

Sustaining change following multisystemic therapy: caregiver's perspectives

Pinder Kaur, Helen Pote, Simone Fox and Daphne A. Paradisopoulos

Keywords: multisystemic therapy; qualitative research; service user perspectives; process of change; grounded theory.

Multisystemic therapy (MST) is an empirically supported intervention for young people presenting with antisocial behaviour. This study explored the process of sustaining positive outcomes following MST from caregiver perspectives. Semi-structured interviews were carried out 5–21 months post-MST with 12 caregivers. A grounded theory methodology was used to analyse the data. Caregivers in this study identified the following themes as contributing to sustaining change; improvements in their relationship with their child, shifting how they viewed difficulties and solutions and feeling personally strengthened and resilient. The therapeutic alliance in MST was described as important in initiating these changes. Clinical implications and how the themes from this study fit into the existing model of change in MST are discussed.

Practitioner points

- Caregivers validated the therapeutic alliance as key to the MST approach.
- Experiencing a positive therapeutic alliance was also identified as important in improving relationships within the family even after therapy was completed.
- Positive experiences of MST developed caregivers' experiences of feeling more resilient in the face of later difficulties helping sustain positive outcomes.

Conduct problems and antisocial behaviour underlie most of the referrals to child and adolescent mental health services in the UK (National Institute of Clinical Excellence, 2013). The negative consequences of these difficulties are far-reaching and have a significant impact on the individual, their family and the community due to the involvement of health and social care services and the criminal justice system (Nock *et al.*, 2007; Office of National Statistics, 2004). A clear trajectory from antisocial behaviour problems in adolescence through to adulthood has also been well documented; for example continued poor occupational outcomes and high levels of mental health problems (Farrington *et al.*, 2009). Given the significant and long-term impact of conduct problems there is a need for effective interventions and a better understanding of the process of positive change for these young people and their families.

Multisystemic therapy (MST) is an empirically supported intervention for young people aged 11–17 years presenting with conduct disorder and antisocial behaviour (Henggeler *et al.*, 2009a). It offers family and community-based therapy from therapists available for contact, 24 hours a day, 7 days a week. Therapy is delivered intensively for 3–5 months. MST is based on Bronfenbrenner's (1979) social-ecological conceptualization of human development and focuses on targeting known causes and correlates of antisocial behaviour (for example, low parental monitoring and negative peers [Loeber and Stouthamer-Loeber, 1986]) to effect change for the young person. Behaviour is considered

to be multi-determined and best understood in its naturally occurring context. Family and peer influences on young people are considered systemically, noting the reciprocal processes involved in the development and resolution of difficulties.

Following nine treatment principles, MST uses an individualized, present-focused, strengths-based, action-orientated approach. Therapists work with many members of the system around the referred young person to effect change and are comprehensively supervised to ensure fidelity to the MST model.

The efficacy of MST has been extensively researched. There are over forty-eight published outcome studies and twenty-five randomized controlled trials (RCT) determining the impact of MST (see Multisystemic Therapy, 2015, for an overview). Three outcomes, referred to as ultimate outcomes (Henggeler *et al.*, 2009a), have all shown significant improvement as a result of MST; reduced offending behaviour, decreased out-of-home placements and increased participation in education or training. Follow-up data demonstrate sustained improvement for these ultimate outcomes ranging from 6 months to over 21 years after MST has been completed (Sawyer and Borduin, 2011). While reporting on ultimate outcomes dominates MST research, an integral part of outcome monitoring involves recording instrumental outcomes (for example, family cohesion and adaptability) and MST has shown significant improvements in these outcomes too (for example, Borduin, *et al.*, 1995).

The role of caregivers in the process of change in MST

MST emphasizes the role of the caregiver in influencing change in young people. Figure 1 outlines an overview of the process of change in MST. The MST therapist seeks to target evidenced family risk factors by improving family functioning, which includes caregiver effectiveness, for example, consistent effective discipline strategies such as limit setting and increased monitoring of the young person (Henggeler *et al.*, 2009a). Improvements in these areas then influences change across the young person's context of school, home and peers, which then leads to improvements in antisocial behaviour and improved functioning.

Insert Figure 1. Model for the process of change in MST

Mediation studies have provided strong support for MST's process of change. Two studies have shown that MST, measured via treatment adherence measures, mediated positive outcomes (for example, reduced negative peer association) via caregiver variables (for example, caregiver consistency) (Henggeler *et al.*, 2009b; Huey *et al.*, 2000). This is also supported through studies that show that caregiver variables are important in effecting positive change, for example parental monitoring of the referred young person (Racz and McMahon, 2011).

It is clear that MST upholds the principle of collaborating with young people and caregivers. This is shown through joint goal setting and the completion of therapist adherence measures. It is therefore surprising that there is a lack of published research detailing families' accounts of MST and their understanding of the process of achieving and sustaining positive change. Such accounts seem important for the future development of MST and would be consistent with the service user focus central to current practice (for example, Department of Health, 2010).

Exploring caregiver experiences of the process of change in family therapy research is not uncommon (for example, Sheriden *et al.*, 2010). However, these experiences cannot be

assumed to generalizable across all family-based therapies. There may be aspects of change that are particular to MST. Indeed, commentaries have drawn attention to the difference between MST and traditional practice (Ashmore and Fox, 2011). For example, MST uses multiple evidence-based intervention methods, addresses presenting difficulties in their natural context and is delivered intensely through one therapist. Further examination on how this is experienced and what insights families can provide on the intervention process are therefore needed.

Despite the theoretical and clinical importance placed on caregivers in the MST model there has been only one published qualitative study exploring their perspectives, that by Tighe *et al.* (2012). It is important to build on this initial study, investigating caregiver perspectives during and after therapy, in order to determine how families achieve and sustain change through MST.

Qualitative research with caregivers and young people in MST

Tighe *et al.* (2012) interviewed twenty-one parents and sixteen young people up to 2 months post-MST about their experiences and the process of change, analysing the data using thematic analysis. Their results suggest that, for at least eighteen of the caregivers, the therapeutic alliance (TA) and the therapist as a source of support contributed to their positive experiences of MST. Parents reported that their relationship with their child also improved. In addition they said that they felt MST had increased their parental confidence and skills.

Tighe *et al.*'s (2012) qualitative research was an important first step in providing rich detail on the experiences and process of change from a carer perspective. However, the outcomes in this short follow-up period are complex, and the differences reported between those who had positive outcomes and those with less positive outcomes suggest that it would be valuable to explore each group's experiences further to elucidate the nuances of change particular to them.

Exploration of the long-term process of change is also needed using studies with a longer follow-up of MST outcomes. Butler *et al.* (2011) carried out the first RCT of MST in England. They found that reductions in offences in the MST group compared to the treatment as usual group were significantly improved only at 18 months post-intervention. The authors hypothesized that changes might be occurring over the long term, which warrant further exploration. This supports the need to continue to ask service users about their experience of the process of sustaining positive changes following MST.

The current study extends that of Tighe *et al.* (2012) in a number of ways. Given the indication that the change process evolves over time (Butler *et al.*, 2011) longer follow-up periods were used to explore specifically the process of sustained change (5– 21 months). The current study also focused only on those families who had achieved positive changes, as defined by the three MST ultimate outcomes. The study also enabled an exploration of the process of successful change. In its qualitative grounded theory approach, the study also enabled the development of themes that could be used to hypothesize a process of sustained change following MST as perceived by caregivers, which could then be examined in the context of the existing model of in-therapy change in MST.

Method

Participants and setting

Caregivers were recruited from an outer London MST service. In order to meet the study's inclusion criteria only families who had met all three ultimate outcomes, as measured by the MST service (no new convictions, in education or training and still living at home) at the end of their MST intervention were followed up. Additionally, families needed to have fully completed their MST intervention at least 5 months before the research interview. Exclusion criteria included families who did not meet the positive ultimate outcome criteria and caregivers who were unable to give their informed consent.

Eighteen families from the MST service met the inclusion criteria for the study and the researcher was able to contact fifteen of these. Participation rates were good, and 80 per cent (12/15) of the families agreed to participate in the study. Personal circumstances were cited as reasons for declining participation (because of bereavement and work commitments).

Of the twelve consenting caregivers, two participated in developing and piloting the interview schedule and a further ten caregivers participated in the interviews. Two families identified an additional caregiver to participate in the interview due to their direct involvement in the MST intervention. Participants were predominantly from a white British background (see Table 1).

Table 1 around here

Table 2 shows the referred child's age at the time of the interview. This ranged from 13 to 18 years (average 16.1 SD: 1.85). At the point of the research interview six out of ten of the young people still met all three MST ultimate outcomes. Reasons for not achieving the positive outcomes at follow up included criminal charges, as two of the young people had been arrested following MST. The other two young people who did not meet all outcome criteria had partially positive outcomes in that they had completed education and were becoming more independent, with one working and living away from home.

Table 2 around here

Procedure and analysis

The interviews took place in the family home ($n = 11$) or at the MST office ($n = 1$). They lasted between 45 and 81 minutes and all interviews were digitally recorded and data transcribed verbatim by the first author.

An interview schedule was devised based on Tighe *et al.*'s (2012) study and on published interview schedules exploring the process of therapeutic change (Elliott *et al.*, 2001; Llewelyn, 1988). Questions included, 'What changes, if any, have you noticed [in yourself, your child] since finishing MST?' 'How were you able to keep these changes going?' 'What (if any) were helpful aspects of MST?' The interview schedule was piloted with two caregivers and refined further.

Grounded theory analysis was conducted using Charmaz's (2006) social constructionist approach. This was selected because it acknowledged the role of the researcher in constructing the data through interactions with participants and during data analysis. Grounded theory permitted the development of a hypothesized process of sustained change, closely rooted in the data. Efforts were made to ensure that recruitment was as purposeful as possible to begin with and was followed by theoretical sampling thereafter.

Saturation of themes was also sought by following up on emerging themes in later interviews with caregivers.

The analysis followed the process of open coding, focused coding stages, diagramming, and the abstraction of theoretical codes in the final stage. Memos were written up and a reflective journal was kept throughout. The analysis process was constant and comparative. All data were analysed by the first author, a female trainee clinical psychologist with an interest in systemic practice. The QRS-NVivo software program was used to assist in organizing the data. To achieve a rigorous analysis two independent reviewers assessed the coding for one quarter of the transcripts and two caregivers reviewed the codes assigned to their own interview as well as the final theoretical codes across all interviews.

This research used Elliott *et al.*'s (1999) guideline to evaluate qualitative research to increase the quality of the research. Guidance ranged from providing credibility checks of themes and theories to grounding in examples provided through quotes in the Findings section below.

Findings

Nine themes were generated from the analysis. Table 3 details all the themes and subthemes and Figure 2 proposes how these themes might connect with the current model of change in MST.

Table 3 around here

Figure 2 around here

The themes appear to support the established model of change for MST. Figure 2 details particular aspects of the model that may contribute to sustaining positive change for caregivers. Specifically, the analysis identified two important themes, systemic change in family functioning and the importance of a positive TA, which contributed to two later themes of increased personal resilience and increased family resilience over time. This resilience appeared to be central for sustaining change after MST. These key themes are defined in more detail below.

Systemic change in family functioning

Caregivers outlined how, through therapy, they had experienced improved family functioning and developed a more relational process of change. This included an increased reciprocity in the relationship between the caregiver and young person and improvements in the young person's behaviour leading to improved family functioning and vice versa. Bi-directional arrows are drawn on Figure 2 to emphasize these relational change processes. At follow-up caregivers noted shifts in how they viewed their difficulties following MST. They felt that their relationship with their child and other family members had altered and commented on how they were now sharing responsibility for change with others. They described these as important outcomes that contributed to their feeling more resilient and able to sustain changes initiated during MST. The caregivers suggested that the positive TA during therapy was helpful in initiating these changes.

A positive TA

The theme of a positive TA in MST (Figure 2) captured the following sub-themes: the therapist helping families shift their relationship to help, the caregiver therapist alliance as a helpful model and the MST therapist supporting family relationships. It appeared the TA was related to the caregivers' experiences of becoming more resilient. The caregivers spoke

about the importance of having a non-judgemental, available therapist who was 'on their side' and 'listened'. This followed previous experiences of mistrust, feeling blamed or not being helped. Having the MST therapist in their home environment appeared to facilitate this relationship. From this foundation of initial trust, the caregivers were able to take risks in trying new strategies or refresh old strategies to help their child. Their therapist helped them to negotiate planning and implement strategies.

Change was evident after MST as the impact of the TA remained, with the caregivers citing examples of how they followed what the therapist did. They also described how a secure relationship that they experienced was one that they created within the context of their own family and with their relationship with their child. This appeared to help sustain positive changes due to the collaborative nature of the relationship and the safety to continue to try new things. All names have been anonymized:

I think what helped me and us was somebody coming in from the outside and just helping us to get a grip on it all um but in way that we didn't feel that they were being hostile to us. It's always, it wasn't like someone else coming and saying 'You must clean up your act', it was something quite different, really.
(Penny's mother)

Yeah, I think it's more, it's as if they want the family to stay together; it's kind of different thing to a social worker where the social worker can say they will put it on the children's fault or your fault. (Kelly's mother)

Increased personal resilience to new challenges

The concept of resilience appeared central to the caregivers' perceptions of sustaining change. Resilience included a sense of feeling strengthened through their experiences, which enabled them to carry on and continue to sustain positive outcomes achieved after MST ended. The caregivers said this might have helped them to feel less isolated in managing challenges and shifting their relationship to seeking help, enabling them to go on to draw upon family and friends for support.

The caregivers said that increased personal resilience was facilitated through the therapeutic relationship with the MST therapist. This was described as a transformative experience where they felt they were not judged and were empowered to believe in their capabilities and capacity to change. They spoke about often hearing the therapist's voice, especially after the intervention ended. They said this was a helpful reminder for them to carry on with MST interventions. The MST therapist was seen as an intense motivator and it appeared self-motivation developed through the influence of a positive, encouraging MST therapist who was invested in helping them towards their goals. This relationship appeared to develop caregiver's self-confidence as parents:

You do feel like you can't do it – you can't parent um but actually somebody coming in and going 'Yes, you can, you know, try these strategies', it gives you more confidence in what you're doing. (Joanne's mother)

[The MST therapist] never gave us the answers or told us what to do, they were sort of such of strategies that she worked with us on, you call it homework or whatever else, but also an opportunity to talk. (Lola's mother)

I felt more confident as a parent you know like dealing with schools dealing with the doctors and all sorts of things. (Kelly's mother)

Caregivers described a shift in their approach to parenting that appeared to add to their resilience to new challenges. At the start of MST the focus was on developing parenting strategies to decrease difficult behaviour such as putting in place boundaries, structure, rewards and consequences. Towards the end of MST caregivers appeared to describe parenting more broadly, holding an interpersonal conceptualization of problems and focusing more on their child's emotional needs:

One person doesn't create the whole situation; there's differences, we each have a role to play but it's shared. (Penny's mother)

I'm giving them the responsibility a bit as well to sort of stop it [arguing] and they do tend to and much more quickly as well. (Lola's mother)

The caregivers identified a support network that included close friends, family members and professionals. They described this as important in sustaining change because social support (both informal and formal) offered practical assistance, support, companionship, advice and problem-solving during challenging times. Crucially, this support seemed to reduce the feelings of isolation that had existed prior to MST.

Increased family resilience over time

Caregivers articulated the importance of family resilience in maintaining change. This was developed through a mastery of MST techniques, alongside the development of shared goals and hopes. Valuing different family members' input and views and noting the positive changes achieved in family relationships (for example, working collaboratively more and spending more time together) appeared to be important in sustaining change over time.

The caregivers referred to a tool box of resources that they had developed during MST and maintained beyond the intervention. For example, a resource frequently used by the caregivers involved the use of rewards and incentives. These resources were described as shared by the caregivers because their child participated and collaborated with the tool and goals:

I've still got some of the consequence charts at home but it was about re-establishing those principles and boundaries again where we'd lost everything, uh, so I still use some of those strategies although the counters in a jar thing, she is beyond that now but [pause] it allowed you to begin the process of negotiation and agreement, you know, so that for me was really something quite significant. (Penny's mother)

She had quite a close relationship with my mum which was sort of separate to everything else, so we decided to nurture that and then Betty (daughter) has been sort of been to stay with my parents um on her own and that has been really good for her. (Lola's mother)

The caregivers spoke about how having MST helped them to step back and also look at other relationships in the family, including relationships with their partners and other children. These reflections seemed important in developing family resilience because they enabled a positive reconnection between family members. This supported sustained change as the caregivers said that they felt they had a more balanced focus among all their children. They felt they were developing a more cohesive family where there was mutual support, collaboration, loyalty and respect for individuals:

When you've got one child all is well but when you've got three children you haven't got just that whole day to devote on that one: you've got to put a bit in

to all of them because then you're looking at another problem. (Tommy's mother)

Another aspect of increased family resilience was strengthening family hopes and goals. This applied to day-to-day tasks and future goals. The caregivers spoke about how working together on achievable goals during MST and continuing this after MST increased the families' confidence and competence, enabling them to meet greater challenges.

The caregivers spoke about how their initial success using MST interventions motivated and sustained change in the longer term. They said that they had implemented strategies during MST that worked and things working acted as a motivator to continue with strategies:

I think once you get in that position, where you are doing something like that um it's just natural to carry on with it because you don't want to go back to them old ways so you want to keep going on with what you've been taught, so to speak. (Joanne's mother)

How do you keep it going? It's just you see the benefits of it and it's the driving force, you see the differences that can be made and can be reached but it's hard work as well. (Kelly's mother)

Discussion

In this study, at 5–21 months follow up all caregivers spoke positively about their experience of MST and felt it had been a beneficial experience. When positive outcomes were sustained it appeared that the process was initiated through a transformative relationship with the MST therapist and a strong TA. The caregivers reported that this relationship helped them engage with MST, helped them formulate their child's difficulties more broadly and supported them to persist with positive behaviour strategies. There appeared to be an increase in reflection. There were changes in beliefs about challenges and setbacks. The caregivers shifted in how they viewed their child's capacity to change and how they could influence this.

The existing model of change in MST highlights the importance of the caregiver and outlines how improvements in family functioning impact on the other systems around the young person. The current findings fully support this model and emphasize the contribution of the TA in initiating change, expanding how caregivers experienced improved family functioning and how they felt able to sustain changes through an increased sense of resilience.

Sustained change following MST

Figure 2 shows how themes gathered from this study support the current MST model of change by emphasizing the concepts of individual and family resilience as important in supporting change over time. The caregivers outlined how positive changes in themselves, in their child's functioning and in their family and wider system relationships strengthened their self-confidence as parents and increased their resilience. This resilience appeared relevant to caregivers in enabling them to sustain change, make new changes and respond to challenges more effectively.

Figure 2 includes explicit bi-directionality to capture the process of change that is occurring between the young person and their caregiver as well as the changes caregivers are making themselves. This fits with MST's systemic underpinning. This reciprocal process was reported by caregivers as being crucial to the ongoing process of change following MST.

The model of change in MST recognizes the importance of the TA in achieving change. This crucial role of the relationship between the family and MST therapist was validated by the caregivers in the current sample. They said that a supportive, collaborative therapist who listened was important for in-therapy change, in line with Tighe *et al.* (2012). For sustained change the TA extended beyond the MST therapist and caregiver relationship, appearing to facilitate connections and improvements in relationships between caregivers, their other children, partners, schools and other agencies.

The TA is known to be important in systemic therapy. Robbins and colleagues have demonstrated the importance of the TA between the therapist, young people and their caregivers in engaging families and ensuring the completion of therapy for multidimensional family therapy (Robbins *et al.*, 2006) and brief strategic family therapy (Robbins, 2008). Although these studies focused on young people misusing drugs, they shared anti-social behaviour difficulties similar to the current sample. The current study suggests that the effects of the TA in MST stretch beyond the delivery of therapy. Looking at the role of the TA in sustaining change may be an important area for further research in MST.

The broadening of the TA to family relationships also seems important in sustaining change for this sample. Positive effects that caregivers said MST had on their family relationships appear to fit with a notion of the family alliance put forward by Chenail *et al.* (2012). The family alliance was proposed as an original factor common to couple and family therapy from their qualitative meta-synthesis of articles based on clients' experiences of family therapy. They described how family alliances or 'within family system alliances' demonstrated a shared sense of purpose and working together, the presence of which could improve outcomes.

Changes in caregivers' beliefs about themselves, about their child and about their relationships (for example, with their partner and schools) were also important in helping caregivers to sustain change. This connects with systemic commentaries emphasizing the importance of second-order change in sustaining improvements (Davey *et al.*, 2012). Second-order change broadly refers to change to the structure of the system, including beliefs and relationships, indicating a shift to the point where the structure itself changes (Watzlawick *et al.*, 1974). Second-order change is considered more enduring as it focuses on the problem-maintaining patterns of the attempted solutions rather than the presenting problem itself. Despite MST's emphasis on relational change this has not been discussed with explicit reference to second-order change in the literature. Davey *et al.* (2012) propose that applying these concepts has the potential to say that a particular type of change (second-order change) has a sustained impact on outcomes in MST and is an important area for further research on the processes of change in family therapies.

Themes from this study highlight the role of resilience in maintaining positive outcomes. Resilience was a theme abstracted by the author to capture caregivers' experiences and process of feeling strengthened in their parenting through MST, as well as an increase in their confidence in facing future challenges. Resilience has been defined in the literature as 'a dynamic process including positive adaption and the capacity to rebound from adversity, strengthened and more resourceful' (Luthar *et al.*, 2000). This appears to capture caregiver descriptions from this study. Caregivers in the current study who saw themselves as resilient said they were more able to problem solve and spoke about the value of consistent parenting that adapted to change, which included the developmental changes in their

children. The caregivers who said they wanted to be closer as a family and used wider family support networks appeared to develop relational aspects of resilience. These latter descriptions appear to be consistent with elements of family resilience characterized in detail in Walsh's (2006) framework. This details three main processes for family resilience: belief systems (for example, positive outlook), organizational patterns (for example, flexibility) and communication processes (for example, collaborative problem-solving). All these processes were reflected in the narratives of the current participants as important in sustaining change.

Implications for clinical practice and directions for future research

This study raises the profile of caregiver perspectives as important in understanding the process of change in MST, and in particular how caregivers sustain positive change following therapy. Caregivers in this study expanded upon positive outcomes to include more personal experiences and improvements in themselves, their relationship to their (referred) child and others in their family. These relational improvements are central to positive change in MST therapeutic practice and are measured through MST's rigorous outcome monitoring, for example the family adaptability and cohesion evaluation (FACES-III [Olson *et al.*, 1985]). However, these are not typically discussed in detail in quantitative research outcome studies. Given the emphasis caregivers placed in this study on improved relationships that made them feel more resilient, thus enabling them to sustain change, future research could examine these factors in more detail, making connections between what factors might improve sustained change and therefore what to focus on during the intervention to maximize this.

Caregiver perspectives from this study have the highlighted clinically relevant factors that they felt helped sustain change. A key message from caregivers was the importance of the therapeutic relationship and the multiple roles the therapist employed to enable the caregivers to engage, safely try out new strategies and troubleshoot difficulties early on. This supports the treatment principles for MST, which emphasizes the multiple alliances of the therapist to the family, the caregiver, the young person and the system, to achieve change during therapy and beyond.

MST has drawn upon the existing literature to emphasize the role of the TA in engaging families with the intervention (for example, Tuerk *et al.*, 2012) acknowledging it briefly as a common factor. However, along with Tighe *et al.* (2012) this study supports exploring the influence of the TA in MST on treatment outcomes and sustained change in more detail. Granic *et al.* (2012), for example, have shown how measuring the TA in therapy has been able to show that it significantly mediated improvements in adolescent behaviour via improvements in maternal depression. An integral part of MST includes gathering feedback from families on the therapist and treatment and includes questions relating to the quality of the therapeutic relationship. MST could potentially use a more formal measure of TA to aid understanding of any interaction between it and the intervention.

This study used a small sample size, therefore generalizations cannot be made beyond this sample. The findings may not generalize to fathers' perceptions of sustained change, as only one father was represented. Further research in this area is warranted. Young people's perspectives of the intervention are also an important part of the model development and are presented in a parallel article by Paradisopoulos *et al.* (2015).

Conclusion

The study analysed caregiver perspectives on what supports sustained positive outcomes in MST. Using a grounded theory methodology it generated themes relating to sustained change supporting MST's existing model of change. In particular, caregivers elaborated on the role of the TA in initiating change and developing caregiver's own resilience and broader family resilience. Making explicit the connections between the TA and sustained change as well as exploring a potential connection between resilience factors and positive outcomes may complement the current focus of MST on risk factors and the treatment method.

Acknowledgements

We would like to thank all the caregivers and their families who took part in this study.

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Appendices

TABLE 1. Caregiver characteristics

<i>Caregiver</i>	<i>Age (years)</i>	<i>Ethnicity</i>	<i>Marital status</i>	<i>Age of young person at interview</i>
Mother	49	White British	Married	13
Mother	52	White British	Cohabiting	16
Mother	32	White British	Dating long-term partner	15
Mother	53	Black British Caribbean	Widowed	18
Mother	46	White British	Single	14
Mother & father	35, 39	White British x2	Married	16
Mother	49	White British	Separated	18
Mother	45	White British	Divorced	15
Mother	50	White British	Married	18
Mother & grandmother (maternal)	40	White British x2	Married	18

TABLE 2. Young people's characteristics and outcomes at interview

<i>Young person pseudonym</i>	<i>Age of young person at interview</i>	<i>Gender</i>	<i>Time since MST completion (months)</i>	<i>Any new arrests since MST?</i>	<i>Living at home?</i>	<i>At school/college/working?</i>
Lola	13	F	16	No	Yes	Yes
Penny	16	F	15	No	Yes	Yes
Tommy	15	M	14	Yes	Yes	Yes
Joanne	18	F	21	No	Yes	Yes
Kelly	14	F	10	No	Yes	Yes
Ed	16	M	5	No	Yes	No
Jamie-Lee	18	F	21	No	No	Yes
John	15	M	15	No	Yes	Yes
Derek	18	M	14	Yes	Yes	Yes
Anna	18	F	19	No	Yes	Yes

TABLE 3. Caregiver themes and sub-themes at 5–21 months post MST

Thematic codes	Sub-themes	Number endorsed during interview (n = 10)
Transforming the relationship to help	From ambivalence to trust	9
	Facilitative MST therapist qualities and approach	9
	Renewed possibilities to seek future help	5
Caregiver therapist alliance as a helpful model	Safety in the relationship facilitating risk taking	9
	Experiencing a collaborative relationship	6
Therapist supporting a family alliance	Facilitating connections between the family	9
	Valuing family goals	7
Privileging a positive story	Accepting differences	2
	Respecting independence	8
	Recognising exceptions & strengths in my child	10
Shifting perspectives, from individual to interpersonal	Become more reflective	7
	Maintaining open expressive communication with school	7
Increased positive communication in relationships	Increased communication with school	8
	Maintaining open expressive communication within the family	10
Sharing responsibility for change	Recognising each others roles	7
	Balancing my input	7
Increased personal resilience to new challenges	Increased confidence in parenting	9
	Increased social connections	6
	Personal growth and self confidence	9
Increased family resilience	Applying shared resources flexibility to fit new challenges	8
	Addressing other parent-child/family member relationships	6
	Addressing other parent-child/family member relationships	8
	Strengthening family hopes and goals	8

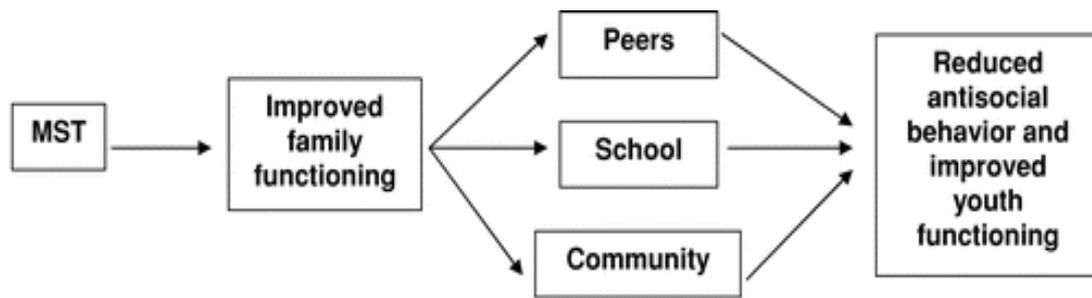


Figure 1. MST theory of change (Henggeler et al., 2009)

From Henggeler et al., (2009) The Multisystemic Theory of Change. In: Henggeler, et al., S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009).

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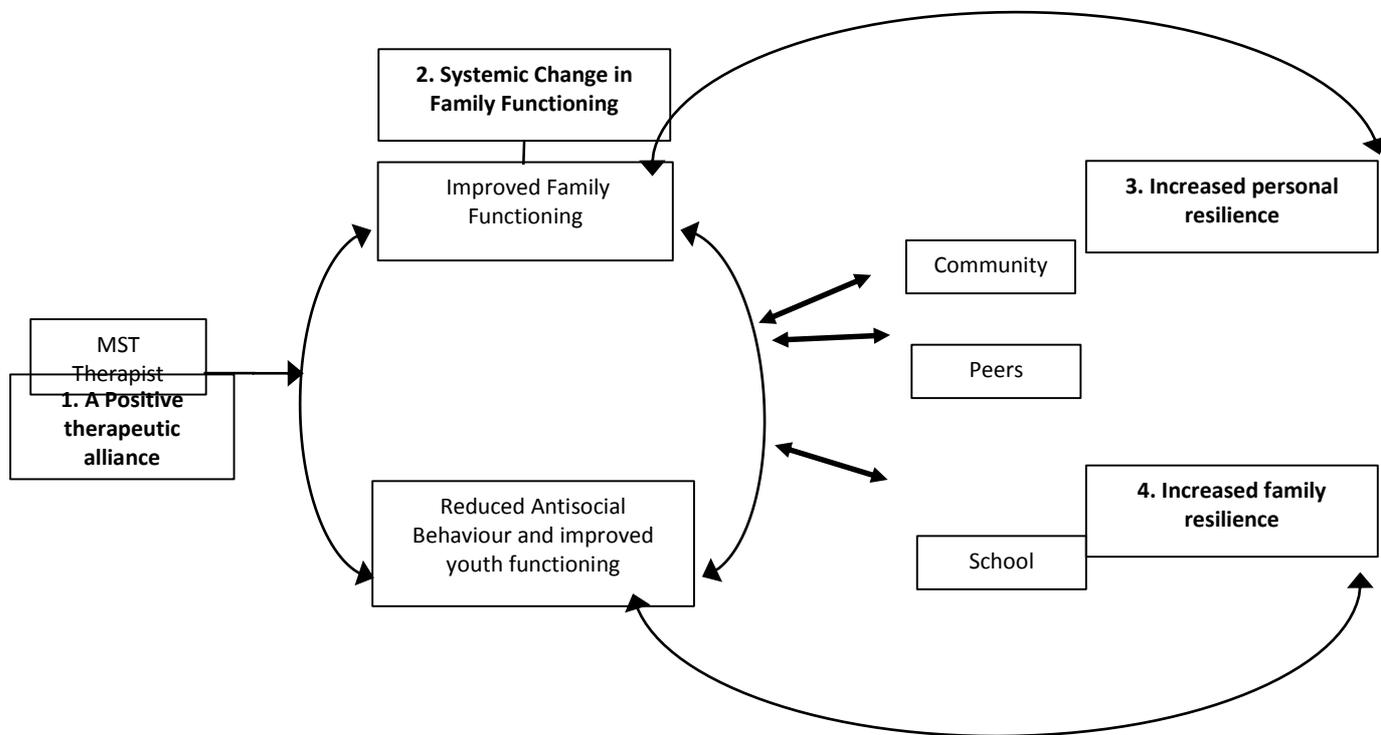


Figure 2