

**Multisystemic Therapy for Serious Juvenile Offenders: A
Qualitative Study of Service Users' Perspectives**

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OVERVIEW

This thesis is in three parts.

The literature review examines a range of psychological interventions for youth delinquency and Conduct Disorder. Multisystemic Therapy is focused on and is discussed in terms of its strengths and limitations. Limitations include a lack of empirical trials conducted by those other than the founders of the therapy, uncertainty about how the treatment is delivered in practice, what the key elements of the intervention are and how families experience this intensive home based treatment. The need for further research to address these areas is highlighted.

The empirical paper presents the results from a qualitative phenomenological study investigating the experiences of nine parents and three young people who received Multisystemic Therapy. The findings indicate the importance of the therapeutic relationship in service users' experience of the treatment. Furthermore, the findings underline the need to include both parents and young people in family interventions for youth delinquency.

The third paper provides a critical discussion of the research undertaken. It raises issues in relation to carrying out research with this population group, conducting qualitative analyses and the context within which the research was carried out. A personal reflection on the research process is also included.

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No research takes place without some stress on behalf of those in the researcher's life. Tom, Daphne and Ross, thank you for giving me so much help and support throughout, it is much appreciated.

Part 1

Literature Review

Multisystemic Therapy for Persistent and Serious Juvenile Offenders

Abstract

This literature review examines the main psychological interventions for youth offending with a focus on Multisystemic Therapy (MST). As a large proportion of youth offending is carried out by youths diagnosed with Conduct Disorder, an overview of the nature of this disorder is firstly given. Traditional treatment approaches are then reviewed and the limitations of these are highlighted. A description and review of MST, which has been specifically developed for treating persistent juvenile offenders is provided, in which it is argued that this approach addresses the limitations of other psychological interventions. MST targets the known multiple determinants of Conduct Disorder and aims to intervene in the multiple settings that the youth and family are embedded. Although it is considered to have a relatively large evidence base, nearly all studies have been carried out by its developers, there is uncertainty about its 'active ingredients', and little is known about service users' experiences of MST. Qualitative research may be one useful approach to understanding the processes and outcome of MST from the perspectives of youth and families themselves.

Overview

Youth offending poses a serious challenge not only for the individual youth but also for society. For example, it has been shown that youth who persistently offend experience a range of significant personal problems, including reduced educational and occupational opportunities. Additionally the victims and communities of such crimes experience detrimental emotional, physical and economic effects.

A large proportion of juvenile offending is carried out by youth diagnosed with Conduct Disorder. Accordingly within this literature review persistent and serious juvenile offending has been mainly conceptualised as comprising of Conduct Disorder. Conduct Disorder is considered to be pervasive, has a developmental trajectory and can entail serious long lasting effects for the individual and society. Importantly, Conduct Disorder is also understood to be multidetermined thus, indicating the complex interacting processes underlying these behaviours.

The nature, aetiology and developmental trajectory of Conduct Disorder pose significant challenges for psychological interventions. Interventions must not only address the multiple determinants and developmental trajectory of what are often long term problems, but also the multiple systems (e.g. family, school and community) within which behaviours occur. Whilst many interventions for Conduct Disorder and juvenile offending have been developed, typically only some of these factors are targeted, possibly accounting for their limited success. Indeed, problems of conduct constitute the largest group of clinical referrals and of most case loads. This exerts a huge toll on mental health and social services, indicating the need for effective psychosocial interventions that systematically tackle all of these issues.

Multisystemic Therapy (MST) is a treatment for juvenile offending that is clearly founded on the theoretical understanding of Conduct Disorder as it aims to specifically target its multiple causes. In addition it works closely with families and their wider systems and uses elements of other efficacious treatments for Conduct Disorder. It has an increasing evidence base and is currently considered to be “the most effective treatment for delinquent adolescents in reducing recidivism” (Fonagy & Kurtz, 2002, pp. 385). Despite this there is much that remains to be known about this treatment; in particular there is a need for qualitative investigations of how MST is experienced by families and how the process of change may or may not occur.

This literature review focuses on MST and thus encompasses an overview of the therapy and a discussion of its limitations and areas for future research. In order to place MST within its context as a treatment for juvenile offending and Conduct Disorder, a review of terminology and the features of Conduct Disorder, including its developmental trajectory and its multiple determinants is firstly given. Next a review of the main psychosocial treatments that have been developed for this disorder is presented. This includes Problem Solving Skills Training and Parent Management Training (directed at families with pre-adolescents), and Functional Family Therapy (directed at families with adolescents). The theoretical background and underlying rationale is given for each treatment, followed by a description of the intervention, a summary of the empirical evidence base and a discussion of its limitations.

It is then argued that, given what is known about the multifactorial nature of the aetiology of Conduct Disorder and the limitations of the main psychological treatments available, MST goes some way to address these issues. A detailed description of the theoretical basis of this intervention and the main therapeutic techniques is given. This is followed by a summary of the empirical support for this

approach. Finally, a discussion of the limitations of the evidence base for MST is provided which highlights areas for future research, specifically the need for qualitative investigations to elucidate how families and youths experience this intervention.

The Population Group

Juvenile offending has been extensively researched resulting in a vast literature with many terms to refer to this population group. For the purpose of this review, however, persistent and serious juvenile offending has been conceptualised in relation to two key legal and mental health terms: respectively delinquency and Conduct Disorder. The term antisocial behaviour is used throughout to refer to a variety of aggressive and violent behaviours that can be displayed by youths with Conduct Disorder; these include theft, damage to property and initiating physical fights.

Delinquency

This term, taken from a legal framework, designates behaviours that violate the law (e.g. robbery, drug use and vandalism). Acts such as homicide, robbery, aggravated assault and rape can be carried out by adults and juveniles and are referred to as index offences. Other acts, known as status offences are illegal only due to the age at which they occur, specifically for juveniles. These include: underage drinking, running away from home, truancy from school and driving a car. Due to its legal context, delinquency can technically be defined by a single act rather than a pattern of behaviours. It typically refers to antisocial behaviours the young person has been caught engaging in. Thus, studies of youth delinquency tend not to account for the aggressive or antisocial activities of young children and fail to consider their “predelinquent” behaviour patterns (Hinshaw & Lee, 2003).

Conduct Disorder

Several terms are associated with the literature on youth offending:

internalising and externalising behaviours, Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD). This review provides an overview of CD, including diagnostic behaviours, age at onset, comorbidity, developmental trajectory and aetiology.

Diagnosis and Behavioural Features

CD is “a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated” (DSM IV, APA, 1994). Young people diagnosed with CD show a pervasive pattern of antisocial behaviours, including the infliction of pain (initiating fights, fire setting), denial of the rights of others (stealing, breaking and entering), and status offences such as running away from home.

The diagnosis is given only to those under the age of 18 who have displayed criterion behaviours within the past 12 months. Behaviours occur in multiple settings, are considered to be severe and persistent and may be present from an early age. Alternatively, ODD is defined as “a pattern of negativistic, hostile, and defiant behaviour lasting at least 6 months” (DSM IV, 1994). It is a more circumscribed and less pervasive disturbance and may act as a developmental precursor of CD (Kazdin, 1995); however only a small proportion of ODD children go onto develop CD.

In addition to these behavioural patterns, other associated clinical features of CD have been identified: disturbances in cognition, affect, relationships and physical health problems. The combined effects of all of these factors not only significantly impact on the young person but also on those around them. For example, within peer relationships a hostile attributional bias can affect the negotiation of friendships, and

are thus typically characterised by bullying and aggression. This clearly indicates the need for treatments of CD that address the persistent, severe and early origins of behaviours as well as the wide ranging effects of the disorder.

Estimates of CD range from less than 1% to over 10% (Lahey, Miller, Gordon & Riley, 1999) and from 4 to 14% (Cohen et al., 1993). It is more prevalent in boys than in girls, with rates of 6-16% for males and 2-9% for females and male to female prevalence ratios from 4:1 to 2:1 (Carr, 1999; DSM IV, 1994).

Age of Onset

Numerous studies have shown two subgroups of CD based on age at onset and the DSM-IV makes a clear distinction on this basis. In the childhood onset type at least one of the criterion behaviours must be present before the age of 10; while in the adolescent onset type none of the behaviours are present before the age of 10. Research has shown these definitions to be robust (Lahey et al., 1994) and valid (Waldman & Lahey, 1994) and important differences in the characteristics between these two subgroups have been found (Moffit, 1993).

The childhood onset group is relatively small; however it accounts for a disproportionate percentage of illegal antisocial acts. It is mainly made up of boys who show early age of onset for aggressive behaviours. These youth are at higher risk for displaying a persistent course of antisocial activity which unfolds and expands with development and are thus referred to as “life-course persistent” (Moffit, 1993). They also have features suggesting a pattern of more chronic psychopathology. For example, high levels of Attention Deficit Hyperactivity Disorder (ADHD) symptoms, neuropsychological deficits, problems with academic underachievement, family members within the antisocial spectrum and difficult family interaction patterns (Moffit, 1993; Hinshaw & Lee, 2003).

The adolescent subgroup is a much larger group, with a far higher proportion of girls, whose antisocial behaviours begin later in development, specifically in adolescence. They tend not to go on to show violent offending and their behaviours are typically time limited in that they do not necessarily go onto show antisocial behaviour later in life. As a result of this profile, Moffit (1993) refers to this group as “adolescent-limited”.

Thus while the “life-course persistent” group may form the smallest group, overall they tend to display antisocial behaviours the earliest, have a higher number of risk factors, develop in their antisocial behaviour and have the worst prognosis. They also tend to be responsible for a disproportionate percentage of illegal antisocial acts, which is likely to persist across the life span (Moffit, 1993). Not only does this indicate the need for effective psychosocial interventions for CD but also significantly impacts on how these treatments are developed and delivered.

Co-morbidity

CD has been found to have co-morbidity with a range of psychiatric disorders: ADHD, anxiety, depression, substance misuse and learning difficulty. Only ADHD is discussed as co-morbidity rates of ADHD and CD are relatively high, with estimates in community populations of 23.3% (Carr, 1999). Comorbid ADHD and CD has specifically been shown to lead to a more pernicious form of psychopathology than either single diagnosis. Juveniles with both disorders display greater physical aggression, a wider range and increased persistence of antisocial activity, more severe academic underachievement (including learning disability) and higher rates of peer rejections (Hinshaw, 1999). There is also strong evidence to suggest that the conjoint presence of ADHD brings about an earlier onset of CD symptoms (Hinshaw, Lahey & Hart, 1993; Loeber, Green, Keenan & Lahey, 1995;

Rutter, Giller & Hagell, 1998) which are likely to escalate and persist into adulthood, suggesting a developmental pathway. Thus, CD co-morbid with ADHD is complex requiring effective psychosocial treatments that can intervene within this situation.

Developmental Trajectory

Longitudinal studies have demonstrated continued disturbance in conduct from early to middle childhood (Campbell, 1995), from childhood to adolescence (Lahey et al., 1995) and from adolescence into adulthood (Farrington, 1995). Furthermore, a large majority of adolescents who receive a diagnosis of CD have typically shown early signs of disturbed conduct which have persisted and escalated over the years. Thus, research has demonstrated that CD has a linear increase with age and is considered to have a developmental trajectory. This has a significant impact for mental health services as it is likely that youth diagnosed with CD will present to services at many points across the lifespan. Consequently, interventions must be able to address the different developmental challenges posed by these youth.

Aetiology and Risk Factors

Research has demonstrated a range of risk factors, in multiple life domains contribute to the aetiology of CD. These variables occur within the child, family, peer groups and wider ecology (see Table 1) and are believed to interact in complex ways. As it is beyond the scope of this review to examine each of these in detail, only those factors with important treatment implications are discussed: information processing, coercive interactions and associations with deviant peers.

Social Cognitive Information Processing.

Youth who display antisocial behaviour and CD have been shown to have various social cognitive deficits and distortions. They underutilise pertinent social cues; misattribute hostile intent to ambiguous peer interactions; generate fewer assertive

Table 1 **Childhood Risk Factors for Conduct Disorder and Juvenile Offending**

Child Factors	Family	School	Peer	Community
Genetics – XYY syndrome	Poor parent-child relations	Low academic performance	Association with delinquent peers	Community Violence
Hormonal: testosterone, cortisol	Poor parental child rearing practices: poor supervision, physical punishment, poor communication	Poorly organised and functioning school	Rejection by peers	Socio-economic status / poverty
Perinatal factors	Parental abuse: physical / sexual	Weak bonding to school	Gang membership	Availability of fire arms
Prenatal exposure to teratogenic substances	Parental neglect	Low educational aspirations		Media portrayal of violence
Hyperactivity but only when co-occurring with CD	Paternal antisocial or delinquent behaviour	Low school motivation		
Difficult temperament	Maternal depression	Truancy		
Low IQ	Young age of motherhood			
Neuropsychological deficits	Single parenthood			
Low levels of arousal	Family dissolution			
Deficits in social cognitive information processing	Large family size			
Deficits in social skills	Low socio-economic status of family			
Substance abuse	Parental substance abuse			

(Adapted from Loeber & Farrington, 2000)

solutions to social problems and expect that aggressive responses will lead to reward (Crick & Dodge, 1994). Consequently, the aggressive behaviour of these children which is intended to be retaliatory is, however, seen as unjustified by those against whom it is directed. This then impairs peer relationships providing evidence for the child that peers have hostile intentions and thus justifying further retaliatory behaviour. Treatments based on this model provide clear structured opportunities for learning social rules and correcting social information processing distortions.

Social Skills Deficit Theory.

Children with CD can show deficits in social skills: they struggle to generate and implement alternative solutions to social problems (Kazdin, Esveldt-Dawson, French & Unis, 1987). Treatments based on this model train youths in the development of certain skills: correcting hostile attributional bias; accurately assessing problematic social situations; generating a range of solutions; anticipating short and long term consequences of solutions; implementing the most appropriate solution and learning from feedback.

Coercive Family Process.

It has been consistently shown that parents of children who display antisocial behaviours tend to use a hostile, critical and punitive parenting style (Patterson, 1982; Patterson, Reid & Dishion, 1992). In particular, Patterson et al.'s (1992) theory of coercive-parent child interactions has been strongly linked with child CD and antisocial behaviour. The theory is predicated upon the principles of learning theory (Mowrer, 1960) and modelling, and holds that child antisocial behaviours are learnt as a result of family interactions. Evidence from in-home observations of family interactions (Patterson et al., 1992) provides support for these cycles of interactions.

The theory states that parents who use a coercive style tend to have few positive interactions with their children. Parental attempts to confront and punish the child's inappropriate behaviour are typically brief and are withdrawn when the child's behaviour escalates. Thus, the child's increasingly defiant and aggressive behaviour is learnt via a pattern of negative reinforcement. Furthermore, parents tend to use harsh and abusive practices to discipline severe antisocial behaviour. These result in the temporary cessation of the child's extreme behaviour, negatively rewarding the parenting style. This in turn predisposes the future use of harsh discipline contributing to an overall inconsistent and ineffective disciplinary style.

Importantly, Patterson et al. (1992) also state that other risk factors in the family environment contribute to coercive parenting. These include: marital discord; parental psychopathology; social isolation and a range of social and economic stressors. Moreover, the mutually aversive interactions can precipitate negative familial experiences, such as depressed mood of family members and academic underachievement for the child. The child may also develop an aggressive relational style by middle childhood leading to rejection by non-deviant peers. Thus, the mental health and social circumstances of the parent impact on parenting skills and interactions within the family, serving to promote additional risk factors associated with offspring antisocial behaviour, further highlighting the interacting effect of these variables.

According to this model, treatments for CD attempt to directly intervene with parents in order to promote positive parent-child interactions whilst also teaching parents clear and consistent procedures to alter their child's behaviour. It is expected that ideally this intervention would be applied with younger children in order to circumvent any further difficulties associated with coercive interactions.

Association with Deviant Peers.

Children who display antisocial behaviours tend to have as their friends other children who also engage in aggressive behaviours and this has consistently been shown to have a direct causal influence on the propensity for delinquent behaviour (Capaldi & Patterson, 1994). It is thought that 'selection effects' may influence peer choice: youth who display aggressive tendencies and have poor social skills select friends who are similar and who therefore also display deviant behaviours.

Alternatively the association may lie in the 'facilitation' of antisocial behaviour by deviant peers as a result of differential reinforcement of peer group attitude or altered perceptions of the costs and benefits of delinquent behaviour (Dishion, French & Patterson, 1995). It may also stem from the modelling of behaviour and increased opportunities for antisocial behaviour. Thus, treatments of CD would attempt to reduce negative peer associations and facilitate new peer interactions via the introduction of and access to hobbies and youth groups.

Traditional Treatment Interventions

Many treatments of CD have been developed and extensively described and evaluated in the literature (Fonagy & Kurtz, 2002; Kurtz, 1999). They include juvenile justice system programmes (e.g. institutionalisation, probationary services, boot camps) and a range of psychosocial interventions. It is beyond the scope of this review to examine all of these; the main psychosocial approaches will be examined.

From the pre-adolescent treatment literature Problem Solving Skills Training and Parent Management Training will be discussed. These interventions are considered to be the more popular approaches and have a relatively strong evidence base compared to other treatments (Fonagy & Kurtz, 2002). From the adolescent literature Functional Family Therapy, which has been shown to reduce recidivism in

adolescents who multiply offend (Fonagy & Kurtz, 2002) will be reviewed. For each treatment a brief overview of the theoretical background and underlying rationale will be given, followed by a description of the intervention and its empirical evidence. Finally, the limitations will be discussed and an overall summary provided in which it is argued that there is a need for treatment approaches which address some of these limitations.

For comprehensive reviews of treatments for pre-adolescents see Brosnan and Carr (2002) and Fonagy and Kurtz (2002) which discusses other treatments such as Psychodynamic, Social Skills Training, Anger Management Training and Contingency Management in the Classroom. These approaches have various limitations and thus are not discussed here. Psychodynamic treatments for example, lack a clear empirical evidence base and effectiveness in treating conduct problems. While social skills and anger management skills training have demonstrated efficacy in reducing mild conduct problems, there is no evidence of their efficacy when used on their own with more chronic and severe conduct problems (Fonagy & Kurtz, 2002). Similarly, classroom contingency management methods have established efficacy in controlling problem behaviours; however it is specific to the classroom and there is no evidence to suggest that these effects generalise beyond the setting and program termination (Fonagy & Kurtz, 2002).

Problem Solving Skills Training (PSST)

PSST is rooted in cognitive information processing and is a well investigated form of psychosocial treatment for youth aggression (Fonagy & Kurtz, 2002).

Theoretical Basis and Underlying Rationale

Youth who display antisocial behaviour and CD show deficits and distortions at various levels in social information processing (see page 10). These include lack

of ability to: generate alternative solutions to interpersonal problems; identify the consequences of actions; evaluate effects of their actions; perceive how others feel and to misattribute hostile intent to others. PSST is founded on this basis and aims to modify youth interpersonal cognitions in order to develop interpersonal problem solving skills.

Characteristics of the Treatment

Treatment occurs on an individual basis with the young person and is usually carried out within 20 sessions. Different programs of PSST have been applied to children with CD, but there are some commonalities (Fonagy & Kurtz, 2002). Treatment emphasises how youths approach situations, especially social ones. Therapists explore the ways in which the child typically understands and responds to interpersonal problems from a cognitive perspective. Youths are taught to use a step-by-step approach to solve these difficult situations by using self talk in order to direct attention to aspects of the problem so that effective solutions may be generated.

Treatment focuses on behaviours which help resolve interpersonal difficulties and are introduced or developed via modelling or direct reinforcement. Therapists play an active role in treatment, modelling cognitive process via making verbal self statements to particular problems, providing cues to prompt the use of skills and deliver feedback and praise to correct skills. Structured tasks such as games, academic activities and stories are also used and are anchored to relevant real-life situations for the young person. Other techniques include practice, feedback, homework, role-play and reinforcement and punishment which are used to build increasingly complex behavioural repertoires

Overview of the Evidence

On measures of outcome at post-treatment and at one-year follow up PSST has been

shown to be superior to an attention placebo control (Kazdin et al., 1987) and a relationship therapy control (Kazdin, Bass, Siegel & Thomas, 1989). The latter study also demonstrated efficacy for both in- and out patient groups. Also, in a trial which combined PSST with Parent Management Training, parent ratings of externalising behaviours significantly reduced from clinical to normal levels (Kazdin, Siegel & Bass, 1992). These effects were maintained at one-year follow-up.

Taken together the studies of PSST demonstrate the efficacy and long term treatment effects of a cognitive approach for conduct problems (Fonagy & Kurtz, 2002). PSST may also be more beneficial for children in middle childhood than very young children, possibly due to the cognitive developmental stage (Durlak, Fuhrman & Lampman, 1991); however, potential age related differential effects for cognitive treatments have not been well researched. There is also evidence that cognitive approaches reduce antisocial behaviour in the home, school and community (Kazdin, 1997).

Limitations

Limited evidence base.

The above overview indicates that there is a relatively limited evidence base for PSST, as there are only two studies which specifically investigate PSST. This would seem to indicate the need for further empirical trials to be carried out, ideally using a randomised controlled design.

Suitable for younger children.

PSST appears to be an efficacious treatment, especially when combined with parent training. However, this only seems to be the case for school age children (8 to 12 years) indicating the need for treatments that are able to effectively intervene with

older and more persistent delinquent youth.

Suitable for less complex families.

There is evidence suggesting that treatment effects of PSST are specific to higher functioning families and where the child has fewer additional difficulties (Kazdin, 1995). The factors potentially moderating poor outcome include: parental psychopathology; familial dysfunction and stress; comorbid diagnoses; and academic delay and dysfunction. These variables correspond to the empirically known risk factors for CD and inevitably impact on the successful implementation of treatment. This indicates, therefore, that purely cognitive behavioural approaches may not be the most suitable treatment modality for more complex family situations as only some of the risk factors for CD are addressed. Consequently, PSST is unlikely to be a useful and valid intervention for delivery within typical service contexts.

Large proportion of treatment drop outs.

A relatively large percentage of families, estimated at 40-60% (Kazdin, 1996) discontinue treatment prematurely, which poses a challenge to its applicability. Reasons for this high dropout rate are multifaceted and may be related to PSST not targeting enough risk factors for complex families. This highlights the need for treatments which families can engage in and address multiple risk factors, and thus have validity for families.

Parent Management Training (PMT)

PMT is founded upon evidence that coercive family processes tend to characterise parent-child interactions in families where the youth displays antisocial behaviour (see page 12). It is considered to be one of the most popular, evaluated and applied interventions developed to tackle youth aggression and CD. It has a vast literature as it has been applied in the management of a number of difficulties (child

enuresis, tics, eating disorders, hyperactivity and adherence to medical regimes) and range of populations (for example, preschool children through to adolescents and with youths who have received diagnoses of autism, learning disability and ADHD). It is a programme of therapy aimed at teaching parents procedures to alter their child's behaviour; it is rooted in social learning theory and principles of operant conditioning. It has been associated with improved parent-child interactions and overall relationship quality and subsequent reductions in aggressive behaviours.

Theoretical Basis and Underlying Rationale

Essentially, PMT is predicated on the assumption that many overt disturbances of conduct, including oppositional behaviour and mild forms of aggression, are inadvertently developed and maintained in the home due to parental difficulty in adequately reinforcing socially appropriate forms of conduct and maladaptive parent-child interactions or 'coercive interactions' (Patterson, 1982; Miller & Prinz, 1990).

Characteristics of the Treatment

The intervention is conducted primarily with the parents, usually at home and with limited therapist-child contact. The overall aim is to increase parents' positive reinforcement of pro-social behaviour whilst at the same time reducing inadvertent reinforcement (such as parental attention) to aggressive and disruptive behaviours. Parents are encouraged to focus on and praise pro-social behaviours rather than to concentrate on the elimination of conduct problems. Training is also given on identifying, monitoring and tracking problem behaviours. Parents learn to contingently use mild punishment (for example, ignoring, response-cost and time-out) on the display of unacceptable behaviour and to give consistent, predictable, contingent and immediate consequences.

Programs typically last 6-8 weeks for young, mildly oppositional children and 12-25 weeks for clinically referred children who have received a diagnosis of CD (Fonagy & Kurtz, 2002). There are many PMT programs, some of which include aspects of PSST: group based, (Cunningham, Bremner & Secord-Gilbert, 1995); video-modelling, (Webster-Stratton, 1996); Parent Child Interaction Therapy (PCIT; Eyberg, Boggs & Algina, 1995); and the Oregon Social Learning Centre Program, (Forgatch, 1991; Patterson, Cobb & Ray, 1974). While the individual syllabus of each program may vary, they use the same core principles and have certain common teaching approaches - dyadic instruction, role play, behavioural rehearsal and homework exercise – and various treatment manuals for these programs are available.

Overview of the Evidence

No other technique for CD has been as well studied in controlled trials as PMT (Kazdin, 1997). Indeed several comprehensive reviews and meta-analytic reviews of PMT have been carried out (Brestan & Eyberg, 1998; Serketich & Dumas, 1996; Shadish et al., 1993). The empirical research literature on PMT is vast, dating from the mid 1970s when PMT was initially shown to be effective in producing short-term change in parent-child behaviours (O'Dell, 1974).

Overall, the literature demonstrates both the efficacy and effectiveness of this approach. Studies typically report large to medium effect sizes for PMT compared to no treatment or other treatment procedures, and medium effect sizes occur when PMT is implemented in routine clinical conditions (Farmer, Compton, Burns & Robertson, 2002). Research has expanded to look at how PMT can be implemented in the most clinically effective and cost effective manner. In addition, PMT has now been applied in a variety of settings and it has been shown that gains from this

treatment can be maintained over extensive periods (Fonagy & Kurtz, 2002). In view of this extensive empirical support for PMT, it is currently regarded as one of the most promising treatments for CD.

Limitations

Despite the promising evidence of PMT, it does not have the status as a panacea for CD and youth aggression as a result of some crucial limitations.

Suitable for younger children.

PMT has mainly been applied with pre-adolescent children resulting in few studies examining its efficacy for young offenders (Brosnan & Carr, 2000; Kazdin, 1997). While studies that have investigated treatment efficacy with delinquent adolescents (Bank, Marlowe, Reid, Patterson & Weinrott, 1991) and younger adolescents with conduct problems that have not yet been referred for treatment (Dishion & Andrews, 1995) report favourable findings; there is evidence suggesting that PMT is more effective for pre-adolescent youth (Dishion & Patterson, 1992). Moreover, as PMT tends not include the views of youth and focuses more parental involvement, strategies which are perhaps developmentally more appropriate for younger children, it is possibly less suitable for adolescents when used on its own.

Similarly, Fonagy and Kurtz (2002) highlight several factors that may have contributed to larger effect sizes (regarding fewer drop outs, greater gains and better maintenance) for PMT. These include younger age of child, less comorbidity, less severe disturbance of conduct, less socioeconomic disadvantage, no parental dissolution, low parental stress and discord, no parental history of antisocial behaviour and high social support. This indicates that PMT is most effective for younger children from high functioning family systems, factors which tend to be unlikely for persistent and serious juvenile offenders and thus illuminates the need

for investigations of clinical significance, as well as efficacy and effectiveness. As will be seen, MST shares some commonalities with PMT, in that it uses the efficacious treatment strategies to target parent and youth interactions; however MST also attempts to address many of the empirically known risk factors for youth antisocial behaviour and includes young people.

Lack of consideration of wider domains of outcomes.

CD and aggression are understood to be the result of multiple interacting and transacting variables. It is not unreasonable therefore, to expect that successful PMT interventions would have subsequent effects on multiple areas of youth and family functioning as well as on the quality of parent-child interactions, for example, peer relations, social competence and academic achievement. However, few trials of PMT have assessed and reported on wider domains of outcome, rather the priority has been to demonstrate improved parent-child interactions, the primary experimental variable.

Generalisability of treatment effects.

Whilst the long term effects on parent-child interactions have been shown for PMT, it is unclear the extent to which these treatment effects generalise to other settings, such as school (Fonagy & Kurtz, 2002). Thus, again it is unclear the extent to which PMT acts upon the multiple determinants of youth aggression and CD. This calls into question the clinical significance of treatment change if behaviours across several systems within which the youth is embedded are not also affected.

Suitability and practical limitations.

PMT may not be suitable for all families; it makes several demands on the family (Fonagy & Kurtz, 2002; Kazdin, 1997), for example, reading, grasping, and assimilating educational material; systematically observing the child; implementing

reinforcement procedures and attending weekly review sessions. Such pressures can contribute to families initially failing to take up treatment or dropping out of treatment, and may account for why some families do not respond to this treatment. This potentially limited application of PMT calls its clinical significance into question, indicating the need for more accessible treatments to enable wider therapeutic gains.

The range of interventions for adolescents is extensive and includes, for example, Social and Problem Skills Training and Anger Management. However, in Social and Problem Skill Training the long term maintenance of improvement in social functioning is limited and the effectiveness of Anger Management programmes has not been demonstrated (Fonagy & Kurtz, 2002). Functional Family Therapy on the other hand is considered to be one of the main efficacious treatments for pervasive conduct problems (Fonagy & Kurtz, 2002) and is thus discussed below.

Functional Family Therapy (FFT)

FFT is an integrated treatment approach based on combining aspects of cognitive, behavioural and systemic views of dysfunction. It attempts to include young people and their views and is thus perhaps developmentally more appropriate for adolescent youth.

Theoretical Basis and Underlying Rationale

The principal assumption of FFT is that the adolescent's problem behaviour serves a necessary function within the family and for individual family members (Alexander & Parsons, 1982). These purposes may include the regulation of intimacy and support or distance between family members. It is theorised that maladaptive processes within the family, for example, coercive interactions preclude more direct and functional methods of obtaining needs within the family, such as rule

compliance through clear communication and behaviours.

The focus of treatment extends to cover the interactional aspect of the family process as well as the behavioural and cognitive dysfunctions that may be present. At the system level intervention strategies target interpersonal exchanges and communication to foster more adaptive functioning. Treatment is also based on social learning theory and thus identifies specific stimuli or behaviours for change and reinforces more socially appropriate ways of responding. This in turn directly impacts on how family members then respond to each other as communication is clearer and interactions can be more positive.

Finally, cognitive processes such as the family's attitudes and attributions of adolescent behaviour and expectations and assumptions of potential solutions are elucidated. The aim of therapy however, is not to change underlying beliefs and feelings but to disrupt or alter negative family interactions in order to create a non-blaming and more positive style of exchanges.

Characteristics of the Treatment

Therapy specifically addresses the family communication patterns as evidenced in the consultation room and accordingly the therapy requires that all members of the family attend the sessions conjointly. The overarching goals of treatment are to increase reciprocity and positive reinforcement among family members. Also important are clear communication skills to enable family members to express the desired behaviour that they would like from each other, as well as effective negotiation skills in order to generate solutions to interpersonal problems.

FFT is comprised of several treatment components (Alexander, Waldron, Newberry & Liddle, 1988). Early treatment stages use cognitive methods to identify the blaming attributions that can be common in families of delinquent adolescents.

Cognitive methods are also used to pinpoint and address the behavioural, cognitive and emotional expectations, inappropriate attributions and systemic processes that are in need of change. In addition the therapist highlights the interdependencies and contingencies in the day-to-day functioning of the family members within the context of the youth's behavioural difficulties. Other cognitive techniques of relabelling and reframing are extensively used. The aim of these is to reduce blame and to shift parental understanding of the adolescent as someone who is intrinsically deviant to someone whose antisocial behaviour is maintained by situational factors.

Behavioural components such as communication skills training, behavioural contracting and contingency management are introduced following the cognitive strategies.

Overview of the Evidence

According to Kazdin (1997) relatively few trials of FFT have been carried out. However, in those controlled trials that have been conducted FFT has been compared to client-centred and psychodynamic family interventions, attention placebo and no-treatment control groups (Alexander & Parsons, 1982) and adolescent group homes (Barton, Alexander, Waldron, Turner & Warbuton, 1985). These studies showed FFT to be efficacious in improving family interaction and reducing recidivism compared to other treatment groups. Both short- and long-term effects have been seen, with treatment gains lasting up to 2 years later. These findings have also been replicated by a different research team (Gordon, Arbuthnot, Gustafson & McGreen, 1988) in a rural setting and also provided some initial support for intersibling generalisability.

Furthermore, some research has been carried out to investigate the therapeutic process involved in FFT, thus extending the research on treatment outcome for this

intervention (Fonagy & Kurtz, 2002). Overall, FFT is considered an efficacious treatment strategy for pervasive conduct problems, with evidenced long lasting effects on recidivism and valuable clinical significance (Fonagy & Kurtz, 2002).

Limitations

Lack of widespread application.

FFT has not been widely applied across settings (Fonagy & Kurtz, 2002); thus the extent to which this treatment is effective has not been determined.

Practical limitations.

FFT is a relatively well established treatment, but there are few practitioners of this approach. Hefty time and financial commitments involved in the considerable training and supervision that is necessary for effective delivery may account for its limited availability. Furthermore, this treatment may not be accessible for youths and families as not all members may be able to attend frequent clinic based sessions which are typically conducted during the working day. These limitations indicate the need for a treatment targeting persistent juvenile delinquency and CD that has demonstrable efficacy, effectiveness and is accessible.

Summary

Psychological interventions for CD have become more sophisticated as the understanding of this disorder has evolved. Treatments, particularly for pre-adolescents initially focused on specific risk factors for CD within the individual (e.g. information processing deficits). These then developed to address the factors within the family that have been associated with youth antisocial behaviour (e.g. coercive family interactions). Pre-adolescent treatments, however, have typically not tackled the multiple ecologies within which problem behaviours occur. They also tend to be suitable for younger children with less pervasive antisocial behaviours and

from less complex family situations.

Adolescent interventions have expanded in order to address some of these shortcomings. They aim to target wider contextual variables and have incorporated multiple therapeutic techniques (e.g. Functional Family Therapy). Despite this there continues to be limitations with these approaches particularly regarding access and delivery. More fundamentally, these increasingly complicated interventions do not completely eradicate juvenile delinquency. Success is limited; youths who have completed treatment(s) can continue to offend, albeit at a reduced rate.

Furthermore, CD is understood to have a developmental trajectory. While it seems that treatments have been designed in order to target these specific stages (e.g. PMT for young children, PSST for older children and FFT for young adolescents) a significant implication of this developmental pathway is that children and adolescents can continue to present with treatment needs at multiple times in their life. Importantly, when adolescents access services their problem behaviours have typically escalated and family situations are more complex.

All of these factors indicate the need for a comprehensive intervention that is developmentally appropriate for adolescents, specifically targets the multifactorial basis of CD, intervenes within complex family situations and wider ecologies, and is accessible to youth and families.

Multisystemic Therapy

Multisystemic Therapy (MST; Henggeler & Borduin, 1990; Henggeler et al., 1998) is an intensive home-based intervention for persistent and serious juvenile offenders. It was developed at the Medical University of South Carolina, USA by MST Services Inc. which is responsible for disseminating the model.

Theoretical Basis and Underlying Rationale

MST was originally developed in the 1970s to address the mental health needs of juvenile offenders but is now used with more persistent and serious juvenile offenders. It draws upon a family systems and socio-ecological model of behaviour (Bronfenbrenner, 1979). The latter posits that individuals are nested within a complex network of interconnected systems which have bi-directional and reciprocal transactions. Thus, MST understands youth antisocial behaviour as being multidetermined and linked with the characteristics of each system that the adolescent is embedded in, each of which affects and is affected by each other. For example, aggression in the home may subsequently lead to difficulties at school; this in turn may affect school achievement and impact on the child's view of their self.

In addition, MST is not concerned with past determinants of behaviour or individual pathology but gives importance to current risk factors. It is predicated on empirical findings from causal modelling studies indicating the multifactorial basis of antisocial behaviour (e.g. coercive parent interactions, social information processing deficits and association with deviant peers, Henggeler, et al., 1998). Thus, it is theorised that MST acts on many risk factors contributing to the development and maintenance of CD.

Characteristics of Treatment

Therapeutic techniques.

MST is designed to target the known causes and correlates of CD and antisocial behaviour; thus it intervenes within the family (both immediate and extended), peer, school and neighbourhood systems in which the youth is embedded as well as the relations between these systems (Henggeler, 1991; Henggeler & Borduin, 1990). The therapy does not follow a rigid protocol or use a unique set of

treatment techniques in a predetermined sequence; rather it borrows from the best evidence-based therapeutic modalities (Burns, Hoagwood & Marazek, 1999; Weisz & Jensen, 1999) and thus comprises a range of techniques. Despite this MST is not a mere amalgamation of procedures, as the focus on the interrelationship between the systems is retained.

The design and implementation of treatments and activities are guided by nine core principles of MST (see Table 2). These enable careful ecologically based functional analyses of the identified problem from which interventions can then be strategically selected to provide maximum leverage for achieving a specified goal. Therapists use a model of assessment, hypothesis generation and hypothesis testing as part of this process (Fonagy & Kurtz, 2002). These principles allow techniques to be flexibly applied and thus enable individualised interventions.

The constituent treatments which operationalise MST include techniques from systemic and structural family therapy (e.g., joining, reframing, enactment, paradox, the assignment of specific tasks), parent training, marital therapy, supportive therapy related to interpersonal problems, social skills components, social perspective training, behavioural methods and cognitive therapy techniques, as well as case management with the therapist acting as an advocate to outside agencies.

Goals of therapy are to: improve adolescent behaviours via effective parental involvement and limit setting; eliminate negative parent-child interactions; and build structure, cohesion and emotional warmth among family members. Additionally, it addresses factors in youth social networks contributing to antisocial behaviour. It encourages youths to separate from deviant peer groups, to alternatively mix with pro-social peers and to enhance school attendance and performance. It also aims to develop an indigenous support network to maintain therapeutic gains.

Table 2

Principles of Multisystemic Therapy That Serve as a Basis for Treatment.

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

From Henggeler et al. (1998).

Other features of treatment.

MST is based on a family preservation model of service delivery and thus is intensive, pragmatic, and goal orientated. Sessions are flexibly scheduled to meet families' needs and are delivered across settings (home and community) in order to overcome traditional barriers to service access and to increase cooperation and generalisation. It is a time limited, present focused intervention that occurs within the context of the family's values, beliefs and cultures. It also aims to achieve concrete observable change in the family and adolescent by treating specific well-defined problems. Within MST families are also viewed as valuable treatment resources, even when they have serious and multiple needs. Thus, interventions are designed to empower parents and youths to address the developmental, academic, social and situational challenges that arise throughout adolescence.

Henggeler, Cunningham, Pickrel, Schoenwald, and Brondino (1996) state a further hallmark of MST is its emphasis on outcome accountability among therapists, treatment teams and supervisor. Tangible evidence of behaviour change is used to directly indicate accountability and lack of observable change reflects a problem with the application of the treatment procedures, therapist and team. This directly contrasts with traditional approaches where treatment impasses or failures tend to be attributed to the patient's resistance or lack of motivation. MST therapists, therefore, must do "whatever it takes" to engage the family to bring about change within the context of mutually agreed goals. To achieve this, therapists are given appropriate resources and support, such as low case loads, extensive training, and supervision and case consultation.

Supervision is, therefore, an integral component of the therapy (Henggeler, 1999) and is typically provided by one of the MST developers. It occurs in a small

group format: a team of 3-5 clinicians meet with the supervisor for 1 ½ - 2 hours a week. During this time all of the families may be discussed; however, the amount of time for each case varies according to the needs of the clinician and the family during a given week. Where it has not been possible to follow this model due to members of the original MST team being distant to the treatment site, a model of remote telephone consultation from MST experts to on-site supervisors has been used. Individual supervision is also immediately available if a situation arises which poses a serious threat to the safety of a family member (Henggeler et al., 1998).

Overview of the Evidence

Many trials of MST have been carried out, thus it is considered to be a well validated treatment model (Kazdin & Weisz, 1998). For comprehensive reviews of these studies see Henggeler et al. (1998) and Henggeler (1999).

The first trial of MST (Henggeler et al., 1986) used a quasi-experimental design to evaluate the outcome of youths who received MST against those who had alternative service provision. Compared to treatment as usual, families in the MST condition showed a decrease in the number of adolescent behavioural problems as reported by parents, and a decrease in association with delinquent peers. Furthermore, improved family relations were reported particularly with regards to family communication and affect. These results provided support for the short term efficacy of MST in treating inner-city adolescents who were repeat offenders.

Several randomised control trials have also been conducted which provide additional support for the efficacy of MST. Henggeler, Melton and Smith, (1992) compared MST for violent and chronic juvenile offenders and their families to treatment as usual community services. Results showed that MST was effective at reducing rates of criminal activity (measured by rearrest records and self reported

offences via the Self Report Delinquency Scale and incarceration). Improvements in parental and self reports of youth aggression, family functioning and cohesion were reported as were reductions in peer aggression. Treatment outcome or drop-out was not predicted by the severity of the disturbance of conduct, indicating its applicability for severe cases.

Results from a 2.4 year follow up study (Henggeler, Melton, Smith, Schoenwald & Hanley, 1993) of the above trial found that the MST group had fewer rearrests (61%) than the comparison group (80%). This was taken as evidence to support the longer term capacity of MST to reduce reoffending as the percentage of youth who had not reoffended had essentially doubled.

In Borduin et al.'s (1995) study the effects of home-based MST versus office-based, individual, outpatient counselling representing usual community treatment were compared for 176 chronic juvenile offenders. Family members in the MST condition reported increased family cohesion and adaptability compared to those in the individual therapy condition. Parents of the MST families also showed greater reductions in psychiatric symptomatology.

Results of recidivism from the 4-year follow up showed that 71% of the youths in the treatment as usual group had been arrested at least once, compared with 26% of the youths in the MST group. Thus, youths who had received MST were significantly less likely to be rearrested than youths who had received individual counselling. MST youths were also arrested less often and for less serious offences and violent crimes. In addition those youths who had dropped out of MST continued to show lower risk for rearrest at 4 year follow up than did their counterparts who had completed treatment as usual. The effectiveness of MST was not moderated by adolescent age, race, social class, gender or pre-treatment arrest history.

Thus, it has been concluded from this study that MST is effective in reducing long-term rates of delinquency. Furthermore, as the MST therapists used in this study were doctoral level students in clinical psychology as opposed to community based mental health professionals it has also been concluded that MST has long term success with serious juvenile offenders when delivered in university-based settings.

Henggeler, Melton, Brondino, Scherer and Hanley (1997) investigated MST for serious juvenile offenders compared to treatment as usual – juvenile probation services. Results indicated that MST improved adolescent symptomatology at post treatment and decreased incarceration by 47% at a 1.7 year follow. Importantly, however, there were no treatment effects for improved family or peer relations, nor were they found for youth self reported delinquency. While the annualised rate of rearrest was 26% lower for youths in the MST condition, this did not reach statistical significance. Overall, the findings from this study only provide minimal support for the efficacy of MST in reducing youth offending as measured by rearrest records and are not as favourable as those reported in other MST trials.

Treatment fidelity.

Henggeler et al. (1997) also investigated whether the effectiveness of MST could be maintained in community mental health settings when an important component of MST dissemination was not included. Specifically, experts in MST did not provide weekly clinical oversight. According to the developers of MST, fidelity to the therapy, which has been operationalised via nine principles, is fundamental to good outcome. Therefore, measures of therapist adherence to these principles were made to determine whether lack of ongoing expert supervision was associated with reduced treatment fidelity and resulting measures of delinquency.

Measures of the therapists' adherence were made by the parent, adolescent

and therapist. A 26 item likert scale questionnaire designed to measure therapist and family behaviours specific to the practice of MST was used. Results showed that on the basis of parental reports of MST fidelity, high rearrest rates and subsequent incarceration rates were significantly associated with low therapist adherence to MST principles and non productive treatment sessions. Similarly, from the therapist perspective high adolescent reports of index offences were significantly associated with low therapist adherence to MST principles.

Accordingly, it has been concluded that adherence to MST treatment principles, achieved via ongoing expert supervision, is an important predictor of key outcomes such as reduced adolescent criminal activity (as measured by rearrest records and self reports) and incarceration. Thus, it is hypothesised that the relatively poor outcome of the 1997 study may be attributed to low treatment fidelity resulting from lack of expert supervision. The lack of clinical oversight may have led to an increased variability in the application of the treatment protocol contributing to an overall reduction in the fidelity of MST.

To date the results of only one other randomised controlled trial have been formally published (Ogden & Halliday-Boykins, 2004). In this study MST was compared to treatment as usual services in Norway. Results showed that MST was more effective than Child Welfare Services (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. These findings were considered to replicate those previously reported by the MST team and support the generalisability of the short-term efficacy of MST beyond the USA.

Strengths

MST has many strengths (for a review see Borduin, 1999). These include the

match between the empirically known multidetermined factors of CD, specifically targeted intervention strategies and the flexible use of well-validated therapeutic modalities within the natural ecology of the youth and family. It also appears to have a relatively strong evidence base indicating its efficacy in reducing juvenile delinquency. MST has demonstrated short and long term reductions in rearrest, incarceration and self reported offending and thus overall rates of delinquency. Furthermore, it has produced reductions in emotional and behavioural problems and improved family functioning compared to other treatment options including usual services (e.g., probation court ordered activities), individual counselling and community based eclectic treatment. Additionally, MST is reported to be a highly cost-effective alternative to out-of-home placements such as incarceration (Henggeler, 1999).

Several unique characteristics of MST have been attributed to its success (Brown et al., 1997; Henggeler, Schoenwald & Pickrel, 1995). MST is perceived to ensure high clinical rigor and treatment fidelity that is expected of trials conducted in university settings, compared to the unstructured and diffuse focus of community based treatments, as it provides expert supervision, monitors therapist fidelity to the treatment principles and uses highly trained therapists. Thus, it is seen to bridge the gap between university and community treatments (Weisz, Donenberg, Han & Kauneckis, 1995). Service delivery is also based on various evidence based interventions (behavioural, cognitive behavioural, family therapy) which according to meta-analytic reviews (Weisz & Weiss, 1993) yield the largest effect sizes. These are then applied in a highly individualised, flexible and comprehensive manner.

Moreover, its success may be attributed to the use of several active behavioural generalisation strategies (Henggeler, Schoenwald & Pickrel, 1995).

Services are also provided within the natural ecology or environment of the youth and their families, reducing barriers to service access thus increasing the generalisability of change processes. MST also addresses the known empirically based multiple determinants of serious antisocial behaviour (Hinshaw & Lee, 2003; Thornberry, Huizinga & Loeber, 1995) in a comprehensive yet individualised manner.

Given the success that has been reported for MST it has since been applied with a range of other youth problems. These include adolescent sex offenders (Borduin, Henggeler, Blaske & Stein, 1990); drug use in offenders (Brown, Henggeler, Schoenwald, Brondino & Pickrel, 1999; Henggeler et al., 1991; Henggeler, Clingempeel, Brondino & Pickrel, 2002; Randall & Cunningham, 2003); youths presenting with psychiatric emergencies (Henggeler, et al., 2003; Henggeler, et al., 1997; Henggeler et al., 1999; Shoenwald, Ward, Henggeler & Rowland, 2000) and maltreating families (Brunk, Henggeler & Whelan, 1987).

Limitations

There are however, some important limitations with this approach: problems within the therapy itself; a limited evidence base; barriers to “real world” service implementation and importantly a lack of qualitative research.

Uncertainty over the active ingredients.

Whilst MST has been operationalised through nine core principles, there remains uncertainty as to what the key components of this intervention are and how clinicians choose between them and how it is delivered in practice. For example, how do they choose between behavioural, cognitive and family therapy strategies and the different techniques which make up these approaches within sessions? Additionally it is unclear which of the many treatment procedures are required to

achieve effective practice (Fonagy & Kurtz, 2002) or indeed what the necessary “dosage” of MST is for good outcome.

Furthermore, no research has been carried out to determine whether the theory of MST is reflected in the nine principles and the extent to which they are successfully operationalised within the therapy as delivered. It is unclear to what extent MST intervenes within and changes the empirically known multiple determinants of CD, and if behavioural changes can be attributed to modifications within these. It is also possible that MST principles operationalise more generic psychological processes associated with positive treatment effects. For example, MST’s emphasis on regular supervision and monitoring of therapist fidelity may facilitate the formation of shared tasks, bonds and goals, key factors in the therapeutic alliance which has been associated with good outcome (Horvath & Luborsky, 1993). It may also be that therapeutic effects are associated with pan-therapeutic skills such as listening.

Treatment format.

The model of MST as delivered in practice appears to consist of a one-off 6 month intensive home treatment with no phase out or follow-up sessions. The protocol is unclear, however, as it is not specifically focused on in the literature. This format is surprising given that efficacious child and adult psychological treatment models regularly include follow up and booster sessions (Fonagy, Target, Cottrell, Phillips & Kurtz, 2002; Roth & Fonagy, 1996) to maintain treatment gains. Furthermore, it is unusual that a treatment clearly based upon the theory of CD - multiple determinants, developmental trajectory and pervasiveness – is designed on the basis that a one-off intervention is sufficient. It would be useful for future trials of MST to investigate the long term effects of including follow-up sessions.

Lack of independent supporting evidence.

MST has been criticised due to a lack of independent replication of its findings (Fonagy & Kurtz, 2002) and is thus considered to have a limited evidence base. This is an important criticism as it raises questions regarding the degree to which developers of a treatment can be impartial or what else it is that they bring to the intervention which can affect outcome. Developers of an intervention tend to have much invested in a new treatment which may impact on subtle processes that contribute to positive treatment outcomes. For example, increased motivation may contribute to a therapist working harder to implement the treatment or staying with the trial for longer, thus accumulating more experience and consistency. Alternatively, the developer's background may impact upon treatment delivery: they may have other experiences, skills or training which impact upon intervention effects. These factors reflect the need for independent replication trials to be carried out including those outside of the USA. In addition there is a need for studies to investigate the effectiveness of MST in typical clinical service settings.

While the positive results from the Norway trial (Ogden & Halliday-Boykins, 2004) provide preliminary external supporting evidence for the efficacy of MST, there are, nevertheless, some important limitations of this study. Norway's criminal justice system does not make arrests and convictions for youth under 15 years; rather offenders under the age of 18 are dealt with by the CWS. Consequently, measures of days of incarceration or rearrest were not available. Accordingly, delinquency was assessed by youth self report via the Self Report Delinquency Scale (which was used in previous MST trials). Furthermore, the actual results of the Self Report Delinquency Scale were not reported; rather these were used to form part of a composite score of overall externalising behaviour. These factors make it difficult to

directly compare effects of MST versus treatment as usual on rates of delinquency.

Therefore, the positive results from this trial should perhaps be interpreted with caution and further highlights the need for independent trials.

Other trials of MST with persistent and serious youth offenders have been conducted but as yet are unpublished. For example, Henggeler et al. (1998) stated that research was taking place in Delaware with the Department of Services for Children Youth and Their Families and in Galveston, Texas. This study was under the direction of Dr Christopher Thomas, University of Texas Medical Branch and the results were due to be completed in 1998.

In addition, the results of a randomised controlled trial by Alan Leschied (Principal Investigator) in Canada with The Centre for Children and Families in the Justice System have not been formally published, although they can be accessed via the internet (<http://www.lfcc.on.ca/seeking.html>). Overall the results were not favourable of MST. The MST group and the treatment as usual group were not statistically distinguishable on any measure of outcome suggesting that there was no treatment effect. Analysis of early findings, conducted before the trial was completed were positive; however they were not consistent across all of the trial's sites, indicating that translation of MST to different geographic sites and service contexts may not be straightforward. Thus, there is a need for independent trials of MST to be conducted to determine its efficacy particularly when implemented by teams not associated with the original developers and in different cultural/geographic contexts.

Barriers to service implementation.

Certain features of MST may present potential barriers to MST being used by services as a primary intervention for persistent and serious juvenile offenders.

Trials of MST have demonstrated efficacy when conducted by developers of the treatment, suggesting that it is necessary to have access to expert advice, knowledge and skills from MST Services Inc. This is likely to incur some considerable financial strain and significantly increase the cost of establishing a new MST service.

Similarly, efficacy appears to be associated with therapists who are highly trained in the approach and who have access to weekly expert supervision. Training opportunities are limited (Fonagy & Kurtz, 2002) and whilst MST Services Inc. have now expanded to be able to provide some training, this is expensive and continues to be in short supply. Moreover, Henggeler et al. (1997) comment that involvement of an MST expert “might constitute financial and administrative barriers to the broader dissemination of MST” (p. 822). The combination of the above factors is likely, therefore, to impede the extent to which MST is implemented across multiple services and sites.

Furthermore, the extent to which MST assumes accountability for the lack of behavioural change in youth and families must be considered. As has been pointed out this is counter to some more traditional approaches and thus may impact upon the willingness with which therapists will work within this model.

Lack of qualitative evaluation.

In addition to the uncertainty regarding the “key ingredients” and the lack of independent supporting evidence of MST, little is known about how service users experience MST and what the impact(s) of this intensive home based intervention may be from youths’ and parents’ perspectives. It is important that research examining service users’ experience is conducted as this can provide different or additional information about the treatment, thus strengthening the evidence base. Phenomenological approaches in particular, which aim to obtain detailed

descriptions of individuals' personal worlds and experiences (Smith, 2003), may be one way of addressing these limitations and furthering our understanding of MST.

It is unclear, for example, as to what parents and youths find helpful and unhelpful in the therapy and/or what they consider the strengths and the weaknesses of the treatment to be. Also unknown are the psychological processes that are important for service users in the overall therapeutic process. Furthermore, it is possible that for service users, different factors are important in treatment outcome or evaluation than those that are typically assessed via standard questionnaire measures. Qualitative approaches can, therefore, enable in-depth examinations of the issues relevant for services users in outcome, thus highlighting different or new factors.

The application of qualitative phenomenological approaches can firstly elucidate from the perspective of service users, important psychological processes involved in psychotherapy. Additionally, through the generation of rich narratives of the treatment, the key strategies used within the therapy can be made clear. For example, Lobatto (2002) and Strickland-Clark, Campbell & Dallos (2000), using retrospective accounts, investigated the processes within family therapy for children and adolescents. These studies highlighted respectively, youths' difficulties in negotiating their position within therapy and the importance of being heard, included and accepted in family discussions.

Secondly, McLeod (2001) argues that qualitative methodologies can also be used to evaluate the effects/outcome of therapy. This contradicts current opinion which holds that "randomised controlled trials provide the only valid – albeit limited – source of evidence for the efficacy of various forms of psychological treatment" (Roth & Fonagy, 1996, p.19). McLeod reviews four qualitative psychotherapy outcome studies - family therapy (Howe, 1989); psychotherapy (McKenna & Todd,

1997); counselling in relation to childhood abuse (Dale, Allen & Measor, 1998) and inpatient cognitive behaviour therapy (Kuhnlein, 1999) – and concludes that “qualitative interview data can be used to generate useful information about the effectiveness of therapy” (McLeod, 2001, p. 177).

Importantly, qualitative approaches enable the voice of service users to be heard and thus provide a different perspective on psychological therapies. There is an increasing emphasis within the National Health Service, as evidenced in the National Service Framework for Children (Department of Health, 2005) on including service users’ perspectives in the planning and delivery of services. Thus far, this has typically taken the form of investigating patient satisfaction with services. Qualitative studies, however, through their use of in-depth accounts of therapy, can provide an alternative means of examining service users’ opinions not only about treatment outcome but also regarding service accessibility and implementation.

Furthermore, there is emerging evidence to suggest that parental evaluation of treatment is a complex process involving various factors. This may make it more difficult to study using traditional quantitative approaches. For example, Kopec-Schrader, Rey, Plapp and Beumont (1994) suggest that parent reports of satisfaction tend to be positively related to perceptions of child improvement. However, it is not necessarily the case that positive parental therapeutic experiences and/or outcome are excluded by lack of child improvement; that is, despite a lack of observable behavioural change in the child, parents may still experience the treatment as helpful. Detailed therapeutic accounts obtained via qualitative studies may allow different and perhaps more comprehensive analyses of parent evaluations of treatment outcome that reflect this complexity.

Children also have important information to contribute themselves, however, views about their own treatment are rarely taken into account and in fact little is known about their understanding of mental health (Fonagy, 2002). Their perspective can help us to understand the effects of therapy and evaluate the effectiveness of services and service provision. Qualitative approaches may, therefore, also enable children's views regarding therapy to be expressed and included whilst also giving them a sense of ownership and that they are listened to with respect. Hennessey (1999) also makes the point that questionnaire methods typically used to establish child satisfaction with services may not address aspects of the services that are salient or relevant to children. Again, qualitative approaches may go some way to facilitating therapeutic accounts that describe the relevant issues for young people.

It is also possible that qualitative accounts describing the effects or impact of the intervention can provide a means of determining the internal validity of MST – that is it can offer a way of checking whether the factors and systems that it is theorised as intervening in are actually affected by the treatment as delivered. Additionally, qualitative studies meet with an ethical need to ensure that efficacious treatments for severe and persistent youth delinquency are also valid and acceptable for parents and youths. Qualitative research can, therefore, make an important contribution to understanding the theory of MST as well as addressing some of its limitations.

Conclusion

Multiple risk factors contribute to the severe and persistent behaviour problems of juvenile offenders. These variables occur across several domains of juvenile offenders' and their family's lives and are believed to have reciprocal transactions often leading to complex family situations. Conduct Disorders typically

have an early onset, particularly if the condition is comorbid with ADHD and these factors lead to a particularly poor outcome and prognosis; these young people and their families are likely to present to services at many points.

All of these factors pose significant challenges for psychosocial treatments of CD and youth delinquency. It would seem that in order for treatments to be effective they must be able to address and work within all of these factors. Current interventions for CD, however, do not appear to fully address these issues. Typically, the interventions are for younger children, only one or a few of the risk factors are targeted and the family situations tend to be less complex. Consequently, there is a significant need for a therapy based upon the current theoretical understanding of CD and which addresses multiple risk factors across several domains as well as meeting the challenges and developmental needs of working with adolescents.

One such therapy which appears to meet these needs is MST. This has been shown to significantly reduce rates of delinquency and rearrest rates as well as improving other measures of family and youth functioning, and is thus considered a well validated treatment for youth delinquency. This success has been attributed to several features of MST including: its ability to work within and target several risk factors for youth delinquency; its basis in social ecology and thus its ability to work within several systems; rigorous treatment protocols which include regular supervision and monitoring of treatment fidelity and accessibility to families.

Despite these positive features, MST has some important limitations and much that is still not known. Most trials have been conducted by the developers of the therapy; thus there is a need for independent replications of the positive findings. There is also uncertainty about how the treatment is delivered in practice and what

the key elements of the intervention may be. Furthermore, there is a lack of qualitative evaluations of therapeutic effects as seen from the young person and family's perspective as well as investigations of the psychological processes which occur within therapy. All of these limitations indicate essential and interesting areas for further research.

Ultimately, however, there is much that is unknown about youth delinquency. While treatments have been able to reduce offending, typically the problem is not fully eradicated. This poses a huge challenge for psychological interventions and indicates the need for more research.

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Part 2

Empirical Paper

Multisystemic Therapy for Serious Juvenile Offenders: A Qualitative Study of Service Users' Perspectives

Abstract

Multisystemic Therapy (MST), an intervention for treating youth offending, has been shown to be effective in reducing re-arrest rates. Little research, however, has been carried out to investigate how families experience this treatment approach and the psychological processes that occur within the therapy. This qualitative, phenomenological study examined these issues for nine families that had completed MST. Separate interviews with nine parents and three young people were conducted and were analysed using Interpretative Phenomenological Analysis (IPA). The analysis of the parent accounts yielded four themes clustered in two super-ordinate themes regarding the value of a person-centred approach in therapy and the challenges of being a parent. The young person accounts were characterised by a pervasive sense of confusion about and disappointment in MST. The findings underline the importance of the therapeutic relationship as well as of the need for family interventions to equally involve parents and young people.

Introduction

Juvenile offending poses a significant problem to society, as there are major wide reaching consequences of youth delinquency. For example, chronic juvenile offenders are at high risk for mental health problems, substance abuse, poor physical health, low educational and vocational productivity and interpersonal difficulties (Hinshaw & Lee, 2003; Rutter, Giller & Hagell, 1998); while their families, victims and wider society can experience detrimental physical and economic effects (Reiss & Roth, 1994).

Most juvenile offending is carried out by youths who display antisocial behaviour and/or are diagnosed with Conduct Disorder (CD). CD is a complex disorder that is pervasive and has poor long-term outcome (Fonagy & Kurtz, 2002). Importantly, it is also understood to be the result of multiple risk factors that are present within several life domains such as family, peer groups and school and have complex interactions (Loeber & Farrington, 2000). Youths have been shown, for example, to have deficits in social cognitive information processing (Crick & Dodge, 1994) and tend to associate with other deviant peers (Capaldi & Patterson, 1994), while family interactions are typically characterised by coercive parent-child interactions (Patterson, Reid & Dishion, 1992).

Children and adolescents with conduct problems are likely to display chronic difficulties that often emerge early in childhood and progress into adolescence and adulthood; thus CD is considered to have a developmental trajectory (Hinshaw & Lee, 2003). Youths can, therefore, continue to present with treatment needs at multiple points across their lifespan, placing significant demands on mental health and social services. Indeed, a third to a half of all mental health clinic referrals is constituted of young people with conduct problems (Kazdin, 1995).

The complex nature of youth delinquency and CD poses significant challenges for the development of effective psychosocial interventions. Indeed, whilst many interventions for CD have been developed, (Brosnan & Carr, 2002; Fonagy & Kurtz, 2002) their success is limited, as youths often continue to offend. It has been commented that previous treatments have not been sufficiently effective due to their failure to consider the empirical basis of child psychopathology and to deliver treatments with ecological validity (Brown et al., 1997). This highlights the need for psychosocial treatments that are clearly founded upon the current theoretical

understanding of CD and youth delinquency – the existence of multiple risk factors that are present across several different domains of youths' functioning and which have complex interactions and the developmental trajectory – and that systematically address these factors.

Multisystemic Therapy (MST: Henggeler & Borduin, 1990; Henggeler et al., 1998) is an intensive treatment for serious juvenile offenders. It addresses the limitations of previous psychosocial interventions as it is clearly predicated on the findings from causal modelling studies as to the multiple determinants of delinquency. Furthermore, it is founded on a model of social-ecology (Bronfenbrenner, 1979) which posits that individuals are nested within a complex network of interconnected systems which have reciprocal influences on each other. Thus, youth delinquency is understood not only to be multidetermined but also linked with the characteristics of each system that the adolescent is embedded in such as family, peer and school, and that each of these affects and is affected by each other.

Accordingly, MST is designed to intervene within youth and family ecologies and the specific factors that contribute to youth antisocial behaviour. For example, youths are encouraged to separate from deviant peer groups and to alternatively mix with pro-social peers and to enhance school attendance and performance. Family structure and cohesion is also promoted as well as effective parental involvement and limit setting. An indigenous support network for the family is also encouraged in order to help families maintain therapeutic gains.

MST is also based upon a family preservation model of service delivery in order to increase cooperation and to enhance generalisation to the family and their wider systems. Interventions are, therefore, home-based, pragmatic and time limited.

Individualised goals are developed within the context of the family's values, beliefs and cultures and the family is considered to be a valuable treatment resource. Hence, treatment strategies are designed to empower parents and youths and are based upon elements of the best evidence-based therapeutic modalities (Burns, Hoagwood & Marzack, 1999; Weisz & Jensen, 1999), for example, parent management training and functional family therapy.

MST is considered to be a well validated treatment model (Henggeler et al., 1998; Henggeler, 1999; Kazdin & Weisz, 1998). Several randomised controlled trials of MST have been carried out which have demonstrated its short and long term efficacy in reducing re-arrest rates and time spent in incarceration since treatment termination (Borduin et al., 1995; Henggeler, Melton, Brondino, Scherer & Hanley, 1997; Henggeler, Melton & Smith, 1992; Henggeler, Melton, Smith, Schoenwald & Hanley, 1993; Henggeler et al., 1986; Ogden & Halliday-Boykins, 2004). There is also evidence to suggest that MST increases family cohesion and decreases adolescent aggression with peers (Henggeler, Melton & Smith, 1992).

Despite this relatively strong evidence base, MST suffers from some significant limitations. There are a lack of empirical research trials which have been carried out by those not involved in the development and initial evaluation of MST. There is also uncertainty regarding the "key ingredients" of the intervention and how MST is delivered in practice. Furthermore, little is known about how service users experience this intensive home-based intervention and what they consider the impact of the treatment to be.

Qualitative studies can be used to elucidate the important psychological processes within therapy from the perspective of service users (Barker, Pistrang & Elliott, 2002). It can, for example, enable descriptions of the helpful and unhelpful

aspects of the therapy as well as its strengths and limitations. Indeed such an approach has been used to investigate the processes within family therapy for children and adolescents (Lobatto, 2002; Strickland-Clark, Campbell & Dallos, 2000). Additionally, it may enable a closer examination as to how service users experience psychological interventions when delivered in different contexts, such as the clinic or home.

It has also been proposed that qualitative studies can provide an alternative means of evaluating the effects of therapy (McLeod, 2001). Qualitative interview data which comprises detailed descriptions of therapy can, for example, offer useful information regarding therapy outcome. Moreover, it can enable service users' perspective concerning the impact of treatment to be given. This in turn can offer potentially different or new ideas regarding the theoretical foundations and treatment implementation of psychological interventions. Thus, qualitative approaches are able to complement traditional quantitative methodologies such as randomised controlled trials.

In-depth analyses of treatment outcome from service users' perspective are also vital as there is emerging evidence to suggest that parental evaluation of treatment is a complex process involving many factors (Kopeck-Schrader, Rey, Plapp & Beumont, 1994). Furthermore, qualitative approaches can address the current demand, as evidenced in the National Service Framework for Children (Department of Health, 2005), to work collaboratively and transparently with youth and families and to include service users' perspectives in treatment planning and delivery.

The current study aimed to provide a detailed description of how parents and youths experience MST. It adopted a discovery-orientated, phenomenological approach, which focuses on the individual's experience of their world and recognises

the diversity and variability of individual experience (Willig, 2001).

Phenomenological studies, which aim to provide detailed descriptions of individuals' personal worlds (Smith, 2003), offer a useful approach to explore how individuals experience psychological therapies. Such an approach has the potential to add to our understanding of how MST works and the complex processes that may be involved in effecting change for these families. Accordingly, the study was guided by two central research questions: (1) How do parents and youths experience MST? (2) What do parents and youths perceive to be helpful and unhelpful about the MST programme?

Method

Setting

Participants were recruited from a North London charity whose remit is to provide independent non-National Health Service psychotherapy and counselling services for local youths. Currently, the centre along with a North London Youth Offending Service is supporting an ongoing randomised clinical trial of MST. The trial is funded by the Tudor Trust and Atlantic Philanthropies, with some support provided by the Youth Justice Board and is expected to last for four years. Youths referred to the trial had to have three convictions and be aged from 13 to 16. Furthermore, there had to be enough involvement from a parent or principal carer so that MST could be applied. However, the selection criteria were relaxed half way through the trial in order to maximise the number of young people referred to the trial. MST as delivered in this trial views the parent as essential and thus they are frequently the main focus of the intervention. Although attempts are also made to engage the young person, they tend not be as closely involved.

Ethics

Ethical approval for this study was given by the Youth Justice Board, who had also given ethical approval for the clinical trial of MST and the internal UCL ethics board (see Appendix A).

Recruitment

A continuous sampling procedure was used to recruit families from the MST trial. In order to be included in the study families had to have completed the MST programme within a year. Data collection commenced in August 2004 and ended in April 2005, at which point a total of 25 families had completed the MST programme. Twelve of these however, were excluded from this study as they did not meet the inclusion criteria. Eight cases had completed the MST programme over a year ago; in two cases a consistent carer had not emerged and it was felt that it would be distressing for the young person to be interviewed; one case was closed after the family discovered they had been allocated to MST and thus no work was done and in one case the family refused to be contacted following completion of the MST programme.

Participants

For simplicity, the term 'parent' is used to refer to the person most involved in the adolescent's care and who subsequently had the largest contact with the MST programme; 'young person' refers to the index adolescent. The term parent includes both mothers and fathers as the main carer and does not exclusively refer to biological parents.

Of the thirteen families who met the inclusion criteria, two families were not contactable by telephone. Eleven families agreed to participate. Nine parent interviews took place: one parent withdrew their consent and one was not present at

the time of the arranged interview and subsequent attempts to contact them were unsuccessful.

Attempts were made to contact the young people for all of the nine families that participated. The parents of three families, however, requested that the young person not be contacted due to concern that this may cause difficulties within the family or because the young person no longer lived at home. Of the remaining six young people, five agreed to take part; one did not give consent. Of the five who agreed, two young people could not be contacted to arrange a time for the interview. Three young people were interviewed.

Table 1 presents characteristics of the participants. All of the families recruited to the MST programme came from economically deprived areas. Most of the parents in this study were single, unemployed and claimed benefits. Of the nine carers interviewed, five were mothers, three were fathers, and one was a grandmother.

The MST programme did not collect information regarding the age and ethnicity of parents, thus this information cannot be presented and it is not known if there are any significant demographic differences between those parents who participated and those who did not.

Of the 13 families who were approached for this study all of the young people were boys apart from one and ranged in age from 13 to 16 years. The mean age of the whole sample was 14.6, as was the mean age for the three young people who participated. There was a range of ethnic backgrounds: six young people were white, four were black and three were of mixed ethnic origin. The average age of onset for offending behaviour for all of the young people as measured at intake to the MST trial was 13.5 years and 12 years for the three young people who were

Table 1

Family	Relationship	Length of MST Contact (weeks)	Age of YP	Ethnicity of YP	Age of Onset of Offending	YP Interviewed
Family 1	Mother Son	26	14	White	13	Yes
Family 2	Mother Son	25	16	White	14	No
Family 3	Mother Son	28	13	White	11	Yes
Family 4	Mother Son	23	14	Black	13	No
Family 5	Father Son	23	14	Mixed	N/A	Yes
Family 6	Grand- mother Grand- daughter	29	15	Black	14	No
Family 7	Mother Son	23	14	Black	13	No
Family 8	Father Son	17	16	White	16	No
Family 9	Father Son	15	16	Mixed	15	No
Participant Characteristics						

interviewed. Youths displayed a range of offending behaviours, including non-violent behaviours (e.g. theft) and violent behaviours (e.g. assault), or engaged in both. Overall, there did not appear to be any significant differences between those young people who consented to participate in the study and those that did not.

Researcher's Perspective

It is good practice in qualitative research for the researcher to state their personal assumptions or theoretical orientation which might have an influence on the research carried out (Elliott, Fischer & Rennie, 1999). My theoretical orientation was influenced by my work in a child development team which used a developmental psychopathology approach and a systemic approach to understand child behaviour problems as they occurred within their context. Consequently, I felt that the developmental stage of adolescence provided an important context within which youth offending could be comprehended. Furthermore, rather than conceptualising youth offending as problem specifically as result of difficulties with the child; I understood it as resulting from difficulties within a wider network of people and systems, such as the family, school and community and complex interactions between these. It should also be highlighted that I was not part of the research team for the ongoing MST trial within which the current study took place.

Procedure

Families who had completed the MST programme were initially contacted by letter (see Appendix B1) explaining the purpose of the study; this also included parent and young person information sheets (see Appendix B2 and B3 respectively). This was followed by telephone contact with the parent in order to discuss the study further and to agree a mutually convenient date and time to meet. All interviews were carried out at the participant's home, lasted approximately an hour and a half

and were audiotaped. Parental written consent was obtained at the beginning of the face-to-face meeting (see Appendix B4). Parent and young person interviews occurred at separate times in order to enable the participants to freely speak about their experiences. Attempts to recruit young people were made only for those whose parents had agreed to participate in the study. This was achieved by either face-to-face or telephone contact with the young person or asking parents to speak to the young person about the study and leaving information sheets for them to read. Young person written consent was obtained at the beginning of the face-to-face meeting (see Appendix B5) and interviews lasted a maximum of an hour. For those parents and young people who participated a small reimbursement of £10 was given to each for their time.

Semi-structured Interviews

Semi-structured interviews were used to obtain rich and detailed accounts of how parents and young people experienced MST and their views of the processes that occurred within the therapy. Parallel forms of the same semi-structured interview schedule were used for both parents and young people. However, the content of the schedule evolved over the course of the study. Due to a lack of qualitative investigations in the MST literature as to how participants experience MST the interview schedule was initially based upon the component intervention techniques used within the treatment. For example, participants were asked about behavioural contracting, enforcement of limits, improved communication, interventions with peers and encouragement of wider support. The schedule was also structured to elicit participants' views of what life was like before, during and after the programme (see Appendix C1).

The schedule was used with the first three families and these interviews were subsequently transcribed. Reading the transcripts and reviewing the interview process it was felt that the schedule was too long and that there was a lack of sufficiently rich data as to how participants experienced the MST programme. The schedule appeared to generate detailed descriptions of the problems that families had and continued to have and the components of treatment that were used rather than providing accounts of the experience of MST.

Consequently, the schedule was modified with the aim of obtaining richer accounts from participants. The revised schedule excluded discussions regarding life before and after the programme and de-emphasised the treatment components; it expanded on how families experienced the MST programme and their perceptions of how their meetings with the therapist did or did not make a difference to them. The schedule covered helpful and unhelpful aspects of the therapy; helpful and unhelpful aspects of the therapeutic relationship; experiences of interventions used and changes as a result of MST (see Appendix C2). The construction of the schedule followed the principles of good practice (Smith, 2003). Thus it was designed to act as an aide memoir that covered broad topics of interest and used open ended questions to flexibly guide the discussion.

Qualitative Analysis

Verbatim transcripts of all interviews were made (see Appendix D1 for an excerpt of a parent transcript and Appendix D2 for an excerpt of a young person transcript). There was one exception to this due to a failure of the tape-recording equipment (interview with young person from family 3); in this instance notes of the discussion were immediately made at the end of the session. Transcripts were then thematically analysed using Interpretative Phenomenological Analysis (IPA; Smith,

2003). IPA aims to elicit and explore in detail individuals' perceptions and accounts of their experiences or personal worlds and is thus 'phenomenological'. It is also recognises, however, that the analytic process is dynamic and 'interpretative' involving the researcher's own understandings. IPA was chosen because it is a systematic approach whose procedures have been clearly described.

Parent and young person transcripts were analysed following a number of steps as outlined by Smith, Jarman and Osborn (1999). Whilst the parent and young person transcripts were analysed separately the same analytic procedures were used for both.

The first step involved a detailed reading and re-reading of each transcript in order to identify the ideas and meaning being expressed within the text. At this point tentative labels were generated to capture the essence of each idea (see Appendix E1). Secondly, similar ideas were clustered together into themes and a preliminary list of themes for each transcript was produced (see Appendix E2). The third stage involved integrating and making connections between themes, whereby commonalities and differences in themes across all of the transcripts were examined. Related themes were grouped together, leading to a refinement of theme labels resulting in a consolidated list of themes for the whole sample. For the parent analysis this resulted in two super-ordinate themes comprised of two lower order themes in each; and for the young people a list of three separate themes.

In line with guidelines for 'good practice' in qualitative research (Elliott, Fischer & Rennie, 1999; Smith, 2003; Yardley, 2000), 'credibility checks' were undertaken to ensure that the themes accurately represented the data. The same procedures were used for both parent and young person analysis. At an early stage the researcher and an experienced qualitative researcher independently coded three

young person transcripts. Following discussion a consensus on theme labels was reached before analysis proceeded further. The experienced qualitative researcher audited the researcher's analysis of the remaining parent transcripts. The extent to which the emerging themes and potential theme labels reflected the meaning conveyed within the data were considered by the experienced qualitative researcher and the researcher. Areas of disagreement were discussed and theme labels modified accordingly. In the final stages of analysis, different ways of clustering the themes were reviewed and alterations made until an agreement was made on the 'best fit' of the themes with the data.

Throughout the study the researcher also kept a reflective diary. This was used to document thoughts and notes about the research process including for example, participant recruitment, data analysis and the context within which the research was conducted.

Results

The results of the parent accounts are presented first, followed by the young person accounts. Each theme is presented in turn and is illustrated by excerpts from the interviews. Ellipses (...) indicate omitted material, edited for brevity. The source of parent quotations is indicated by parent (P) and the family identification number given in Table 2; young person quotes are identified by young person (YP) and the family identification number in Table 2.

Parent Accounts

Analysis of the parent accounts yielded 4 themes, clustered into two super-ordinate themes (see Table 2). The first domain regarded themes that were generic to all of the parents while the second was relevant for half of the parents.

Table 2

Themes from the parent interviews

Super-ordinate themes	Themes
A person-centred approach	1. A space to talk and be listened to
	2. A collaborative effort
Struggles of being a parent	3. Reflection on parenting
	4. Being “backed up”

A Person Centred Approach

Most parents, reported feeling that MST had helped them; only one (P1) described a negative experience of MST. Several common aspects of the therapy seemed to contribute to parents’ positive experiences. These features related to the therapist taking a person-centred approach involving listening and collaboration.

A space to talk and be listened to.

All parents strongly felt that it was important there was someone they could talk to about their difficulties. This was particularly valued as it was something that had not typically been available to them:

“I think it is more harder because you’re a one parent, it’s harder because you need someone to talk to.” (P2)

“... it made me feel comfortable just to get it out of, off my chest... [I was] comfortable to talk about things which we couldn’t say in the court.” (P9)

Parents described how those close to them often were not interested in hearing about their difficulties; consequently, they greatly appreciated having the therapist to talk to. It was important for parents however, that this space to talk was specifically

created by someone outside of the usual family situation. This seemed to give parents permission to talk about their problems and thus enabled them to feel comfortable and be more open in talking:

“I think it’s nice to have an outsider who is not completely involved with the family situation and then you can talk to them ...” (P2)

“Well I’ve got my mates, but you try to tell them and they just brush it to one side ... and they don’t really want to know, you try to tell them what’s going on. They’ve got enough problems with their own families, so, it was good to have someone here that you could talk to and know you’re not going to get your head bit off you, because you’ve said something to them.” (P5)

Having this dedicated space to talk also seemed to reduce parents’ sense of isolation and helped them to feel supported:

“You couldn’t really talk to anybody, so it was good to talk to somebody, to tell them what was going on since the last time she’d seen us.” (P5)

“[She] allowed me to open up. Speaking of it, speak of it rather than hold it in. You know by me holding it in there was a time where I will be getting, it was frustrating. Because I was thinking is there nothing out there, is there no system out there that can help working parents?” (P4)

“...and it was like a break in the intensity of being on your own as well...” (P8)

Moreover, parents also conveyed a sense in which it was not just having someone to talk to that was vital to feeling supported and less isolated, but, importantly, the experience of being actively heard and thus a sense of being valued:

“It was good to talk to her, you know, it was good. Took a lot of the stress out of me by just having somebody to talk to... Because, she’ll like listened to you ...” (P5)

“... I could actually breathe and I can actually, I felt a bit of relief, not relief, I don’t know if that’s the word, after all the stuff that’s been going on ... I knew I had a lot to say, I mean if somebody asked me something it would be like, so much, I needed to get it out kind of, so it was nice to have someone to listen...” (P7)

These factors appear to have facilitated parents feeling supported and thus developing close relationships with the therapist. This seemed to be an unexpected experience:

“... I think it was like, it’s a silly thing to say but like a sister, you know support, which she never had any, we’ve never had anywhere else. It was the support she gave you.” (P6)

“... she was really good, it was like having another part of the family, someone to talk to... if I had problems, she was there and I was there too. I wasn’t expected to be that close bound friendship, erm very close bondage.” (P2)

It should be highlighted, however, that Parent 1 did not feel that talking about her difficulties was positive. Rather, it seemed that this mother experienced the time with the therapist as intrusive, as it did not seem to meet with her expectations regarding the focus of therapy:

“In my eyes, I, as I used to say, I think you’re a bit nosey. You know, or you’re here to talk about [son] you know not ask other questions, personal questions or private questions. They was here mainly I thought to help son.” (P1)

Furthermore, this mother felt that she had not been listened to. In particular she felt that the therapist’s suggestion that she speak to the parents of her son’s friend, was impractical and dangerous, and that her refusal to do this was not heard or understood:

“... going up and speaking to [his] mum and dad, well I wasn’t going to do that, no I wasn’t. But [the therapist] didn’t seem to want to take that no. They couldn’t understand why we didn’t want to go and knock at these people’s door. And then they suggested [ex partner] go and knock’s at the door and [son] would then threaten us. It only made things worse... Well, I think they should listen really... you know as a mum, she was saying how did I know this, how did I know about son’s friends.” (P1)

A collaborative effort.

The experience of being able to talk and, importantly, of being heard appeared to be fundamental for parents then to develop a collaborative relationship with the therapist:

“She’ll like listened to you and then she’ll try and advise you. She’ll come up with some suggestions and say have you tried this, have you tried, try it that way.” (P5)

“It was good, it was exciting, I was, we were aiming for something you know. I knew we were going to get somewhere with him.” (P2)

Without this, it was difficult for parents to feel that they were jointly working towards a common goal. This was particularly the case for P1 who did not feel that she had been listened to. This seemed to contribute to the relationship not being experienced as a joint effort but rather as withholding and frustrating:

“...they’d already told us right from the beginning they are not there, you know, they are there to help but they will not, you know tell you what to do, you got to come up with the solutions yourself... ‘cause she used to sit there and say well what do you think and you had to do most of the talking.” (P1)

For P1, the therapist did not seem to provide anything over and above the information available in the parenting guidebook that was given to MST families by the programme:

“Well it all come out of a book really. So it was all cases like, and it’s just the same scenarios coming out from the book. So basically once I had the book I didn’t really need them coming round here.” (P1)

For most parents the way in which the therapist presented ideas about managing the child’s behaviour was important. Tentatively posed suggestions which allowed parents to decide whether to implement a strategy seemed to help parents to feel in control and that their opinion was valued. This further served to contribute to a sense

of parent and therapist equally working together:

“Pointers, they had a lot of pointers that erm the pointers were the direction of which way I can either go that way or this way.” (P4)

“... it’s the way she talked to me, the way, she spoke to me, it made me feel good. I was comfortable talking to her... She’d let you talk first and then she’d come up with a suggestion, you know. And she wouldn’t try and force anything down you, you know, she’d come in and say look you’ve tried doing it this way, try doing it that way, and that was that.” (P5)

“... it was kind of to see light at the end of the tunnel, ‘cos everything was just blocked up as far as I could see, I couldn’t see out, no way out, so if they can help me with solutions, or not, not for them to solve my problem but to help me solve them, then I’d of been happy.” (P7)

Also key to this process of joint working was the therapist’s manner when talking to parents. Parents preferred someone who was approachable, not professionally distant and who did not take a position of expertise:

“Well she wasn’t pushy with you ... she wasn’t toffee nosed, you know she never walked with her nose up. If she’d have did that I’d’ve said I’m not interested, but she was just down to earth...” (P5)

For some families the therapist’s willingness to offer practical help such as driving them to venues and attending meetings also contributed to feeling that the therapist understood their difficulties and wanted to help. Thus, practical help appeared to clearly demonstrate that they were working together:

“... she’d go to all these meetings with us, she’d put questions over which I wasn’t very good at, she knew what to ask... I need someone like that around, she knew what questions to ask em, you she’d listen to the and she’d explain it to me. She’d do it for me, its being like my voice and she’d put it over” (P6)

“[the therapist] was really helpful about coming to meting with the new school as well... chasing people up for me if I couldn’t get a hold of them.” (P3)

Struggles of Being a Parent

The themes in this category relate to the challenges faced in being a parent of a child with significant behaviour problems. As a result of the therapeutic experience and contact, parents' thinking about the parenting process appeared to be facilitated. The use of a person-centred approach in particular seemed to be fundamental in enabling this reflection to occur.

Reflecting on parenting.

All parents commented on the challenges and difficulties posed in raising a teenager. In particular, most felt that they were not prepared for this experience and that the process of parenting them was unknown and mysterious:

"No-one told me this two years back and said you know when they reach teenage you've got a new entity to experience, it's a different ball game."
(P4)

"I don't know this person that lives here now... they are aliens at this age." (P6)

Parents described that having a space to talk in therapy had allowed them to consider their own parenting style. For all parents there was a sense in which this space to think about their own parenting practice was a new experience and that it contributed to them being able to now see different ways of relating to their child:

"I believe that I was set in my own ways by the way that I was brought up by my own parents... so it enabled me to open up my thinking to think what would I have liked as a child of his age, what would I have liked my parents to have done for me, be supportive and understand. It made me open up." (P4)

"I think I'd given up a bit, just thinking I could have any control over him... but it's kind of like open my eyes up to the fact that I've still got to do what I can from son and try and get him to realise that there's lots of things he can do." (P3)

There was also a sense in which the therapeutic experience had helped parents to create changes in their parenting:

“I suppose before it used to be said you’re just a kid, you do it because I say you do it... I think that it’s very difficult with big boys, because physically you can’t make them do anything, so it’s much better that you negotiate them into a position where they’ve got to be doing it.” (P3)

“I used to do things and he probably wouldn’t take me seriously or I never used to put it through, carry it through... now I have to stop and think, regardless if you’re being nice and you’ve calmed down or whatever, you’ve done a little bit of a wrong and now you’re going to have to wait basically.” (P7)

While these changes had occurred for some parents, there was also a sense in which parenting continued to be difficult and posed dilemmas as to what was best for them and their children:

“I have to be hard and stick to no and no and no and don’t relent and it’s difficult... but I suppose I am a soft touch.” (P4)

“I was too soft giving into him all the time... he still runs rings round me you know. I am still weaker than him, I just want peace.” (P5)

“I haven’t got the energy for it, I haven’t got the energy for arguing, it’s so much easier now to, just to let her do it, because I’m making myself ill.” (P6)

Being “backed up.”

In addition to reflecting on their own parenting style, parents described how the therapeutic experience helped them to feel supported and reassured in their parenting practice. This was important for all families as at the beginning of the therapy there was a sense in which parents were exhausted and seemed unsure of their ability to carry things through:

“I was quite weak, I think I was quite weak. I’d collapsed kind of lapsed or whatever, where I think enough was enough, I really couldn’t have gone on anymore. I was just tearful and I couldn’t do anything, I didn’t have no pick me up or no get up and go and I was just drained all the time. So just to have someone come in the house...” (P7)

Parents felt that having someone specifically to help them and encourage them with their parenting was important. Various features contributed to this process of feeling backed up by the therapist and different aspects appeared to be valued by different parents. For some it was the experience of having the difficulties of raising a teenager normalised:

“... and having someone to say to talk to and her saying oh it’s normal to feel like this, you know it was really good, really good.” (P2)

Most parents appeared to benefit from having someone who could clearly and regularly monitor and inform them as to how they were progressing:

“I think it did help because I just didn’t seem to be able to sustain any of it before...I just didn’t think I could implement it... I think [her] encouragement and support was making it, and she’d tell me off if I’d let him get away with anything...” (P3)

This helped parents to feel reassured about their parenting skills:

“...although I sort of knew what I was doing, it was nice to have someone there who was, who was available... it would be nice to have reassurance to know that yeah you’re on the right track...” (P8)

For others, having someone to give feedback and provided suggestions to strengthen parents’ skills; rather than telling them what to do differently enabled them to remember strategies and skills they already possessed:

“... it was things I thought of before but you just put to the back of your mind or you just forget to do it, simple little things like the listening skills, I do that now and I remember...” (P7)

This sense of reassurance and back up seemed to enable parents to persist with and implement different parenting techniques. This in turn led to an increase in confidence regarding their parenting skills:

“So to actually have that little bit of back up, I was able to enforce it.” (P7)

“I suppose it boosted my confidence really... in myself and my ability to do things...” (P3)

Young Person Accounts

The thematic analysis of the young person interviews yielded 3 themes (see Table 3). No quotes are available from YP2 as there was no transcript of this interview due to machine failure.

Table 3

Themes from the young person interviews

Themes
1. Not being listened to
2. Betrayal
3. Playing the game of therapy

Overall, young person accounts were characterised by a sense of confusion as to what MST was:

“I can’t even remember, I don’t even know. Yeah they explained, hold on. Yeah I don’t even know, I think there was something about, about my behaviour.” (YP5)

All three young people also indicated that from their perspective MST had not brought about any benefits. A sense of disappointment and of being let down was pervasive in their accounts:

“It was a waste of time... it was just a whole load of bother for nothing. There was all this arguing going on and really, if she never came anyway it would probably just be the same” (YP1)

“... I don’t know it was just kind of crap.” (YP5)

Not Being Listened To

All three young people described feeling that their views and opinions were marginalised and moreover that efforts were not made to fully include them in the therapy. Decisions were experienced as being unilaterally made, particularly regarding behavioural contracts:

“... it would just be, every meeting it would be the same thing, what has he done this time and just what do you want him to do, because anything they wanted me to do they would write it down in a contract. And if I didn’t do it, they would say we want to make it equal, equal things, want to make like for all of you and what, really whatever I say didn’t really matter.” (YP1)

There was also a sense that the young people felt ganged up on and felt that they were being dictated to:

“Basically, they were just, they weren’t even a contract they were just telling me what to do.” (YP1).

“...they’d still come and try and tell me what to do...” (YP5)

This seemed to result in feelings of indignation and unfairness:

“... but then what I had to do to get credit, making contracts and it kept causing all these arguments in my family ‘cause I didn’t agree to it, ‘cause it weren’t fair.” (YP1)

Furthermore, the young people described that they were made to feel as though they were at fault or somehow responsible for the way things were:

“It’s like they would blame me, they would blame my friends for me getting into trouble, when it ain’t got nothing to do with them at all.” (YP1)

“... she’d tell me that I’m wrong all the time like, not, I’m wrong here but, I’d have to be wrong like, all the time like...” (YP5)

Betrayal

Two participants (YP1 and YP5) clearly conveyed feelings of broken trust both in the therapist and the therapy:

“She was alright but behind my back, she would say stuff about me.”
(YP1)

“She didn’t really do much for me like I said, ‘cos everyone that comes here, they say ah we’re here for you, we’re here for you and then, a couple of months later, not a couple of months but a couple of weeks they just start talking to my dad and then everything what my dad says they just believe him sort of thing, so you ain’t helping me.” (YP5)

Furthermore, YP5 felt that the therapist had been too intrusive; going beyond what was acceptable; he thus questioned the degree to which what she said could be trusted:

“Just she was trying to tell me, she was trying to tell my dad like don’t give him any money, don’t do this don’t do that, and I was thinking to myself who are you? How are you going to tell my dad not to give me money?” (YP5)

For young person 5 there was also a strong sense that false promises were made within the therapy that led to a further breaking of trust and ultimately a sense of betrayal. This was in particular reference to the use of behavioural rewards for ‘good’ behaviour. Rewards were based upon the individual interests of the young person; these were used as incentives for good behaviour and were to be delivered at the end of an agreed time period. However, according to young person 5, the rewards never materialised:

“They just never, they never came back and they said as we’ve got some scrambling, like motor bikes and that... But then never got to go there either... so like they were telling me these places and they weren’t even like hooking them up and I thought, forget it.” (YP5)

Playing the Game of Therapy

All three young people felt that they were not really involved in the therapy and thus seemed indifferent about it:

“...I saw it as something I used to be involved in, but I saw it as something I didn’t really have to take part in. Whatever they said they said they could say because it didn’t really bother me.” (YP1)

“I don’t really care boy, as long as I weren’t there. It just didn’t bother me.” (YP5)

As a result of this lack of involvement, two of the participants (YP1 and YP2) described pretending to be involved in the therapy in order to get through the programme or to have an easy life while MST was taking place. Different strategies were used in this pretence, for example “yeah saying” or telling the therapist and sometimes parents what they wanted to hear:

“...so I thought, well, just sign the contract just to please them and then just do whatever I want...” (YP5)

Ultimately, however, the young people also boycotted sessions:

“In the end I just stopped coming to them.” (YP1)

“Yeah, so I just stopped really... sometimes I would so it on purpose, sometimes I’d forget.” (YP5)

Discussion

This study is based on the semi-structured interviews of nine parents and three young people who had completed the MST programme. Qualitative analysis of the parent accounts yielded two super-ordinate themes relating to the value of a person-centred approach and the struggles of being a parent. The analysis of the young person accounts yielded three themes, reflecting a sense of disaffection with therapy and playing along with the intervention. The findings point to some salient

issues and challenges faced by parents and youths in this population group, and raise interesting questions for the psychological treatment of youth offending.

Parents' accounts of their experience of MST clearly indicated the importance and value of the therapeutic relationship. The factors that were considered to contribute to the development of a good therapeutic relationship included being listened to and understood, and a sense of joint working with the therapist. Some of these factors, such as being listened to and understood are consistent with a person-centred approach first described by Rogers (Kirschenbaum & Henderson, 1990; Rogers, 1957): genuineness, unconditional positive regard and empathic understanding.

Furthermore, the accounts highlight the factors that are now considered to be important across all therapeutic approaches (Horvath & Luborsky, 1993; Hubble, Duncan & Miller, 1999). Parents clearly described the importance of the therapist understanding their feelings and difficulties, which in turn enabled them to feel accepted and not judged. In addition, parents appreciated that the therapist was genuine, approachable, down-to-earth and did not put up a professional front or façade. Moreover, the use of an explicit collaborative stance was also felt to be an important contributing factor to developing a good relationship as it appeared to enable parents to feel that they had equal choice and control in the parenting process whilst also being supported in this.

Importantly, the processes of being listened to, understood and of collaborative working not only provided the basis for the development of the therapeutic relationship, but also for the creation of an environment within which parents could reflect on their parenting practices and the challenges they faced in parenting juvenile offenders. These processes also seemed to contribute to parents

feeling supported and reassured in implementing changes within their parenting. It is possible, therefore, that participants' perceptions of the therapeutic relationship may also affect change processes and subsequent evaluation of the overall treatment outcome.

It should be noted, however, that MST was not positively experienced by all parents. One parent felt she had not been listened to, understood and ultimately supported in the therapy. This appeared to create difficulties in the development of the therapeutic relationship possibly subsequently affecting her perception of overall treatment outcome. This parent, for example, appeared to attribute lack of behavioural change in her child to an overall negative experience of MST; however other parents were able to view MST as a positive experience, especially the therapeutic relationship, despite the lack of apparent significant behavioural change in the child.

The parents who participated in this study were essentially from a high risk population: they were mostly single parents from low socio-economic backgrounds, were unemployed and were somewhat depleted of energy and resources at the start of therapy. It is interesting to note that for these parents from complex contextual situations and who display multiple risk factors for offspring offending, that the significance of the therapeutic relationship was clearly described and highly valued. It is possible that the usual experiences of these parents, such as lack of opportunities to experience positive and supporting relationships and possible subsequent difficulties in trusting others, may actually underline the need for being listened to, understood and supported in therapeutic relationships. Furthermore, the development of the therapeutic relationship via these processes may also be an essential and primary element to the therapeutic process in order to enable

subsequent change to occur. This is perhaps not surprising given what is already known about the importance of the therapeutic relationship.

For the young person accounts, themes of not being listened to and accepted, and a lack of trust in the therapist and therapy were prominent. These difficulties appeared to affect the development of a supportive relationship between the therapist and the young person. This may have subsequently impacted on the degree to which young people were willing to actively take part in the programme. It is possible then that difficulties in establishing a therapeutic relationship may have ultimately affected young people's perceptions of overall treatment outcome.

It is interesting to note that for the young people the factors associated with difficulties in the therapeutic relationship are the converse of those identified by parents as contributing to the development of a good therapeutic relationship. These include having someone to specifically talk to about difficulties and importantly of being heard, understood and accepted by the therapist. These findings replicate those of the Strickland-Clark, Campbell & Dallos (2000) study which used retrospective accounts to investigate the processes within family therapy for children and adolescents. This study highlighted for youths the importance of being heard, included and accepted in family discussions.

Therefore, from the perspectives of service users, these elements seem essential to the overall treatment process and without these it is possible that few treatment gains can be made. Indeed, in the absence of satisfaction with the service or good therapeutic experiences positive clinical outcomes can be difficult to achieve (Lyons, Howard, O'Mahoney & Lish, 1997). Ultimately then, parents' and youths' experiences of MST may be inextricably linked with their perceptions of the therapeutic relationship.

It is important to consider why the young person accounts of MST may have been so negative. The reasons may be multifaceted and complex, although possibly associated with the fact that the MST programme aims to encourage authoritative parenting. Given the developmental stage of these youth, namely adolescence, the young person in forming their own identity may naturally come into conflict with authority. It is perhaps not surprising, therefore, to find that a therapy which encourages parents to set boundaries and limits may not be welcomed and positively viewed by young people.

The young people may have also had difficulties in understanding why their parents' style of parenting had changed and were possibly confused by this. They may have attributed these changes to the therapists' involvement thus leading to negative views of the therapist. They may, for example, have perceived the therapist as not listening to them and thus not understanding their point of view and of trying to tell them what to do. Furthermore, given the typical developmental history of behaviour problems in this population of youths, it is highly likely that learning to obey limits is very difficult. This could, therefore, also result in blaming of the person perceived to be the cause of these new rules.

Although the negative accounts of the young people must be treated cautiously, the findings illuminate some of the processes which may contribute to lack of youth engagement and underline the need to fully include youth as well as parents in systemic based therapies for youth delinquency. Without this involvement, youths seem unlikely to develop a relationship with the therapist which may impede their fully engaging with the treatment. Thus, lack of youth involvement possibly precludes the opportunity for young people to think about their behaviour, thus making any subsequent behaviour changes that much more difficult

to achieve. Furthermore, given the typical developmental stage of these youth, namely adolescence, interventions which aim to include them and their views may be more appropriate.

However, the findings from this study raise difficult questions as to how youth inclusion can be successfully achieved. It seems that within psychological treatments for youth offending there is a delicate balance which needs to be carefully negotiated and monitored throughout the treatment process. Not only must authoritative parenting be maintained, but youth must also be engaged in the therapeutic process. Young people must be able to perceive that their perspective and wishes are being considered before any possible changes in behaviour can be achieved.

This is a complex task and one that warrants further investigation in order to gain a better understanding of the processes involved. Furthermore, it illuminates the multifaceted challenges that psychological treatments of youth offending face. Not only is the nature of Conduct Disorder and youth offending itself complex, there is involvement of multiple risk factors which exist across several life domains and have complex interactions, but there are also challenges as to how to work with antisocial youth.

The findings of this study must, however, be considered in the light of a number of methodological issues. Firstly, as is typical of most qualitative studies, the number of participants in this study was small. This inevitably raises questions as to the degree to which these youth and parents are representative of the wider sample of families who participated in the MST trial and the generalisability of the findings.

Overall the parents in this study were felt to be typical of the sample of the larger group of parents who participated in the MST clinical trial. While it appears that there were no significant differences between the young people who consented to participate in this study and those who did not, it is possible that there may have been a bias within the sample of young people interviewed. The three young people were from families with relatively complex contextual situations, such as physical health problems and severe aggressive behaviours displayed towards the parents. These additional factors may have posed further complications within which the therapy had to be conducted and implemented, potentially affecting the experience of these young people. Furthermore, these young people also had difficulties in talking about their feelings and ideas regarding the MST programme. A strength of this study, however, is the high ethnic variability within the sample of participants, indicating that processes within the therapeutic relationship are perhaps universally important.

A second methodological issue concerns the quality and validity of the participants' accounts. Both parents and the youth participants seemed to speak openly and honestly in the interviews; this was possibly facilitated by the interviewer not being connected in any way with the treatment programme. Nevertheless this may still leave the question as to how 'accurate' participants' descriptions of MST were. However, phenomenological approaches aim to gain an understanding of respondents' perceptions and feelings rather than obtaining an 'objective' description of participants' experiences.

A further issue to be considered is the extent to which the research processes used in this study were able to access and analyse parents' and young people's accounts of their experiences of MST. Although parents' accounts were detailed and

lengthy, they tended to focus more on descriptions of their difficulties rather than on the process of therapy. While there were improvements with the use of the revised interview schedule, there continued to be some difficulties in engaging them to reflect on this. The young people also struggled to reflect on the therapeutic process and seemed to find it easier to say what they did or did not like about the MST programme. It is possible that the lack of rich themes may be associated with some of the known characteristics of this population group such as poor communication skills and a tendency to not reflect on experiences.

In light of this it would be helpful to consider ways in which 'richer' psychological data can be obtained from this population group. This may include for example, the use of a second interview, which may provide participants further opportunities to expand on their descriptions of experiencing MST. Alternatively, it could be helpful if participants were able to be interviewed immediately following a session. This may enable the researcher to base the semi-structured interviews on some concrete ideas and examples, thus potentially providing the 'scaffolding' for participants' descriptions of their experiences of MST. This could potentially also be achieved if the researcher was able to observe some of the sessions for each family.

The findings of this study point to a number of other areas for future research. Firstly, there is a need to further clarify other potential processes which may be important in the development of a good therapeutic relationship and in service users' experiences of MST. There is also an indication from this study of an association between parents' and young peoples' experiences of MST and perceptions of overall treatment outcome such as youth offending behaviour. Further research is needed in order to explicitly examine this link. This research could also be expanded by

investigating whether the MST treatment principles facilitate the operationalisation of the more generic psychological processes seen in this study.

The use of a qualitative approach did not allow for an examination of the association between such variables as family situation, severity of offending behaviour and therapist characteristics/experience which can impact on the experience of MST and overall treatment effects. This is an important area for research as it may illuminate why thus far this relatively sophisticated treatment reduces, but does not eliminate, youth offending.

Finally, qualitative approaches generally can be used to investigate the experience of service users with other systematic approaches for youth offending as well as providing a complementary means of exploring treatment outcome and evaluation. Moreover, qualitative approaches can also meet with the current need in the National Health Service, as seen in the National Service Framework for Children (Department of Health, 2005), to include the views of service users in treatment planning and delivery. Although the negative accounts of the young people must be treated cautiously, the findings illuminate some of the processes which may contribute to lack of youth engagement and underline the need to involve young people in systemic based therapies for youth delinquency.

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Part 3

Critical Appraisal

The challenges of conducting qualitative research with families and youths

Introduction

This paper aims to provide a further critical discussion of the research that I carried out to investigate how parents and families experienced Multisystemic Therapy (MST) for persistent and severe juvenile offenders. It focuses on a personal reflection on the research process and thus includes an examination of the challenges I experienced. Issues regarding difficulties in interviewing families from this population, using a qualitative approach and the context within which research was conducted are discussed.

The Population Group

I experienced a range of challenges related to the process of recruiting families from this population group. The sample of participants that were included in this study seemed to be at relatively high risk for youth offending as they displayed many of the empirically known risk factors and were from complex social situations. The characteristics of this population group also appeared to impact on the degree to which I was able to engage families in participating in the study, as well as in the process of conducting the interviews.

Recruitment

To some extent the recruitment strategy used in the study evolved over time. Initially, I was reliant upon each family's therapist to introduce the idea of the project with the family. I had to wait for the therapist to approach the family and then inform me as to whether I could speak to the family over the telephone to explain the project further and answer any questions. During this process I sensed that there was some reluctance on the part of the therapists to invite all of the families to describe

their experiences. This may have been a reflection of their anxiety for those cases where treatment had perhaps not been as successful as anticipated. Accordingly, I was concerned that the families who would be recruited to the study would have inadvertently been pre-selected as those where treatment went well. This strategy also slowed the entire recruitment process which was a worry given the time constraints within which this piece of research had to be conducted.

Consequently, the recruitment strategy was changed in that I was given access to families' details when they had completed the programme so that I might independently contact them. While this process led to quicker recruitment and enabled all families to potentially participate, it also came with some difficulties. Specifically, by sending the recruitment letter to the parents and then contacting them by telephone it was harder to then recruit the young people. Indeed, in this study parents essentially acted as gatekeepers for accessing young people. I suspect that this further contributed to the low numbers of young people agreeing to take part.

I wonder whether this process in part came about as a result of the model of MST as applied in the larger research trial, where the parent tended to be the main focus of the treatment. In future studies that aim to recruit young people, I would recommend that attempts be made to independently contact them. This would perhaps subsequently enable young people to feel equally involved, listened to and valued, and ultimately increase the number of those who take part. This whole process highlighted to me the importance of methodically planning the recruitment process prior to starting data collection and of liaising with those involved in the treatment process in order to allay any concerns they may have.

On reflection, I do not think that issues of recruitment are unique to this population group. It is possible that parents and particularly youths from these

families may not have had many positive experiences of trusting or therapeutic relationships. This may pose challenges for phenomenological researchers who are by the nature of their research methodology asking participants to discuss their feelings and asking them to reveal their thoughts about the experience.

A further issue relating to recruitment was the point in time at which parents or youths were interviewed. The inclusion criterion for this study was that participants had to have completed the MST programme within one year. This led to variability in the duration between families finishing the therapy and being interviewed. For families that had completed nearly one year ago, there were some difficulties in their ability to accurately remember the treatment in a detailed manner. Furthermore, there was concern that families who had completed the programme more recently may have had insufficient time to reflect on the therapeutic process. This posed a dilemma in recruiting a large enough sample of families who had enough time to think about the experience, but who could also provide adequately detailed descriptions.

Engaging Families and Conducting the Interviews

I experienced a range of challenges in trying to engage families from this population group. These issues were often apparent from the first point of contact (sending the information letter and follow up telephone call) where parents tended to be unsure of why I was calling, despite their having received the information letter. It also became noticeable during these conversations that because the MST programme had finished, there was a sense that parents felt there was little more they had to say about the treatment. This sometimes resulted in families initially seeming to be reluctant to talk about their experience or being bemused as to why I was ‘wasting my time’ in discussing a completed treatment. During the interview,

despite my having explained the purpose of the discussion, they sometimes also appeared uncertain as to what they should talk about. I understood their confusion and surprise about my interest in hearing what they had to say about MST as a reflection of parents' and families' unfamiliarity with being asked their opinion about mental health services and how they experienced these.

It is also possible, however, that difficulties in recruiting families for this type of research and enabling them to talk about their problems may reflect what is empirically known about this population group. In such families there are typically difficulties within family relationships and these tend to be characterised by a lack of clear communication (Patterson, Reid & Dishion, 1992). Therefore, I wonder whether talking about difficult feelings and being asked for their opinions is an unfamiliar experience. I believe that having a researcher independent of the MST programme is vital in enabling families to feel that they can trust the interviewer as it can allay any concerns they have about what they say affecting future contact with services.

In view of the above experience, the process of conducting the interview struck me as being similar to carrying out the first assessment session with a new client. Often the interview was preceded by a half hour discussion in which the participants and myself negotiated the terms of the 'contract' or piece of work we were to undertake. For example, in families with two parents there was some negotiation as to who would be interviewed and there were often discussions about the limits of confidentiality. This seemed to be an integral part of the interview process without which participants may not have been able to be as open as they were.

I also experienced conducting the interviews as a continual balancing act

between obtaining information relevant for the research whilst also allowing participants to talk about other issues in order for them to feel listened to and that what they said was valued. This is a difficult balance to achieve in phenomenological research where it is not always clear beforehand what the important factors are in participants' experiences.

The Challenges of Qualitative Research

Developing the Interview Schedule

I found creating a suitable interview schedule to be challenging. Reflecting upon how the schedule was devised, I initially based my questions on the theoretical model of MST. Accordingly, the focus of the schedule became an examination of the intervention components of MST and whether the changes that would be hypothesised from the theory occurred.

After using this interview schedule with three participants it became apparent that the accounts did not contain enough rich psychological data as to how participants had experienced MST. It appeared that the use of questions based on the nature of the MST programme did not provide participants with an opportunity to share their personal experience; rather they tended to describe the content and structure of the intervention. Consequently, it was agreed that the schedule should be adapted. As a result of this I chose to devise questions that were founded on a basis of exploration so that parents and youths could be facilitated to talk about how they experienced the treatment. Interestingly, while the MST programme continued to be the context of the schedule, the content of this was no longer the focus of the interview.

I observed that in subsequent interviews, using questions from a position of curiosity enabled me to not make assumptions regarding the meaning behind

participants' descriptions or words. Parents and youths were able to take the position as experts about their experiences and they educated me as to what they meant, which in turn led to richer interviews. Furthermore, it highlighted the benefits of having a clear question early in the research process in order to aid the construction of the semi-structured interview.

Despite the benefit of having a clear question early in the research process, I now also perceive that constructing a useful semi-structured interview schedule, particularly for qualitative research, is something that perhaps evolves over time. Schedules are developed not only on the basis of the research question but also on responses from initial interviews regarding the quality of the data in relation to the original research question. As a result of these transactions, I also believe that devising an interview schedule is a process and that this needs to be allowed for within the research methodology. A pilot stage could facilitate this process as well as ensuring the quality of the data set then used in the analysis.

A further point, related to the construction of an interview schedule, was the use of parallel forms of the schedule (which were tailored to the group of participants) to interview both parents and young people. In conducting the interviews I observed that all youths struggled to answer some of the questions. In particular, they found it difficult to respond to questions that asked them to reflect on their own and others' behaviour and to think about why things may not have helped.

This led me to wonder whether the use of parallel forms of the interview schedule was appropriate for adolescents. Moreover, it highlighted the difficult issue as to what type of questions would be more 'manageable' for youths whilst also yielding enough rich psychological data. I subsequently considered how the position we come from (as therapists, academics or those who know about psychological

theories) can lead us to make assumptions regarding what we expect the important issues to be. These can prevent us from examining the issues that are actually relevant or salient for participants. Thus, even in phenomenological research, which is aimed at obtaining descriptions of individuals' experiences, the questions we ask to discover these are not free of assumptions. This reflection helped me to see how the theoretical orientation and assumptions we have about the world can define and limit the information that is obtained. Consequently, the concept of 'epistemological reflexivity' (Willig, 2001), which is used in the qualitative methodology research literature, was clarified for me.

Qualitative Analysis

Interpretative phenomenological analysis (IPA; Smith, 2003) aims to capture and examine rich narratives of individuals' perceptions and accounts of their experiences or personal worlds. Accordingly it is concerned with the phenomenon under investigation and is thus 'phenomenological'. IPA also acknowledges that gaining direct access to participants' life worlds is impossible as the researcher's own biases and understanding of the world are inevitably involved. Moreover, the process of obtaining an insight into the participants' experiences is necessarily based on a course of interactions between the researcher and the participant. Thus, the analytic process is dynamic and 'interpretative' involving the researcher's own understandings.

Furthermore, IPA is based on the assumption that the transcripts of participants' accounts of their experiences reflect the connection between their language and cognitions or thinking. Accordingly it can be used to reflect the 'psychological processes' that are important and occur within therapy for service users.

Whilst I understood the above theoretical foundations of IPA, I found that conducting the data analysis was a difficult and at times confusing process. Despite having a sense of what participants thought about MST, I was unsure how this differed from psychological processes. Moreover, it was unclear to me what 'psychological processes' meant in practice and how these could be illuminated within participants' accounts of therapeutic experience. Consequently, during the initial data analysis stage I observed that I focused on identifying concrete factors that were associated with participants' positive experiences of therapy. For example, therapists going to the family home, 24 hour availability of the therapist and use of behavioural contracts. This was perhaps also as a result of the context within which this research was carried out, namely an on-going clinical trial (see section below).

As a result of this observation, a second phase of analysis was undertaken with the aim of focusing more on the psychological processes that could be seen in the text. During this stage I found that adopting a stance similar to that used in clinical practice to understand and interpret deeper psychological constructs or ideas, enabled me to more clearly interpret the data. However, some uncertainty remained as to what constituted a theme and how to potentially cluster these. On reflection it seemed that being 'immersed in the data' by continually reading and re-reading the transcripts was essential; it enabled me to compare and contrast the ideas within the transcripts and so to develop themes. Thus, I now perceive this stage in the analysis as a process that evolves over time.

As stated above, in IPA there is a degree of interpretation involved in the analysis of the data set and the subsequent themes that are generated. While this interpretation is a transparent aspect of the theory and is inevitable in the analysis, it unavoidably raises questions as to the validity of the themes and the analytic process.

In accordance with the guidelines for 'good practice' (Elliott, Fischer & Rennie, 1999; Smith, 2003) in qualitative research and in an attempt to ensure that the themes accurately reflected the data, 'credibility checks' were carried out. The researcher and an independent qualitative researcher independently coded three of the young person transcripts. However, in line with other 'verification methods' (Barker, Pistrang & Elliott, 2002) it would have been beneficial if all of the transcripts were independently coded. Additionally, multiple researchers could have been involved in this process. This may have helped to ensure the overall validity of the themes, a pertinent issue given the small sample size used.

Furthermore, it would have perhaps been useful to have discussed with participants a summary of themes identified in the interview in order to provide a form of 'testimonial validity' (Stiles, 1993): that is, to check if the interpretation of the data corresponded to what the participants felt they had described. It is possible that the first interview may have encouraged parents to reflect on their experience, and a second interview may have provided them with an opportunity to give more or new information.

The Importance of the Research Context

Research no matter what it investigates, is rarely carried out by one person with no involvement from others. For example, there may be a team of researchers or technicians; a reliance on participants or data analysts; a management team of supervisors and those who fund and monitor the study. Thus research, particularly that which involves evaluation of services, is always carried out within a variety of contexts. The varied needs, or motivations, of the different stakeholders involved in the research can pose challenges to the individual researcher (Barker et al., 2002).

Conducting Research within an Ongoing Clinical Trial

Upon reflection some of the difficulties I faced in conducting this research project were related to the context within which it occurred, namely an ongoing clinical trial. At the time of my data collection, the trial had their first few families finish the programme. Consequently, no outcome data had been analysed and the therapists and the project manager had no information as to how they and families had performed. This seemed to exert certain unspoken pressures or needs upon this study and the research process, which at times were hard to balance with my own research needs.

As discussed above, I struggled to construct an appropriate semi-structured interview schedule, which was initially based on the content of the MST programme. I wondered whether a schedule that effectively monitored the components of the intervention met with the team's need to gain some information about their performance, as this study had become the programme's first form of evaluation; or with a desire to learn what they could do differently to maximise their programme; or if it illuminated the team's anxiety at being evaluated. Overall, this process highlighted to me the need to be aware of and to juggle the different motivations/needs of those involved with the research and ultimately of the importance of keeping my particular research questions at the forefront of my mind.

Furthermore, this need to have information as to how the trial was performing also seemed to stem from the wider context within which the clinical trial was taking place. MST has been shown to be an efficacious treatment for reducing juvenile offending (Fonagy & Kurtz, 2002) and is considered a cost effective alternative to out-of-home placements such as incarceration (Henggeler, 1999). Consequently, it has become a popular treatment and many countries are now considering adopting

this approach. It has also been commented, however, that there is a lack of sufficient independent replication of these findings (Fonagy & Kurtz, 2002). This has created a climate within which independent trials of MST are much needed and the findings of these are of interest to several research bodies and service providers.

This external pressure appears to have contributed to the demand for the MST trial to produce results early on in the research process. For example, the team have frequently been asked to speak at conferences and to indicate how the trial is performing. Moreover, the pressure created a sense of anxiety about the findings, as there was much need for the results to be positive of MST. However, for reasons of good practice and possibly as a result of this anxiety, the trial did not wish to release findings prematurely. There seemed to be a concern that therapists' morale could be adversely affected if findings at this stage were released.

In order to meet the needs of external pressures whilst not jeopardising the ongoing trial, there was subsequent pressure exerted on the results of my study as a source of evaluation. These findings were perceived by the trial as being able to fulfil this need for results - they could provide information earlier than the completed results of the trial, but also hopefully give positive information and reassurance to the therapists about their performance. It was difficult not to become involved up in this anxiety about how the team was performing and to give lots of reassurance. I felt that in order to maintain impartiality and to be able to accurately reflect on less positive comments made by parents and youths, I had to position myself outside the trial team. This made the process of gaining access to families problematic and reflects the transactional impacts that wider systemic issues can potentially have on research.

The Impact of the Doctoral Training Course

This study was also carried out within another important and influential context. Specifically, it was conducted in order to meet with the demands of the Doctoral course in Clinical Psychology. This course lasts for three years during which time several significant and varied types of work must be simultaneously conducted. This includes writing case reports, being on a clinical placement three days a week and carrying out the major research project. Consequently, there is a limited time within which work must be carried out and an inevitable need therefore, to balance the competing demands of these different pieces of academic work.

Whilst these pressures were not new at this stage of the training, I found that they contributed to an overall sense of a lack of time within which the research was conducted. This impacted on the degree to which there was time for reflection and subsequent modification of research strategies. Furthermore, as several types of work were simultaneously conducted it was difficult to establish clear blocks of time in which to work on the study and to develop a sense of continuity and momentum, particularly during the writing up phase.

This experience has, overall, given me what I consider to be a realistic insight as to the wider contextual difficulties within which research is carried out. Additionally, it has highlighted the potential challenges and issues that can be faced in conducting research whilst also maintaining a clinical psychology role. Consequently, I am now able to have a clearer understanding of what is meant by the scientist-practitioner model (Barker et al., 2002).

Personal Reflection

Overall the process of carrying out his piece of research has impacted on my understanding of youth offending, Conduct Disorder and some of the main

psychological treatments for these. Previously, I had a somewhat intellectual and distant understanding of Conduct Disorder. Whilst I knew that multiple risk factors were associated with its development, I assumed that these were mainly located within the youth and their family. Talking to youths and families that are affected by this problem has, however, afforded me a personal insight as to the complex nature of this disorder. In particular I now have a better appreciation of the wider contextual issues that can affect these families (e.g. association with deviant peers, school difficulties, community crime and poverty) and in particular the multifaceted manner in which risk factors interact. Consequently, I now know the difficulties that clinicians, psychological treatments, schools and wider society face in addressing this problem. I also feel that there is much to learn not only about the disorder and how best to treat it, but how to have treatments that families can understand and make use of.

I have also observed that through the process of conducting qualitative research interviews I now use different questions within clinical therapy sessions. I tend to ask more open ended questions and questions of clarification. For example, I might ask how coming to therapy leads to an increase in confidence but, furthermore, I might ask clients to tell me what they mean by 'confidence'. Thus, I try to no longer assume what clients mean in their use of words and language as a whole. I have also found as a result of this that my hypotheses as to the nature and determinants of clients' problems are more easily testable, thus also enhancing my practice within the applied scientist model – integrating the principles of research and clinical practice (Barker et al., 2002).

Furthermore, the importance of conducting qualitative research in order to learn from service users' experiences of therapy has been emphasised. In addition

the value of carrying out routine service evaluation has been brought to my attention, whether this is achieved via the use of standard questionnaires or by asking service users about their experiences. As a result I now routinely include evaluation sessions and tools within my clinical practice. I have observed that not only does this information help patients and myself to monitor progress, but it also directly impacts on my clinical practice.

Conclusion

Conducting this study raised several issues and challenges. Having an opportunity to reflect on these not only helped me to gain some understanding of them but also impacted on the overall research process. Consequently, I believe that conducting research involves a cyclical process of interactions between the researcher, research methodology and the participants. Furthermore, I believe that the issues and challenges that are raised by this study potentially provide important areas for future researchers to be aware of.

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APPENDICES

APPENDIX A

Ethical Approval

27 April 2004

Geoffrey Baruch Ph.D
Brandon Centre for Counselling and Therapy for Young People
The Brandon Centre
26 Prince of Wales Road
London NW5 3LG



Bill Kerslake: Direct Line:

Dear Geoffrey

Multi-Systemic Therapy for Chronic Juvenile Offenders: A Qualitative Study of Users' Perspectives

Thank you for your letter dated 23 March 2004 regarding interviews with 10-12 families as part of the evaluation of your MST programme with young people in the Youth Justice System.

As the Youth Justice Board's representative on the Project Steering Board, I am pleased to confirm our ongoing support for both the MST programme and the comprehensive evaluation programme you have put in place. Work with families and parents is an important part of the YJB's strategy to reduce re-offending by young people. We support your work with parents and young people to gain their views on their experiences of being part of the MST programme, having established their informed consent as outlined in your letter.

Yours sincerely

Bill Kerslake
Head of Policy: Health and Substance Misuse



2-6 Middle Lane, London N8 8PL
Enquiries: ;

Duty:

Direct Line:

www.haringey.gov.uk

To: Mr Geoffrey Baruch: Director
The Brandon Centre
26 Prince of Wales Road
Kentish Town
London NW5 3LG

27th April 2004

Dear Geoffrey

Re: Multi-Systemic therapy for chronic juvenile offenders: a qualitative study of users' perspectives

Thank you for your letter dated 23rd March 2004. I am replying to give authorisation and written approval on behalf of Haringey Youth Offending Service for the above research work to take place. I understand this will involve interviews of 10 to 12 families, and that you will ensure written consent is obtained from these families prior to interviews.

From your letter, I understand that this part of the study will be carried out by a 2nd year Trainee Clinical Psychologist from University College London and supervised by yourself, Stephen Butler and Nancy Pistrang. I confirm that this meets with our approval.

We very much look forward to hearing of the results from this part of the evaluation regarding the effectiveness of the MST project. We are very excited to be part of this project and believe it offers a very real alternative to addressing young people's frequent offending behaviour.

Yours sincerely

Jean Croot
Haringey Social Services Assistant Director: Youth Offending Service

If you require this document in Braille, large print or on audio tape, please contact the signatory.



APPENDIX B

Information and Consent Forms

Appendix B1

Recruitment Letter

Ms Stephanie Lawrie
Sub-department of Clinical Health
Psychology
University College London
Gower Street
London
WC1E 6BT
TEL: 020 7679 2000
E-mail: steph.lawrie@ucl.ac.uk

Date

Family
Address

Dear (Parent or parents name),

My name is Stephanie Lawrie and I am a Trainee Clinical Psychologist studying at University College London. Together with the Brandon Centre, I am working on a study that is interested in finding out about people's experiences of having received Multisystemic Therapy (MST). We would like to learn whether you found MST useful for yourself and your son/daughter.

I understand that you have been involved with _____ and I would like to talk to you about how you found the experience. Taking part in the study is completely voluntary and if you do or do not decide to meet with me this will not affect any future help that you may receive from the youth offending service.

I would like to contact you by phone over the next few weeks to ask whether you would agree and to answer any questions you may have. I enclose for your information some more details about the project.

Yours sincerely,

Ms Stephanie Lawrie
Trainee Clinical Psychologist

Dr. Stephen Butler
Senior Lecturer, UCL

Appendix B2

Information for Parent

University College London and the Brandon Centre

Multisystemic Therapy for Chronic Juvenile Offenders: A Qualitative Study of Service Users' Perspectives

Introduction

My name is Stephanie Lawrie 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, 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 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.

Stephanie Lawrie, 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 7678 2424
E-mail: steph.lawrie@ucl.ac.uk

Project supervisors:

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

Dr Nancy Pistrang
Sub-Department of
Clinical Health Psychology
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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 B3

Information for Young Person

University College London and the Brandon Centre

Multisystemic Therapy for Chronic Juvenile Offenders: A Qualitative Study of Service Users' Perspectives

Introduction

My name is Stephanie Lawrie 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, 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 £10.

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

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Manager and Director of the Brandon Centre:

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26 Prince of Wales Road
London NW5 3LG

Appendix B4

Consent Form – Parent

CONSENT FORM – PARENTS/GUARDIAN

TITLE OF STUDY: MULTISYSTEMIC THERAPY FOR SERIOUS JUVENILE OFFENDERS; A QUALITATIVE STUDY OF SERVICE USERS' PERSPECTIVES

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 B5

Consent Form Young Person

CONSENT FORM – YOUNG PERSON

**TITLE OF STUDY: MULTISYSTEMIC THERAPY FOR SERIOUS
JUVENILE OFFENDERS; A QUALITATIVE STUDY OF SERVICE USERS'
PERSPECTIVES**

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

Original Interview Schedule

Getting to know you:

- I would really like to hear about your experiences of working with the MST programme.
- How did you end up becoming involved with MST?
- Whose idea was it?
- How did it all get started?
- What did you think about MST when you first started?
- What made you think that MST might be helpful? Or what made you try this programme?
- What did you hope would change within your family as a result of MST?
- How much contact have you had with ____, weekly, fortnightly etc?
- How long have you been working with ____?
- How often did you see them?

Life before:

Family

- Before you started MST, can you tell me what things were like?
- How did you get on with your child before MST?
- Before the work with ____ what kind of things bothered you about life at home?
- What kind of things made you feel really fed up?
- How did you get on with your child before?
- What was it like when things were not going well at home?
- Did ____ get into trouble?
- Can you give me an example of that?
- How were you feeling at the time? Or when things were tough at home, what was it like to be a parent?
- What did you think was wrong at home? Or what did you think were some of the reasons why there were problems at home?
- Did you have an idea of what might help?

Friends

- Who did they spend their time with?
- What kind of things did ____ do with his/her friends?
- What did you think of his/her friends?
- What was that like?
- Did you have an idea of what you would have preferred your child to be spending their free time?

School

- Can you tell me what school was life for ____?
- Did ____ like school?
- What kind of friends did he/she have?
- What kinds of things happened at school?
- Can you give me an example?
- What was that like? Was that OK or did it bother you?

- How did you make sense of it all?

Support

- If problems came up with ____, were there people you could turn to?
- Can you tell me a bit about them and how they were helpful?
- Can you give me an example of a time when someone did help you out?
- What was it like having someone to talk to about things?
- Do you think that having someone outside of the home to talk with made things any easier for you at home?

Life during the programme:

- What was it like working with ____?
- What was it like having someone come to your home for meetings?
- What was it like to have someone to talk to and to work on problems?
- Some people have said that they felt listened to and understood by counsellors or therapists. Sometimes they don't. How was it with ____? Or how did you get on with
- Can you give me an example?
- Compared to when you first met ____, how do you think about them now?
- How did you decide what to work on?
- Had you talked about these things before?
- Who was to be involved in these tasks?
- What was it like having these conversations?
- Do you feel that your views were important? In what way? Or What about the meetings gave you the idea that your views were important?
- What was it like talking about difficult thing together as a family?
- I imagine that there were times when things seemed quite tough. Were there times when you felt like giving up?
- What do you feel you learnt from working with ____?
- Where there any ideas that you have found to be helpful?
- Can you give me an example of when you used one of the ideas?
- Did you expect that the meetings would help?
- Did the meetings change the way you felt towards your child?
- Did the meetings change the way you felt about yourself in any way?
- Looking back on it now, how come you thought it would be worth it to give this a go?
- I am wondering what made you try this programme.

Life now:

- How are things going at home now?
- For example, are there ways that you talk differently with your child now? Or if you talk more now?
- I wonder if you feel that you get on better now?
- What is this like?

- Most families have arguments no matter how well they get on. Can you tell me a bit about these times in you family now?
 - Can you give me a recent example?
 - How might this be different from before?
 - What is this like?
 - Has MST had an influence on how you get along? Or has MST had an influence on how you behave during arguments?
 - Do you think that MST has had any influence on ____ behaviour?
 - Has MST had an influence on situations around rules and at home? For example, knowing where ____ is or putting limits on what ____ is allowed to do.
 - Is this different to how things were done before?
 - How does this affect how you now think about your child?
 - In what other ways do you think that your child is different since MST?
-
- I am curious to find out if you now have more people to support you?
 - How are things at school?
 - Have you noticed a change in who your child spends time with?
 - Is getting in trouble still a problem for ____? Or to what degree might this still be a problem for ____?
 - If there were to be a problem at home, how do you feel about dealing with it now?
 - Do you feel any differently about his/her risk for re-offending?
-
- Are there any ways that you feel you are different, or behaving differently since MST?
 - Has MST changed your view of yourself as a parent? Can you tell me about that?
 - Are there ways you feel differently about the future?

Thank you very much for taking part in this interview. What has it been like for you?

Do you have any questions you would like to ask?

Appendix C2

Revised Interview Schedule

Getting to know you:

- I would really like to hear about your experiences of working with the MST Programme. How did you end up becoming involved with MST?
- What made you think that MST might be helpful?
- What did you hope would change within your family as a result of MST?

What was it like working with [therapist]?

- What was it like having someone to talk to and work on problems?
- Some people have said that they felt listened to and understood by counsellors or therapists. Sometimes they don't. How was it with [therapist]?

Working on problems:

- How did you decide what to work on?
- What was it like having these conversations?
- Do you feel that your views were important? or What about the meeting gave you the idea that your views were important?
- What do you feel that you learnt from working with [therapist]?
- Did you expect that the meetings would help?

Life now:

- Are you still using any of the ideas now?
- 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 is different since MST?
- Are there any ways that you feel you are different or behaving differently since MST?
- Has MST changed your view of yourself as a parent? Can you tell me about that?
- 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
- How do you know it affected you, e.g. confidence?
- I think I know what you mean when you say e.g. confidence, but sometimes people mean very different things. Can you tell me what it means for you?
- Are you still using any of the ideas now?
- What do you think it might have been like for your e.g. son

APPENDIX D

Interview Transcript Excerpts