

**Multisystemic therapy in families of adopted young people referred for  
antisocial behaviour problems**

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## **Abstract**

The number of looked-after children being adopted in the UK is at its highest recorded point. Many of these adopted children have experienced difficult beginnings to their lives that can give rise to serious emotional and behavioural challenges. A primary intervention delivered to adopted young people presenting with antisocial behaviour is Multisystemic Therapy (MST). Despite the substantial evidence base for MST in non-adoptive populations, no research evaluating the effectiveness nor the experience of MST in adoptive populations exists. The aim of this study was to fill this gap in knowledge. A quantitative review of outcome data from 29 adoptive cases across five MST sites concluded comparable effectiveness of MST in adoptive to nonadoptive populations, but highlighted behaviours showing most and least change. To explore adoptive families' experience of MST, a qualitative approach was adopted and 10 semi-structured interviews were carried out with 11 adoptive parents. Thematic analysis identified five major themes that were service user validated: situation prior to MST, enablers to change, barriers to change, outcomes of MST, and modifying MST to better meet the needs of adoptive families. The study highlighted that, whilst MST can effectively reduce antisocial behaviour in adopted young people, there is scope to improve the experience of MST for adoptive parents by better consideration of the unique factors facilitating engagement and change. Potential modifications to current MST practice are highlighted, including the importance of appropriate training and supervision, sensitive working with adoption, and the incorporation of adoption related theory. Research implications, study limitations, and personal reflections are also discussed.

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# 1 Introduction Chapter

## 1.1 Background

The number of looked-after children being adopted in the United Kingdom (UK) is at its highest recorded point, with figures showing an increase of 31% between the years 2013 to 2015 (Department of Education, 2015; Vickerstaff, 2014). It is well evidenced that many of these adopted children have experienced challenging beginnings to their lives that can increase the risk of a range of serious emotional and behavioural challenges (Richardson & Lelliott, 2003; Selwyn, Wijedasa, & Meakings, 2014). To ensure that the needs of this vulnerable population are being appropriately addressed, there is a growing drive in government to improve the therapeutic support for adoptive families in the UK (Selwyn et al., 2014; Stock, Spielhofer, & Gieve, 2016). However, despite such an increased focus on the population, there is a distinct lack of knowledge of both the content of different interventions being delivered and their efficacy in adoptive families (Lewis, 2015; National Collaborating Centre for Mental Health, 2015).

A primary intervention delivered to adopted young people presenting with behaviour problems and at risk of placement disruption is Multisystemic Therapy (MST; Department of Education, 2015; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009; National Institute for Clinical Excellence, 2013). Although there exists a substantial evidence base for MST in nonadopted young people (Van der Stouwe, Asscher, Stams, Deković, & Van der Laan, 2014), there exists no known published research that evaluates its efficacy in adoptive populations (J. Littell, personal



communication, 28<sup>th</sup> July 2015; T. Van der Stouwe, personal communication, 28<sup>th</sup> July 2015).

The present research will provide the first insight into the effectiveness and experience of MST in adoptive families. The study aims to contribute to the MST knowledge base and to inform MST programme developers, services, and therapists around potential practice modifications to better meet the needs of adoptive families.

This chapter provides the foundation for the research aims. Commencing by providing an overview of adoption in the UK, with a focus on the subset of the adoptive population at risk of *adoption disruption*, the chapter will go on to consider factors associated with the development of behavioural difficulties in particular reference to adopted young people. The evidence base for interventions targeted specifically for adoptive families at risk of adoption disruption will be appraised before moving the focus on to MST. A brief background of MST will be offered, including a review of its evidence base, adaptations, and current standing in adoptive populations. Arguments in favour of developing targeted interventions to address the unique context of adoptive families will be considered, leading to the rationale and aims of the current study.

## **1.2 Adoption in the UK**

The use of adoption for children unable to live with their birth family has been promoted by the UK government since 1998 (Local Authority Circular, (98) 20) and remains seen as the best option for providing vulnerable children with security, stability, and love through their childhood and beyond (Department

of Education, 2012). In 2012, the government built on the standards and regulations outlined in the Adoption and Children Act (2002) and the Adoption Support Services Regulation (2005) by publishing the Action Plan for Adoption (2012). The UK Government is set on continuing to enhance both the number and the quality of completed adoptions, with emphasis on reducing delay and providing adequate support and guidance during the adoption process and beyond (Department of Education, 2012).

In 2016, 70,440 children were looked-after by English local authorities, of which approximately 4,690 were entered onto the Adoption register (Department of Education, 2017). Of the children adopted, there was an even gender ratio, although the majority were of White ethnicity (83%) and adopted between 1 and 4 years of age (74%). Moreover, 89% of children were adopted by two people and 11% were adopted by a single adopter.

Evidence suggests that approximately three-quarters of all adopted children have been abused or neglected at time of adoption (Selwyn et al., 2014).

Although the majority of children adopted into a stable family overcome the challenges related to their earlier experiences with the potentially reparative experience of new attachment relationships and standard family life (Argent & Coleman, 2012; Holloway, 1997), adopted children are at greater risk of developing physical, emotional, cognitive, educational, and social development needs (Richardson & Lelliott, 2003). In response to the evidenced traumas experienced by many adopted young people, there has been a growing drive in the UK to improve the therapeutic support for this vulnerable population (Department of Education, 2013). In May 2015, the

national Adoption Support Fund was launched for this purpose; funds of £19.3 million were initially offered over 2 years and then extended for a further 4 years in January 2016. The fund recognises that, whilst adoption can improve outcomes and stability for many looked after children (Holloway, 1997), the appropriate and targeted therapeutic support available to adoptive families is lacking. Without this necessary therapeutic support, there is an increased risk that adoption placements breakdown and for the legally adopted child to leave their family before the age of 18 years old (Selwyn et al., 2014); this breakdown in placement is known in the UK as adoption disruption.

### **1.3 Adoption Disruption**

In the first national study of adoption disruption, Selwyn et al. (2014) found that over a 12-year period the disruption rate in England was between 3 and 8%. Higher figures have been reported for children placed with special needs, such as emotional and behavioural problems and/or physical or mental disabilities, with Triseliotis (2002) reporting an overall breakdown rate of around 19%, with the follow-up periods ranging from 2 to 8 years after placement. Higher figures have also been reported for children placed into adoption later; Rushton and Dance (2006), for example, described a disruption rate of 19% in their study of children placed for adoption between 5 and 11 years old.

The national report by Selwyn et al. (2014) identified critical features of the adopted population that experienced placement disruption compared to those that remained intact. Particularly, the children whose adoptions had disrupted

were significantly older at entry to care, recorded significantly more placement moves, and waited longer to be placed with their adoptive family. Moreover, two-thirds of adoption disruptions occurred during the secondary school years with children being on average 13 years old when they left their families. The finding that adoption disruptions are 10 times more likely to occur with teenagers compared to young children highlights the critical need for support services to be available across all phases of the adoption life cycle and not only in the initial months and years of placement. Finally, gender and ethnicity were not found to be associated with greater risk of disruption, therefore challenging the view that boys are more difficult to parent than girls.

There exists an extensive literature on adoption disruption (Child Welfare Information Gateway, 2012; Coakley & Berrick, 2008; Rosenthal, 1993; Rushton, 2004; Sellick, Thoburn, & Philpot, 2004) which produces consistently comparable findings as to the associated factors. Such factors include child-related factors such as age of adoption, birth family factors such as child abuse and neglect, and system-related factors such as waiting times and a lack of adequate understanding and support for adoptive families (Selwyn et al., 2014). Clinicians' accounts of working with adopted children further highlight the importance of the internal world of the child in regards to adoption disruption; failure to appropriately attend to a child's grief and loss and incomplete or misunderstood histories can prevent a child from developing an integrated sense of self necessary for successful placements (Hopkins, 2006; Rustin, 2006).

Of the factors recognised as being reliably associated with adoption disruption, the most consistently cited across the literature concerns child behavioural problems (Child Welfare Information Gateway, 2012; Coakley & Berrick, 2008; Selwyn et al., 2014). This factor will form the basis of the subsequent review.

#### **1.4 Behavioural Problems and Adopted Young people**

Many children adopted into a stable family overcome the challenges related to their earlier experiences with the potentially reparative experience of new attachment relationships and standard family life (Argent & Coleman, 2012; Holloway, 1997). However, empirical literature has consistently evidenced that adopted young people are at a greater risk of developing behavioural problems than nonadopted young people (Hoksbergen, Rijk, Van Dijkum, & Ter Laak, 2004; Juffer & van Ijzendoorn, 2005, 2009; Merz & McCall, 2010; Stams, Juffer, Rispen, & Hoksbergen, 2000; Wiik et al., 2011). Keyes, Sharma, Elkins, Iacono, and McGue (2008), for example, reported that adopted adolescents were twice as likely to be diagnosed with disruptive behaviour disorder as nonadopted adolescents, and Rueter and Koerner (2008) reported that the odds of presenting with externalising problems were three times greater for adopted over nonadopted young people.

The developmental pathway to behavioural problems is heterogenous for all individuals, independent of whether one is adopted or nonadopted, and a common theme from comprehensive reviews of the literature is that risk factors are both plentiful and diverse (Frick, 2004). Behavioural problems are multidetermined by a number of factors that cluster together and interact in

the lives of young people, including those pertaining to the individual (e.g. low cognitive functioning, poor social skills), family (e.g. low warmth, ineffective discipline, lack of parental supervision, conflict), peers (e.g. association with deviant peers), school functioning (e.g. poor academic performance, dropping out), and community (e.g. disorganisation and neglect, attachment a criminal subculture) (Office of Juvenile Justice and Delinquency Prevention, 1993; Youth Justice Board, 2001). Abuse during childhood and time spent in public care have also been identified as increasing risk of behavioural problems; one explanation for this is that such experiences increase the intensiveness with which other risk factors cluster together (Youth Justice Board, 2001).

Beyond general risk factors to the development of behaviour problems, the literature has drawn on several targeted explanations to account for the finding that adopted young people are at a greater risk of developing behavioural problems than nonadopted young people, including pre-adoption adversity, attachment difficulties, family processes, and identity development. Although such explanations are not generalisable to all adopted young people, nor exclusive to the experiences of this population, they are recognised as significant risk factors worthy of further description. The review will present a brief narrative of each in relation to adoption before drawing on evidence associated with the development and maintenance of behavioural problems.

#### ***1.4.1 Pre-adoption adversity***

In a review of 68,110 children in care in the UK in 2013, three-quarters of children had been abused or neglected prior to placement in adoptive families

(Selwyn et al., 2014). Beyond maltreatment, adopted young people may also be exposed to low-levels of maternal warmth, emotional support, and contingent responsiveness and heightened levels of maternal stress; researchers subscribe to the notion that these early life conditions might contribute to the advancement of behaviour problems in later life (Howe, 1997; Johnson et al., 2002; Kitzmann, Gaylord, Holt, & Kenny, 2003; Merz & McCall, 2010). This notion was further supported by a longitudinal study of 95 children adopted in infancy which demonstrated a significant relationship between pre-adoption adversity and the development of behavioural problems at school age (Gagnon-Oosterwaal et al., 2012). Consequently, the authors concluded that, due to pre-adoption adversity, adopted children are at greater risk of developing behaviour problems than their nonadopted peers.

#### ***1.4.2 Attachment issues and grief***

Children's attachment relationships are believed to reflect the prior quality of interaction with their primary caregiver and to predict later socioemotional competence (Bowlby, 1969, 1988). However, due to the number of adopted children exposed to insensitive, nonresponsive caregiving, they are more likely to acquire maladaptive patterns of emotional control and interpersonal communication and to develop insecure attachment relationships (Belsky & Nezworski, 2015; Dozier & Rutter, 2008). In a meta-analysis of 39 studies that reported on the attachment relationship between adopted children and their adoptive parents, van den Dries, Juffer, van Ijzendoorn, and Bakermans-Kranenburg (2009) found that whilst children who were adopted before 12 months of age were as securely attached as nonadopted children, those

adopted after this age showed significantly less attachment security and significantly more disorganised attachments than nonadopted children. In another review of disinhibited attachment disorder (DAD) in adopted children without a history of institutional care, Kay, Green, and Sharma (2016) reported a difference between children placed at birth and those placed between 7 and 24 months; 82% of the latter group showed DAD, nine times more than the former group. Of note, this association was observed only for DAD and no other form of psychopathology.

The notion that insecure attachment may be related to the development of aggression and antisocial behaviour has been presented in the literature from as early as Bowlby's initial works on attachment and separation (Bowlby, 1944). In a recent meta-analysis drawing on data from nearly 6,000 children tested in standardised observational assessments of mother-child attachment security, Fearon, Bakermans-Kranenburg, van Ijzendoorn, Lapsley, and Roisman (2010) supported this notion by evidencing a large significant effect for the association between insecure and disorganised attachment and the development of children's externalising behaviour problems. Of note, this effect does not inform causality and allows for the role of unspecified moderating factors on the relationship. Nonetheless, the association between adoption, insecure attachment, and externalising behaviour problems is a fundamental one when exploring explanations for the increased behavioural problems presented by adopted young people.



### **1.4.3 Family processes**

Rueter, Keyes, Iacono, and McGue (2009) reviewed the similarities and differences in interaction processes of adoptive and nonadoptive families utilising self-report and observational measures. Moreover, they controlled for unmeasured differences between adoptive and nonadoptive families by utilising both between and within family comparisons. A total of 284 families of adopted adolescents, 208 families of nonadopted adolescents, and 123 families with both adopted and nonadopted adolescents were included in their analysis. Rueter et al. (2009) observed several similarities in the parental behaviours shown in adoptive and nonadoptive families, including levels of parental warmth, supportive communication, and control. However, the authors recognised that adopted adolescents were less warm and more conflictual than nonadopted adolescents towards their parents. Moreover, adoptive families evidenced a greater level of parent-child conflict than nonadoptive families and in families with adopted and nonadopted adolescents a higher level of conflict was evidenced between parents and their adopted adolescents. This high-quality study highlights the unique aspects of adoptive family interactions, which is significant considering the strong association demonstrated in the literature between family processes and the adjustment of adolescents. A recent meta-analysis of 401 effects from 52 studies, for example, highlighted evidence for a robust correlation between parent-child conflict and child maladjustment (Weymouth, Buehler, Zhou, & Henson, 2016).

#### **1.4.4 Identity development challenges**

Identity development is a challenge for all adolescents (Erikson, 1968). However, the challenge is recognised as pertinent for adopted adolescents due to several factors including persisting feelings of abandonment and rejection (Van Gulden & Bartels-Rabb, 1997), ongoing resentment from a sense of disadvantage (Schechter & Bertocci, 1990), the extension of the *birth family romance* fantasy (Rosenberg & Horner, 1991), and a conflict between *false-self* as an adoptee and *real-self* pertaining to the biological family (Haimes, 1987). Whilst these explanations are largely theoretical in nature, Smith, Howard, and Monroe (2000) conducted a formal review of identity issues in adopted young people by analysing the assessment data on 292 adopted children between 3 and 20 years of age who had been living with their adoptive families for a mean of 9 years. Of the adopted children, 64% experienced a range of identity-related concerns, conflicts, and anxieties, with one child quoted as saying “I want to know more about who I am” (p. 553). These young people reportedly expressed their frustration and desperation to resolve these issues behaviourally and verbally, presenting with above average behaviour problems. Although exploratory in nature, the study provided the first insight into the identity development challenges adopted young people face and concludes with the notion that problem behaviours presented by adopted young people represent outward signs of underlying, unresolved emotional problems. This finding conforms with others in the field demonstrating a significant association between identity distress and both internalizing and externalizing symptoms in adolescents (e.g. Hernandez, Montgomery, & Kurtines, 2006).

## **1.5 Interventions for Adoptive Families on the Edge of Disruption**

A growing body of evidence indicates that unaddressed mental health needs in adopted children can have a serious impact on placement success and increase the risk of disruption, further risking the long-term outcomes of adopted children (Selwyn, 2014). Consequently, there is a growing drive by the UK government to improve the therapeutic support for adopted young people and their families, with the aim to address and reverse the emotional, psychological, and developmental traumas they may have suffered in their early lives (Department of Education, 2013; National Implementation Service, 2016; Pennington, 2012). However, despite increasing focus on improving post-adoption therapeutic support, there is a lack of knowledge of both the content of different interventions being delivered to adopted families and their effectiveness in the population. Moreover, considering adoption disruptions are 10 times more likely to occur with teenagers compared to young children, adoption services have been slow to develop for adopted teenagers and for adopters who are parenting teens; this is highlighted by a review of interventions available to UK adopted families on the edge of placement breakdown that identified a serious lack of targeted interventions (Selwyn et al., 2014).

As part of their report, Selwyn et al. (2014) interviewed adoptive parents, adopted young persons, and service managers. In describing their experiences of accessing appropriate support services, parents frequently used words such as “nightmare” and “struggle” (p. 88). Moreover, managers reported that local Child and Adolescent Mental Health Services (CAMHS)

lacked clinicians who were trained in helping young people with attachment difficulties, with some areas of the country refusing to accept referrals from children with insecure attachments stating a lack of sufficient evidence base. Adoptive parents provided examples of being turned away in such circumstances and refused help, conforming to additional findings that therapists are not adoption sensitive (Barth & Miller, 2001). Due to adoptive parents' struggle to identify effective interventions for their children, Selwyn and colleagues reported that almost half had paid for private therapy and nearly a third had been in touch with their local member of parliament. The authors called for the development of specialist services for the proportion of adopted children who present with behavioural problems and are at risk of adoption disruption.

In 2015, the Department of Education commissioned an evidence review of the 15 most prescribed and high profile therapeutic post-adoption support interventions (Stock et al., 2016). The review identified that although some interventions – namely MST, Eye Movement Desensitisation and Reprocessing Therapy, Dialectical Behaviour Therapy, and Non-Violent Resistance – demonstrated an extensive evidence base in nonadoptive populations, there existed none, or very few, robust published studies providing evidence of intervention effectiveness in adoptive populations. This was particularly pertinent for conduct problem therapies aimed at addressing child antisocial and offending behaviour.

As a means of building the evidence base for post-adoption support interventions, Stock et al. (2016) recommended the exploration of qualitative

and process evidence to better understand adoptive family experiences and why nontargeted interventions may or may not work. In addition, they called for more robust quantitative research on the impact of interventions in adoptive populations.

## **1.6 Modifying Interventions for Adoptive Families**

It is well suggested in the literature that the behavioural difficulties presented by some adopted young people may be qualitatively different from those presented by nonadopted young people due to the unique process of adoption (Barth & Miller 2005; see Section 1.4.). Such differences may be the foundation for why many adoptive parents appraise that therapists are not adoption sensitive (Barth & Miller 2001). Beyond qualitative differences between adopted and nonadopted young people presenting with behaviour problems, research in the field indicates several differences between adoptive and nonadoptive families with regard to: (a) adoptive parents higher levels of education on average than most other parents receiving child services (Ingersoll, 1997; Zill, 1996); (b) divergence between the cognitive and behavioural styles of adopted young people and their adopted parents (Plomin et al., 1997; Rueter et al., 2009); (c) particular dynamics and challenges of blended families with biological and adopted children (Barth & Berry, 1988; Barth & Brooks, 1997); (d) greater level of parent-child conflict evidenced in adoptive families (Rueter et al., 2009); (e) adoptive parents greater level of parental investment strategies including economic, cultural, interactional, and social resources (Hamilton, Cheng, & Powell, 2007); and (f) adoptive parents high participation in social service agencies prior to referral

for post-adoption services (Ingersoll, 1997; Selwyn et al., 2014). Because of such outlined differences and the unique context of adoption, it follows that interventions targeted at overcoming the difficulties of adopted young people and their families should be qualitatively different than standard intervention approaches to ensure their needs are appropriately considered (Barth, Crea, John, Thoburn, & Quinton, 2005).

Researchers and practitioners acknowledge the need to draw on interventions that are grounded in theory with demonstrated effectiveness in nonadoptive populations, and then adapting them to better meet the needs of adopted families (Barth & Miller, 2001; Torrey, Finnerty, Evans, & Wyzik, 2003). In line with this, a leading recommended evidence-based intervention for young people with antisocial behavioural problems is MST (National Institute for Clinical Excellence, 2013). Of note, antisocial behaviour is defined in law as behaviour which causes, or is likely to cause, harassment, alarm, or distress to others (Home Office, 2014).

## **1.7 MST**

MST is a family- and community-based therapy for young people aged 11 to 17 years presenting with antisocial behaviour, including violent offenders, sexual offenders, substance-abusing offenders, and youth with serious emotional disturbance (Henggeler & Borduin, 1995; Henggeler & Schoenwald, 1998; Henggeler, Schoenwald, et al., 2009; Henggeler & Sheidow, 2012). MST is an intensive intervention with one therapist offering a family on average three sessions a week for 3 to 5 months; the MST team are also on call to families 24-hours a day, seven days a week. The intervention

strategies used by MST therapists are evidence-based and include cognitive-behavioural, behavioural, functional, and behavioural family systems theory approaches (Henggeler & Borduin, 1995).

### **1.7.1 *Origins of MST***

Originally developed in the United States, MST emerged in response to research demonstrating the influence of all individual, family, caregiver, school, and community factors on the development and maintenance of antisocial behaviour in young people (e.g., Farrington, 2005). Unlike the traditional treatment provision for antisocial behaviour, the developers of MST moved away from focusing exclusively on individual risk factors and instead developed a treatment model to address the multiple risk and etiological factors associated with antisocial behaviour (Fox & Ashmore, 2015). MST can be seen, therefore, as representing a more comprehensive and ecologically valid approach to the treatment of antisocial behaviour in young people (Kazdin & Weisz, 1998).

### **1.7.2 *Theoretical rationale***

Bronfenbrenner's theory of social ecology (1979) acts as a conceptual foundation for MST. Young people are understood within multiple systems including the family, peer, school, and community and it is theorised that each system acts to directly and indirectly influence behaviour. The aim of MST is to enable the systems to efficiently manage the young person so that their antisocial behaviour reduces and their prosocial behaviour increases (Henggeler, Schoenwald, et al., 2009).

### **1.7.3 MST principles**

The development and implementation of MST is underpinned by a set of nine treatment principles (Henggeler, Cunningham, Pickrel, Schoenwald, & Brondino, 1996):

1. "Finding the fit," where the primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
2. "Focusing on positives and strengths," where therapeutic contacts emphasise the positive and use systemic strengths as levers for change.
3. "Increasing responsibility," where interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
4. "Present focused, action oriented and well defined" interventions.
5. "Targeting sequences," where interventions target sequences of behaviour within and between multiple systems that maintain the identified problems.
6. "Developmentally appropriate," where interventions fit the developmental needs of the youth.
7. "Continuous effort," where interventions are designed to require daily or weekly effort by family members.
8. "Evaluation and accountability," where intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.



9. “Generalisation,” where interventions are designed to promote treatment generalisation and long-term maintenance of therapeutic change by empowering caregivers to address family members’ needs across multiple systemic contexts.

Fundamentally, MST is unique in its ability to adapt to the individual family’s circumstances and their broader systemic context. It draws on a strength-based approach with the aim of empowering the family to develop the skills, resources and competencies to aid responsible functioning. In turn, these aim to overcome sequences of behaviour maintaining the problem behaviour. Finally, central to the fidelity of the model is the use of comprehensive quality assurance from multiple perspectives and the recognition of barriers to successful outcomes.

#### **1.7.4 MST and change**

The MST theory of change proposed by Henggeler, Schoenwald, et al. (2009) is underpinned by the notion that a problem can be reduced by treating its causes. In terms of adolescent antisocial behaviour, the MST treatment model builds on identified strengths and targets known risk factors by improving family functioning with emphasis on the empowerment of caregivers and parental effectiveness (Henggeler, Schoenwald, et al., 2009). The MST theory of change, depicted in Figure 1, proposes that improvements in family functioning lead to improvements across a young person’s systems and, consequently, reduced antisocial behaviour and improved functioning. The MST model of change has been updated to highlight the bi-directionality of the change process (MST UK, 2016).

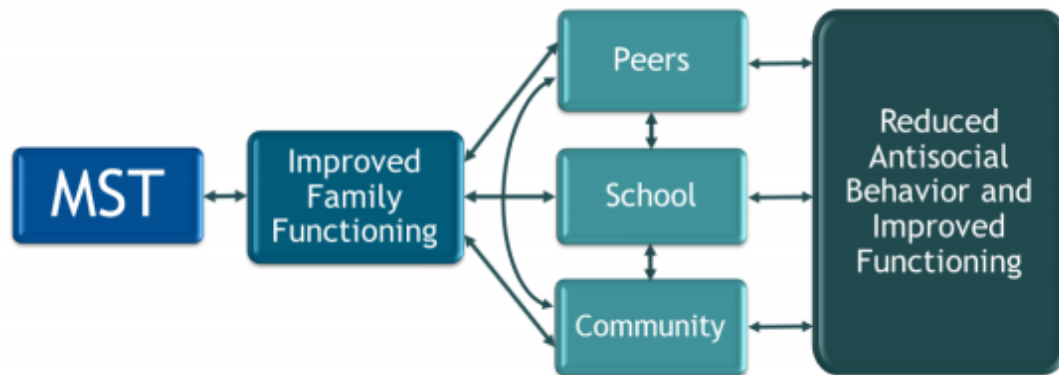


Figure 1. MST Theory of Change (MST UK, 2016).

### 1.7.5 MST evidence base

Since the first efficacy trial of MST (Henggeler et al., 1986), the field has gone on to produce a further 62 outcome, implementation, and benchmarking studies, yielding more than 120 published, peer-reviewed journal articles (MST Group, 2017). There exist 25 randomised control trials (RCTs), recognised by many as the gold standard for evaluating the effectiveness of interventions (Barton, 2000); 11 of these were conducted with serious juvenile offenders and four with adolescents with serious conduct problems. The MST evidence-base has, more recently, been supplemented by several process studies investigating the mechanisms of change and engagement related to the MST model.

#### 1.7.5.1 Outcome studies

The first independent review of MST in the UK was conducted by Butler, Baruch, Hickey, and Fonagy (2011) with the aim of comparing MST to usual services delivered by youth offending teams. Using an RCT design with 108 families, Butler and colleagues concluded that although both interventions were effective in reducing offending, MST showed significantly greater

reductions in aggressive and delinquent behaviours from pre-treatment to time of discharge. Moreover, compared to youth offending teams, MST demonstrated greater long-term benefits with a significantly greater reduction in non-violent offending during an 18-month follow-up period. Conclusions are limited due to the study's small sample size, resulting in insufficient power to detect more modest treatment effects. Furthermore, the study fails to address what aspects of MST are most beneficial or unique in addressing the problems of youths and families in the UK. These limitations are hoped to be addressed in the larger, multi-site RCT currently taking place in the UK (Fonagy et al., 2013).

As a means of collecting and critically analysing the array of individual MST research studies that have been published over the past 30 years, Littell, Popa, and Forsythe (2005) conducted a systematic review of MST behavioural and psychosocial outcomes in young people and their families. The review identified eight RCTs eligible for inclusion and pooling of results demonstrated effects favouring MST over usual services, although these were not significant. The authors highlighted concerns around poor study quality due to inadequate randomisation procedures, lack of assessor blinding, self-report measures, and the exclusion of dropouts from analyses. Due to the low statistical power and quality of the analysis and the heterogeneity of effects across studies, the authors were unable to conclude whether MST has clinically significant advantages over other services.

Van der Stouwe et al. (2014) looked to build on Littell's review with a larger body of studies including unpublished and quasi-experimental, and the use of

multi-level meta-analytic techniques to control for dependency of study results. Their review included 4,000 young people from 22 studies dated between 1985 and 2012. In this analysis, small but significant treatment effects were found on the primary outcome delinquency and on the secondary outcomes including psychopathology, substance use, family factors, out-of-home placement, and peer factors. Whilst some of the studies included in the review were of weak study design and therefore of questionable validity, the inclusion of such studies allowed for a broad and thorough overview of MST research from across the world. The findings from the meta-analysis demonstrate MST as effective in reducing antisocial behaviour in young people. Moreover, they provide support for the MST theory of change (Henggeler, Schoenwald, et al., 2009; see Section 1.6.4) in emphasising the role of improved parenting and family functioning on antisocial behaviour of young people. The additional impact on outcomes such as peer factors and substance use further emphasise the multi-modal approach of MST.

It must be noted that personal communication with the authors highlighted that no study included in either review referred to the inclusion of adoptive populations or made attempts to explore this population specifically (J. Littell, 28th July 2015; T. Van der Stouwe, 28<sup>th</sup> July 2015). Consequently, one is unable to apply conclusions to this unique population or draw inferences as to the effectiveness of MST in adopted young people presenting with antisocial behaviour or their families.

### **1.7.5.2 Process studies of MST**

Beyond outcome studies, there has been a recent emphasis on the exploration of the mechanism through which clinical improvement occurs in MST (Kazdin, 2007). In the assessment of juvenile offenders, Huey Jr, Henggeler, Brondino, and Pickrel (2000) identified that therapist adherence to MST protocol was associated with improved family functioning and decreased affiliation with antisocial peers which were both, in turn, associated with decreased delinquent behaviour.

Furthering investigation into the mechanisms of change in MST is the recent influx in qualitative studies exploring parents' and young peoples' experiences of MST. Caregiver perspectives, in particular, are recognised as fundamental given MST's emphasis on their role in facilitating changes in youth antisocial behaviour (Henggeler, Schoenwald, et al., 2009). Tighe, Pistrang, Casdagli, Baruch, and Butler (2012), for example, interviewed 21 parents and 16 young people and using thematic analysis highlighted two main themes relating to engagement in MST and initial process of change and the complexity of outcomes. Overall, families' accounts of their experiences of MST were positive, appreciating the person-centred approach, the flexibility of the model around their schedule, and it being in the family home. The importance of the therapeutic alliance was emphasised along with the MST engagement model. Moreover, value was placed on the ecological systems approach to understanding and resolving difficulties. A criticism of the intervention was its time-limited nature, with families reporting that they struggled after the intervention had ended and would have favoured a more tapered approach to

ending. In terms of MST outcomes, families reported a wide range of benefits beyond reductions in antisocial behaviour such as the emotional quality of the parent-adolescent relationship, educational reintegration, increased parental strength and changed perspectives on behaviour by both parent and young person. Researchers noted less discussion around the impact of MST on peers, despite it being a primary focus of change in the MST model. Although Tighe et al. (2012) highlighted enhanced parenting skills and improved family relationships as mechanisms of change in MST, they were unable to make generalisations as to the sustainability of change because the average interview time was only 2 months' post-intervention. Moreover, the sample focused exclusively on birth families; as such, one is unable to apply the study's findings to the experiences of adopted young people and their families.

Further qualitative studies have built on Tighe and colleague's initial findings by review of process factors contributing to sustained change over a longer follow-up period (Kaur, Pote, Fox, & Paradisopoulos, 2015; Paradisopoulos, Pote, Fox, & Kaur, 2015). In a study of parents' experiences, Kaur et al. (2015) expanded on caregivers' experience of improved family functioning, emphasising the contribution of the therapeutic alliance, parental efficacy, and positive family relationships in initiating change. In a parallel study of young persons' experience, Paradisopoulos et al. (2015) highlighted the systemic, developmental and individual factors in relation to how change is sustained. A limitation of both studies is that they excluded parents of families who did not meet the service's positive outcome criteria at the end of MST. Although this

exclusion criteria stemmed from the studies focus being on how positive outcomes were sustained in order to generate a model of sustained change, their conclusions only offer a partial picture relating to long-term change and no insight into the factors which were perceived as hindering this outcome. Moreover, as with the previously-cited studies, Kaur et al. and Paradisopoulos et al. (2015) focused exclusively on the experiences of birth families and did not address adoptive families in their investigation.

### **1.7.6 Adaptations of MST**

In addition to the original *standard* MST programme (Henggeler, Schoenwald, et al., 2009), multiple adapted versions of MST have been developed to better-target the unique contexts of vulnerable populations (MST Services, 2015). For example, MST for Child Abuse and Neglect (MST-CAN) was developed to treat families who have come to the attention of Children's Services due to physical abuse or neglect, MST Family Integrated Transitions (MST-FIT) uses standard MST principles with additional components to address the specific issues and contexts of young people returning home from care or custody, and MST Substance Abuse (MST-SA) treats young people who are abusing drugs and alcohol. All such programmes developed from the recognition that, by combining the standard MST principles with components tailored to meet the unique circumstances of a population, MST will increase in effectiveness. Many high-quality effectiveness trials have gone on to support this notion (Henggeler, Clingempeel, Brondino, & Pickrel, 2002; MST Group, 2017; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010; Trupin, Kerns, Walker, DeRobertis, & Stewart, 2011).

## **1.8 MST and Families of Adopted Young People**

Despite the considerable evidence base for MST, there is no published research that evaluates the effectiveness nor experience of MST in adoptive populations (J. Littell, personal communication, 28<sup>th</sup> July 2015; T. Van der Stouwe, personal communication, 28<sup>th</sup> July 2015). Nonetheless, MST is widely offered to the families of adopted young people presenting with antisocial behaviour at risk of placement disruption because, to date, there exists no targeted intervention to meet the unique needs of this population in this situation (Department of Education, 2015; Selwyn et al., 2014).

The MST model is such that it moulds itself to the individual and complex needs of families and young people, recognising the heterogenous developmental pathways to antisocial behaviour (Barth & Miller, 2001; Henggeler & Schoenwald, 1998). Nonetheless, because the MST model has been neither designed for nor evaluated in adoptive populations, MST begins with some assumptions that may not consider the contextual characteristics and needs of adopted young people who present with antisocial behaviour and their families (see Section 1.4 & Section 1.6). For example, MST is present focused (Principle 4) and would often not consider the family's relationship history nor the adopted child's pre-placement experience which may be fundamental to the development and expression of an adopted child's antisocial behaviour (Barth et al., 2005). Importantly, adoptive parents have been critical of interventions that decline to consider a child's history in the formulation of the problem (Selwyn et al., 2014). MST's current lack of focus on the unique context of adoption might feed into anecdotal reports from MST



therapists querying the interventions suitability and effectiveness in adoptive populations (personal communication, 2016).

As no review of MST in adoptive families has been conducted, its suitability to this vulnerable population is unknown. Although no formal evidence indicates that knowledge of adoption issues is critical to the successful outcome of an intervention with an adoptive family, it is argued that for MST to be most effective in this population then modifications to practice should be considered to address their unique context (Barth et al., 2005; Barth & Miller, 2001; Pennington, 2012). Moreover, beyond modifications to current practice, adapting the MST model to better meet the needs of adopted populations would mirror earlier MST adaptations designed to target the unique contexts of other vulnerable populations (Pennington, 2012; see Section 1.6.6).

### **1.9 Rational for Current Study**

In response to the above, the current study will conduct the very first review of MST in families of adopted young people referred for antisocial behaviour problems. Initially, the study will review MST behavioural outcome data with the aim of providing an understanding as to the effectiveness of MST on behavioural change in adopted young people. This knowledge will provide the necessary foundation for the qualitative exploration of adoptive parents' lived experiences of MST which will form the primary focus of the project.

It is hoped that the findings from both the quantitative and qualitative evaluation of MST in adoptive families could be used to inform MST programme developers, services, and therapists around potential modifications to practice to ensure MST is better suited to the needs of this

understudied and vulnerable population. Finally, as this is the first study in the area it is hoped that it will highlight gaps in knowledge that would benefit from further research.

### **1.10 Aims of Current Study**

The aims of the study were:

- Using quantitative methodology, review MST behavioural outcome data to determine the effectiveness of standard MST in reducing antisocial behaviour and promoting behaviour change in adopted young people.
- Using qualitative methodology, explore adoptive parents' lived experiences of standard MST in relation to their context as an adoptive family.

## **2 Quantitative Review Chapter**

### **2.1 Introduction**

The current chapter describes the first quantitative review of MST effectiveness in adoptive populations with the aim of gaining an initial understanding of the impact of MST on behaviour change in adopted young people referred for antisocial behaviour problems. The quantitative review stands as a prerequisite to the main body of the research project: the qualitative exploration of adoptive parents' experience of MST.

### **2.2 Procedure**

The current study reviewed retrospective routinely-collected non-standardised MST behavioural outcome data from past adoptive cases identified from databases of five MST sites located across the UK. Although research ethics committee review was not required for the quantitative review due to the secondary use of information previously collected during normal care (UK Health Departments, 2011), full ethical approval was obtained as part of the larger research project; complete details can be found in Section 3.3.1.

To be included in the analysis, adoptive cases had to be on an included MST sites database for the receipt of standard MST. To optimise external validity, both treatment completers and treatment dropouts were included. Reasons for treatment dropout included lack of engagement, placement in a restrictive setting prior to or during MST, and family moving out of programme area. No exclusion criterion was applied.

The study reviewed two non-standardised behavioural outcome measures collected as routine in MST at the beginning of treatment and at time of discharge: ultimate outcomes and overarching goals (OAGs).

Ultimate outcomes are fundamental to the MST treatment protocol (Henggeler & Schoenwald, 1998) and are common to all treatments for young people with antisocial behaviour (Borduin & Schaeffer, 2002). The three MST ultimate outcomes are: living at home, attending education or employment, and no new arrests or criminal charges. All three ultimate outcomes are rated either *Yes* or *No* by the MST team (i.e. therapist, supervisor and MST expert) at time of referral and time of discharge. All ultimate outcome data is then recorded on the MST Institute website for quality and adherence purposes (MST Institute, 2017).

Where ultimate outcomes represent general MST outcomes, OAGs represent more idiosyncratic MST outcomes. OAGs are set early in treatment in collaboration with the family and key stakeholders and relate to goals specific to the young person. Any person or agency that may influence attainment of these goals is engaged by the therapist and caregiver with specific interventions designed to encourage actions. OAGs are focused on eradicating or meaningfully reducing the frequency and intensity of a referral behaviour, can be measured directly, and are written in a concise and coherent manner (Henggeler & Schoenwald, 1998). Examples of an OAG include reducing physical or verbal aggression in the home, increasing attendance in education, and reducing absconding from home. Each MST case is likely to develop three to five OAGs early in therapy that are reviewed

weekly over the course of treatment. Each OAG is rated by the therapist in conjunction with the family initially at baseline and then each subsequent week of therapy on a scale of 0 to 10, with 0 representing *goal not met/ high frequency of behaviour* and 10 representing *goal met/ no evidence of behaviour*. This study represents the first attempt to incorporate OAGs into a review of MST effectiveness on group behaviour change. Previous reviews of MST effectiveness have not included OAGs into their analyses due possibly to their idiosyncratic nature and the variability of data collection procedures between sites. However, by being the first known study to review OAGs the present study hopes to offer a richer insight into the specifics of behaviour change in adopted young people.

## **2.3 Analysis and Findings**

### **2.3.1 Ultimate outcomes**

Ultimate outcome data for adoptive cases were descriptively compared to the UK MST ultimate outcome data (James, 2016). The UK data involved outcomes from all young people referred for standard MST from January 1<sup>st</sup> until December 31<sup>st</sup>, 2015. UK ultimate outcome data reported 94% of cases lived at home, 81% were in school or work, and 88% had no new arrests.

Ultimate outcome data were identified for 29 adoptive cases across the five MST sites. Ultimate outcomes retrieved from adoptive cases at time of discharge indicated that 93% were living at home, 83% were in education, and 86% had not been arrested (see Table 1).

Table 1. *Ultimate outcome data for UK cases and adoptive cases referred for standard MST*

Ultimate outcome	All UK cases	Adopted cases
Living at home	94.0%	93.1%
In education/ employment	81.1%	82.8%
No new arrests/ charges	88.1%	86.2%

By descriptively comparing the identified data from adoptive cases with published UK MST data, the adoptive cases appear to respond to MST similarly to all UK cases but with a slightly lower percentage living at home and recording no new arrests and a slightly higher percentage being in education or employment at time of discharge.

### **2.3.2 Overarching goals**

Jacobson and Truax's (1991) method was used to calculate Reliable Change Index (RCI) for OAGs, using the following formula:  $RCI = (X_1 - X_2) / \sqrt{2(S_1^2(1 - r_{xx}))}$  where  $X_1$  is baseline rating,  $X_2$  is time of discharge rating,  $S_1$  is the standard deviation at baseline, and  $r_{xx}$  is the test-retest reliability. Estimates of test-retest reliability were obtained by reviewing OAG ratings between week 9 and 10 ( $r = 0.70$ ). Reliable change was consequently regarded as a four-point increase in OAG rating.

In accordance with previous research (e.g. Jacobson & Truax, 1991), clinically significant change was deemed to have been achieved if the following two criteria were met: firstly, the change in baseline to time of discharge rating was reliable according to the RCI ( $RCI = 3.62$ ); and secondly, time of discharge scores fell below or above clinical cut-off scores.

A clinically significant cut-off score for OAGs was determined following methods outlined by Jacobson, Follette, and Revenstorf (1986) who proposed that clinical significance represents a move from the dysfunctional population range into the functional population. To determine clinically significant cut-off, the present study used *criterion a*: a baseline to post-change of at least two standard deviations from the original mean (Jacobson, Follette, & Revenstorf, 1984). Calculations yielded a clinical cut-off score of 7.59; rounded to the nearest whole number this meant that a cut-off of eight or above indicated clinically significant improvement.

Of the 29 adoptive cases identified in the previous analysis of ultimate outcomes, OAG data was available for 18. This was a result of one of the five MST sites collecting OAG data in a format that could not be utilised in the current analysis. From the 18 adoptive cases identified, there totalled 90 OAGs, representing an average of five OAGs per case.

Analysis of reliable change according to the RCI and clinically significant change according to calculated cut-off score was carried out on all 90 OAGs identified. Findings demonstrated that 60 of the 90 OAGs demonstrated reliable change from baseline to time of discharge (67%), and 52 demonstrated clinically significant change (58%). An Excel spread sheet was utilised with the Leeds Reliable Change Indicator to graph the reliable and clinically significant change (Morley & Dowzer, 2014) (see Figure 2).

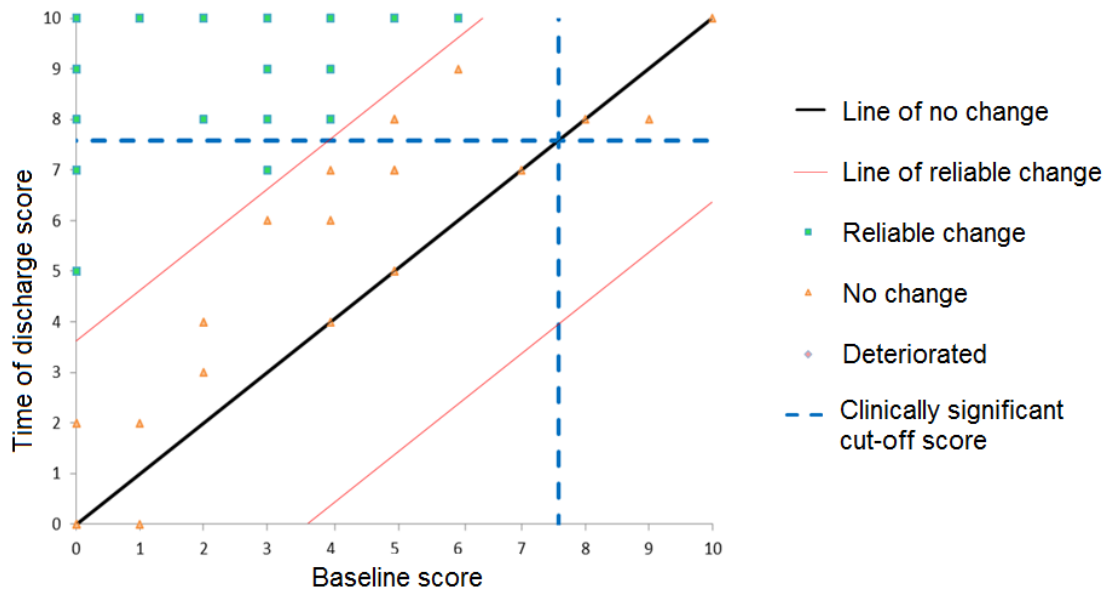


Figure 2. Scatterplot of adoptive cases' baseline and time of discharge OAG rating score and associated change classification.

To further examine the particular types of antisocial behaviour demonstrating change, the 90 OAGs were grouped into the following exclusive categories:

Physical aggression, home (N = 16); Verbal aggression, home (N = 13); Absconding, home (N = 12); Education, attendance (N = 10); Compliance with household rules (N = 7); Self-harm (N = 6); Theft (N = 6); Property aggression (N = 5); Substance use (N = 4); Education, behaviour (N = 2); Engaging with antisocial peers (N = 2); Inappropriate sexualised behaviour (N = 2); and Other, including attitude, button pushing and false allegations (N = 5). All OAGs relating to behaviour in education, theft, property aggression, compliance with household rules, physical aggression at home, absconding from home, and self-harm demonstrated 67% reliable change or greater.

However, verbal aggression at home, attendance in education, engaging with



antisocial peers, sexual behaviour, and substance use demonstrated reliable change below the mean. Reliable and clinically significant change for each of the OAG categories is presented in Table 2.

Table 2. *Reliable and clinically significant change of OAGs per behaviour category*

<b>OAG Category</b>	<b>Cases (N)</b>	<b>Reliable change</b>	<b>Clinically sig change</b>
Physical aggression, home	16	69%	63%
Verbal aggression, home	13	62%	46%
Absconding, home	12	67%	67%
Education, attendance	10	50%	30%
Compliance with household rules	7	71%	57%
Self-harm	6	67%	67%
Theft	6	83%	83%
Property aggression	5	80%	80%
Substance use	4	25%	25%
Education, behaviour	2	100%	0%
Engaging with antisocial peers	2	50%	50%
Inappropriate sexualised behaviour	2	50%	50%
Other	5	100%	100%
Total	90	67%	58%

## **2.4 Discussion**

The current chapter represents the first quantitative review of MST effectiveness on behaviour change in adoptive populations. It must be noted that all conclusions should be interpreted speculatively since the review was exploratory and not driven by hypotheses. Moreover, as only five of a possible 23 UK MST sites were included in the study the sample concerns

only a subset of adoptive cases and is therefore not representative of all adoptive cases who have received standard MST across the UK.

The review of ultimate outcomes from adoptive cases alongside UK MST data suggests that both populations demonstrate comparable outcomes at point of discharge, although a slightly lower percentage of adopted young people were living at home and recording no new arrests and a slightly higher percentage were in education or employment at time of discharge compared to nonadopted cases. The finding that MST has comparable effectiveness in adoptive and nonadoptive populations contradicts the anecdotal reports from MST therapists that queried MST's effectiveness in adoptive populations (personal communication, 2016). However, the examination of ultimate outcomes concerns only three broad areas of behaviour outcomes and offers little insight into the distinctive behaviour change undergone by each case.

The review of OAGs enables a more specific exploration of MST effectiveness on idiosyncratic behaviours from time of referral right through to time of discharge. On review of reliable change, MST with adopted young people appeared to be effective in reducing two thirds of behaviours, with over half of these reaching clinically significant change. On further analysis of categories of behaviours, MST appeared particularly effective in reducing idiosyncratic outcomes related to physical aggression at home, property aggression, compliance with household rules, and theft. However, it demonstrated relatively poor effectiveness for those outcomes related to education attendance and substance misuse. Unfortunately, it is not possible

to draw comparisons with nonadoptive cases as this study represents the first formal review of OAG data.

The findings from this quantitative review provide an initial insight into the effectiveness of MST on behaviour change in adopted young people referred for antisocial behaviour. However, the review of ultimate outcomes and OAGs have several limitations that are important to highlight.

Regarding the review of ultimate outcome data, it must be noted that UK cases will include an unspecified number of adoptive cases as they are also part of the national MST picture. Moreover, although it was not possible to source the sample size of the UK national data, it can be expected that it was significantly larger than the sample of adopted young people identified in the current study. Consequently, any conclusions should be interpreted as tentative and exploratory. Future studies might consider directly comparing ultimate outcome data from adoptive and nonadoptive cases within each MST site.

Regarding the review of OAGs, the use of non-standardised measures prevents the application of more sophisticated norm-based methods for calculating clinically significant and statically reliable changes (Jacobson & Truax, 1991). Standardised measures of behaviour were not included in the review as these have not historically been administered as standard practice across MST sites. Moreover, the quality and quantity of the OAG data was impacted on by several inconsistencies identified across MST sites in terms of how data were collected and stored. For example, demographic data was not consistently reported with the data file, sites differed on the direction of

the scale, and the weekly recording of OAGs was irregular. Consequently, OAG data from 11 adoptive cases was excluded due to it being uninterpretable and demographic data was not able to be documented alongside the data so conclusions as to the generalisability of findings is minimal. The sample size meant that the number of cases included in each OAG category was small, with some categories including only two cases; the validity of conclusions made from such small numbers is therefore impaired. Nonetheless, the analysis is presented as a means of offering a preliminary understanding into the type of behaviours being addressed in MST with adopted young people and the change in that behaviour from baseline to point of discharge. Considering the limitations, future studies may want to build on this first review of OAGs by completing similar analyses with data from nonadoptive cases within the same MST sites and drawing comparisons. Moreover, the review highlights the need for a larger, more formalised review of MST effectiveness in adoptive populations.

Despite the outlined limitations, the findings from the quantitative study do suggest that a fundamental aim of MST, reducing antisocial behaviour within the family system, is being addressed effectively in adoptive populations. The subsequent qualitative study will aim to build on this initial understanding by offering a broader and more detailed insight into MST in adoptive populations through the exploration of the lived experiences using qualitative methodology. It is hoped that the findings from both studies will enable a comprehensive overview of MST in this understudied and vulnerable population.

### **3 Method Chapter**

#### **3.1 Research Design**

A qualitative study was designed to explore adoptive parents' lived experience of MST, building on the previous quantitative study of MST effectiveness on behavioural change in adopted young people (see Chapter 2).

##### **3.1.1 *Rationale for a qualitative design***

The current study aims to understand the experience of MST from the perspective of adoptive parents. A qualitative methodology was opted for over quantitative due to its ability to provide a rich, overall description of an individual's experience necessary for a comprehensive understanding of a phenomenon (Braun & Clarke, 2006). The use of quantitative methodologies would likely restrict any exploration of subjective experience (Lyons & Coyle, 2016). Moreover, as this is, to the researcher's knowledge, the first exploration into adoptive parents' experience of MST, the project is exploratory in nature and therefore not testing any hypothesised relationships. Qualitative methodology is widely accepted as the optimal method for exploring new and developing areas (Elliott, Fischer, & Rennie, 1999), and particularly those areas concerned with exploring individual subjective experiences (Strauss & Corbin, 1998).

#### **3.2 Position of the Researcher**

The principle researcher was a female trainee Clinical Psychologist, from a white and middle-class background. Unlike the participants involved in the study, the researcher was not a parent. The researcher adopted elements of the essentialist paradigm position (see Braun & Clarke, 2006), thus presuming

a simple one directional relationship between meaning, experience and language. Although the researcher had conducted the previously outlined quantitative review of MST outcomes in adoptive families, she held no prior expectations of adoptive parents' experience of the intervention.

### **3.3 Procedure**

The qualitative project built on the previously outlined quantitative review of MST behavioural outcomes (see Chapter 2), drawing on the adoptive cases identified from the five MST sites used previously.

#### **3.3.1 Ethical approval**

Of the five included sites, three were run under the NHS, one was run by Social Services and the other was run by a Charity. For NHS MST sites, full ethical approval was obtained from the National Research Ethics Service (NRES, see Appendix A), and local Research and Development committees (see Appendix B). For the MST site under Social Services, approval had to be gained from the Director of Child's Services sitting within the Council; a similar application was also made for the Charity-operated MST site. In addition, ethical approval was gained from the Royal Holloway University of London Ethics Committee (see Appendix C) prior to commencing the research.

Ethical issues around informed consent, confidentiality, and disclosure of risk or discomfort were carefully considered and addressed in the following ways:

##### **3.3.1.1 Consent**

To ensure participants could make an informed decision about their participation in the study, all were provided with a detailed information sheet

(see Appendix D) and an opportunity to discuss any related queries with the researcher over the telephone in the weeks prior to interview, and again on the day on the interview face-to-face prior to completing the consent form (see Appendix E). All participants were made aware of their entitlement to withdraw from the study at any stage without this affecting their current or future care.

### **3.3.1.2 Confidentiality**

Only the administrators and supervisors of each site were aware of who was being contacted for the study, and verbal consent from participants was obtained before their details were passed on to the researcher. Participants were informed that the information they shared in the interview would be kept confidential and that their identities would be anonymised.

### **3.3.1.3 Disclosure of risk and distress**

Prior to interviews, the limitations of confidentiality in relation to the disclosure of risk were fully explained to participants both verbally and on the written information sheet. If any risk issues were identified during the interview, the researcher would contact the respective site supervisor and local risk procedures would be followed. If the family was no longer in contact with MST services, risk would be reported to social care teams following the local Child Protection guidelines.

After the completion of interviews, participants were provided with an opportunity to debrief to identify any unforeseen harm. If the researcher felt concerned about a participant, it was agreed with site supervisors that a conversation about seeking support would be appropriate.

### **3.3.2 Inclusion and exclusion criteria**

To be included in the study, participants had to be a parent of an adopted young person who had begun standard MST services for antisocial behaviour problems. To enhance external validity and due to sampling opportunities, both treatment completers and treatment dropouts were included. Moreover, the study did not impose any criteria related to a time-frame for when participants had received MST. Due to inability to offer interpreters, all participants had to be English-speaking and able to provide informed consent.

Participants were excluded from the study if they were currently in receipt of MST services to prevent any disruption of treatment. As the focus of the study was on standard MST, participants were excluded if they had received, or were receiving, adapted MST programmes (e.g. MST-CAN, MST-SA, MST-FIT). Moreover, participants who were identified with current risk to self or others by respective site supervisors were also excluded from the study.

### **3.3.3 Recruitment**

Contact attempts were made by site supervisors to all identified adoptive cases meeting criteria. If verbal consent was obtained, details were passed on to the researcher who would contact potential participants with further information regarding the study. The study aimed to recruit between six and 12 participants to conform to recent guidelines on thematic analysis (Braun & Clarke, 2013, p. 50) and to optimise the likelihood of achieving data saturation (Guest, Bunce, & Johnson, 2006).

Each participant was offered a fee of £10 as compensation for their time in accordance with recommendations by the Mental Health Research Network



(2013). To ensure participants were not inadvertently encouraged to risk harm beyond that which they faced in their normal lifestyles, participants were informed that their right to withdraw was not affected by the offer of any financial compensation for participation.

#### **3.3.4 Interview schedule**

Semi-structured interviews were selected as the means of data collection due to their suitability for the in-depth exploration of participants' experience of sensitive and complex issues (Barriball & While, 1994). Moreover, whilst semi-structured interviews involve direct questions they also allow for the investigation of issues not previously anticipated, thus insuring a fine balance between researcher-led questions and participant-led issues (Hugh-Jones & Gibson, 2012). By providing participants with a space to explore and expand on their experiences within the containment of a standardised interview schedule, semi-structured interviews were deemed optimal for the gathering of rich and detailed data on adoptive parents' experience of MST.

A draft interview schedule was developed with the academic supervisor in accordance with established guidelines (Smith, 1995) and based on that used by Tighe et al. (2012) in their study of nonadoptive parents' experience of MST. To ensure that the questions were suitable for the population, the draft interview schedule was consulted on by a site supervisor who was a practising MST therapist, as well as an adoptive mother who had previously received MST.

The final interview schedule (Appendix F) covered parents' experiences prior to, during, and after the intervention and was underpinned by the context of

adoption on that experience. Follow-up questions and prompts were designed to be used flexibly to ensure all participant accounts were fully elaborated (Sullivan, Gibson, & Riley, 2012).

### **3.3.5 Interviews**

All interviews were conducted by the researcher in a setting deemed comfortable by the participant, thus conforming to the MST treatment model (Henggeler, Schoenwald, et al., 2009). Eight of the interviews were conducted in participants' homes, with one being held in the community and another at the participant's place of work.

Before commencing the interviews, participants were provided with full study information and had an opportunity to ask any further questions. If they were happy to participate, they completed the consent form and their demographic details were collected.

Interviews lasted between 34 and 78 minutes and were recorded on a digital voice recorder with participants' consent.

## **3.4 Thematic Analysis**

Inductive thematic analysis at the semantic level was used to identify, analyse, and report patterns within the qualitative data (Braun & Clarke, 2006; Patton, 1990).

### **3.4.1 Rationale for using thematic analysis**

Although all qualitative analytical methods are underpinned by the elemental process of thematising meanings (Holloway & Todres, 2007), the process of thematic coding is recognised as a specific approach in its own right (Braun &

Clarke, 2006). Thematic Analysis was the chosen method of analysis in the current study as it enables the identification and analysis of patterns of meaning in a dataset with the aim of highlighting those that are most salient to the phenomenon under study (Braun & Clarke, 2006). Distinct to other methodologies, thematic analysis is not tied to a particular theoretical or epistemological position so acts as a flexible and useful research tool suitable for providing a rich and complex account of data (Braun & Clarke, 2006). Moreover, thematic analysis is deemed the most appropriate method of analysis in under-researched areas as it provides a rich overall description of data sets (Braun & Clarke, 2006).

An inductive approach to thematic analysis, in contrast to a theoretical approach, means that the themes identified in the analysis are strongly linked to the data collected, as opposed to being influenced by the researcher's own theoretical interests or analytic pre-conceptions (Braun & Clarke, 2006; Patton, 1990). Moreover, thematic analysis at a semantic level identifies themes within the explicit meanings of the data as opposed to a latent level of analysis that looks beyond the surface meaning for underlying ideas, assumptions or conceptualisations (Braun & Clarke, 2006; Patton, 1990). Both approaches conform to the researcher's previously-outlined essentialist position (see Section 3.2) and enables the researcher to draw direct links between the language of adoptive parents and their experience of MST (Braun & Clarke, 2006).

Although thematic analysis was considered the most appropriate qualitative method of analysis, other qualitative methods were considered when designing the current study and are outlined briefly below:

#### **3.4.1.1 Grounded theory**

Grounded theory facilitates the development of theory to explain the experiences, concepts, and categories arising directly from the data; data is therefore conceptualised as an essential basis from which theory develops (Glaser & Strauss, 1965; Strauss & Corbin, 1994, 1998). However, as this is the first investigation of MST in adoptive populations, the project is exploratory in nature and is not at a stage whereby theory development is deemed appropriate. Instead, a rich overall description of adoptive parents' experiences is necessary. Subsequent studies may wish to build on this description by using methods such as grounded theory to explore the phenomenon in greater depth and complexity.

#### **3.4.1.2 Interpretative Phenomenological Analysis**

Interpretative Phenomenological Analysis (IPA) aims to understand the experiences of participants through interpreting data to then hypothesising the meaning ascribed to that data (Larkin & Thompson, 2012; Smith & Osborn, 2003). For the purposes of the current research questions, IPA goes beyond the data as opposed to developing descriptive themes which are grounded in the data. Given that this is the first review of MST in adoptive populations, it felt more appropriate to remain close to the data to ensure adoptive parents' experiences are reflected as accurately as possible (Braun & Clarke, 2006).

### **3.4.1.3 Discourse analysis**

Discourse analysis examines the way language is used to construct the reality of an individual's world (Potter & Wetherell, 2001). The approach assumes that multiple realities of the world exist, shaped by existing knowledge or discourses. Due to the exploratory nature of the current study, it was appropriate to take a more essentialist stance to ensure broader societal narratives would not detract from participants' own accounts of their experiences, meanings, and reality (Braun & Clarke, 2006).

### **3.4.2 Stages of analytic process**

The analytic process within the current study followed the six phases of thematic analysis described by Braun and Clarke (2006). For clarity, the six phases of thematic analysis in relation to the current study are outlined below as discrete stages. However, it must be noted that the analytic process of thematic analysis is not a linear process but a recursive one, where the researcher moves fluidly back and forth between stages until a comprehensive thematic framework is produced (Braun & Clarke, 2006, 2013).

#### **3.4.2.1 Phase 1: Familiarisation with data**

To ensure familiarity with the depth and breadth of content, the researcher was immersed in the data by conducting, recording, and transcribing all interviews. Interviews were transcribed verbatim and interview checked against audio recordings to ensure accuracy of the written translation of verbal responses (Braun & Clarke, 2006). Once accuracy was confirmed, transcripts were transferred to QSR International's NVivo 10 Software (2012)

for analysis. All finalised transcripts were read and re-read until a thorough overview of the data set was achieved.

#### **3.4.2.2 Phase 2: Generating initial codes**

Once the researcher had appropriately familiarised themselves with the data, transcribed interviews were systematically analysed for initial codes related to participants' experience of MST. At this stage of analysis, codes relate to the most basic segment of the data that can be assessed in a meaningful way regarding the phenomenon (Boyatzis, 1998). The process of coding was entirely data-driven in that coding stemmed from participants' own words; no attempt was made to interpretively analyse the data. Generation of codes represents the initial assembly of data into meaningful groups (Tuckett, 2005).

Coding was completed using NVivo, which allowed the researcher to manually scrutinise each interview transcript systematically by adding relevant tags and names to selections of text (Welsh, 2002). Moreover, searching facilities within NVivo allowed the researcher to carry out quick and accurate searches, thus adding to the validity and rigour of the analysis process by ensuring that all instances of a certain usage were found (Welsh, 2002). The application of both techniques ensured a thorough integration of data. In accordance with Braun and Clarke (2006), no limitation was placed on the number of codes generated to ensure the production of a thorough, inclusive and comprehensive list of codes.

#### **3.4.2.3 Phase 3: Searching for themes**

Once codes were collated, the researcher refocused the analysis at the broader level of themes rather than codes by comprehensively examining the

associated data extracts. Through the recognition of similarities and differences between such extracts, the list of codes was refined into potential themes through the process of re-categorising, collapsing, and dividing (Braun & Clarke, 2006). Unlike codes, the development of themes incorporates the interpretation of the analyst and thus goes beyond participants' own use of language.

At the end of this phase, the researcher remained over inclusive until a deeper exploration of all extracts was conducted (Braun & Clarke, 2006).

#### **3.4.2.4 Phase 4: Reviewing themes**

Once the set of candidate themes had been identified, the next phase involved two levels of reviewing and refining such themes (Braun & Clarke, 2006). The first level involved the review of coded data extracts to identify whether they formed a coherent pattern appropriate for a theme. If the candidate themes did not suit, themes were reworded, subdivided, collapsed, or discarded from the analysis. Once the researcher was satisfied that the candidate themes reflected the contours of the data set, they moved onto the second level of the phase.

The second level concerned the assessment of themes in relation to the entire data set. The researcher reviewed the validity of each theme as a sole entity but also as a part of the wider candidate thematic map to ensure the meanings evident in the data set were appropriately reflected. In line with Braun and Clarke (2006), the whole data-set was re-read to determine, firstly, whether the themes fit with the data set and, secondly, that all data relevant to each theme had been captured.

At the end of this stage an initial thematic map of the data was produced.

#### **3.4.2.5 Phase 5: Defining and naming themes**

Once a satisfactory thematic map of the data had been achieved, the researcher further defined and refined the themes to ensure a clear understanding of what each theme represented (Braun & Clarke, 2006). The process involved reviewing the collated data extracts for each theme to ensure that they represented a coherent and internally consistent account, with an accompanying narrative (Braun & Clarke, 2006).

Through the process of open discussion between the researcher and two project supervisors, the risk of selective perception within the interpretive process at this stage was minimised through the method of triangulation (i.e. the combining of multiple perspectives; Patton, 1999). Together, the researcher and supervisors worked to finalise over-riding themes and sub-themes; the sub-themes enabled greater structure of the more complex themes and a hierarchy of meaning within the data (Braun & Clarke, 2006). Any differences in interpretation were addressed by the further restructuring and refinement of themes until all the researcher and supervisors reached consensus.

Once themes had been determined, the data extracts for each were thoroughly reviewed by the researcher and organised to form an internally consistent account. As described by Braun and Clarke (2006), the researcher then developed an accompanying narrative for each, outlining the fundamental characteristics underpinning the theme and providing an



explanation of how it fits to the wider story in relation to adoptive parents' experience of MST.

#### **3.4.2.6 Phase 6: Producing the report**

The aim of the final phase is to tell the story of the data in a manner that demonstrates the validity of the analysis (Braun & Clarke, 2006). The researcher ensured that each theme was represented by the most suitable data extracts to demonstrate their prevalence. Additionally, the researcher aimed to embed each extract within the analytic narrative around adoptive parents' experience of MST.

An example of how data from interview transcripts was developed into the final themes through Braun and Clarke's (2006) phases of thematic analysis can be found in Appendix G.

### **3.5 Methodological Quality Controls**

Although there is no formal set of quality standards for thematic analysis, the project observed Braun and Clarke's (2006) 15-point checklist of criteria for good thematic analysis throughout the analytic process (see Table 3). The concise checklist of criteria was deemed the most suitable methodological quality control for the present study due to it being specific to thematic analysis.

Table 3. A 15-point checklist of criteria for good thematic analysis from Braun and Clarke (2006)

Process	Point	Criteria
Transcription	1	The data have been transcribed to an appropriate level

		of detail, and the transcripts have been checked against the tapes for “accuracy.”
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples, but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed- interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other- the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written	12	The assumptions about and specific approach to

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report	thematic analysis are clearly explicated.
13	There is a good fit between what is claimed to have been done and what is shown to have been done.
14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
15	The researcher is positioned as active in the research process; themes do not just emerge.

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Beyond the methodologically specific criteria, and because it is deemed unwise to consider any single set of guidelines as definitive (Mays & Pope, 2000), the study also employed the seven quality criteria described by Elliott et al. (1999) as a more general quality control check of qualitative research. Each of these, and the methods by which the current study considered the criteria, are outlined below:

### ***3.5.1 Owning one's perspective***

As a researcher's values, interests, and assumptions are fundamental to a reader's interpretation of qualitative research (Elliott et al., 1999), the position of the current researcher was clearly stated early in the report (see Section 3.2). It was fundamental that the positions of the researcher were reflected upon and the impact of them considered at all stages of the research process. Supervision was used as a space to consider these issues.

### **3.5.2 *Situating the sample***

Relevant demographic characteristics of participants are provided to give context to readers necessary for them to assess the generalisability and applicability of the reported results.

### **3.5.3 *Grounding in examples***

As a means of illustrating the analytic procedures used in the study and the resultant understanding gained from such procedures, direct quotations extracted from the transcribed interviews are utilised throughout the report. All examples optimise the reader's ability to appraise the fit between the data and the researcher's understanding of them, and to consider potential alternative meanings or understandings.

### **3.5.4 *Proving credibility checks***

As a primary means of credibility checking, half of the research transcripts were double coded by both the primary researcher and academic or site supervisor to examine whether there was agreement between the codes identified (i.e. triangulation; see Section 3.4.2.5 for more detail). The academic supervisor also commented on whether the themes were appropriately supported by the quotes as the analysis progressed and provided verification of the resulting themes and subthemes. This method of credibility checking ensured that codes or themes were not overlooked and that the resulting themes were well grounded in the data.

As recommended by the ethics board (see Appendix A), the study opted against using member checking as a final means of credibility checking. The process of returning analyses to informants for the confirmation of accuracy

has been criticised for relying on the foundational assumption of a fixed truth or reality against which the account can be measured (Sandelowski, 1993). Moreover, the process may cause confusion rather than confirmation because participants may have changed their minds about the issue because of factors such as new experiences since the interview or the interview process itself (Angen, 2000). Finally, if respondents disagree with the themes identified by the researcher, there remains a dilemma as to the best way to proceed and the question of whose interpretation should stand emerges (Angen, 2000). Alternatively, validation of emergent themes was achieved by consulting a service user not involved in the interviews to review whether they resonated with their own experience. Whilst the themes may not fit all aspects of the validator's own experience, it is hoped that they are recognised as applicable to their context (Strauss & Corbin, 1998).

### **3.5.5 Coherence**

To ensure an integrated summary of the analysis, written descriptions of themes and sub-themes and the relationships between them are both thorough and coherent. Moreover, a thematic map is provided as part of the appendices to offer a graphical representation of the overall conceptualisation of the data patterns (Braun & Clarke, 2006).

### **3.5.6 Accomplishing general versus specific tasks**

The current research aimed to achieve a general understanding of adoptive parents' experiences of MST, rather than understanding the experience of only one or two individuals. The sample included a mix of both fathers and

mothers, from different ethnic and socioeconomic backgrounds. Of course, any conclusions made are specific to the context of adoptive families.

### ***3.5.7 Resonating with readers***

To ensure the report holds meaning to the readers, the write-up was discussed and reviewed with both academic and field supervisors to ensure an accurate reflection of the subject matter. Moreover, the process of validation required the additional consultation from an adoptive parent not involved in the interviews to ensure the final report resonated with them. It is hoped that the account of adoptive parents' experience of MST is therefore both clear and accessible.

## 4 Results Chapter

### 4.1 Participants

Of the 29 adoptive cases identified, 27 met inclusion criteria, 14 were successfully contacted, and the adoptive parents of 10 cases consented to participate in the study. Nine of the 10 interviews were conducted with one parent and one interview involved both parents jointly at their request. The final participant pool consequently concerned 11 parents representing 10 adoptive cases.

Of the four participants that did not consent, reasons cited included current family circumstances, reluctance to revisit difficult memories, and too great a period since the completion of MST.

Demographic information gathered from adoptive parents at the time of interview are presented in Table 4. Participants were aged between 42 and 62 years of age (mean age = 55 years) and the majority described themselves as White British (N = 8) and married (N = 10). Eight participants were adoptive mothers and three were adoptive fathers. Of the 10 cases, all but one (Participant 10) completed treatment; this case was closed 3 months into the programme due to the involvement of the criminal justice system in response to a serious crime.

The demographics of each participant's adopted child are presented in Table 5. Six of the ten young people were female and seven were White British. The mean age at adoption was 46 months and ranged from 6 months to 8.5 years. The majority of referrals to MST were made through Social Services (90%);

others included the involvement of school or CAMHS. The average age of young people at MST completion ranged from 11 to 17 years (mean = 14 years) and time since the completion of MST ranged from 1 month to 84 months (mean = 32 months).

Table 4. *Adoptive parent demographics*

Participant	Gender	Age	Ethnicity	Marital status
1	Female	53	Indian British	Married
2	Female	55	White British	Single
3	Female	53	Anglo-German	Married
4	Female	53	White British	Married
5 <sup>a</sup>	Female	50	White British	Married
	Male	65	White British	Married
6	Female	42	White British	Married
7	Female	62	South American	Married
8	Female	57	White British	Married
9	Male	57	White British	Married
10	Male	59	White British	Married

<sup>a</sup> Joint interview with mother and father



Table 5. *Adopted young person demographics*

Participant	Gender	Ethnicity	Age at adoption (months)	Referrer to MST services	Age at time of MST (years)	Time since completion of MST (months)
1	Male	White British	30	School	13	84
2	Female	White British	102	Social worker	14	48
3	Female	British Nigerian	22	Social worker	14	24
4	Female	White British	42	Social worker & school	11	72
5	Male	White British	78	Social worker	15	1
6	Male	Black British	6	Social worker	11	7
7	Female	Irish Ghanaian	52	Social worker	15	18
8	Female	White British	36 <sup>a</sup>	Social worker	17	20
9	Female	White British	20	Social worker	13	18
10	Male	White British	18	CAMHS	15	24

<sup>a</sup> Young person was fostered by family at 1 week of age and formally adopted at 36 months

MST outcomes at time of discharge and at time of interview, as recalled by parents, are displayed in Table 6. At time of discharge, 90% were living at home, 80% were in education or employment, and 80% of young people had no new arrests or charges over the course of the intervention. At time of interview, 70% were living at the family home or in their own residence, 60% were in education or employment, and 60% of young people had no new arrests or charges since discharge from MST.

Table 6. *MST outcomes at time of discharge and at time of interview*

Participant	Outcomes at time of discharge			Outcomes at time of interview		
	Living at home	In education	No new arrests	Living at home	In education	No new arrests
1	Yes	Yes	Yes	No	No	No
2	Yes	Yes	Yes	Yes	No	Yes
3	Yes	No	Yes	No	No	No
4	Yes	Yes	Yes	Yes	Yes	Yes
5	Yes	Yes	No	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes	Yes	No
7	Yes	Yes	Yes	Yes	Yes	No
8	Yes	Yes	Yes	Yes	Yes	Yes
9	Yes	Yes	Yes	Yes	Yes	Yes
10	No	No	No	No	No	Yes

## 4.2 Themes

Five major themes emerged from the thematic analysis to describe adoptive parents' experience of MST from the moment of referral, to discharge, to looking towards the future. Within each of these themes, there were three to

five associated subthemes. Theoretical saturation was achieved by the tenth interview in that code definitions were stable and new themes were emerging infrequently (Guest et al., 2006).

Reporting the prevalence of individual themes within thematic analysis is a topic of much debate (Braun & Clarke, 2006). Whilst some argue that the reporting of prevalence demonstrates the true existence of themes within a dataset, others contend that the frequency of a theme is not directly associated to its “keyness” (Braun & Clarke, 2006, p. 10). The current chapter will conform to the latter perspective and base the inclusion of a theme on its centrality to participants’ accounts. Nonetheless, prevalence will be conveyed to the reader by reporting whether themes or subthemes were regularly or rarely expressed by participants.

The key themes and associated subthemes are presented in Table 7, and the related thematic map can be found in Appendix H. In keeping with criteria for good qualitative practice, detailed descriptions and interpretation of themes are provided in the subsequent text and supplemented by supporting extracts from transcripts (Elliott et al., 1999). To maintain the confidentiality of participants, all identifying information was removed or changed.

Table 7. *Summary table of themes and subthemes*

Theme	Sub-theme
Situation prior to MST	Severity of family situation
	Desperation to try anything
	Desire to feel understood
Enablers to change	Positive therapeutic relationship
	High intensity
	Behavioural Strategies
	Home or community setting
Barriers to change	Participants' sense of shame and failure
	Context of adoption not considered
	Young person's refusal to engage
Outcomes of MST	Changed expectations of young person's behaviour
	Increased parental confidence and strength
	Continued use of MST strategies
	Foundation for further change
Modifying MST to better meet the needs of adoptive families	Greater therapist knowledge of adoption and attachment
	Incorporation of information specific to adoptive families
	Earlier intervention
	Addition of follow-up calls or sessions

#### **4.2.1 Theme 1: Situation prior to MST**

As part of the semi-structured interview schedule, all participants were asked about their family situation prior to MST referral. What was consistently identified across transcripts was the severity of their current family situation, their desperation to try any kind of intervention to help that situation, and their underlying desire to feel that somebody understood what they were experiencing.

##### **4.2.1.1 Severity of family situation**

Prior to starting MST, all participants described extremely difficult circumstances resulting from the antisocial behaviour of their adopted child.

*Participant 2: We were both struggling and she was in an awful state really because she didn't have a relationship with me, or anybody in fact, and I was also really struggling. Many times, I wanted to give up.*

*Participant 6: Before MST... behavioural difficulties, quite severe behavioural difficulties. Smashing up the house, smashed up the back garden, trying to get physical to me and my husband. Just very unruly. No control. It just felt that we were at the end of our tether.*

Many participants recognised that they “*were moving towards the conclusion of our child completely falling apart and us not being able to cope because her behaviour was getting more and more extreme*” (Participant 3).

Paramount to some participants' reports was their concern not only for their child's safety in terms of the consequences of their antisocial behaviour, but also for the safety of themselves and other family members.

Participant 1: *I was aware of the community support officer so I made myself known to him and he always said to me, 'If you ever don't feel safe, then just dial 999.' And there was one night, you know, my son was having a go at my husband...and I just thought 'no, I don't feel safe now,' and I did dial 999.*

Participant 5: *There had been nights I had taken the other kids to a hotel because it was just too much in here, it was too intense. I mean, when it all blew up he went to hit me. So, I didn't feel safe with him.*

It seemed that for most participants, MST was recognised as a final attempt to improve their situation before the placement disrupted.

Participant 5: *We did feel our family had completely broken down when they came. I didn't think it could get any worse. It probably couldn't have got any worse.*

Participant 9: *Because we were saying to her, the (CAMHS) psychologist, we were coming to the end of our tether, we don't know how to cope with our child. At that point, they introduced the idea of MST, really saying that it is the last of the line option.*

#### **4.2.1.2 Desperation to try anything**

Participants reported “*constantly trying to find somebody that would help*” (Participant 2), but found it difficult “*because you don't know what help is out there and what help would be a benefit to you*” (Participant 1). Once referred to MST, participants admitted that they “*didn't really know what it (MST) was about*” (Participant 10) in terms of either the model's theory or practice.

Nonetheless, participants were desperate and willing to try anything to help their family situation.

Participant 3: *We were clutching at straws desperate to try anything...*

*Do you know, I would have done quest ball, I would have done anything to try to help.*

Participant 8: *I don't think I really knew what to expect but I was desperate enough to try anything.*

#### **4.2.1.3 Desire to feel understood**

A common report from participants was that they felt that no one understood their unique situation as an adoptive parent managing the antisocial behaviour of their child.

Participant 1: *I was feeling that I wasn't being heard, that we were living with this but nobody seemed to understand.*

This lack of understanding was felt across several professional services prior to MST referral.

Participant 3: *If you are in an educational context, for instance, and you are dealing with the SENCO (Special Educational Needs Co-ordinator), they generally haven't a clue and they usually say, 'oh it is nothing to do with adoption,' you know, and you think 'it is everything to do with adoption!'*

Participant 4: *You feel through life when you are talking, for example when we would talk to CAMHS, we felt with some counsellors that they*

*would sort of nod their heads but they weren't really thinking that you were any different than anybody else.*

Moreover, beyond professional services some participants also reported a lack of understanding from friends and family.

*Participant 8: Sometimes, when I tried to talk to friends about it, I would get back 'oh they all do that don't they' and I felt like clobbering them because, actually, no, they don't all do that and if they do they don't do it like this! This isn't just the normal run of the mill issues that you get with teenagers at all. It really wasn't the same and I found that very frustrating to the point that I actually started to withdraw from people quite a lot simply because I felt like they didn't understand.*

Prior to commencing MST, it was apparent that this desire to feel understood sat as a primary hope of treatment for adoptive parents.

*Participant 8: I know the thing I needed most was to feel like somebody understood that I was doing my best and that these were unusual issues.*

#### **4.2.2 Theme 2: Enablers to change**

Many participants reported that MST enabled behaviour change in their family and identified several factors contributing to this, including the positive therapeutic relationship with their MST therapist, the high intensity of the intervention, the development of behavioural management strategies, and the intervention being set in the home or the community.



#### **4.2.2.1 Positive therapeutic relationship**

Participants described their MST therapists as “*non-judgemental*” (Participant 4), “*personable, warm, humorous*” (Participant 3), “*sympathetic*” (Participant 10), and “*caring*” (Participant 5). Participants highlighted these characteristics as encouraging a positive therapeutic relationship that optimised engagement and encouraged change over the course of intervention.

Participant 6: *Do you know the major thing was a bit of support, to be honest...it has helped us and it was somebody there for us and I do think, me and my husband have said it all along, that with adoptive families sometimes you adopt the child and then social workers all go and you are on your own, you know, but having somebody there is what you need. It is definitely 100% what you need.*

Participant 10: *So it was quite good to get things off our chest and it was nice to know that there was somebody there trying to help us rather than us feeling as though we are on our own and ‘what on earth do we do?’ So, I mean, that was a benefit.*

A number of participants frequently returned to the notion of feeling understood (see Section 4.2.1.3), reporting that their therapist was “*very understanding*” (Participant 10) and highlighting this as fundamental to the therapeutic alliance.

Participant 1: *I kind of felt we had someone that understood and that we could call on at any time and say, ‘What do I do, how do I handle this situation?’*

Participant 2: *She was great, she was really great. I really enjoyed being with her and she totally got it and understood it: my situation, my experiences. She would always, when I left I would always become very positive and upbeat and very strong and when I used to go in I was very weak, very sad, and very tearful. So, she was able to give me strength and hope.*

A further factor that strengthened the therapeutic relationship was the 24-hour availability of therapists; although some participants did not make use of the on-call service, they valued the containment that it provided.

Participant 2: *I feel as though, maybe, she was always there for me when I needed to speak to her out of those hourly sessions. She was always there for me, she would always phone me back.*

Participant 5: *I think them being there at any time was the most helpful thing. We only probably used them about twice outside of that but there were times when you think 'I don't know what I am going to do, what can I do'. I think the fact that she was on call, well not her, but that somebody was on call was helpful.*

#### **4.2.2.2 High intensity**

Participants reported being initially apprehensive about the high frequency of the intervention, which involved meetings “*several times a week, and then there is sort of texts and emails and lots of reading*” (Participant 8). However, participants recognised the need for such intensity in managing the demanding situation that their family was in.

Participant 6: *An hour a week or an hour every 8 weeks to see him is not enough when we were going through what we were going through, when he's absolutely off the wall smashing everything. You need that person there that you can talk to so that you can sort of like breath again, you know?*

Participant 8: *It did kind of take over your life for a while a little bit but I think that was unavoidable and I felt that was a price worth paying. It was quite hard work really. You really had to focus in. You really had to kind of be prepared to put the time in.*

Participants reported that the intensity of the intervention enabled for optimal progress in behaviour change by ensuring the family remained engaged and motivated.

Participant 1: *There is so much that goes on that by the time you have waited 3 weeks to see somebody you have forgotten and by then everything has probably calmed down a bit and you have forgotten how bad life was when you were going 'I need help' and 'where do I go?' So, with the therapist coming every week, you could go 'well this has happened and that's happened.'*

Participant 4: *I wasn't looking forward to it and thought 'oh God this is going to be terrible, twice a week or three times a week' but it was good that it was so intensive I think because she would, we would come and discuss things, and then she would say 'right, I want you to try this now,' um, so literally like you couldn't rest from your laurels*

*because you couldn't think 'right I have got a couple of weeks to do that.' It had to be that you had to be doing that by the end of the week because she was going to come again.*

The intensity of MST marked it out from previous interventions that participants had tried.

Participant 8: *I think MST is much more practical, much more specific, and much more intensive so you felt like you were getting somewhere.*

It seemed that participants needed the intensity not simply as a motivator to engage in the practices recommended, but also as a means of containing them and working alongside them during a time when they felt vulnerable and alone.

Participant 4: *It felt like somebody was holding your hand and helping you rather than you have been told, 'We have given you the directions now so go away and do it and I will come back in a month's time and check up on you.'*

#### **4.2.2.3 Behavioural Strategies**

Initially, some participants expressed doubt as to the suitability of behavioural strategies for adopted young people due to the increased prevalence of attachment difficulties.

Participant 4: *I had these misgivings at the beginning, like, 'is this going to work?' because I was absolutely convinced it wasn't going to work. I thought, 'No, they (children with attachment difficulties) don't respond to that reward consequence stuff.'*

However, frequently identified as contributing to behaviour change were the “*realistic, tangible strategies*” (Participant 2) developed collaboratively with the therapist. The strategies worked to add a sense of clarity and certainty to a situation that had previously been unpredictable, both for the parent and for their child, because “*it was something that we had all agreed on*” (Participant 1).

Participant 8: *I think it was really helpful to have it so clear for her and for me because I think she needed the security as well as knowing exactly the way the land lies and it has helped her.*

Participant 4: *I think it takes away uncertainty and it gives you one less thing to worry about because you know what is going to happen. But we had to say, ‘This might change but hopefully we will be able to stick to the plan.’*

Moreover, the behavioural strategies acted as a means of giving participants back some of the control that they felt they had lost over the years and fed into increasing parental strength and confidence (see Section 4.2.4.2).

Participant 1: *It gave us strategies to deal with his behaviour and pointing out that, actually, his behaviour was unreasonable and that we didn’t need to put up with it. So, making a behaviour plan was useful.*

Participant 5: *Even though he feels he has got that control, rightly so, because he can control his own temple and we can’t, but, he also knows where we are going to go if he doesn’t do it and we have done it. We have stuck by it.*

Participant 8: *I think what was really big for me was to be given permission that it was okay to have this kind of behaviour plan, where as I felt that if I had tried to put something in on my own I wouldn't have had the confidence.*

It was evident that the sense of control and strength achieved through having behavioural strategies to utilise was, in itself, an enabler to change.

#### **4.2.2.4 Home or community setting**

Participants commented on the benefits of MST being based in the home or in the community, making the intervention more ecologically valid than other interventions that were based in a clinic setting.

Participant 1: *I think because it comes into your home. Thinking about it, everywhere else you go off to, but coming into your home, talking to all of us, having the strategies in place. Here rather than somewhere else; I think that was a big part of it.*

Some participants indicated a preference to having the MST sessions in a mutually agreed community setting, as opposed to the family home that held negative associations with the problem and therefore was deemed un conducive to productivity. Participants felt that by removing themselves from the home environment, they were removing themselves momentarily from the severe situation. This respite enabled greater engagement in the intervention and consequent behaviour change.

Participant 6: *It was just sometimes nice to be away from the environment it was all happening in and to go to somewhere really,*

*really, I don't know, that is not based on the behaviour. This is his home, this is where it all happens, but it is nice to get out somewhere different.*

Participant 2: *So we had our sessions on our own and we chose, or the worker chose, a very nice venue. So, it was, you know, I have fond memories of the venue itself. It was in a hotel in the lobby which was nice because it is a nice environment, it's not, it's got...it's pleasant to look at. So at least I had somewhere to go to that was pleasant to experience.*

### **4.2.3 Theme 3: Barriers to change**

As well as referring to those things that participants found helpful in MST, participants identified several factors that they perceived as barriers to change in their family, including: the sense of shame and failure they felt around having to be referred to MST, the context of adoption not being adequately addressed over the course of MST, and their child's refusal to engage in the intervention.

#### **4.2.3.1 Participants' sense of shame and failure**

Some participants described feelings of shame and failure on being referred to MST and suggested that it fed into their already negative view of themselves as an inadequate parent to their adoptive child. It seemed that participants sense of both shame and failure going into the intervention linked with their perception that MST was blaming them for the situation their family found themselves in. Participants reported that their sense of shame and failure acted as a barrier to their initial engagement in the intervention.

Participant 8: *I found it was just confirmation of being a failure. It was a big barrier for me and I think it slowed down the initial progress with working towards the behaviour plan was this. Well, I suppose it is pride when it burrows down to it, and this sense of not being understood, and it felt that it had an element of blame.*

Participant 9: *Once you start explaining something and people are feeling 'whoa, he's just blaming me,' which is what my wife felt, I could feel her, and I said 'no, no, no.' So, I spent half my time saying, 'No, no, that is not what he means.' It becomes a barrier to taking on board what they say and you just have it in the back of your mind and, of course, if you start thinking that you know what is going to happen!*

The sense that MST was blaming participants for the difficulties in their family may have been further catalysed by participants reports that they “*didn't really know what it (MST) was about*” (Participant 10) (see Section 4.2.1.1) and as such were unsure of the aims or intentions of the intervention.

#### **4.2.3.2 Context of adoption not considered**

In relation to participants desire to feel understood (see Section 4.2.1.3), it was apparent that several participants felt that MST failed to achieve this and as such immediately constructed a barrier to change.

Participant 8: *I sensed frustration when, it is hard to put into words really, but it is back to this thing about not feeling they were getting it, not feeling like they had understood what was going on and stuff.*



Participants reported that this lack of understanding stemmed from their therapist's inability to appropriately consider the context of adoption, the associated trauma, and the consequent attachment difficulties in the formulation. For participants, such factors were recognised as pertinent to the family's current situation and their child's presenting behaviours.

*Participant 3: They have suffered huge trauma, even if they were really tiny. It is massive what has happened to them.*

*Participant 7: In some ways, I don't think that they considered the issue of adoption. I don't think that any of them know anything about adoption. We mentioned to them things about what we have read about the children but for them they just have this narrow mind, 'This is my problem, this is the thing I need to teach you, this is the thing you need to follow, this is the thing you need to do and I don't care that the children are in this way.' I didn't like that.*

*Participant 8: I know in my head I was thinking they don't realise what attachment is. MST didn't stand a chance at making me feel like they understood and I didn't. I didn't ever feel like they understood.*

Participants felt that MST's incapacity to consider the context of adoption resulted in the intervention focusing exclusively on the behavioural features of the problem as opposed to its underlying causes. Participants consequently expressed levels of concern and disappointment regarding this aspect of the intervention.

Participant 9: *What I was surprised at was it very much seemed to be looking at the symptoms, the bad behaviour, and trying to control that. I thought it would also go on to the attachment issues, the underlying issues, and it didn't really touch those. There didn't seem to be the understanding of the attachment part and how that effects consequences et cetera, and what is beneficial, and what she would never even bother trying to get. So, that made it slightly more difficult I think.*

Participant 8: *I don't know that it (MST) got to the root causes. It dealt with the behaviour but the root causes, I think, are still there.*

By not addressing the underlying causes of their child's behaviour, participants felt MST created a barrier to significant, long-lasting change for both their child and their family as a system.

Participant 6: *I personally think there is something deeper in him that needs to be addressed and I have said that all along and I did express that to people and sort of like, once or twice, it was sort of like 'no I don't think it is an attachment issue,' and I have always maintained 'yes there is, yes there is.' There is. Definitely. It is an identity thing; I think deep down he needs to know where he comes from.*

Participant 7: *There are two reasons that I think they don't work well. First, the children have identity problems, their connection with the family. When you are young and growing up you look and find who are you, and they have a double dilemma there: 'Who am I? Who do I*

*belong to?’ And this programme doesn’t do anything with that. A lot of the things are to do with identity and nobody treats that and I always said to them, ‘These children need to be treated at the root of that.’*

#### **4.2.3.3 Young person’s refusal to engage**

Nearly all participants described their adopted child’s refusal to engage in MST as being a barrier to change.

*Participant 10: Well, she created barriers because of her disruptiveness really. She didn’t, I mean... she is very disruptive when she’s not getting all the attention.*

Beyond their child’s refusal to engage with either the therapist or the regular meetings, participants spoke of their child being “*very anti it (MST)*” (Participant 3) and “*would retaliate*” (Participant 6) against the intervention.

*Participant 8: She has rebelled against it lots and lots and lots of times where she’s sworn or gone on and said, you know, ‘flipping MST,’ and ‘I shouldn’t have to do this, I shouldn’t have to do that, everybody says it is ridiculous’ and all these kind of things, you know?*

It seemed that some children felt threatened by the presence of MST, finding it intrusive and unsafe.

*Participant 3: I think she was quite threatened by it because twice a week she would come home we would either be sitting around the table and she would know we were talking about her and she found that incredibly intrusive. She probably felt extremely hostile.*

In addition, participants often described their child's ability to use MST against them to confirm their belief that they were a failure as a parent (see Section 4.2.3.1).

*Participant 2: A couple of times she said, 'Oh I know why you are behaving like that, you are not fooling me, I know why you are doing that, it's just those stupid things that you are on,' or something like that. So, you know, she has always been very clever and manipulative and turns it into me feeling bad again.*

*Participant 3: I mean, even if you tried not to draw attention to the fact that you are doing something different because somebody suggested it, she still says to me, and this is pertinent, that 'You are doing what x has told you to do, why can't you stand on your own two feet and do what you want to do?'*

*Participant 6: He is the type of person who hears things and will use it against you; he will take that on board and will use it against you.*

It was also apparent in some participants' reports that their child did not see the problem as their problem but instead saw it as a problem with their adoptive parents.

*Participant 1: I think although we may have wanted change in our lives, in our family lives, that he wasn't prepared to take it on board fully. I think you have to want the help to accept it and I am not sure he has ever been ready to accept the help. I think he feels that it's everybody else that has the problem and not him.*

Participant 8: *I guess really, from her point of view, like I said, she can't ever see how controlling she is so she can't see why she is a problem. I think in her head it is not her that is the problem, it is everybody else.*

The young persons' refusal to engage and low alignment to the intervention meant that participants felt that the onus of the intervention was very much on them. This was noted as a related barrier as a few participants felt the problem did not relate only to their management of it, but also to the functioning of each member of the family system.

Participant 2: *Well the main thing was that my daughter refused to engage, so, MST is a family therapy and it only works if, you know, there are two in the relationship and if one doesn't tango, like my dad says, then you can't tango.*

Participant 7: *She always tried to put to us that it was the best thing to do, and I would say 'No; I know how to be a parent. I need this help for them. Why you don't talk to them?' But they (MST therapist) said 'That is not our problem, it is talking to adults.' I said, 'But that is not my problem, the problem is them! They have the problem of the adoption, they have the problem of rejection, they have everything, anxiety, anger, everything needs to be treated. So, why us? They are creating the anger. They are creating me with anxiety.'*

Participant 9: *Find out more with her (daughter) as it was all orientated towards us and our behaviour which I can understand because we... it is almost saying, 'She can't change hers so you have got to change*

*yours.' It's getting more involvement from the child so they get more investment in it.*

#### **4.2.4 Theme 4: Outcomes of MST**

Participants identified a range of outcomes arising from their course of MST. Particularly, participants recognised that their understanding of their child's behaviour had been enhanced resulting in changed expectations and interpretations in response to it. Participants also spoke of their greater sense of control in managing the behaviour and a sense of feeling stronger and more confident in their parenting practices. It was apparent that participants continued to use the parenting strategies learnt in MST and felt confident in adapting those strategies as their child developed. However, what was evident for several participants was that MST was not a *fix* but instead acted as a stabiliser, laying a solid foundation on which families can go on to seek further therapy to address the root causes of their difficulties.

##### **4.2.4.1 Changed expectations of young person's behaviour**

The analysis identified that, over the course of MST, participants' expectations and priorities regarding their family's functioning changed. Prior to MST, participants admitted to feeling overwhelmed by their own expectations of how their child *should* behave, how they themselves *should* parent, and what a perfect family *should* present as. However, MST encouraged them to change their expectations and to focus only on those things most important to them and their family.

Participant 4: *It sort of taught me just to focus on the really important things and what I thought was most important was my relationship with*

*my children. So, just focus on that and my reaction to things rather than thinking 'they must do well in school,' for example, 'they must absolutely brush their teeth every night,' which, ideally, they would but just not to let that become a thing where it causes a big argument.*

*Participant 5: It just gave us some time to just really think of what the real problems were. I guess also the small problems become big problems when your head is full of everything so that made us sort of step back and go, 'You know what, just let that one go because that is just a small problem and as long as we deal with the big problems we can sort of continue.'*

*Participant 8: Actually, one of the things that did happen at some point during MST or maybe after, I'm not quite sure when it happened, but I got to the point where I didn't care anymore. Whereas being understood, and not being judged, and what people think I suppose, really, was quite a big thing for me at one time.*

By changing participants' expectations around family functioning, it was evident in the analysis that participants also started to view their child's behaviour in a different light. Participants seemed to move away from the problem-saturated narrative around their child's behaviour to a more strength-based narrative.

*Participant 2: I remember one statement, she said, 'She is doing her best in her own way and you have got to sort of cling on to that.' So, if she can't articulate the words that she loves you but then if she makes*

*you a cup of coffee after she has sworn at you, that is her way of saying 'I am sorry mum, I didn't mean it.' So, relish that rather than expect what you want to happen.*

*Participant: 9 It did help in getting my wife to change her attitude slightly, that you won't get this from her so all you are going to do is bash your head against a brick wall. We have got to put in place the bits that are most important.*

#### **4.2.4.2 Increased parental confidence and strength**

It was clear from reports that, prior to MST, participants had lost confidence in their own ability as a parent to their adoptive child.

*Participant 8: I had lost a lot of confidence about being a parent. Probably the biggest focus of my life was being a parent and to feel like you have failed at that almost feels like you have failed at everything...*

However, an outcome of MST that emerged from the analysis was that participants gained a new-found confidence in their parenting ability, stemming from an enhanced belief that they were “*doing the right thing*” (Participant 1).

*Participant 8: ...MST gave me that confidence to be able to address the issues in a way that, in the way that we did. So yeah, to have that weight behind me.*

As well as feeling more confident in their parenting ability, the frequent MST sessions, together with the positive therapeutic relationship and enhanced



knowledge and skill base, worked also to make participants feel stronger in themselves and “*more able to cope with anything*” (Participant 4).

Participant 2: *When I had my MST sessions I was putting myself forward and I was strong, in a strong position. So, it is almost like my sort of vitamins you know. She (MST therapist) gave me vitamins in my body to be able to cope with the next conversation or the next situation.*

Participant 6: *I think it's made, going through MST and talking through stuff, it sort of like made, I don't know, made me feel that I can do things more. I can achieve what I want to, if that makes sense?*

#### **4.2.4.3 Continued use of MST strategies**

A common outcome recognised across multiple participants' accounts was their continued use of MST strategies post discharge to assist in the continued management of their adopted child's behaviour.

Participant 3: *I mean, we still have our MST file and look at it from time to time as a little refresher.*

Participant 4: *Obviously, we had times when it did get a bit dodgy again but, on the whole, it was okay. We would hold onto those routines and obviously use the charts and all that stuff. So, I kept on using those for quite a long time afterwards, particularly the holiday charts so we knew what we were going to do.*

Participants reported that, as their adopted child got older, they could draw on the knowledge that they had learnt over the course of MST to appropriately adapt the strategies to suit the ever-changing behaviour of their child.

Participant 2: *I don't necessarily use the strategies all the time but maybe I used them because times progressed. Because obviously a 9-year-old, a 14-year-old and 18-year-old, they are very, very different and you adapt your parenting according to the age of the child as well.*

In addition, participants also reported that they had found it helpful to incorporate and adapt the strategies in the parenting of their other adopted and nonadopted children.

Participant 1: *The behaviour plan sticks out in my memory and, in fact, we did it to his sister when she was slightly older.*

Participant 3: *I think it was probably all helpful and I think I certainly found it, and have found it since, certainly helpful in dealing with her younger sister.*

It was therefore evident from the analysis that the strategies learnt over the course of the intervention were both generalizable and long-standing to participants' parenting practices.

#### **4.2.4.4 Foundation for further change**

Participants frequently noted that the MST programme did not act as a "fix" (Participant 2) to their child's antisocial behaviour. Instead, MST was recognised as enabling a foundation for further behavioural change by working to stabilise the unstable situation that the family found themselves in.

Participant 2: *I wouldn't say it is a fix. I wouldn't say you go into it thinking you are going to come out of it and everything is going to be*

*hunky dory because it is not. It is just another small stepping stone to ultimately create where you want to get to, but not overnight.*

*Participant 4: It sort of taught me that you can use sort of quite a practical method to help support a change in behaviour and then hopefully build on that. So, if you wanted to do actual therapy you could probably build on that. But it is actually hard to start doing therapy if you are coming from a place where everything is out of control. So yeah, I think that is what it taught me.*

By stabilising the situation, participants felt better able to address the underlying causes of their child's antisocial behaviour problems through further forms of therapy.

*Participant 9: But that extra bit of attachment, I don't think was taken into account. They wanted us to stabilise, get the system stabilised, get it to a point where help for the underlying problems could be addressed.*

#### **4.2.5 Theme 5: Modifying MST to better meet the needs of adoptive families**

Whilst participants reported many positive outcomes from MST, they were also clear on ways that MST fell short in considering their context as an adoptive family and identified several ways that MST could be adapted to better suit their needs. These included therapists possessing greater knowledge of adoption and attachment and the incorporation of materials specific to adoptive families. It seemed that it was fundamental for MST to

portray the message that they have worked with adoptive families before, that they understand the impact of adoption on families and that they have a range of strategies that have been demonstrated to be effective in this population. As a further means of meeting the needs of adoptive families, participants highlighted the need for MST to intervene earlier as the years of eight to 10 are particularly pertinent for adopted children in terms of processing their adoption and the associated sense of loss, confusion, and anger. Finally, due to adopted children's need for consistency and longevity, participants suggested improving MST by offering some means of follow-up.

#### ***4.2.5.1 Greater therapist knowledge of adoption and attachment***

In relation to participants citing MST's lack of consideration to their context as an adoptive family as a barrier to change (see Section 4.2.3.2), participants noted that the intervention could be improved by ensuring that therapists recognised their unique context and possessed the relevant knowledge of the associated literature.

*Participant 4: I mean, I think it is useful for the therapist to know themselves about how adopted children can behave and I am sure there is a lot of knowledge out there, and look at the attachment literature, the literature on attachment difficulties. Yeah, I think they really have to have a good knowledge of that.*

*Participant 7: The only way MST works in adopted children is that the therapist needs to have some psychology background to understand more problems.*

Participant 9: *Their experience of attachment I felt was, for the practitioner... needs bumping up if they are going to work with adoptive families.*

Participants stressed the importance of MST therapists having adoption and attachment related training prior to working with adoptive parents to ensure that they possessed the skills and knowledge necessary for parents to feel understood and appropriately supported in their situation (see Section 4.2.1.3).

Participant 2: *I think it is really important to get trained, skilled workers, who are interested in finding out. For example, if an MST worker was going to do some work with an adopted child I would have expected them to know the big, like, like all the things that adoptive children have, all the issues they have. They can have all sorts of attachment issues and goodness knows what so they have to have an understanding of that because they won't be able to support you if they don't understand what that really means.*

Participant 9: *(MST should have) come across with a plan that took the attachment issue into account. Maybe even say, 'look' - because we have never had an official confirmation of her issues- to say, 'Look, we need to sort that out and let's have someone look at her and just check this is what it is, these are the classic things she will show, therefore there is nothing unique about her.' Ask other people, 'What are the best plans for someone with that attachment disorder?' Because it is, as far*

*as I understand, different to how you treat a teenager. I think that could have been better handled.*

#### **4.2.5.2 Incorporation of information specific to adoptive families**

Participants highlighted the importance of incorporating information specific to adoptive families into the MST programme. Specifically, participants highlighted the potential benefit of communicating to them the literature around adoption, attachment, and behavioural problems at the beginning of the programme. Some participants offered that introducing such theory early in the intervention would address the initial sense of failure and shame that adoptive parents may be experiencing (see Section 4.2.3.1), helping them to recognise that their situation is not uncommon and eradicating any sense of blame that they may have.

*Participant 8: I think it might have of helped if there was something a little bit more specifically adoption-related. It would have perhaps helped me to feel like this happens sometimes with adopted families and there isn't any, necessarily, any shame around that. It doesn't mean that you have failed, it doesn't mean that you have somehow damaged your child so that they are at this point, it just sometimes happens that way.*

As well as greater information relating to the association between adoption, attachment, and antisocial behaviour, participants highlighted the benefit of hearing about the experiences of other adoptive families who have had MST.

Participant 4: *It would really sort of help to relay people's fears if the therapist could say, 'We have already worked with these families, with adopted children, and it has worked.' That would be good so that they could see, you know, some success stories.*

Participant 7: *I said to them 'I'd like to talk with parents having MST to find out if it is working,' but they never allowed us to contact any parents having the treatment. It means you feel isolated as well. I said, 'That is not the way to work.'*

Participant 8: *Perhaps some reassurance that they've got other people that are in a similar situation, or that they dealt with other people, or had experience with other people, with adoptive parents; 'Lovely family, but...' Maybe that might have helped? I don't know.*

It seemed, therefore, that hearing about the experiences of other adoptive cases would not only further help to eradicate the initial sense of shame and failure experienced by adoptive parents, but would also increase their confidence and consequent engagement in the programme.

#### **4.2.5.3 Earlier intervention**

Common to many participants' reports was that their adopted child began to demonstrate behavioural problems around 8 to 10 years of age. These years were described as particularly pertinent for adopted children due to their matured perception of their adoption bringing with it a multitude of challenging thoughts and feelings including loss, anger, and identity confusion. Parents

suggested that their child's antisocial behaviour developed in response to these difficult and hard to process thoughts and feelings.

*Participant 4: A lot of problems with adopted children can start towards the end of primary school because recognition of being adopted can cause a lot of problems; they would have accepted that situation but then their brain matures and they are able to think things through and they have this grief reaction and, I think in our case, this lead to the bad behaviour. This reaction to grief that is very deep seated which I think was why she always found it hard to explain why this was happening. It was like she was becoming blind with this anger and sort of feeling of not having any power in your life.*

*Participant 7: Nine years, 10, when they start growing up as well and they notice difference. I think that was when they started asking, 'Why are you our parent?' and these kinds of things. If you are a kid in reception, year one, two, three, you are quite blind to all that but four and five and six, you notice more difference: 'Why your mother is this?' 'Why your father is this and that?' They started having problems in that and we tried to talk and say, 'Look, it is this, it is that, because we are different; I am from this place, your father is from there, your mother is this, your father is that. It means that you are a completely different mix of us.' But, telling them 'it doesn't matter, families are all in different colours,' they were not able because they feel ashamed to talk and that is what needs to be treated.*



Consequently, several participants hypothesised that if MST was offered during these fundamental years, instead of the current 11 to 17 years of age, it would have been better able to address the predisposing events and, accordingly, *“would have had much more effect”* (Participant 3).

Participant 9: *I think if someone had come in earlier more intense- and this is with our insight- quicker when she started to show these characteristics early in secondary school... now you could say ‘well you don’t know if she is going to continue that way’ but as I understand it, all the signs were there for an adopted child, this is going to happen, this is going to happen. And as it started to happen, let’s get in there quick.*

Participant 4: *I would definitely say the older years of primary school it could really work quite well on because then it would build a basis for the years of early teen, you know, when they are 12, 13.*

Participant 7: *I think in adopted families now the government has noticed that it needs to be from the beginning, when the child arrives at the house because when they start primary school we notice they started, say, in year four, five, when they grow a little, they started to have more problems there and have fights and so on, which never happened before.*

In addition, participants reported that by the time MST was offered to them the problem had *“gone too far down the line”* (Participant 3) and was too fully-fledged to be responsive to intervention. If MST had been introduced earlier,

participants felt that their child would have been more responsive to the changes and better able to engage.

Participant 3: *I think if it would have come in earlier in her life she might have been more amenable to joining in which would have made a huge difference. She was very, very anti it. Plus, if you can get kids before they get to the age where they are doing weed and vodka, which I am quite convinced they all do, then you have much better chance of reaching them.*

Participant 9: *It would have been easier then (if it had come in earlier) because she was easier to control when she was younger.*

#### **4.2.5.4 Addition of follow-up calls or sessions**

Participants made several comments around the need for interventions targeted at adoptive families to be aware of children's attachment difficulties in relation to engagement with the therapist and the programme. As such, some participants highlighted the importance of MST being available for a longer and more consistent period of time.

Participant 1 *I think the help that you need isn't in a set time because the problems that adopted children have, and adopted families, maybe not all adopted families, carry on throughout their lives. It's not just, 'We will sort out your attachment issues and that will be fine.' The people, I am speaking from our perspective, the people that I know who have adopted children, their problems carry on all the way through the time that they have had the adopted children.*

Participant 2: *Because she was so damaged, the period of time that needed to be available was going to have to be a very long time.*

It seemed that participants felt that the sudden ending of MST after an intense period replicated the difficult earlier relationships in the young person's life.

Participant 3: *You don't get the consistency that kids like her need because with attachment and so on. I really, I have got numerous friends whose kids have got assorted different problems, mental health, or otherwise, and I really think there is something very particular about kids who are adopted because they have this very primal dislocation at birth.*

As a means of preventing this replication, and of addressing the issues of longevity and consistency in adoptive families, participants called for a phased and gradual ending using follow-up sessions or calls.

Participant 2: *So, if I could have had weekly phone calls for another 3 months or 6 months or even two weekly phone calls or follow-up meetings; the time-frame for me wasn't long enough.*

Participant 10: *We would still have wanted a little bit of some support to perhaps tweak certain things or get some advice about certain things, whether they were working as well as they should have done or not.*

### **4.3 Participant Validation of Themes**

As a means of validation and confirmation of thematic saturation, the initial thematic map (see Appendix H) was reviewed by a service user not previously involved in the study. The interview was transcribed and her

comments on each theme described below. The service user was a 55-year-old, White British, married, adoptive mother. Her adopted daughter was also White British and aged 32 months at time of adoption and 15 years at time of MST. At time of discharge from MST and time of interview, the adopted young person was living at home, in education, and had recorded no new arrests. It had been 20 months since the family had completed MST.

#### **4.3.1 Situation prior to MST**

In support of the themes identified in the analysis, the service user described identifying with participants' family situation prior to MST, describing her own as being at "*breaking point.*" As with many participants, the service user was also hoping that "*there had to be something else out there that could help*" their situation. Whilst the service user had been "*quite lucky because we had had a lot of support from the agency,*" she could recognise why adoptive parents may have a desire to feel understood, stating that, whilst the desire was "*probably not as much as for some, I can understand how, because I have a lot of friends who are adopters, I can understand people feeling like that.*"

#### **4.3.2 Enablers to change**

The service user agreed with all four of the factors identified in the analysis as being important enablers to change. Particularly, the service user described the benefits of a "*non-threatening environment,*" "*being able to offload very regularly,*" and the use of the behavioural strategies to "*tighten things up and turn things right round.*" In terms of the therapeutic relationship, the service user concurred with the importance of this in terms of encouraging change in

the family and touched particularly on the therapist's "*non-judgemental*" stance.

#### **4.3.3 Barriers to change**

In validation of the sub-themes, the service user highlighted her own child's lack of engagement as a fundamental barrier to change. Regarding adoptive parents' sense of shame and failure being a potential barrier to change, the service user reported, "*You do feel that all the time as an adopter, you know, you should put it right for these poor children and all the rest of it.*" She went on to say that the sense of blame "*is heightened for adopters because you feel you have gone through the training, you have done this, that and the other, you know, you ought to be able to make it right because these children have been through enough.*" However, unlike a few participants interviewed, the service user reported that "*MST certainly didn't make me feel that and I think they were very proactive in saying, 'The fact you are seeking help, the fact you're are doing this, the fact you are taking on this, the fact you are prepared to put in all those hours, proves that you are not doing that.'*" This highlights the value of MST addressing this barrier early on in therapy.

The subtheme related to the context of adoption not being considered did not resonate with the service user because she felt that she already had the necessary adoption and attachment training for it to be okay for MST not to focus on her context as an adoptive parent. Nonetheless, the service user suggested, "*If you hadn't have had that (training), if you got somebody who wasn't understanding the adoption side of their child and hadn't got their head round that bit first, I think it could be quite different.*" She noted, "*If you are*

*going to mend a broken child you have to look at their emotional needs before you can.”*

#### **4.3.4 Outcomes of MST**

The subtheme that resonated most with the service user was increased parental strength and confidence, reporting that *“MST made me feel far more in control and that it was fine to put boundaries in and expect them to be stuck to.”* The service user also validated the continued use of MST strategies saying, *“We used it with our next one who is only a year younger so we did the same sort of system with her, and it just pulled things back before they got out of hand with her.”* She also appreciated the changed expectations of young person’s behaviour as a key outcome of MST, encouraged by discussion and reflection and the opportunity to *“look at some of those issues more than you do when you are caught up in the day to day.”* Because the service user and her family had attended a lot of therapy and training addressing the root causes of the behaviour difficulties prior to MST, the subtheme around MST as a foundation for further change *“doesn’t fit with where we were,”* but she admitted that she could *“see how it would”* for other adoptive families who had not had this prior training.

#### **4.3.5 Modifying MST to better meet the needs of adoptive families**

In terms of therapists having greater adoption and attachment specific knowledge, the service user agreed that *“it would be useful for them to know where the children and where the families were coming from.”* However, unlike some of the participants in the study the service user *“wouldn’t want strategies adapted too much”* and valued the behavioural take of the

intervention. It seemed that knowledge was fundamental but not to the detriment of the MST model. Moreover, the service user expressed a sense of reassurance knowing that her therapist had worked with other adoptive families and could appreciate the incorporation of information specific to adoptive families.

The subtheme concerning MST intervening earlier in the problems course resonated strongly with the service user who said that she did “*wish it had come sooner so we could have headed things off.*” As with participants in the study, the service user highlighted the years of eight to 10 as the optimal age for MST in adopted young people. As an adoptive mother to five children, the service user recognised the ages of eight to 10 as a time when adopted children “*start thinking*” and processing the loss, anger, and identity confusion associated with adoption. Consequently, it “*is when the behaviour kicks off and that is when they need to feel tight and secure and held as well.*”

The service user also confirmed the benefits of additional follow-up calls or sessions, reporting that “*being weaned off a bit more rather than just ‘bye’*” would help to minimise the sense of abandonment, if nothing else.

## **5 Discussion Chapter**

The aim of the current study was to provide the first insight into adoptive parents' lived experience of MST. Discussion of the main findings is presented below in relation to the relevant research and theoretical literature, prefaced with an overview of the study. The application of the results for MST services, programme developers, and therapists are presented in relation to MST better meeting the needs of adoptive families. The limitations of the study are recognised and future developments suggested before the researcher's personal reflections are presented.

### **5.1 Overview**

The current study builds on the earlier quantitative review of MST (see Chapter 2) that demonstrated comparative effectiveness in adoptive and nonadoptive populations when looking at the three ultimate outcomes of MST: living at home, in education or employment, and no criminal charges. Further exploratory analysis of idiosyncratic outcomes also suggested that the fundamental aim of MST, reducing antisocial behaviour within the family system, was being effectively addressed. However, the quantitative review was unable to provide insight into the lived experience of adoptive families necessary for the appropriate interpretation of results and comprehensive understanding of MST in this understudied population. Consequently, the current study utilised qualitative methods with the aim of providing the first detailed insight into the lived experience of MST from the perspective of adoptive parents.



The study interviewed the parents of 10 adopted young people referred to standard MST for antisocial behaviour problems. Adoptive cases were identified from the databases of five MST sites from across the UK. Of the parents interviewed, eight were adoptive mothers and three were adoptive fathers aged between 42 and 62 years of age. All but one of the adoptive families completed the full course of MST.

The findings from the study are specific to the research participants interviewed and are not intended to be generalised to the broader population of adoptive families. However, interviews and analysis were designed to provide deeper understanding of adoptive parents' experience of MST; some of these may be applicable to other adoptive families managing with antisocial behaviour of their child.

Thematic analysis was deemed to be the most appropriate methodology for the current research, partly because it allows for a rich overall description of an under-researched area and identifies themes that are strongly linked to the data collected. Several of the themes that emerged in the current study overlap with the experiences of nonadoptive parents identified in other studies of MST (Kaur et al., 2015; Tighe et al., 2012). This overlap demonstrates the factors universal to all parents, be it adoptive or nonadoptive. Nonetheless, many unique findings relating specifically to the experience of adoptive parents arose from the analysis. Whilst all themes are fundamental to the overall experience of MST, those unique to adoptive parents will be discussed in greater detail as they are central to providing new insight into their experience of MST.

## **5.2 Discussion of Findings**

Five key themes, with between three to five associated sub-themes, emerged from the analysis of adoptive parents' experience of MST:

- Situation prior to MST
- Enablers to change
- Barriers to change
- Outcomes of MST
- Modifying MST to better meet the needs of adoptive families.

These themes will be discussed below with regards to existing literature to enable consideration of how the findings contribute to and advance the current knowledge base.

### ***5.2.1 Situation prior to MST***

Within adoptive parents' description of their situation prior to MST, there were three subthemes relating to the *severity of family situation, desperation to try anything, and desire to feel understood*. It was apparent from each parents' account that, prior to their referral to MST, their family situation had reached a point where the adoption was close to disruption. In themselves, parents reported feeling that they had been pushed to their limit by their child's behaviour and felt unable to appropriately contain the situation. Parents demonstrated concern not only for their child's safety in terms of the consequences of their antisocial behaviour, but also for the safety of themselves and other family members.

The severity of the family situation meant that parents reported a willingness to accept and engage in any intervention offered to them. This finding conflicts with that reported by Tighe et al. (2012) who found that nonadoptive parents, despite also feeling stressed and exhausted by the situation, were reluctant or uncertain to engage in MST at the beginning. The discrepancy in findings highlights a potential difference around the engagement of adoptive and nonadoptive parents, with the former possibly being more willing to engage with new interventions in times of stress. The finding alludes also to the level of commitment adoptive parents have to preventing placement breakdown, something also identified by Selwyn et al. (2014) who concluded that many adoption disruptions were prevented due to the commitment and tenacity of adoptive parents. It can also be hypothesised that the reason most adoption orders disrupt during adolescence, unlike special guardianship or residency orders which occur irrespective of the child's age, stems from adoptive parents' commitment to persevere with their children for longer compared with guardians and carers.

Prior to commencing MST, adoptive parents described feeling misunderstood and overlooked by friends, family, and professionals. They expressed a hope that their MST therapist would understand their situation and recognise the unique challenges that they faced. Adoptive parents' desire to feel understood has been documented by other studies in the population with Johnstone and Gibbs (2012), for example, reporting that many adoptive parents expressed frustration that professionals seemed to lack an understanding of the specific needs of their adopted child. The finding is also evident in studies of

nonadoptive parents' experiences, which highlight the value they place on feeling heard and understood by the therapist (Tighe et al., 2012). The consistency of this finding suggests the universality of a parent's desire to feel understood by the systems that support them. However, from an identity theory perspective (Stryker, 1987; Stryker & Burke, 2000), the importance of feeling understood may be recognised as more fundamental to adoptive parents than nonadoptive parents, as validation in their new role by others is critical in the verification of their identity as a parent. If adoptive parents do not feel understood and they are not receiving validation from their social environment, identity verification processes are disrupted and they are likely to evaluate themselves and their relationships less positively (Cast & Burke, 2002).

### **5.2.2 Enablers to change**

Within the factors adoptive parents identified as enablers to change were four subthemes: *positive therapeutic relationship, high intensity, home or community setting, and behavioural strategies.*

The positive therapeutic relationship as an enabler to change in MST is a finding that has been consistently reflected in studies with nonadoptive parents (Kaur et al., 2015; Tighe et al., 2012) and validates the frequently evidenced association between the therapeutic alliance and positive outcomes in therapy (Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). However, due to the increased prevalence of attachment difficulties in adopted children, it can be argued that the positive therapeutic relationship between therapist and parent is particularly pertinent to change as it can work

to model the positive relationship between parent and child; as parents use their therapists as a secure base to explore their parenting, so too will the parents act as a secure base for their adopted child to explore their world (Bowlby, 1988). Moreover, for secure attachments to develop, caregivers need to be able to reflect on and attempt to understand the child's emerging internal world (Berlin, 2005; Dozier, Stoval, Albus, & Bates, 2001; Fonagy, Steele, Steele, Moran, & Higgitt, 1991). Through the availability and responsiveness of the therapist, parents may be appropriately contained to get their needs met to facilitate this reflective capacity. The benefit of the therapeutic relationship for adoptive parents therefore extends beyond simply enabling change, and may lend support for the hypothesis that the therapeutic relationship is beneficial in and of itself (Norcross, 2011).

In a similar vein, adoptive parents' recognition of the programme's high intensity and its home or community setting as enablers to change also replicates findings from nonadoptive populations (Kaur et al., 2015; Tighe et al., 2012). In line with Bion's (1967) concept of the container-contained, the MST model may act as a container for parents to manage their own emotions and develop a capacity to mentalise, whilst also enabling parents to take the role of container for their child. In relation particularly to adoptive families, by taking the role of container, adoptive parents could facilitate their child's processing of thoughts and feelings associated with their adoption that may previously have been too difficult or painful to be tolerated, understood, and put into words.

A final enabler to change identified by parents was the development and implementation of behavioural strategies. Initially, parents described feeling uncertain as to whether rewards and consequences would work on adopted children due to the increased prevalence of attachment difficulties. This conforms with the common belief in the field that behaviour modification strategies are less effective with children who have attachment difficulties (Thomas, 2004, as cited in McGinn, 2004). However, adoptive parents found that the behavioural strategies helped them gain clarity and retain some control of the family situation by taking away uncertainty. In relation again to the concept of containment in this population (Bion, 1967), the consistent application of behavioural strategies and the elimination of uncertainty are likely to become containing for the young person and provide a sense of boundary and safety that they can operate within. Complementing the current findings are those found from research in nonadoptive populations, with parents reporting that the introduction of behavioural strategies reduced emotional strain and brought about a reduction in their child's antisocial behaviour (Tighe et al., 2012).

### **5.2.3 Barriers to change**

Within barriers to change, there were three subthemes relating to adoptive parents' *sense of shame and failure*, their *context of adoption not being considered*, and the *young person's refusal to engage*.

Parents noted that before commencing MST, they experienced feelings of shame and failure resulting from their perceived inability to parent their adopted child. This self-critical style of thinking has been demonstrated across

other studies exploring the experiences of adoptive parents, with Hull (2016) reporting feelings of shame, guilt, and failure when they were unable to always contain or respond to their children's needs. In the current study, parents suggested that these negative feelings acted as a barrier to their initial engagement in the programme and that if addressed earlier might have meant greater possibility for change. Moreover, in a review of nonadoptive parents of children presenting with antisocial behaviour, Baden and Howe (1992) found that it was common for parents to hold cognitive stances of blame and helplessness which were shown to contribute to aversive parenting behaviours and parental withdrawal in response to escalating antisocial behaviour. As such, addressing the reported cognitive stances of parents early in treatment may be fundamental not only to engagement but also to the initiation and maintenance of behaviour change.

A further barrier concerned parents' belief that their context as an adoptive family was not considered in the development of the intervention targeting their child's antisocial behaviour. Parents believed that their child's antisocial behaviour was underpinned by their pre-adoption experiences, the associated trauma, and consequent attachment difficulties. These parental beliefs conform to previously reviewed literature demonstrating the association of insecure attachment, pre-adoption adversity, and identity confusion with antisocial behaviour (Fearon et al., 2010; Gagnon-Oosterwaal et al., 2012; Smith et al., 2000). Of the factors referenced by adoptive parents, attachment difficulties were highlighted as the leading root cause to their child's antisocial behaviour yet parents did not feel MST appropriately addressed it. This

finding mirrors those reported in other qualitative descriptions of adoptive parents that describe frequent encounters with professionals who dismissed or failed to accept their attachment-oriented conceptualisations (Hull, 2016). From adoptive parents' experiences, coupled with the literature evidencing that the process of adoption can underpin the development of behavioural problems in some children, it follows that not considering these difficulties in an intervention for adopted young people might act as a potential barrier to optimal behaviour change.

Parents' reports that their adopted child failed to engage in the programme is consistent with reports from nonadoptive families (Tighe et al., 2012).

However, adoptive parents spoke particularly of their child feeling threatened by the presence of MST in the family home, finding it intrusive and unsafe.

Moreover, parents described their child's clear defiance and resistance to the changes they were trying to put in place. This finding resonates with the attachment theory that maintains that if the contact between child and caregiver is disturbed, the child will respond with passivity, avoidance, or reactive fear when the caregiver or some other person approaches (Bowlby, 1969). In this situation, a child fails to explore their environment and instead an infantile variant of resistance to change is established. MST may be interpreted by an adopted young person as a threat to their current world and their resistance to change may be exemplified. Recognising the challenges of engagement and resistance to change in this population will, therefore, be helpful to overcoming barriers.



#### **5.2.4 Outcomes of MST**

In terms of outcomes, there were four subthemes relating to: *increased parental strength, continued use of MST strategies, changed expectations of young person's behaviour, and a foundation for further change.*

Parents reported that prior to MST they had lost confidence in their ability to appropriately parent their adopted child. However, through the support of the MST therapist and the acquisition of new skills, parents described feeling stronger, having a greater sense of control, and possessing an increased confidence in implementing management strategies in response to their adopted child's antisocial behaviour. The importance of having confidence in one's ability to parent (i.e. parental self-efficacy) has been demonstrated as fundamental in the literature, with evidenced links to parental competence, parental psychological functioning, reduced child antisocial behaviour, and improved child adjustment (Jones & Prinz, 2005; Morawska, Winter, & Sanders, 2009). Furthermore, by emphasising the impact of enhanced parenting the current findings provide support for the MST theory of change (Henggeler, Schoenwald, et al., 2009; Huey Jr et al., 2000). Whilst increased confidence is not unique to adoptive parents' experience of MST (Kaur et al., 2015; Tighe et al., 2012), it may be fundamental to adoptive parents who will be facing their own challenges regarding their role identity (Child Welfare Information Gateway, 2015); increasing parental self-efficacy will work in the validation of their role as a parent and container to their adopted child (Bion, 1967; Cast & Burke, 2002).

A further outcome of MST recognised by parents was their changed expectation of their child's behaviour. Prior to MST, parents admitted to being overwhelmed by their own expectations as to how their adopted child *should* behave, how they *should* parent, and how their family *should* function. This conforms to other reports reviewing the impact of adoption on adoptive parents that recognise an uncertainty relating to the expectations that accompany their new identities and the vulnerability and destabilisation associated with that (Child Welfare Information Gateway, 2015; Hull, 2016). Importantly, negative parental expectancies around child behaviour and parenting effectiveness have been linked to the establishment and maintenance of child antisocial behaviour and coercive parent-child exchanges (Baden & Howe, 1992). However, over the course of MST parents reported a change in these expectations and were supported in compartmentalising and prioritising key behaviours of concern. Consequently, parents demonstrated a level of acceptance of their family situation and a consequent sense of control and calm.

A frequent report from adoptive parents was that they continued to draw on the skills and knowledge that they had acquired in MST after the intervention had finished. This conforms with findings around the sustainability of MST in nonadoptive populations (Kaur et al., 2015; Paradisopoulos et al., 2015).

Parents described adapting the strategies to suit the ever-changing behaviour of their child as they progressed through the years but also used the strategies in the parenting of their other children. This outcome links with a number of MST treatment principles (Henggeler & Schoenwald, 1998),

including ensuring the intervention is developmentally appropriate (Principle 6) and that treatment generalisation and long-term maintenance of therapeutic change is promoted by empowering caregivers to address family members' needs after the intervention is over (Principle 9).

A final outcome reported by parents was that, whilst MST did not act as a fix, it did enable a foundation on which the family could seek further therapeutic support necessary to address the root causes of the problem that the family felt were not addressed in the intervention itself. Parents recognised that to address the underlying difficulties the family situation needed to be appropriately stabilised. This notion of stabilisation prior to addressing the origins of behaviour is well recognised in the literature. For example, in trauma-focused therapy for traumatised children and families the treatment protocol allocates up to half of the treatment sessions to the stability and safety of the client (Cohen & Mannarino, 2015). Gaining that stability can therefore be crucial for families of adopted young people who want to seek further therapy to address the origins of their antisocial behaviour that were felt to be overlooked by MST.

Of note, no parent in the current study referred to the impact of MST on deviant peers or on school. This lack of reference may be fundamental considering peers and school are a primary focus of change in the MST model. Moreover, one may draw links with the speculative finding in the quantitative review that MST appeared less effective in improving school attendance when compared to other behavioural categories (see Section 2.3).

However, absence of evidence is not evidence of absence and future studies may wish to explore this further before drawing any conclusions.

The current findings do, however, represent the multi-level nature of MST outcomes in that, at an idiosyncratic level of analysis, negative and positive outcomes are likely to co-occur. This point was also recognised in the review of nonadoptive parents' experience of MST (Tighe et al., 2012). Moreover, the range of outcomes beyond improved antisocial behaviour highlights the range of secondary outcomes in MST and supports Tighe and colleagues call for the use of relevant outcome measures in MST research studies to capture the full range of social, emotional, attitudinal, and behavioural benefits of the intervention. This is an aim of a current multi-site RCT being conducted by Fonagy et al. (2013) who, beyond the primary outcome of out-of-home placements, will be evaluating the impact of MST on youth offending outcomes, adolescent well-being outcomes, and family functioning outcomes.

#### ***5.2.5 Modifying MST to better meet the needs of adoptive families***

Within modifying MST to better meet the needs of adoptive families, parents' suggestions were categorised into the following four subthemes: *greater therapist knowledge of adoption and attachment*, the *incorporation of information specific to adoptive families*, the *earlier provision of MST*, and the *addition of follow-up calls or sessions*.

Several adoptive parents called for therapists to possess a greater knowledge base around both adoption and attachment related issues. It is important to highlight that several parents evidenced substantial - and, at times, expert-knowledge of adoption and attachment pertinent issues owing to extensive

self-education. To enhance the formation of a strong and collaborative therapeutic relationship, and also to optimise clinical outcome, it is well evidenced that client's perception of therapist expertise is fundamental (Patterson, Anderson, & Wei, 2014). Consequently, for some adoptive parents to feel appropriately understood and supported by their MST therapist it seemed important that that therapist demonstrate comparative or advanced knowledge of adoption and attachment to themselves. Therapist knowledge was related also to parents' sense that their context as an adoptive family was being appropriately considered in the development of the intervention.

In addition to therapist knowledge, parents highlighted the potential benefit of therapists communicating the literature around adoption and behavioural problems to them at the beginning of the programme as a means of helping them recognise that their situation is not uncommon. It seemed that adoptive parents felt that the process of feeling understood and having the unique challenges of adoptive families recognised by professionals was fundamental to challenging any attributions of blame, shame, or failure that acted as initial barriers to engagement (see Section 5.2.3).

A frequently documented point made by parents was that the years of eight to 10 were critical in the development of their adopted child's behavioural problems. Parents recognised that these were the ages when their child began to perceive and recognise the meaning of their adoption. In response to this new insight, parents reported that their adopted child was faced with an inevitable mix of difficult feelings including loss, sadness, anger, and identity confusion. Parents hypothesised that their adopted child's inability to

appropriately process these thoughts and feelings may have contributed to the development of their behavioural problems.

Parents' recognition of the ages of eight to 10 years as important in their child's processing of adoption conforms to those documented in the literature; as early as Piaget's theory of cognitive development (1964), these ages encapsulated the concrete operational stage of development and represented the beginning of logical and operational thought whereby children's thinking becomes less egocentric, they are increasingly aware of external events, and they begin to recognise that their own thoughts and feelings are unique and different to others' thoughts and feelings. More recently, Melina (1998, 2015) reported that whilst adopted children of this age recognise the differences between blood relations and adoptive relations, they are yet to understand the legality of adoption and as such feel uncertain as to their place in their adoptive family. Additionally, the literature posits that adopted children between eight and 10 may experience a grief response in relation to their recognition of adoption and must, therefore, process significant feelings of separation and loss (Melina, 1998, 2015). In addition to children's cognitive maturation, this age frame concerns the commencement of hormonal and physiological changes and the important transition from the relatively small, containing environment of primary school to the larger, ever-evolving social and learning experience of secondary school. As such, the delicate coping mechanisms developed by children with attachment difficulties are threatened and may catalyse the development of antisocial behaviour (Furnivall, McKenna, McFarlane, & Grant, 2012). It is also a time when young people

look to meet their attachment needs through peer relationships and are, consequently, at greater risk of being influenced by antisocial peers (Furnivall et al., 2012).

Adoptive parents in the current study suggest that MST could better address the needs of their family by offering MST between the years of eight to 10 instead of the currently prescribed 11 to 17 years of age. Parents felt that, if offered earlier, MST would be better able to address the predisposing events and enable them to take back control before the problem became too entrenched; this is particularly pertinent as two-thirds of adoption disruptions occur during the secondary school years (Selwyn et al., 2014). Offering MST earlier to a vulnerable population would mirror the adapted MST-CAN model which is open to children aged between 6 and 17 years of age who have come to the attention of Child Protective Services due to physical abuse and/or neglect (MST Services, 2015).

Finally, as a means of further meeting the needs of adoptive families, parents highlighted the potential benefits of follow-up sessions or calls after the core treatment period. Although the call for follow-up *booster sessions* replicates findings from nonadoptive populations (Tighe et al., 2012), the current MST position statement provides several reasons why such booster sessions are not standard to the model (Strother, Swenson, & Schoenwald, 1998). Firstly, it is suggested that the knowledge of possible booster sessions would undermine the therapists' and families' desire for sustainability *during* treatment. Secondly, it is argued that the availability of booster sessions to families would take away from the resources available to other families yet to

start treatment. It would also add to the workload of therapists if the slots were not formalised into their schedules. Finally, the position statement cites threat of significant legal risk related to lack of formal contracts for such sessions.

Despite the organisational manual's reasons as to why follow-up booster sessions are not standard, the majority concern the organisational and practical concerns of increased resources. However, there is a large literature base that highlights the effectiveness of brief booster sessions after behavioural parent training for maintaining treatment gains (Eyberg, Edwards, Boggs, & Foote, 1998; Lundahl, Risser, & Lovejoy, 2006; Tolan, Gorman-Smith, Henry, & Schoeny, 2009). In the current study, adoptive parents corroborated with this finding by suggesting that follow-up sessions would be beneficial in improving the sustainability of their outcomes by acting as a booster to skills and confidence. Moreover, as some underlying difficulties identified in adopted children have been theorised to stem from broken attachments and lack of containment in their early years (Fearon et al., 2010; Gagnon-Oosterwaal et al., 2012; Smith et al., 2000), one must consider the influence of terminating an intensive, home-base intervention of these children. If follow-up booster sessions were appropriately incorporated into the MST programme, accounting for the increased resources, adoptive parents reported that it would enable the consistency and longevity fundamental to this population by offering a means of containment over an extended period.

### **5.3 Implications for Clinical Practice**

The analysis of adoptive parents' accounts of MST have highlighted several clinical implications and recommendations to MST programme developers,



teams, and therapists around potential considerations to ensure the needs of adoptive populations are appropriately met.

Firstly, the ability to work understandingly and sensitively with adoption emerged as paramount in the engagement and change process for adoptive parents. Accordingly, it may be beneficial for MST services and those involved in the delivery of training, such as MST consultants, to provide targeted training to all therapists on adoption salient issues such as attachment difficulties, identity challenges, family processes, and other unique experiences which contribute to an adoptive family's presentation. The current study suggests training could draw on areas of attachment theory, neuroscience, developmental psychology, and the impact of trauma and neglect in the early years of life in the development of the training programme. A platform for additional training specific to adoption might be *MST booster training sessions* which encourage the effective implementation of MST and are provided to all MST therapists each quarter (Henggeler & Schoenwald, 1998).

A further implication related to the development of skills and knowledge may be to provide an appropriate resource base for therapists working with adoptive families via the MST Institute, MST Services, or MSTUK websites. The current study suggests resources might include real life case studies from MST teams who have worked with adoptive families, feedback and recommendations from adoptive families, links to recent and relevant adoption research and news, and a set of guidelines for therapists working with adoptive families. The guidelines might include encouraging therapists

working with adoptive families to address the context of adoption early on in therapy through open and honest discussion, to explore the family's own views of the behaviour problems in relation to the context of adoption, and to incorporate appropriate adoption related information across all stages of the intervention. Resources of this type will empower MST therapists to apply the knowledge and skills learnt in training to better undertake work with this client group and to be appropriately attuned to the relevant areas prior to, and during, the intervention. However, therapists will require appropriate and quality supervision from knowledgeable supervisors when adapting their practice to appropriately meet the needs of adoptive families.

Beyond the development of MST therapists' individual knowledge and skill set, findings from the current study implicate the value of training to include ways that adoption related knowledge might be incorporated into the intervention to ensure therapists achieve an appropriate balance between the needs of the adoptive family and the remits of the MST model of working. Unlike the social learning theory, which draws on behavioural principles such as rules, rewards, and consequences, attachment ideas place greater emphasis on the emotional importance of having a secure figure who is reliable, consistent, and responsive to a child's needs. Without this, Scott and Dadds (2009) propose a child is likely to continue to develop maladaptive behaviour patterns in response to adoptive parents in times of stress. Moreover, it may be necessary to consider a means of appropriately incorporating the family's relationship history and the adopted child's pre-placement experience within MST's present-focused, action oriented stance.

By enabling therapists with the training to appropriately incorporate adoption salient ideas into the MST model of working and with the confidence to better integrate the range of practices from strategic family therapy, structural family therapy, and cognitive behaviour therapy, the process of change in adoptive families may be enhanced.

A further clinical implication relates to some adoptive parents' feelings of guilt and inadequacy, attributed as a significant barrier to engagement. As a means of overcoming this barrier, adoptive parents highlighted the benefit of therapists providing them with accessible information related specifically to MST for adoptive families in the initial session or point of referral. Some suggestions include presenting adoptive parents with case studies of other adoptive families who have received MST, reinforcing messages of *good enough* parenting in the context of caring for children who present with antisocial behaviour, and normalising the challenges that each member of the adoption circle adapts and copes with across the entire life cycle. Moreover, families could be signposted to local support groups and resources for adoptive families. All these methods would work to normalise the situation and remove any sense of blame or shame felt by adoptive parents necessary for optimal engagement in the process.

Adoptive parents' desire for follow-up sessions post-discharge is currently outside the remit of the standard MST model. However, MST therapists could consider some accommodations to assist adoptive parents in identifying a resource, such as a counsellor, that could collaborate with the MST therapist and the family during treatment and provide the ongoing support the family

needs post-discharge from MST. Enabling a planned transition from MST to a less intense, supportive treatment could be a direct way for MST to meet adoptive families need for consistency and longevity that were identified by the parents in the current study.

Finally, it is pertinent to acknowledge that although adoptive issues have been highlighted as important in the formulation of behaviour problems, each adoptive family is unique in their experience. Consequently, it is fundamental that MST services and therapists work sensitively with adoption and do not assume that because a family is adoptive this is the most salient issue to their presentation.

#### **5.4 Implications for Clinical Research**

As a means of meeting the unique needs of adoptive populations, it is acknowledged that programme developers need to adapt interventions that are already grounded in theory and have demonstrated effectiveness in nonadoptive populations (Barth & Miller, 2001; Torrey et al., 2003). In cases where adaptations to the standard MST model might produce an effective intervention for a challenging clinical problem, MST Services (2015) recommend pilot studies as the first stage in determining the feasibility and preliminary effects of that adaptation. Findings from the current study offer initial grounding for pilot studies to investigate the benefit of adaptations to the MST model in two possible areas to more appropriately meet the needs of adoptive populations.

Firstly, the current study highlights the potential benefit of exploring the effectiveness of MST in families of adopted children as young as 8 years of

age. The ages of eight to 10 are recognised by parents in the current study, and supported by the wider literature, as critical in the trajectory of adoptive children's antisocial behaviour (see Section 5.2.5). Consequently, by offering MST to adoptive families during this critical point, there may be opportunity to remediate the development of negative outcomes in the short-term and interrupt the potential long-term cascade of adverse developmental trajectories and risk factors that stem from these early challenges (Harold, Hampden-Thompson, Rodic, & Sellers, 2017; Webster-Stratton & Taylor, 2001). Moreover, by intervening earlier MST would be better placed to optimally engage the young person in the change process as antisocial behaviours are less crystallised and there is greater opportunity to provide adequate fertilisation for building necessary protective factors (Webster-Stratton & Taylor, 2001).

Secondly, to address adopted children's need for consistency and longevity, and to affect the sustainability of outcomes, MST could consider investigating the effectiveness of facilitating a phased and gradual ending using follow-up booster sessions or calls after the core treatment period. Prior to investigation, consideration would need to be made in relation to the nature and content of the follow-up sessions (i.e. whether the original treatment would be reviewed or whether new techniques would be introduced to maintain or enhance positive gains) and, also, the timing over which the sessions would be offered to maximise the optimal maintenance of treatment effects. Consideration of such factors could be informed by the findings of the current study and a more extensive review of the literature and evidence base.

## **5.5 Limitations and Future Developments**

In interpreting the findings of the current qualitative study and considering potential future developments, several methodological constraints need to be reflected upon.

### ***5.5.1 Quality and validity of reports***

Adoptive parents appeared to speak openly and honestly in the interviews, perhaps facilitated by the interviewer being independent of the MST team.

However, self-report data collected retrospectively is susceptible to several shortcomings (Giorgi & Giorgi, 2008; Smith, Leffingwell, & Ptacek, 1999).

Firstly, memory may be impaired given the time-frame that has elapsed since the event; whilst the current study opted to include all available participants irrespective of time since MST as a means of enhancing sampling opportunities, the result was that some adoptive parents had to recall details from as far back as 7 years. Secondly, the variation in each parents' reports may be further influenced by their phase within the adoption life cycle and the distance from which they are reflecting on the time of crises (Rosenberg, 2010). Finally, the difficult nature of the topic required adoptive parents to identify and express complex internal and relational processes, which may have been beyond awareness. Nonetheless, whilst some parents struggled to remember finer details such as dates or names of organisations, all appeared proficient in the recall of their experience of MST due to the significance it played in their life. Parents also described a benefit in having the opportunity to revisit and reflect on their experiences. However, as a means of improving the quality and validity of parental self-reports, future research may consider

the use of cognitive strategies, such as prompts, to help overcome difficulty with recall and the incorporation of inclusion/exclusion criteria related to participants' time since MST completion.

### **5.5.2 Heterogeneity of sample**

As a further means of optimising the sampling opportunity, the study limited the exclusion criteria and included all available adoptive cases that had received standard MST and were not a current risk to self or others. However, due to the heterogeneity of adoptive populations, a consequence of this was that several unforeseen variables were identified at point of interview that had not been anticipated.

A primary variable in the sample that evidenced the greatest heterogeneity was the age of adoption, ranging from as young as 1 week to as old as 8 years. This variable is pertinent to consider due to older placed children typically having pre-placement histories of adversity, deprivation, neglect, rejection, and abuse that place them at greater risk of developmental impairments in the realms of their emotional, behavioural, and social development (Howe, 2001). Due to pre-placement histories, some late placed children may therefore bring adaptive and coping strategies, and a range of dysfunctional behaviours developed in their pre-placement caregiving environment that may be implicated in the development and management of antisocial behaviour (Cederblad et al., 1999; Stams et al., 2000; Stovall & Dozier, 1998). The association between age of adoption and adoption disruption is well evidenced in the literature; compared to children placed under 12 months old, the risk of adoption disruption is three times more for

children who were placed when 1 to 2 years old, six times more for children who were aged 2-4 years, and 13 times more for children aged 4 or older at placement (Selwyn et al., 2014). Future studies should consider closer review of this variable and the implications of this on the development, management, and outcome of antisocial behaviour.

A further variable identified only during the interview process, and therefore not directly collected, was parental mental health. Several adoptive parents spoke of their own challenges and the impact of these on themselves and on their family. Literature demonstrates the association of parental mental health with child outcomes, and particularly on child externalising behaviour problems (Van Loon, Van de Ven, Van Doesum, Witteman, & Hosman, 2014). Future research could explore the specific influence of parental mental health on MST outcomes and experience.

A further factor worthy of comment concerns family ethnicity, with some families being of the same ethnicity and others being different; this could be pertinent to the identity issues cited by some parents. Moreover, variability existed in the quality and type of support families had received from post-adoption services resulting from factors such as postcode, adoption agency, and family uptake. On reflection, it would be important to consider such distinctions in the experiences of adoptive families (Fisher, 2015) and future research should attempt to explore them further to enable greater specificity of conclusions.

Despite the unforeseen variables, it must be noted that the sample were representative of the UK adoptive population (Department of Education,



2017). For example, the average age at adoption for the sample was 3 years and 4 months which is on par with the 3 years and 5 months reported in 2016 national data. Moreover, the one adoptive mother in the sample represented the 11% of national adoptions by a single person and 70% of the young people in the sample were White compared to 83% of those adopted nationally. Nonetheless, by controlling for the identified variables in future research, further insight will be gained into the experience of MST in adoptive families.

### ***5.5.3 A single perspective of a multi-systemic intervention***

Unlike previous MST studies that focused on parents' and young persons' perspectives conjointly to produce a compilation of themes (e.g. Tighe et al., 2012), the current study focused exclusively on the voice of adoptive parents. This decision resulted from the study being the very first in adoptive families and a consequent desire to focus initially on parents' experiences due to MST's emphasis on parental empowerment. However, due to the multisystem approach of MST it will be fundamental for future research to build on the current findings by incorporating the voice of adopted young people, peers, and schools to gain a more complete insight into MST in the adoptive population. Moreover, due to previously stated anecdotal reports around MST therapists' concerns as to the suitability and effectiveness of MST in adoptive populations (personal communication, 2016), it may also be valuable to explore MST therapists' experience of working with adoptive families.

#### **5.5.4 Level of analysis**

As this study represented the first exploration of MST from the perspectives of adoptive parents, thematic analysis was deemed the most appropriate method of analysis due to its ability to identify the most salient patterns of meaning in a dataset whilst also offering a rich overall description (Braun & Clarke, 2006). Through the list of themes produced in response to the research questions, the current study has identified several key areas for further study. As a means of building on these findings, future research could consider the use of methods such as grounded theory, where the level of abstraction is taken further, to allow for the development of theory related to the processes of engagement and change in adoptive populations (Glaser & Strauss, 1965; Strauss & Corbin, 1994, 1998).

#### **5.6 Personal Reflections**

Being new to the field of adoption, my own insight into the experiences of adoptive families matured greatly over the course of the research process. I was affected by each adoptive parent's narrative in some unique way and particularly by the challenges both they and their adopted child had faced and overcome. Due to the impact of parents' narratives on me emotionally, I gained much value in having the opportunity to debrief with site supervisors after each interview and to reflect upon my own feelings prior to the more concrete analysis of the transcripts.

Due to the openness and honesty of the adoptive parents involved in the study, I developed an affection for them and for the population more generally. This level of affection, together with the fact that the study

represented the first into adoptive parents' experience of MST, meant that I felt a strong sense of responsibility to ensure that I appropriately depicted their views as accurately as possible. As a means of managing this sense of responsibility, consultation with other trainees completing similar research and reflective supervision were imperative throughout the process. I also felt a sense of reassurance during the validation procedure with the adopted parent who had not been involved in the interviews when it was clear that the themes resonated with her own experience or the experience of the wider adoptive community.

A challenge I was faced with during the research was the disparity between my role as a trainee clinical psychologist and my role as a research interviewer. Whilst many of my clinical skills were pertinent to the process, particularly those around client engagement and the management of emotional content, I found that I was having to curb my own clinical curiosity and desire to offer reflections to allow the narrative of adoptive parents to unfold naturally using the semi-structured interview schedule and appropriate prompts. A method I found useful for recognising and addressing this was listening back to each audio recording immediately after the interview to enable greater self-awareness of when I was allowing the psychologist in me to override the researcher. This reflection upon the challenge of conflicting roles was strengthened further by open discussions with both peers and supervisors.

Prior to commencing clinical training, I came from a predominantly research-based background and consequently felt confident in completing the project

whilst also cherishing the opportunity to develop my research skills further. Over the course of the project I developed a deep sense of ownership and pride in it and in the recognition that it could have important clinical implications to such a vulnerable population. I have also particularly valued the role of researcher-clinician and hope to take a similar stance after qualification.

## **5.7 Conclusions**

Despite the outlined limitations, the current study provides the first insight into adoptive parents lived experiences of MST. These findings add depth to the quantitative review of MST efficacy in this population (see Chapter 2) by demonstrating that, whilst MST can effectively reduce antisocial behaviour and increase positive behaviour in adopted young people, there is scope to improve the experience of MST for adoptive parents by better consideration of their unique needs.

The study illustrates several features of MST that the adoptive parents in the current study recognised as enablers to positive change in their family situation, including the intensity and setting of the intervention, the positive therapeutic relationship with the MST therapist, and the behavioural strategies developed to manage behaviour. The study also highlighted several barriers to change for adoptive families stemming from adoptive parents' cognitive stances of shame and failure and their sense that their context of adoption was not appropriately considered in the development of the intervention.

The findings of the study were used to suggest ways in which current MST practice could be modified to better consider the unique factors facilitating

engagement and change in adoptive families, stressing the importance of appropriate training, supervision and consultation of MST therapists, and the incorporation of adoption pertinent theory and materials into the intervention. It is important to add that several of the themes that arose replicated previous MST research into nonadoptive populations; this highlights the importance of adoption sensitivity and the recognition of universal similarities in addition to difference, as well as the value of maintaining fidelity to the core elements of MST.

The findings of the study also act as a foundation on which future research can build, including the exploration into potential adaptations to the MST model in response to identified needs and the development of a theoretical model of the processes of engagement and change in adoptive populations.

It is hoped that the findings of the current study add to the wider MST evidence-base and enhance the clinical practice of MST therapists working with adoptive families.

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## 7 Appendices

### 7.1 Appendix A: NHS Ethical Approval



## Health Research Authority

### London - Bloomsbury Research Ethics Committee

HRA RES Centre Manchester  
Barlow House 3rd Floor  
4 Minshull Street  
Manchester  
M1 3DZ

Telephone: 0207 104 8002

16 March 2016

Miss Bronwyn Harrison  
Trainee Clinical Psychologist  
Camden and Islington NHS  
Royal Holloway, Clinical Psychology  
Egham Hill  
Egham, Surrey  
TW20 0EX

Dear Miss Harrison

**Study title:** Multisystemic therapy in families of adopted young people referred for antisocial behavioural problems  
**REC reference:** 16/LO/0431  
**IRAS project ID:** 194490

The Research Ethics Committee reviewed the above application at the meeting held on 02 March 2016. The Committee thanked you and Dr Simone Fox for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Kieran Hall, [nrescommittee.london-bloomsbury@nhs.net](mailto:nrescommittee.london-bloomsbury@nhs.net). Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

#### Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Amendments and additions to the Participant Information Sheet;

- i. State explicitly how long participants data will be kept

A Research Ethics Committee established by the Health Research Authority

- ii. Amend the following text to ensure neutral content *'to ensure MST is better suited to the needs of families of adopted young people; recommendations may also be made to current MST therapists/teams around what they could be doing differently to improve practice.*

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

##### *NHS Sites*

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### **Summary of discussion at the meeting**

##### **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

Due to the small size of participants, the Committee sought assurance that anonymity would be protected.

*The researcher confirmed it would not be possible to identify any subjects through the data. The data would be provided by MST supervisors who would remove any identifiers before sending to the researchers for analysis. This data had previously been gathered as part of routine clinical care but would be passed to the researcher in an anonymous format for using within the study.*

*The researchers further stated that even though the study was set up to contain Qualitative data set and a Quantitative data set, the same participants' data would be present in both sections.*

The Committee noted that the researchers planned to send themes back to parents and asked them to clarify what they expected from this.

*The researchers confirmed they would want to involve parents in the outcomes however they would be asked first if they want to receive feedback. If they agreed to receive feedback, the researcher would contact the parents by telephone and ask for thoughts at this point. The researcher stated that it would be a reflection exercise.*

The Committee noted that both the IRAS Form and Protocol stated that in order to assess the validity of the themes that emerge from the analysis; participants will be asked to comment on the first draft of the report or 'member-check'. Members acknowledged the value of respondent validation in a study of this type, however, it was also recognised that the technique of member-checking was in itself a highly complex process, e.g. what is going to be checked, how would you interpret agreement, how do you interpret disagreement, etc. In addition, a member check can also adversely transform the data should an interviewee (or several interviewees) request that statements attributable to them be removed from the final publication. Thus written clarification was sought regarding the process of member-checking. (Mandatory)

##### **Suitability of supporting information**

The Committee stated that the interview questions were lengthy and asked if the researcher intended on asking all the questions.

*The researcher confirmed that potentially yes but due to the nature of the conversation, some of the questions would be used as prompts for her only.*

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The Committee raised a number of comments in relation to the Participant Information Sheet and Consent form which would be provided in writing

*The researchers noted the comment.*

### Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Letter]		03 August 2015
Interview schedules or topic guides for participants [Semi-structured interview schedule]	1	12 February 2016
Participant consent form [Participant consent form]	1	12 February 2016
Participant information sheet (PIS) [Participant information sheet]	1	12 February 2016
REC Application Form	5.2.1	18 February 2016
Research protocol or project proposal [Main Research Project Proposal]	1	12 February 2016
Summary CV for Chief Investigator (CI) [B Harrison CV]	1	16 February 2016
Summary CV for supervisor (student research) [S Fox CV]	1	16 February 2016

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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

### After ethical review

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received

A Research Ethics Committee established by the Health Research Authority

and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

### HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

16/LO/0431

Please quote this number on all correspondence

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

Yours sincerely



On behalf of  
Reverend Jim Linthicum  
Chair

E-mail: [nrescommittee.london-bloomsbury@nhs.net](mailto:nrescommittee.london-bloomsbury@nhs.net)

**Enclosures:** List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to:

Mental Health NHS Trust

17 March 2016

**Miss Bronwyn Harrison**  
**Trainee Clinical Psychologist**  
**Camden and Islington NHS**  
**Royal Holloway, Clinical Psychology**  
**Egham Hill**  
**Egham, Surrey**  
**TW20 0EX**

Dear Miss Harrison

**Study title:** **Multisystemic therapy in families of adopted young people referred for antisocial behavioural problems**  
**REC reference:** **16/LO/0431**  
**IRAS project ID:** **194490**

Thank you for your email 17 March 2016. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 16 March 2016

**Documents received**

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Participant information sheet (PIS)	2	16 March 2016

**Approved documents**

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Letter]		03 August 2015
Interview schedules or topic guides for participants [Semi-structured interview schedule]	1	12 February 2016
Participant consent form [Participant consent form]	1	12 February 2016
Participant information sheet (PIS)	2	16 March 2016
REC Application Form	5.2.1	18 February 2016
Research protocol or project proposal [Main Research Project Proposal]	1	12 February 2016
Summary CV for Chief Investigator (CI) [B Harrison CV]	1	16 February 2016

Summary CV for supervisor (student research) [S Fox CV]	1	16 February 2016
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You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

<b>16/LO/0431</b>	<b>Please quote this number on all correspondence</b>
-------------------	---

Yours sincerely



**Ewa Grzegorska**  
**REC Assistant**

**E-mail:** [nrescommittee.london-bloomsbury@nhs.net](mailto:nrescommittee.london-bloomsbury@nhs.net)

**Copy to:**

Mental Health NHS Trust

## 7.2 Appendix B: Letters of approval from Research and Development (R&D)

### NHS TRUST (1)

Miss Bronwyn Harrison  
Trainee Clinical Psychologist  
Royal Holloway, University of London  
Egham Hill  
Egham  
Surrey TW20 0EX

31 March 2016

Dear Miss Harrison,

<b>Research Title:</b>	<b>Multisystemic therapy in families of adopted young people referred for antisocial behavioural problems</b>
<b>Principal Investigator:</b>	<b>Miss Bronwyn Harrison</b>
<b>Project reference:</b>	<b>PF653</b>
<b>Sponsor:</b>	<b>Royal Holloway, University of London</b>

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study.

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.
- Under the terms of the Research Governance Framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.
- The PI must ensure appropriate procedures are in place to action urgent safety measures.
- The PI must ensure the maintenance of a Trial Master File (TMF).
- The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).

Terms and conditions of Approval, version 1.1 05/04/2016

- The PI must comply with the Trust's research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.
- The PI must report any cases of suspected research misconduct and fraud to the Research Office.
- The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.
- Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.
- Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.
- Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.
- All research carried out within Mental Health NHS Trust must be in accordance with the principles set out in the Department of Health's Research Governance Framework for Health and Social Care 2005 (2<sup>nd</sup> edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact

Yours sincerely,



Dr Robert M. Lawrence  
 Research & Development Director  
 Chair, Research & Development Committee.

# NHS TRUST (2)

21 March 2016

Miss Bronwyn Harrison  
Royal Holloway, University of London  
Egham Hill  
Egham  
Surrey  
TW20 0EX

Dear Miss Harrison

This NHS Permission is based on the REC favourable opinion given on **16 March 2016**

I am pleased to confirm that the following study has now received R&D Approval, and you may now start your research in **the trust(s) identified below:**

<b>Study Title:</b> Multisystemic Therapy (MST) in Families of Adopted Young People Referred for Antisocial Behavioural Problems <b>R&amp;D reference:</b> 194490 <b>REC reference:</b> 16/LO/0431		
Name of the trust	Name of current PI/LC	Date of permission issue(d)
NHS Foundation Trust	Dr. [REDACTED]	21 March 2016
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

<b>Specific Conditions of Permission (if applicable)</b>
If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours Sincerely  
  
Emmanuel Rollings-Kamara  
Regulatory Compliance Manager

Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact

## NHS TRUST (3) Research and Development Department

17 May 2016

R&D Ref: M00735

Miss Bronwyn Harrison  
Trainee Clinical Psychologist  
Royal Holloway, Clinical Psychology  
Egham Hill  
Egham, Surrey  
TW20 0EX

Dear Miss Harrison

### **Re: 16/LO/0431 Multisystemic therapy in adoptive families**

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and approval from the Department of Research and Development (R&D) prior to commencement.

R&D have reviewed the documentation submitted for this project, and has undertaken a **site specific assessment** based on the information provided in the SSI form, and I am pleased to inform you that we have no objection to the research proceeding within

**Sponsor: Royal Holloway University of London**

**Funder: n/a**

**End date: 24.07.2017**

**Protocol: Version 1, 12.02.2016**

#### **Conditions of Trust Approval:**

- The project must follow the agreed protocol and be conducted in accordance with all Trust Policies and Procedures especially those relating to research and data management. Any mobile devices used must also comply with Trust policies and procedures for encryption.
- You and your research team must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998 and are aware of your responsibilities in relation to the Human Tissue Act 2004, Good Clinical Practice, the NHS Research Governance Framework for Health and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.
- Members of the research team must have appropriate substantive or honorary contracts with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold a suitable contract.



- You and your research team must provide to R&D, as soon as available, the date of first patient first visit.

**If the project is a clinical trial under the European Union Clinical Trials Directive the following must also be complied with:**

- the EU Directive on Clinical Trials (Directive 2001/20/EC) and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials ) Regulations 2004;
- the EU Directive on Principles and Guidelines for Good Clinical Practice (EU Commission Directive 2005/28/EC); and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006;

**Amendments**

Please ensure that you submit a copy of any amendments made to this study to the R&D Department.

**Annual Report**

It is obligatory that an annual report is submitted by the Chief Investigator to the research ethics committee, and we ask that a copy is sent to the R&D Department. The yearly period commences from the date of receiving a favourable opinion from the ethics committee.

Please refer to our website [www.cpft.nhs.uk](http://www.cpft.nhs.uk) for all information relating to R&D including honorary contract forms, policies and procedures and data protection.

Should you require any further information please do not hesitate to contact us.

Yours sincerely



Stephen Kelleher  
Senior R&D Manager

## 7.3 Appendix C: Royal Holloway University of London Ethics Approval



### Ethics Review Details

You have chosen to self certify your project.	
Name:	Harrison, Bronwyn (2014)
Email:	PBVA074@live.rhul.ac.uk
Title of research project or grant:	Multisystemic therapy in families of adopted young people referred for antisocial behavioural problems
Project type:	Royal Holloway postgraduate research project/grant
Department:	Psychology
Academic supervisor:	Simone Fox
Email address of Academic Supervisor:	Simone.Fox@rhul.ac.uk
Funding Body Category:	No external funder
Funding Body:	
Start date:	21/03/2016
End date:	24/07/2017

#### Research question summary:

Multisystemic therapy (MST) is an intervention provided to the families of young people showing behaviour problems such as criminal, aggressive, or antisocial behaviour. Families are seen two to three times a week for three to five months.

MST has been shown to be effective at treating behaviour problems in young people who are living with their biological families. However, anecdotal reports from MST therapists highlight concerns around poor outcomes from adoptive families. Whilst there is no formal evidence to suggest that MST does not work in adoptive families, literature highlights the particular difficulties experienced by adopted versus non-adopted young people. Moreover, there is no evidence to suggest that MST does work in adoptive populations.

This mixed methods project will first assess whether or not MST is effective in causing behaviour change in adoptive families by reviewing weekly and pre-post MST data. Secondly, the project will explore adoptive parents' experience of MST through the use of semi-structured interviews, focusing on aspects of the intervention that promoted and hindered change and the context of adoption throughout the intervention experience.

The MST programme has already seen adaptations to better suit the needs of other vulnerable groups. It is hoped that findings from the current project could also be used to make recommendations to the MST programme developers around potential adaptations to better suit the needs of families of adopted young people.

#### Research method summary:

Participants will be recruited from five MST services:

To be included in the project, participants must be a parent of an adoptive young person who began standard MST services for antisocial behaviour problems between the ages of 12- 17 years; both treatment completers and non-completers will be included. Participants will be excluded from the project if they are currently in receipt of MST services or if they received- or are receiving- adapted MST programs. Moreover, participants who do not speak English will be excluded from the project due to the projects inability to provide interpreters.

The qualitative aspect of the project will involve interviewing participant's at their home using a semi-structured interview schedule to explore their experiences of MST. Interviews will be transcribed and analysed thematically.

The quantitative aspect of the project will look at pre and post outcome data to determine whether MST led to behaviour change in the said participants. An opportunity sample will be utilised, involving all available data files of adoptive families that have received services from the said MST services.

#### Risks to participants

Does your research involve any of the below?

Children (under the age of 16),

No

Participants with cognitive or physical impairment that may render them unable to give informed consent,

No

Participants who may be vulnerable for personal, emotional, psychological or other reasons,

No

Participants who may become vulnerable as a result of the conduct of the study (e.g. because it raises sensitive issues) or as a result of what is revealed in the study (e.g. criminal behaviour, or behaviour which is culturally or socially questionable),

No

Participants in unequal power relations (e.g. groups that you teach or work with, in which participants may feel coerced or unable to withdraw),

No

Participants who are likely to suffer negative consequences if identified (e.g. professional censure, exposure to stigma or abuse, damage to professional or social standing),

No

Details,

## Design and Data

Does your study include any of the following?

Will it be necessary for participants to take part in the study without their knowledge and/or informed consent at the time?,

No

Is there a risk that participants may be or become identifiable?,

No

Is pain or discomfort likely to result from the study?,

No

Could the study induce psychological stress or anxiety, or cause harm or negative consequences beyond the risks encountered in normal life?,

No

Does this research require approval from the NHS?,

Yes

If so what is the NHS Approval number,

Are drugs, placebos or other substances to be administered to the study participants, or will the study involve invasive, intrusive or

potentially harmful procedures of any kind?,

No

Will human tissue including blood, saliva, urine, faeces, sperm or eggs be collected or used in the project?,

No

Will the research involve the use of administrative or secure data that requires permission from the appropriate authorities before use?,

No

Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?,

No

Is there a risk that any of the material, data, or outcomes to be used in this study has been derived from ethically-unsound procedures?,

No

Details,

Full NHS ethics approval has been granted for the project.

### **Risks to the Environment / Society**

Will the conduct of the research pose risks to the environment, site, society, or artifacts?,

No

Will the research be undertaken on private or government property without permission?,

No

Will geological or sedimentological samples be removed without permission?,

No

Will cultural or archaeological artifacts be removed without permission?,

No

Details,

### **Risks to Researchers/Institution**

Does your research present any of the following risks to researchers or to the institution?

Is there a possibility that the researcher could be placed in a vulnerable situation either emotionally or physically (e.g. by being alone with vulnerable, or potentially aggressive participants, by entering an unsafe environment, or by working in countries in which there is unrest)?,

No

Is the topic of the research sensitive or controversial such that the researcher could be ethically or legally compromised (e.g. as a result of disclosures made during the research)?,

No

Will the research involve the investigation or observation of illegal practices, or the participation in illegal practices?,

No

Could any aspects of the research mean that the University has failed in its duty to care for researchers, participants, or the environment / society?,

No

Is there any reputational risk concerning the source of your funding?,

No

Is there any other ethical issue that may arise during the conduct of this study that could bring the institution into disrepute?,

No

Details,

#### Declaration

By submitting this form, I declare that the questions above have been answered truthfully and to the best of my knowledge and belief, and that I take full responsibility for these responses. I undertake to observe ethical principles throughout the research project and to report any changes that affect the ethics of the project to the University Research Ethics Committee for review.

Certificate produced for user ID, PBVA074

Date:	17/03/2016 10:03
Signed by:	Harrison, Bronwyn (2014)
Digital Signature:	Bronwyn Harrison
Certificate dated:	3/17/2016 11:02:33 AM
Files uploaded:	2016.03.16 Harrison 16-0431 Favourable Opinion with Conditions.pdf

## 7.4 Appendix D: Participant information sheet



**[INSERT RELEVANT SITE LETTER HEAD]**

### **Participant Information Sheet**

#### **Title: Multisystemic Therapy in Adoptive Families**

#### **Invitation and brief summary**

My name is Bronwyn Harrison and I am a Trainee Clinical Psychologist at Royal Holloway, University of London.

You are being invited to take part in a research study. Before you decide whether you want to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

#### **Purpose of the research**

The study is interested in finding out about your experience of MST, how well suited you found MST to your family context, what MST-related factors you felt impacted engagement and change, and the outcome of MST on your family.

#### **What will happen to me if I take part?**

If you would like to participate you would be asked to take part in one tape-recorded interview lasting around 1 hour in a comfortable setting, which could be your home. The meeting will involve talking to the researcher, one-to-one, about your experiences of MST, how appropriate you felt the treatment was in addressing your specific family context, and what you felt the advantages and disadvantages of this treatment were. You will also be asked to complete a short questionnaire asking you about details of when you adopted your child, specific intervention details, and current placement situation. If you consent, you may be contacted at a later date to ask if you wish to comment on the research findings. You are able to decline this offer without giving a reason.

#### **Do I have to take part?**

No. It is entirely up to you to decide whether or not to take part. If you choose not to take part in this study, then you do not have to give a reason and no pressure will be placed on you to change your mind. If you do decide to take part, you will be given a copy of this information sheet to keep and you will be asked to sign a form recording your consent. If you do decide to take part, you are still free to withdraw at any time without giving a reason. Your care will not be affected if you do not wish to participate, or if you decide to withdraw from the study at any point.

#### **What are the possible risks of taking part?**

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 you can take a break or stop the interview at any point. You will be given further information about resources and help that are available to you should you need them after the interview.

### **What are the possible benefits of taking part?**

This study will allow you to have time and space to reflect on your experiences.

### **If I do take part what happens to my information?**

All the information you give will stay confidential. This means we will only tell those who have a need or right to know. No information will be disclosed to your individual MST therapist. The audio-taped recording of our discussion will be stored securely and destroyed when the study has finished. All anonymised information will be stored securely for up to three years at a secure location.

If, in the course of our discussions, we learn that someone is seriously planning to harm another or themselves, or commit criminal damage then we would need to inform the relevant site supervisor. However, this will be discussed with you first to explain the reasons and the process.

### **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, your family or know that you participated. In other words, we can guarantee that information about you will remain anonymous.

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Research Ethics Committee.

### **Expenses**

You will be offered £10 as a thank you for taking time to talk to me. Any travel expenses to the amount of £5 will be covered.

### **Further information and contact details**

If you would like to take part in this study, I will be in touch within the next week, to answer any further questions you may have, and to arrange a time for us to meet. My contact details are outlined below.

#### **Researcher**

Ms Bronwyn Harrison  
Clinical Psychology Department  
Royal Holloway University of London  
Egham  
Surrey  
TW20 0EX  
Tel: 01784 414012

#### **Research Supervisor**

Dr Simone Fox  
Clinical Psychology Department  
Royal Holloway University of London  
Egham  
Surrey  
TW20 0EX  
Tel: 01784 414012  
Email: simone.fox@rhul.ac.uk

#### **Site Supervisor**

[Insert relevant site information]

## 7.5 Appendix E: Participant consent form



Site Identification Number:

Participant Identification Number:

### CONSENT FORM

Title of Project: Multisystemic therapy in adoptive families

Name of Researcher: Bronwyn Harrison

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I agree for my information to be shared with authorised people from Royal Holloway University of London and understand that all personal data relating to me is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).
4. I agree for the named researcher access to my demographic information notes from case held within the MST team.
5. I have read and understood the remits of confidentiality regarding risk.
6. I agree to being contacted for my comments on the findings of the study.
7. I agree for anonymised quotes from my interview to be used in publications
8. I agree to take part in the above study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature



## **7.6 Appendix F: Interview Schedule**

### **Pre-intervention experience**

- What difficulties were you having with your child? Did these differ from your other children?
- Had you received any other interventions prior to MST? Can you briefly tell me about the?
- Why/ how were you referred to MST?
- What were your expectations of MST? What did you hope to achieve?

### **Intervention experience – Parent**

- How would you describe your overall experience of MST?
- Do you feel that MST considered your situation as an adoptive family / addressed the context of adoption?
- Do you feel it needed to be addressed... why? Why not?
- How could MST have better considered your situation as an adoptive family/ addressed the context of adoption?
- Can you tell me about your experience of working with the therapist?
- How did you decide what to work on? Did you feel your views were considered?
- Can you tell me what you found helpful about MST?
- Can you tell me what you found unhelpful about MST?
- What feature of MST encouraged change? What features acted as barriers to change?
- Was the overall experience of MST what you expected? Did the things that you hoped would change, change?
- Do you have any ideas about why MST didn't do what you hoped it would? / why things didn't work out?
- What would have made your overall experience better?

### **Intervention experience- Child**

- How much was your child involved in the intervention? Were they involved much with the therapist?
- How do you think the experience was for your son / daughter?

### **Post-intervention experience**

- What was it like finishing MST after such an intense period of work? Did you feel ready to finish?
- Has your life changed in any way since MST? Can you describe how?
- In what ways do you think your child is different since MST?
- What things (internal and external) do you think facilitated this change?
- Has MST changed your view of yourself as an adoptive parent? Can you tell me about that?
- Has MST changed how you think about your child/ your child's behaviour?
- Would you recommend MST to other adoptive families? Why/ Why not?
- How does MST compare to other interventions you have received?

- As an adoptive parent with past experience, what intervention would you design?

**Closing questions**

- Is there anything else you would like to say about your experience of MST as an adoptive parent?
- How has it been talking to me today

**7.7 Appendix G: Example of data analysed through the phases of thematic analysis, adapted from Braun and Clarke (2006).**

Data Extract	Phase 2: Generating initial codes	Phase 3: Searching for themes	Phase 4: Reviewing theme	Phase 5 & 6: Defining and name theme
<i>When I had my MST sessions I was putting myself forward and I was strong, in a strong position. So, it is almost like my sort of vitamins you know. She (MST therapist) gave me vitamins in my body to be able to cope with the next conversation or the next situation.</i>	<p>Increase parental strength</p> <p>Therapeutic alliance</p> <p>Better able to cope</p>	MST resulted in increased parental strength	Increased parental confidence and strength as an outcome of MST	<p><b>Key theme:</b> Outcomes of MST</p> <p><b>Subtheme:</b> Increased parental confidence and strength</p>
<i>MST gave me that confidence to be able to address the issues in a way that, in the way that we did. So yeah, to have that weight behind me.</i>	<p>Increased confidence</p> <p>Collaborative working</p> <p>Supported</p>	MST resulted in increased parental confidence		
<i>I think it's made, going through MST and talking through stuff, it sort of like made, I don't know, made me feel that I can do things more. I can achieve what I want to, if that makes sense?</i>	<p>Increased self-belief</p> <p>Optimism</p>	MST resulted in increased confidence in parenting ability		

**7.8 Appendix H: Thematic map showing five core themes and associated sub-themes**

