day, C., Carey, M., & Surgenor, T. (2006). Children's Key Concerns: Piloting a Qualitative Approach to Understanding Their Experience of Mental Health Care. *Clinical Child Psychology and Psychiatry*, 11, 139-155.
- Elliott, R., Fischer, C.T., & Rennie, D.L.(1999). Evolving guidelines for publications of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Lawrie, S. (2005). Multisystemic therapy for serious juvenile offenders: A qualitative study of services users' perspectives. D.Clin.Psy.thesis. University College London.
- Potter, J., & Wetherell, M. (1987). *Discourse and Social psychology*. London: Sage.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

APPENDICES

APPENDIX A

Ethical Approval



Camden & Islington Community Local Research Ethics Committee

Room 3/14
Third Floor, West Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

31 March 2005

Dr Geoffrey Baruch

Brandon Centre
26 Prince of Wales Road
Kentish Town
London
NW5 3LG

Dear Dr Baruch

Full title of study: *A Study of Multisystemic Therapy (MST): A new type of help in the UK for young people in trouble with the law*

REC reference number:

Protocol number:

Thank you for your letter of 18 March 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

It was noted that as this research will not be taking place within the NHS, and is not a clinical trial of a medicinal product for human use, it falls outside the remit of Research Ethics Committees as set out in the Governance Arrangements for NHS Research Ethics Committees (GAFREC).

However, the Committee was happy to review the ethics of the research on a voluntary basis and to offer the following opinion.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application	3	10/02/2005	10/02/2005
Investigator CV	Geoffrey Baruch	10/02/2005	10/02/2005

Investigator CV	Stephen Butler	10/02/2005	10/02/2005
Protocol	2	10/02/2005	10/02/2005
Covering Letter		10/02/2005	10/02/2005
Summary/Synopsis	2	10/02/2005	10/02/2005
Peer Review	1	08/02/2005	10/02/2005
Compensation Arrangements	Geoffrey Baruch	10/02/2005	10/02/2005
Compensation Arrangements	J Cannon	10/02/2005	10/02/2005
Compensation Arrangements	C Wells	10/02/2005	10/02/2005
Compensation Arrangements	F D Gorenstein	10/02/2005	10/02/2005
Compensation Arrangements	M Manning	10/02/2005	10/02/2005
Copies of Advertisements	2 - For Young People	10/02/2005	10/02/2005
Copies of Advertisements	2 - For Young People - Illustrated	10/02/2005	10/02/2005
Copies of Advertisements	2 - For Professionals	10/02/2005	10/02/2005
Copies of Advertisements	2 - For Parents/Carers	10/02/2005	10/02/2005
Letters of Invitation to Participants	2 - For Young Person - Haringey	10/02/2005	10/02/2005
Letters of Invitation to Participants	2 - For Parents/Carers - Haringey	10/02/2005	10/02/2005
Letters of Invitation to Participants	2 - For Young Person - Camden	10/02/2005	10/02/2005
Letters of Invitation to Participants	2 - For Parent/Carer - Camden	10/02/2005	10/02/2005
Letters of Invitation to Participants	2 - Teacher - Non-MST Group	10/02/2005	10/02/2005
Letters of Invitation to Participants	2 - Teacher - MST Group	10/02/2005	10/02/2005
Participant Information Sheet	2 - For Young Person - Interview	10/02/2005	10/02/2005
Participant Information Sheet	2 - For Parent/Carer - Interview	10/02/2005	10/02/2005
Participant Information Sheet	3 - For Parent/Carer	18/03/2005	21/03/2005
Participant Information Sheet	3 - For Young People - Age 13-14	18/03/2005	21/03/2005
Participant Information Sheet	3 - For Young People - Age 15-16	18/03/2005	21/03/2005
Participant Consent Form	2 - For Parent/Carer	10/02/2005	10/02/2005
Participant Consent Form	2 - For Young Person	10/02/2005	10/02/2005
Participant Consent Form	1 - For Parent/Carer re: Release of Information	10/02/2005	10/02/2005
Participant Consent Form	1 - For Teacher	10/02/2005	10/02/2005
Response to Request for Further Information		18/03/2005	21/03/2005
Letter from Funder	The Atlantic	21/10/2004	10/02/2005

	Philanthropies		
Letter from Funder	The Atlantic Philanthropies	04/10/2002	10/02/2005
Letter from Funder	The Tudor Trust	04/04/2002	10/02/2005
Letter from Funder	The Tudor Trust	14/01/2005	10/02/2005
Letter from Funder	Youth Justice Board	18/12/2002	10/02/2005
Letter from Funder	Youth Justice Board	08/01/2003	10/02/2005

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,

Stephanie Ellis
Chair

E-mail: kathryn.simpson@camdenpct.nhs.uk

Enclosures *Standard approval conditions*

Site approval form (SF1)

APPENDIX B
Information and Consent Forms

Appendix B1

Parent Letter

Lucy Casdagli
Sub-department of Clinical Health
Psychology
University College London
Gower Street
London
WC1E 6BT
Tel:

Date

Dear (Parent),

My name is Lucy Casdagli and I am a Trainee Clinical Psychologist studying at University College London. Together with the Brandon Centre, I am working on a study about people's experiences of Multisystemic Therapy (MST). We would like to learn what you found most and least helpful about MST and whether or not you found MST useful for yourself and (son/daughter).

I understand that you have worked with (therapist) and I would like to talk to you about how you found the experience. Taking part in the study is completely voluntary and whether you decide to meet with me or not will not affect any future help that you may receive from the youth offending service. If you decide to take part I can come and visit you in your home and talk for about an hour. Everything you say is confidential and I would like to give you £10 to thank you for your time.

I am also writing to (son/daughter), as I am interested in hearing about his/her experience of MST. If you and (son/daughter) agree, I would like to meet with him separately to find out about his/her experience.

I will contact you by phone over the next few weeks to see whether you are interested and to answer any questions you may have. You can contact me at the above number if you don't want to take part. I enclose for your information some details about the project.

Yours sincerely,

Lucy Casdagli
Trainee Clinical Psychologist

Dr. Stephen Butler
Senior Lecturer, UCL

Appendix B2

Adolescent Letter

Lucy Casdagli
Sub-department of Clinical Health
Psychology
University College London
Gower Street
London
WC1E 6BT
Tel:

£15 HMV voucher or £10 in Cash!

Dear (Adolescent),

I'm Lucy and I'm a Trainee Clinical Psychologist studying at University College London. I am interested to hear what **you** think about Multisystemic Therapy (MST) and working with (therapist).

Would you be happy to talk to me? Taking part is completely up to you and will not affect any future help that you may receive. Everything you say to me is confidential. If you decide to take part you can choose to receive **either** a £15 HMV voucher **or** £10 in cash. I can come and visit you **or** we can meet at the Brandon centre, and it would last for about half an hour.

I'd like to contact you by phone over the next few weeks to see whether you're interested and to answer any questions you may have. I've enclosed some information about the project.

Yours,

Lucy Casdagli
Trainee Clinical Psychologist

Dr. Stephen Butler
Senior Lecturer, UCL

Appendix B3

Information for Parent

University College London and the Brandon Centre

Unheard Voices: Parents' and Adolescents' Experiences of Multisystemic Therapy for Young Offenders

Introduction

My name is Lucy Casdagli and I am a Trainee Clinical Psychologist studying at University College London. Together with the Brandon Centre, I am working on a study which is interested in finding out about people's experiences of having received Multisystemic Therapy (MST).

The Study

This study is interested in finding out what your experience of receiving MST was like, any thoughts you may have on the process, what life is like now and how life was before. Any discussions you take part in will be in addition to the questionnaires that you fill in as part of receiving the MST intervention from the Brandon Centre.

What will I have to do if I take part?

If you agree to participate we would like to talk to you about your personal experiences of being in the MST programme. Our discussion should last about an hour and will be tape recorded.

Do I have to take part?

No. Participating in this part of the MST project is completely voluntary. If you do not want to take part you do not have to give a reason and no pressure will be placed on you to try and change your mind. If you decide to take part you have the right to pull out of the discussion at any time. Choosing not to take part or pulling out of the discussion will not affect any future input you may receive from the MST Team, Haringey Youth Offending Service or the Brandon Centre.

If I agree to take part what happens to what I say?

All the information you give us is confidential. The audio taped recording of our discussion will be stored in a secure area and will only be listened to by the researchers involved in this study. Any specific thoughts or views you have about the MST project will not be disclosed to any members of the MST team. However, if in the course of our discussions, we learn that someone is seriously planning to harm another or themselves then we would need to inform the Brandon Centre.

Reporting the findings of the study

A report will be written about the findings of this study. In that report the results will be presented in such a way that no one can identify your child, your family or know that you participated. In other words, we can guarantee that information about you will be anonymous because we will talk about groups not individuals.

Conclusions

We hope that what we learn in this study may be used to help other young people and their families.

It is not anticipated that you will experience any psychological distress as a result of our discussions. If however, you become uncomfortable when we talk we will of course stop discussion and think about any possible support you may need.

To thank you for taking part in the discussions we would like to give you a small reimbursement of £10.

Lucy Casdagli, as the principal investigator for this study, will be available if you have any further questions. You can contact her at:

Sub-Department for Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT
TEL: 020 7424 9935

Project supervisors:

Dr Stephen Butler
Sub-Department of
Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

Dr Nancy Pistrang
Sub-Department of
Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

Manager and Director of the Brandon Centre:

Dr Geoffrey Baruch PhD
26 Prince of Wales Road
London NW5 3LG

Appendix B4

Information for Young Person

University College London and the Brandon Centre

Unheard Voices: Parents' and Adolescents' Experiences of Multisystemic Therapy for Young Offenders

Introduction

My name is Lucy Casdagli and I am a Trainee Clinical Psychologist studying at University College London. Together with the Brandon Centre, I am working on a study which is interested in finding out about people's experiences of having received Multisystemic Therapy (MST).

The Study

This study is interested in finding out what your experience of receiving MST was like, any thoughts you may have on the process, what life is like now and how life was before. Any discussions you take part in will be in addition to the questionnaires that you fill in as part of receiving the MST intervention from the Brandon Centre.

What will I have to do if I take part?

If you agree to participate we would like to talk to you about your personal experiences of being in the MST programme. Our discussion should last about half an hour and will be tape recorded.

Do I have to take part?

No. Participating in this part of the MST project is completely voluntary. If you do not want to take part you do not have to give a reason and no pressure will be placed on you to try and change your mind. If you decide to take part you have the right to pull out of the discussion at any time. Choosing not to take part or pulling out of the discussion will not affect any future input you may receive from the MST Team, Harringey Youth Offending Service or the Brandon Centre.

If I agree to take part what happens to what I say?

All the information you give us is confidential. The audio taped recording of our discussion will be stored in a secure area and will only be listened to by the researchers involved in this study. Any specific thoughts or views you have about the MST project will not be disclosed to any members of the MST team. However, if in the course of our discussions, we learn that someone is seriously planning to harm another or themselves then we would need to inform the Brandon Centre.

Reporting the findings of the study

A report will be written about the findings of this study. In that report the results will be presented in such a way that no one can identify you or your family or know that you participated. In other words, we can guarantee that information about you will be anonymous because we will talk about groups not individuals.

Conclusions

We hope that what we learn in this study may be used to help other young people and their families.

It is not anticipated that you will experience any psychological distress as a result of our discussions. If however, you become uncomfortable when we talk we will of course stop discussion and think about any possible support you may need.

To thank you for taking part in the discussions we would like to give you a small reimbursement of either a £15 voucher or £10 in cash.

Lucy Casdagli, as the principal investigator for this study, will be available if you have any further questions. You can contact her at:

Sub-Department for Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT
TEL: 020 7424 9935

Project supervisors:

Dr Stephen Butler
Sub-Department of
Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

Dr Nancy Pistrang
Sub-Department of
Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

Manager and Director of the Brandon Centre:

Dr Geoffrey Baruch PhD
26 Prince of Wales Road
London NW5 3LG

Appendix B5

Parent Consent Form

CONSENT FORM – PARENTS/GUARDIAN

TITLE OF STUDY: Unheard Voices: Parents' and Adolescents' Experiences of Multisystemic Therapy for Young Offenders

Please complete the following:

- | | Delete as necessary |
|--|---------------------|
| 1. I have read the letter which describes this study | Yes/No |
| 2. I have had an opportunity to ask questions and discuss this study | Yes/No |
| 3. I have received satisfactory answers to all my questions | Yes/No |
| 4. I have received sufficient information about this study | Yes/No |
| 5. I have spoken to a member of the MST team about this study | Yes/No |
| 6. I understand that I do not have to take part in this study | Yes/No |
| 7. Do you agree to take part in this study? | Yes/No |

Signed _____ **Date** _____

Name in Block Letters _____

Signature of researcher _____

Appendix B6

Adolescent Consent form

CONSENT FORM – YOUNG PERSON

**TITLE OF STUDY: Unheard Voices: Parents' and Adolescents' Experiences of
Multisystemic Therapy for Young Offenders**

Please complete the following:

- | | Delete as necessary |
|--|---------------------|
| 1) I have read the letter which describes this study | Yes/No |
| 2) I have had an opportunity to ask questions and discuss this study | Yes/No |
| 3) I have received satisfactory answers to all my questions | Yes/No |
| 4) I have received sufficient information about this study | Yes/No |
| 5) I have spoken to a member of the MST team
about this study | Yes/No |
| 6) I understand that I do not have to take part in this study | Yes/No |
| 7) Do you agree to take part in this study? | Yes/No |

Signed _____ **Date** _____

Name in Block Letters _____

Signature of researcher _____

APPENDIX C
Interview Schedules

Appendix C1

Parent interview schedule

General/ Overall Experience:

- What was MST like?
- Having someone come to your home?
- Having someone involved in different aspects of your life?
- What's been most helpful?
- Was there anything you didn't like/bothered you?

Expectations:

- Was it what you expected?
- What did you hope might change?
- What got in way/allowed change?
- Were there things it didn't do that you hoped it would?

What was it like working with [therapist]?

- What was it like having someone to talk to and work on problems?
- How did you feel about _____?
- What were they like to work with?
- How was it similar or different to previous work with other professionals?

Working on problems:

- How did you decide what to work on?
- What was it like having these conversations?
- Did you agree or disagree with the Therapist? What was this like?
- Do you feel that your views were important?

Adolescents experience:

- How do you think the experience was for your son/daughter?
- How did they find working with the therapist?
- Do you think that MST has had an influence on your child's behaviour?
- How does this affect how you now think about your child?
- In what other ways do you think that your child different since MST?

Life now:

- Are you still using any of the ideas now?
- Has anything changed since MST?
- Is your behaviour different?
- Are there any ways that you feel you are different since MST?
- Has MST changed your view of yourself as a parent?
- Do you feel any differently about son's/daughter's risk for re-offending?

Probes to follow up questions:

- What was that like?
- How did that work?
- What was the reason behind doing that?
- Had you thought of doing that before?
- Had you talked about these things before?
- How did you experience that?
- What did you do?
- How was it trying it out?
- What did you think?
- Was it helpful or not?
- Did it make any difference?
- Were you expecting that to happen?
- Is that what you wanted?
- Were you able to talk about that with _____?
- Why did/didn't it work out?
- What was it about _____ that did/didn't work?
- What was the impact on you?
- What was the impact on your child? Behaviour, offending

Appendix C2

Adolescent Interview Schedule

Engaging the adolescent:

- Sometimes it's easier to start at the beginning. Could you tell me about first time you heard about MST? What led up to them working with your family?
- How involved were you?
- If you were talking to your friends about MST, what would you say?

General/ Overall Experience:

- What was MST like?
- Having someone come to your home?
- Having someone involved in different parts of your life?
- What's been most helpful?
- Was there anything you didn't like/bothered you?

Expectations:

- Was it what you expected?
- What did you hope might change?
- Were there things it didn't do that you hoped it would?

What was it like working with [therapist]?

- What was it like having someone to talk to and work on problems?
- What were they like to work with?
- What do you think she thought of you/ thought your problems were?
- How was it similar or different to previous work with other professionals?

Working on problems:

- How involved did you feel in the sessions?
- Did you agree or disagree with the Therapist? What was this like?
- Do you feel that your views were important?

Experience for parent:

- How do you think the experience was for your parent?
- Did they find it useful?
- Do your parents treat you differently? In what way?
- Do you see your parents differently

Life now:

- Has anything changed since MST?
- Is your behaviour different?
- Do you feel any differently about re-offending?

Probes to follow up questions:

- What was that like?
- How did that work?
- What was the reason behind doing that?
- Had you thought of doing that before?
- Had you talked about these things before?
- How did you experience that?
- What did you do?
- How was it trying it out?
- What did you think?
- Was it helpful or not?
- Did it make any difference?
- Were you expecting that to happen?
- Is that what you wanted?
- Were you able to talk about that with ____?
- Why did/didn't it work out?
- What was it about ____ that did/didn't work?
- What was the impact on you?
- What was the impact on your parent?

APPENDIX D

Steps taken in Framework Analysis