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**Title:**

A grounded theory of multisystemic therapist roles in achieving positive outcomes for young people and families

**Abstract 150 of 150 words**

Research on the application of Multisystemic Therapy (MST) has focused on the experiences of caregivers, families and the young people with behavioural conduct difficulties for whom MST has been established as an effective intervention. Perspectives of MST therapists are lacking, yet hold relevance for MST model adherence and services. Using a social constructivist Grounded Theory approach, eight MST therapists in the United Kingdom took part in a semi-structured interview designed to explore the requirements of the role. Data revealed four categories. Two of explicit roles that included establishing rapport, engaging with families, defining the drivers to a young person’s behaviour, and doing *‘whatever it takes’* to overcome challenges. Underpinning these were two categories of implicit roles related to coping with the organisational environment and interpersonal skill demands of the role. This study widens the understanding of both individual and organisational factors/climate and its impact on therapist performance in MST practice.

**Running Head:**

A grounded theory of MST therapist roles

**PRACTITIONER POINTS**

* There is a need for supervisors to monitor workloads, organisational climate, and the emotional impact of the role on therapists, provide additional support as required, and implement contingency plans for staff shortages. In doing so, applying a greater duty of care to therapists adhering to the ‘whatever it takes’ ethos.
* Maintaining engagement is a distinct and essential phase of MST. Non-engagement can be overcome by therapists who adapt their interpersonal style to meet individual needs.
* Collaboration with external agencies (e.g. schools) supports cross-agency working in line with MST principles.

**MAIN TEXT**

**Introduction**

Multisystemic Therapy (MST) is a multi-faceted, intensive family-based intervention for young people typically aged between 11-17 years old with severe psychosocial and behavioural problems (Henggeler, Melton & Smith, 1992). The premise of MST corresponds with a socio-ecological framework (Bronfenbrenner, 1979), to address an array of interconnected systems surrounding a young person, including their family, school, peers and wider community (Randall, Henggeler, Cunningham, Rowland & Swenson, 2001), with a view to supporting positive outcomes for the young person, such as improved family relationships, increased responsibility and desistance from crime (Paradisopoulos, Pote, Fox & Kaur, 2015). These systems can act as risk factors to a young person’s behavioural challenges; preventing further criminal activity in serious young offenders and lead to favourable outcomes within their family and surrounding community (Schaeffer & Borduin, 2005).

**The Principles of MST**

MST therapists are flexible in their approach to meeting the needs of individual families, but the underlying nine principles of MST must still be adhered to for the therapy to be delivered effectively (Henggeler, Schoenwald, Borduin, Rowland and Cunningham, 1998). The nine principles are:

* Finding the fit
* Focusing on positives and strengths
* Increasing responsibility
* Present-focused, action-oriented and well-defined
* Targeting sequences
* Developmentally appropriate
* Continuous effort
* Evaluation and accountability
* Generalisation

The principles set out a developmentally appropriate, formulation-driven, strengths-based and action-oriented approach that is designed to promote responsible behaviour of family members. The principle of commitment to the process of change through MST is expected of family members and modelled through therapists, who offer daily or weekly interventions depending on the needs of the problem and the family. Empowerment of families to continue to drive positive change beyond the period of MST intervention is promoted, rather than the fostering of dependency on an intervention. In line with these principles, the accountability for the outcome of a MST intervention is placed with the MST team who, through training, reflection, supervision, and consultation, empower families to sustain positive outcomes and generalise learning to future problems.

**The Role of the MST Therapist**

The role of the therapist in establishing rapport with families is a critical mechanism of behavioural change in the child exhibiting behaviour problems (Fox, Bibi, Millar & Holland, 2016). The development of a strong therapeutic relationship with young people and their family members has been designed to enhance engagement and reduce resistance to treatment, through an accepting and supportive environment (Karver, Handelsman, Fields & Bickman, 2006). Therefore, a distinct feature of MST, in line with the principles of maintaining continuity and supporting families to take forward the process of change, is that therapists adopt a home or community-based service, to enhance family access to therapy and resolve issues in an environment within which they naturally occur (Ashmore & Fox, 2011; Randall et al, 2001).

MST conceives of change as caregivers being the catalyst for positive outcomes, and good family relationships as a natural form of social control for crime and long-term reductions in youth antisocial behaviour (Fox & Ashmore, 2014; Laub & Sampson, 2001). A qualitative exploration of young people’s perspectives of MST found that the therapeutic alliance was highly valued in the facilitation of positive outcomes, such as greater systemic awareness, increased responsibility and improved family relationships (Paradisopoulos, Pote, Fox & Kaur, 2015). The relationship between the therapist and young person might therefore be a mediating factor in therapeutic outcomes. In other MST studies, families have valued the therapeutic alliance for engagement and forming a collaborative, non-blaming approach reflecting the MST principle of ‘*focusing on positives and strengths*’ (MST Services, 2017; Norcross, 2010). Therapists’ person-centred approach, warmth, empathy, understanding and genuine support was reportedly unlike previous family interventions (Tighe, Pistrang, Casdagli, Baruch & Butler, 2012). However, few studies have thus far sought to examine the therapist experience of delivering MST.

**Adherence to the MST Model**

Since its development, the MST model has been adapted to meet the needs of young people and families with various clinical presentations. Whilst there is scope for flexibility in approach, successful outcomes are linked to adherence to the nine key principles of the model. High adherence from therapists was associated with reductions in criminal deviancy (Ellis, Naar-King, Templin, Grey & Cunningham, 2007) and antisocial behaviour in young peoples’ offending (Schoenwald, Carter, Chapman & Sheidow, 2008), the latter outcome linked to high supervisor adherence to the MST model.

Although adherence to the nine principles is critical to positive outcomes, in practice therapists are encouraged to think creatively and flexibly when assessing risk and protective factors with families (Timmons-Mitchell, Bender, Kishna & Mitchell, 2006). The role of a MST therapist involves identifying a clearly formulated, well-informed set of treatment goals that are individualised to address idiographic needs of a young person, together with the factors of contributing systems that influence their behaviour by *‘finding the fit’,* and to do so with adherence to the nine principles. Therefore, a MST therapist is a critical part of the treatment process and in facilitating positive outcomes. Research on the experiences of therapists through this process is lacking. This is surprising given that therapists are a critical component of the MST system. Therapist perspectives on how they achieve the goals of MST would offer practical and theoretical value to the optimising of treatment alliance and therefore positive outcomes.

**Organisational Climate for Therapists**

Organisational climate refers to the psychological impact of one’s work environment (Schoenwald, Sheidow, Letourneau & Liao, 2003) and involves issues of role overload, conflict, growth and advancement, job satisfaction, emotional exhaustion and personal accomplishments (Glisson & Hemmelgarn, 1998). It has been reported that therapists and health workers are vulnerable to the development of burnout and emotional depletion that can overlap with a lack in motivation or disenchantment from the role (Campagne, 2012). Addressing the organisational climate of MST therapists is crucial, as therapists are tasked with working alongside challenging clinical populations, offering continuous support and adequate clinical resources. The demand placed on MST therapists, such as providing a 24/7 on-call service to support families in crises, requires a significant amount of flexibility and prioritisation of time and resources (Fox & Ashmore, 2014). Whilst this makes MST accessible for families and promotes engagement to the service, the impact on MST therapists is largely unknown; evidently an important area of exploration given the criticality of the MST therapist in effecting positive outcomes. Additionally, the demands of high workloads for therapists reflected in the nine principles; found to be detrimental to a healthy work-life balance due to working long-hours which can consequently lead to feelings of exhaustion (Tyrell, 2010).

**Rationale for study**

MST is an empirically supported and effective family-based treatment for young offenders (Littell, 2005), particularly so when therapists and supervisors have strong model adherence (Ellis et al, 2007; Shoenwald et al, 2008). Although quantitative methods indicate outcomes against behavioural indicators, the experience of the process of MST (through qualitative approaches) has received less attention. An understanding of the experience of MST, both in terms of therapist experience of working within the model and the relationships between therapist and families, is critical to supporting positive outcomes in families. There has been some exploration of the experiences of caregivers, families and the young people involved in MST therapy. However, the experiences and perspectives of therapists are lacking, despite their critical role of facilitators of positive outcomes. Additionally, there is a lack of research that examines practice context effects on therapist adherence to the MST model and therapeutic relationships with families. Hence, this study aimed to explore how MST therapists (1) engage with families and build trusting relationships and (2) navigate the organisational climate to achieve MST goals with families.

**Method**

**Participants and Context**

A semi-structured interview approach was adopted involving individual interviews. The study design included a pilot stage, with interviews conducted as part of a service evaluation (Adhyaru & Lawson, 2016). These interviews yielded high quality data and were included in the total sample.

**Sampling and Participant Characteristics**

In line with the assumptions of grounded theory, participants were recruited purposively (Sbaraini et al, 2011), using a snowball approach within MST teams. Of the 23 MST teams in operation in the United Kingdom in 2016, six (26%) were contacted for recruitment. Eight MST therapists participated in interviews. With an average of three to four therapists per team, this study recruited approximately 10% of the UK’s MST therapists. MST therapists currently or recently (within the past 12 months) working in an MST service were included. Practitioners who had supervisory or consultant roles were excluded because their workload, contact with families, and general role would differ substantially from the therapist role and the focus of the research questions.

Participants were aged 29-53 (*M*=35.5) years of age, White British, with an average of 2.5 years experience in implementing MST interventions, across a range of between eleven months to five years. Six participants were female and two were male.

**Procedure**

The interview schedule comprised of open-ended questions allowing participants to express their own experiences, and for new themes to emerge (Charmaz, 2006). Intermittent data analysis was conducted as interview schedules were adapted and altered following each interview, drawing themes from previous interviews to explore further. The questions were based upon the surrounding literature on MST and questions were developed by the researcher as the interview commenced. The interview schedule included the following structure: (i) General information regarding the study and the structure of the interview and asking demographic questions to build rapport, (ii) The role of an MST therapist, (iii) Training and supervision (iv) Average caseloads (v) Maintaining a work-life balance, (vi) Overcoming barriers in delivering therapy, and (vii) The MST model.

Four interviews from the pilot study were conducted face-to-face, by two of the authors who were working in an MST service. Four additional interviews were conducted over the telephone by another author with no training in the delivery of the MST model. All interviews were audio-recorded with consent. Pseudonyms were applied during the transcription process. Ethical permissions were obtained from Royal Holloway, University of London and MST services UK following completion of the MST Services UK checklist.

**Analytic Approach**

Grounded theory is a social constructivist approach (Charmaz, 2006), encompassing an inductive analysis whereby a theory is generated that emerges from the data (Glaser & Strauss, 1967). A grounded theory approach offered a framework within which to explore the meanings that therapists attached to their interactions with young people and families engaged in MST (Sbaraini, Carter, Evans & Blinkhorn, 2011). This approach is relevant to the meanings made by MST therapists of their interactions with young people and families, particularly as there is no existing research on this subject. Analysis occurs immediately following the collection of data and continues with further data collection, so the methodology permits theoretical sampling by highlighting gaps in the data and seeking additional information in further interviews to clarify uncertainties (Sbaraini et al, 2011). This is particularly useful when exploring new areas of research investigation.

In the preparatory phase of analysis, all interviews were transcribed and proof read for errors. Subsequent analysis involved a series of coding and comparison procedures to reduce the data and identify any variations. The analysis was continued until theoretical saturation was reached, whereby there were no new codes emerging in the data and all the theory was developed and well understood (Henwood & Pidgeon, 1992). This reduced the possibility of researcher bias through imposing preconceived ideologies regarding the roles of a MST therapist in engaging with families. Data were analysed by two of the authors, neither of whom had received training in MST.

**Results**

Four overarching categories were elicited from the data. The first category ‘*Building a therapeutic alliance with families’* encompassed the formation of a trusting rapport between the therapist and families, by doing *‘whatever it takes’* to provide parents with the autonomy and empowerment for sustaining change in a young person’s antisocial behaviour. The second category, ‘*Coping with organisational hazards*’, involved challenging aspects of the role including physical and emotional exhaustion and how this was mediated by the support therapists received. The third category, ‘*Pursuing and maintaining engagement’* involved alignment and engagement challenges that were explicitly recognised as such, due to the multisystemic nature of the treatment, and strategies adopted in this area. The final category ‘*Utilising and expanding on interpersonal skills and expertise’* directly addressed individual therapist’s strengths and their specific skills. The importance of the role of the therapist in empowering change also emerged*.* An illustrative map of the final grounded theory can be found in Figure 1. All four categories reflect different levels of the system within which MST Therapists operate: the extrinsic factors (therapeutic relationship between families and other systems) and intrinsic factors (unique to the therapist).

[INSERT FIGURE 1].

**Category 1: Building a Therapeutic Alliance with Families**

The importance of establishing rapport with families appeared to intertwine with achieving successful outcomes. Therapists spoke of providing strength and autonomy for families as a driver to achieving desired outcomes of therapy, with families having a strong belief in the therapist as the first individual to *“actually make a difference”* (Ben) for their situation.

***Kelly*** *- “It’s very rewarding, you can see that they absolutely believe in what you want them to do. I always like that little bit about it, when you get a family or a parent that goes ‘You’re the first person that has A) suggested that, B) told me you think I could do it and C) absolutely believed in me*.’”

The prominence of doing ‘*whatever it takes’* as a therapist appeared to be a resonant and deeply held value of delivering MST and the formation of a therapeutic alliance with families. Therapists approached doing ‘*whatever it takes’* with mixed emotions. A theoretical link emerged with regards to therapists going ‘above and beyond’, with a strong motivation to deliver therapy in a way that overcomes any potential barriers.

***Charlie*** *– “It’s inclusive, and to sit at the dinner table with the family to join them … have a walk around a park … You’ve really got to break down those boundaries.”*

***Holly*** *– “I sort of struggle with the ‘whatever it takes’ and I feel that’s very one-sided. It’s whatever it takes as a therapist, not whatever it takes as a team, as a service. It’s very much expected that as a therapist I will go above and beyond.”*

Further indication of therapists adhering to the ‘*whatever it takes’* concept was expressed with regards to the effectiveness of the therapy. This coincides with the “*extremely rewarding”* (Amy)nature of the role, in that therapists’ challenges are outweighed by the successful outcomes accomplished.

***Serena*** *– “It’s the only service that actually addresses the issues that are prevalent and pertinent in our risky young people, things like knife carrying, school absenteeism, missing episodes, gang involvement, drug use, these issues are what put our vulnerable young person at risk, and MST is the only thing that addresses them. I have seen it work.”*

Working closely with families provides therapists with a level of familiarity to young people and therefore regard them as “*more than just their client”* (Jenna). Ben reflected that “*the professional and personal really overlap … because you are going in three times a week … you have to share some of yourself to actually make something move.”* Serena refers to individuals she works with as “*our”* young people, expressing a level of *‘*immersing into’ the families she engages with which can result in successful outcomes. For Kelly, *“having that face-to-face direct interaction with families is probably the most appealing thing about the role.”*

Across therapists, there was a strong emphasis on the rewarding nature of seeing families develop an autonomous approach in dealing with a young person’s antisocial behaviour: “*It is the best feeling in the world! Seeing families make positive changes, and treat their kids safe, is so rewarding”* (Serena).

Data suggest that when families implement MST interventions and principles themselves, therapists feel a sense of pleasure and satisfaction. Therapists referring to this effect as *“rewarding”* (Kelly) demonstrates an implicit motivation driving them to continue in the role. Additionally, therapists spoke positively of families working through problems themselves, whilst adopting values derived from the MST principles and processes.

**Category 2 - Coping with Organisational Hazards**

Participants spoke about a strong sense of organisational hazards inherent within the role of a MST therapist: *“MST can be really long hours, it can sometimes be really draining, that combined with me having my own family, you know, and working full-time can be difficult”* (Amy).The challenges faced by therapists were somewhat counteracted by the effectiveness of implementing this evidence-based approach with families. For example, offering an accessible service that works around the commitments of a family (such as employment) *“makes a massive difference”* (Holly) to the opportunities for positive outcomes: *“even though [MST] can sometimes be challenging, it is a very effective treatment”* (Amy). Holly and Amy held the view that despite the challenges faced within the role, a sense of hopefulness and perseverance is felt, whereby seeing families succeed following MST makes coping with these challenges worthwhile. The occurrence of families effecting behavioural shifts in a young person’s life following MST was referred to as seeing a *“light at the end of the tunnel”* (Charlie), with the hope that positive changes can be sustained.

Participants had varied experiences of formal mechanisms of support in coping with organisational hazards. Some therapists highly valued supervision and peer support, with group supervision providing a platform for “*bouncing ideas off each other”* (Charlie)*.* For example, Amy said “*the supervision process is fantastic and … I feel like I get a lot of support through that”.* For others, supervision did not meet expectations, particularly when this was experienced as directive rather than collaborative. Furthermore, a lack of connection and communication between therapists lead to feelings of solitude and isolation for some therapists:

***Serena*** *– “You’re just in your car, all the time, going from family to family, sitting in traffic, and then the only person you’ve got to support you is your supervisor and that is over the telephone! It’s just horrible, it’s a horrible existence.”*

The disparity of experience of supervisory support is evident, and might reflect differences in supervisory style. For example, one supervisor having “*so much skill and knowledge, that it would be hard not to learn from”* (Jenna)*,* or criticised for being over-demanding and *“telling me what to do”* (Kelly) rather than reaching a collaborative alliance.

MST teams are typically small (three or four therapists). The small team size was experienced as challenging, particularly at times of transition: “*You’re trying to manage on a two-therapist team after the loss of a colleague and you are having to re-engage with families who have basically lost their therapist”* (Lucy). Furthermore, a small team compromised life outside of work: *“it really does knock your work-life balance out because it’s constant, you are taking on the extra cases which can take you over. It was very stressful”* (Holly).

Challenges to maintaining a work-life balance stemmed from the on-call service provided to families, to which therapists attributed feelings of resentment and exhaustion. Some therapists valued the unique qualities of this service for families but the consequence of this for others was an “*inability to switch-off from work”* (Kelly), the *“anxiety provoking”* (Charlie) nature of being on-call due to the fear of the unknown and the “*emotional labour”* (Ben) that is put on the therapist to always be available to their families.

***Lucy*** *– “In the beginning I used to get anxious about it, now I get annoyed by it, it’s the anxiety … the unknown and what might come up. I’ve had too many occasions in the past where it’s interrupted meals, all sorts of things. So I arrange my social life on times when I’m not on call.”*

Despite the demands of being on-call, participants remained willing to pursue and employ a “*sense of acceptance”* (Jenna)of on-call as being part of the therapist role*,*linking into the ‘*whatever it takes’* ethos. Furthermore, some participants enjoyed being on-call because it brought to the fore personal strengths in proactivity and problem solving with families in crisis. These contrasting positions demonstrate the complexity of balancing the unique nature of MST delivery with personal life and the impact that this can have on therapist wellbeing.

**Category 3: Utilising and Expanding on Interpersonal Skills and Expertise**

Versatility and innovation in approach is encouraged of therapists within the MST model and valued by participants: “*constantly trouble-shooting new approaches, trying things, doing things. You can really start to spread your wings and be a bit more creative”* (Charlie). Participants spoke of their skill set being a strong basis from which to work proactively with families, with positive outcomes in mind: *“you’re there … with them seeing why maybe why the plan that you’ve made with them isn’t working. You can see immediately what the barriers are and you can put changes in place immediately”* (Holly). The development of these skills was supported through supervision (a space “*for learning and growth*”; Holly) although some participants felt limited in professional development beyond this (linked to Category 2, Coping with Organisational Hazards): *“I’ve been told no, that’s not how MST works. It’s not really encouraged to go off and do other things … I cannot do anything else while I’m working for MST”* (Kelly). The required commitment of therapists to the MST model was valued by participants who held positive experiences of development through supervision but limiting to those who felt constrained by their supervisor.

**Category 4: Pursuing and Maintaining Engagement with Families**

The data demonstrated a sense of frustration in working alongside other services that work in different ways to MST therapists. Reasons for misalignment with other systems included a “*lack of understanding and awareness of MST*” (Serena), particularly those that removed agency and responsibility from parents and so being out of line with MST principles. Collaborating with schools appeared to be particularly challenging for participants due to the reluctance by teaching staff to treat one young person differently to the other pupils.

***Kelly* –** *“To go back to the school and say that this young person is our focus, they say they’ve got 1,500 people to deal with they’re not really the focus for them. So that’s quite difficult in getting aligned with what we are trying to do.”*

In the spirit of MST, solutions were offered to the challenges of working with external agencies.

***Jenna*** *– “It’s about spending time with them, taking that opportunity to not just say things in an e-mail but actually go out to meet them and understand their role. The more time you can spend understanding their perspective, the more time they have for you.”*

Striving to overcome barriers was paramount for participants, including “*immersing into different cultures”* (Serena) and finding enjoyment in working with diverse populations. This feeds into the category *‘Utilising and expanding on interpersonal skills’* as therapists recall working with families from different cultures as “*a big learning point”* (Ben)*,* guiding the awareness and understanding with future cases.

***Lucy*** *– “We just had this really kind of long heart-felt conversation about our different cultures. It doesn’t matter if they’ve got a different background to me, because I have found that even with some families who are white British their culture is very different to mine.”*

An overarching theme underpinning therapists’ problem solving with families involved investing time and patience when delivering therapy. The ability to “*shift gears”* (Charlie) was another frequently expressed view, with therapists tailoring the delivery of MST to match the needs and cultural values of a family.

**Discussion**

The roles of a MST therapist and the experiences of working alongside families to effect positive outcomes and sustain behavioural improvements in young people with behavioural conduct difficulties were explored. Being a MST therapist is both rewarding and challenging. Participants in this study were sustained in their roles through hopefulness, optimism and perseverance, but encountered periods of exhaustion and resentment relating to demands on time, an inability to switch-off from work, inconsistent experiences of personal support through supervision, and limited peer support. In order to sustain the delivery of MST in line with the aims of achieving positive outcomes for young people and their families, attention must be paid to the experience of therapists, the facilitators of change.

The relationship between staff burnout and poor outcomes is well established (Saxon & Barkham, 2012). Therefore, it was of specific concern that the participants in this study experienced feelings of emotional exhaustion, an inability to switch-off from work, and a reduced sense of efficacy, all of which would be indicative of burnout and can be detrimental to therapist performance. Participants were motivated to overcome high job demands by the rewards of working with families and these experiences of positive outcomes might have maintained sufficient well-being and contained workplace strain such that burnout was not reached. However, this hypothesis renders the therapist vulnerable when experiencing family drop out from therapy, and family outcomes that do not align with the therapist’s expectations. Furthermore, it seems that the challenges of separating out work from personal life may leave limited capacity for coping with adverse personal events.

In the context of the MST model, it seems particularly important that supervision provides opportunities for the formulation of problems and interventions, the development of a therapist ‘tool kit’ of skills from which to draw competently and confidently ‘in the moment’ (enhancing self-efficacy), and personal validation and support (Aponte & Carol-Carlsen, 2009). Personal support through supervision is likely to be critical to the role of a MST therapist, particularly given the context of a therapist’s working life and environment that offers limited scope for peer connection, communication and support, which therefore might increase feelings of apprehension and isolation (Kossek, Pichler, Bodner & Hammer, 2011).

Across the four domains elicited through the data, participants reflected on explicit and implicit roles of a MST therapist. The explicit roles of a MST therapist were identified through adherence to the MST principles. That is, establishing rapport and engaging with families, defining the main drivers to a young person’s behavioural issues and tailoring therapy to each family (Henggeler, 2011). Furthermore, doing *‘whatever it takes’* to overcome challenges – such as aligning with external systems that operated on principles that were not explicitly compatible with those of MST, and dealing with a lack of awareness and understanding of MST in external agencies – was required to achieve the explicit objectives of MST. Exploration of how therapists engage and build trusting relationships with families (explicit roles) revealed the implicit roles related to coping with the organisational environment and interpersonal skill demands of the role. The identification of implicit roles brings to the fore the importance of supervision and management of MST therapists, because without these there seems to be a risk that therapists might be vulnerable to burnout in the context of high organisational demand and – in some cases – workload. Despite findings on burnout and self-care, the potential impact on therapists has not been acknowledged and addressed within the MST model. Key attributes and skills identified in a MST therapist role included resilience, reflection, and engaging in and responding to supervision. To achieve the explicit and implicit roles of a MST therapist, supervisors can additionally support therapists with personal flexibility, adaptability, sensitivity, openness, coping with a demanding organisational climate, and managing high workloads.

**Congruity of the MST Model and the Final Grounded Theory**

The nine principles outlined within the MST model were evident throughout the data, indicating strong adherence. Participants referred to the clarity of the model as reassuring when delivering therapy, but also valued the scope for flexibility of delivery with families. This balance between a stringent delivery model, adherence to key principles, but flexibility in intervention development and delivery context is a critical aspect of MST.

MST aims to prevent the adverse complications of removing a young person from their home and supports parental involvement in a young person’s behaviour. This includes creating strength and autonomy in families, and allowing them to orchestrate their own changes (Ashmore & Fox, 2011; MST Services, 2017). This aspect was seen throughout the data, with therapists achieving a sense of reward when families embraced MST principles and developed the confidence to autonomously maintain positive outcomes in the short- and longer- terms. The reward of observing families build autonomy appeared to motivate therapists further, suggesting that perseverance within the role is reflected in the success of delivering an evidence-based approach, or perhaps in also looking for positives and successes and sharing them with families. This practice might outweigh challenges faced, motivating therapists to persist in the role.

A prominent theme was therapists’ ‘*whatever it takes’* ethos, in line with the MST principle of making a ‘*continuous effort’* with families. Therapists doing ‘*whatever it takes*’ also stems from MST being a home or community-based service, encouraging engagement, finding the *‘fit’* between identified problems, how they play out and easing accessibility with families (Randall et al, 2001). Important was therapist perseverance, using appropriate communication styles and uniquely adapted strategies, adding up to a person-centred approach to families (Tighe et al, 2012).

**Limitations and Caveats**

Although approximately 10% of the UK MST therapists were interviewed, the sample size remains small and did not encompass the perspectives of other MST team members such as supervisors or consultants. Future research should aim to explore experiences of these other MST team members, as doing so would provide an analytical insight into how the system of people involved in therapy can work together to successfully deliver MST. Furthermore, there might be limitations of the data relating to participant self-selection to participate; this could be in terms of therapists who did not feel heard about the challenges within their working roles, but the self-selection would also demonstrate commitment to the MST model by finding the time in a busy working environment (‘*whatever it takes’*) to contribute to the further understanding and development of MST. Despite these limitations, clear developments in understanding the roles and relationships of MST therapists and the impact of these on model adherence and potential effectiveness have been made.

**Relevance of Research**

Therapists in this study recalled issues relating to high workloads and a lack of personal downtime to switch-off from work, inhibiting a healthy work-life balance. As MST teams are typically small, the absence of one therapist in a team appeared to have an adverse knock-on effect on wellbeing for the remaining therapists. Although MST guidelines provide a minimum and maximum caseload criterion, the reality of needing to provide cover for colleagues means that therapists sometime exceed this caseload. As previously discussed, experiencing organisational hazards can be detrimental to therapist performance (Saxon & Barkham, 2012), hence indicating a crucial recommendation to be considered regarding the further development of MST teams.

The differing levels of support therapists received were mapped onto the supervisory styles within their teams, indicating a practical implication for MST teams. Findings demonstrated that improvements to the therapist-supervisor relationship could impact therapists’ confidence and certainty, leading to better outcomes with families. Although a key objective of supervision was to address practical and case-specific challenges, some therapists wanted more opportunities to influence the agenda of supervision in order to gain support for managing the emotional ‘toll’ and personal challenges of the role. MST monitors therapist adherence (through the Therapist Adherence Measure; Schoenwald et al, 2008), but should perhaps focus on the more reflective or process-oriented functions of supervision.

**Conclusion**

This study has widened the understanding of organisational climate and its impact on therapist performance in MST literature. Through a qualitative insight into MST therapist experiences of delivering MST, it has been highlighted that factors such as building a therapeutic alliance with families, negotiating organisational hazards, adapting interpersonal skills and maintaining family engagement are all key drivers towards the successful delivery of MST. The intensive nature of MST delivery and the time spent with families infers that rapport building is a crucial aspect to effective behavioural change and outcomes. Providing 24/7 support to families in crises, as well as delivering the therapy in environments in which behaviour most commonly occurs, at times means therapists experience symptoms of burnout, such as a poor work-life balance and an inability to ‘switch off’. While this may be counteracted by supportive teams and supervisors, this was not found unanimously across all therapists interviewed, thus highlighting the need for more structured support through supervision. Finally, a significant element driving the effective behavioural change in young people is the engagement that is pursued and maintained from families, whereby therapists ensure their approach is developmentally appropriate to each family’s idiosyncratic needs.

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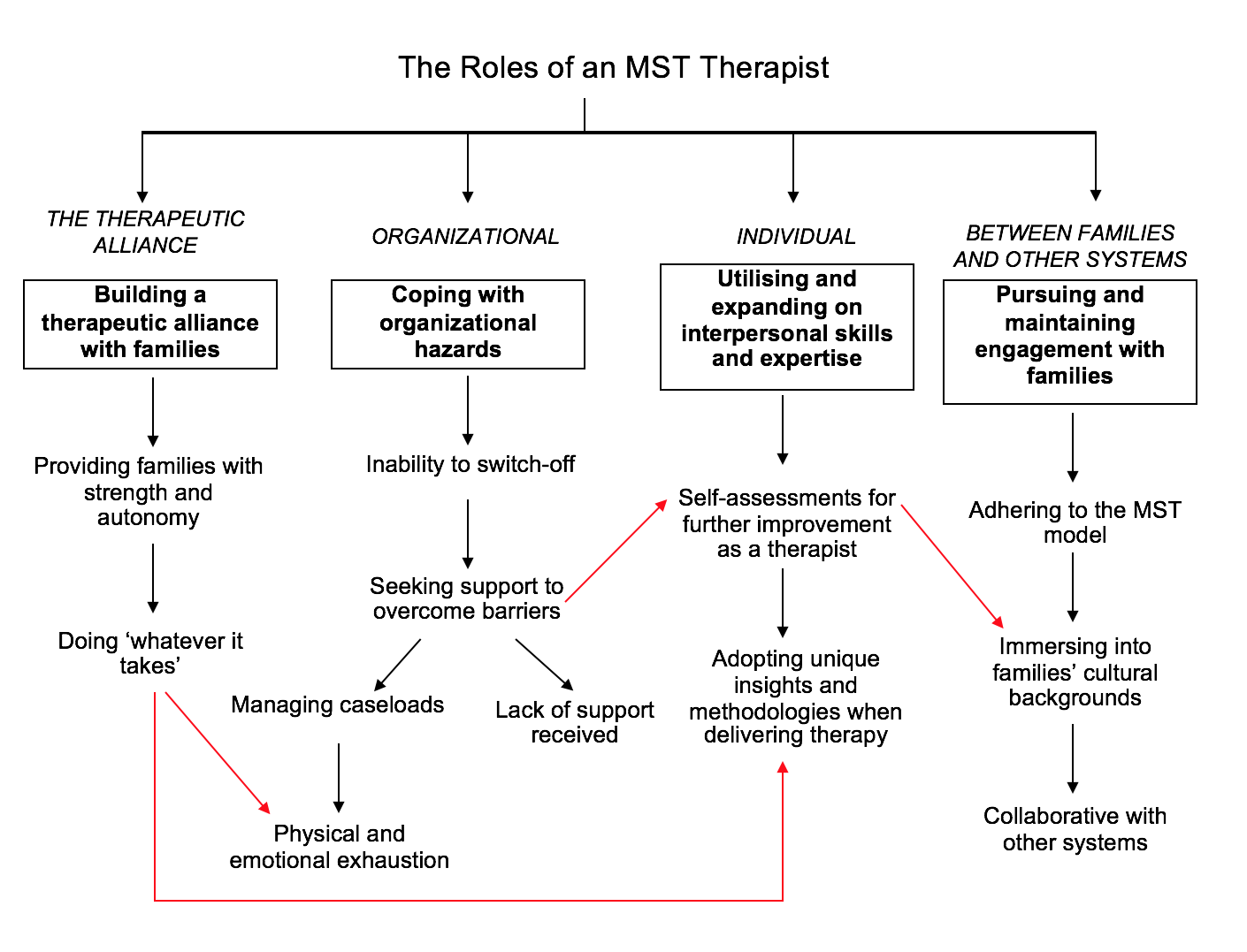
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**FIGURE**

FIGURE 1. *Analytical diagram of the final Ground theory of four overarching categories guided by their sub-categories*



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