



Developing a model of sustained change following multisystemic therapy: young people's perspectives

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Multisystemic therapy (MST) is an empirically validated, family and community-based intervention for young people presenting with antisocial and offending behaviour. This qualitative study aimed to explore young people's experiences of MST and learn what had helped them to sustain positive outcomes over time. Semi-structured interviews were conducted with eight young people at an average of 14 months after MST (range: 5–21 months). A constructivist version of grounded theory was employed to analyse the data, leading to the development of a model of sustained change in MST. Themes from the model included therapeutic alliance, increases in systemic awareness, recognizing responsibility, positive peer relationships, acknowledging and celebrating success, continued use of specific strategies (for example, worry boxes) and the identification and creation of a preferred future. This research presents an understanding of how change may be sustained after MST, highlighting systemic, developmental and individual factors in relation to this. Clinical implications and a proposed model of sustained change in MST are discussed.

Practitioner points

- The therapeutic alliance was perceived by young people as central to the process of change and sustained change following MST
- Young people's contribution to sustaining therapeutic gains at follow up, alongside caregivers, highlighted the importance of actively engaging them in therapy
- Peer relationships were identified as relevant to sustaining change, particularly in relation to shared values and goals for the future

Keywords: youth offending; qualitative research; child and adolescent mental health.

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Introduction

Significant advances in treatments for antisocial behaviour and conduct problems have been made over the years, including the development of multisystemic therapy (MST) (Henggeler *et al.*, 1986). MST is an intensive family and community-based treatment programme for young people (11–17-year olds) who exhibit antisocial behaviour (Henggeler *et al.* 2009a). The intervention aims to address a comprehensive list of systemic and contextual risk factors associated with youth delinquency. It is considered to constitute an ecologically valid approach for antisocial behaviour in children and young people and one that addresses concerns in context, rather than focusing on individual symptomatology (Fox and Ashmore, 2011).

Although much has been written about the effectiveness of MST (see Henggeler and Sheidow, 2011) there is a paucity of information into the personal meanings and experiences of caregivers and young people who have participated in the intervention. Little is understood about their perceptions of (i) what contributes to positive change and (ii) how this is then sustained over time. At the time of writing, there is one published qualitative study that has attempted to redress this by providing direct accounts from caregivers and young people on their experience of participating in MST (Tighe *et al.*, 2012).

The evidence base for conduct disorder

Antisocial behaviour, conduct disorder and offending in young people are viewed as serious and costly phenomena, with effects that are felt on an individual, familial, societal and financial level. Conduct disorder and anti-social behaviour are cited as the most common reasons for referral to child and adolescent mental health services (National Institute for Health and Care Excellence [NICE], 2013). Significantly, it is reported that approximately half of all children diagnosed with conduct disorder receive a diagnosis of antisocial personality disorder as adults (NICE, 2013). Due to the chronic nature of antisocial behaviour and conduct disorder, and the significant ensuing individual and social costs, it is vital that effective treatments are available, which are also effective over the long term.

Longitudinal research suggests that a number of systemic, family, individual and environmental risk factors are associated with the development of these difficulties (Farrington, 2005). These include impulsiveness, poor parental supervision, high-crime communities and poor parental child-rearing practices, including harsh discipline

and parental conflict. Arguably, most of these broader risk factors have been overlooked in traditional treatments, which have conventionally focused on individual and punitive approaches, such as institutionalization and imprisonment when addressing antisocial behaviour (Ashmore and Fox, 2011).

Numerous studies draw attention to MST as an evidence-based intervention for antisocial behaviour (see Henggeler and Sheidow, 2011). Few treatments for antisocial behaviour have been researched as extensively and intensively as MST. Thirty-four outcome studies have been conducted to date, of which twenty-three have been randomized controlled trials and a number have found positive outcomes following MST, such as reductions in recidivism rates, out-of-home placements and youth externalizing behaviour, which are sustained over the long term, up to 22 years post-intervention (Sawyer and Borduin, 2011).

A recently published review of the evidence base for family therapy and systemic interventions for child-focused problems also places MST among a number of empirically supported treatments for conduct disorder (Carr, 2014).

The process of change in MST

MST is based on the theory of social ecology which suggests that human behaviour is multi-determined, as an individual is influenced by the multiple systems and contexts in which they exist (Bronfenbrenner, 1979). Interventions should ideally aim to work with all these systems to bring about change. This is the principle that guides MST and provides a focus for intervention. By identifying the systems which serve to maintain the difficulties, MST aims to develop interventions targeted at breaking identified maintenance cycles (Fox and Ashmore, 2011).

MST interventions are focused on empowering caregivers through the acquisition of skills to effectively manage their child's behaviour (Henggeler *et al.*, 2009a). Emphasis is placed on the caregiver, who is central to achieving and sustaining decreases in antisocial behaviour and improvements in functioning in various contexts. The current model of the process of change in MST (see Figure 1) provides general information about this change, which indicates the impact of improved family functioning on reduced antisocial behaviour and youth functioning through interactions with the multiple systems described above.

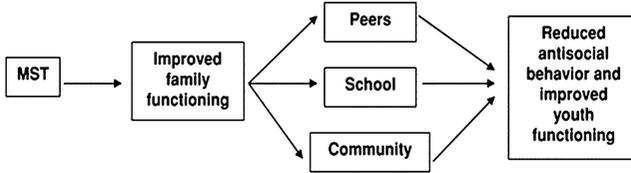


Figure 1. MST theory of change.

One of the main assumptions of MST is that the caregiver is the main catalyst for change. The aim of MST is to increase parental skills and confidence in order to facilitate change in the young person's behaviour. In order to achieve these outcomes MST integrates approaches and techniques from a variety of individual and family evidence-based models, including cognitive behavioural therapy, family therapy and behavioural management approaches. Rather than developing new therapeutic approaches or techniques, MST utilizes pre-existing approaches that are known to be effective for particular difficulties.

The MST research literature has been predominantly individual and symptom focused, with an emphasis on reducing recidivism and out-of-home placements. Although this emphasis is undoubtedly important for this client group, a number of systemic and relational factors have received less attention and could provide useful insights into the subtleties of how and why MST works.

Qualitative research

Authors have noted the limited number of studies into young people's perspectives in family therapy research (Moore and Seu, 2011), despite the fact that family therapy is often conducted in relation to problems presented by children (Dallos and Draper, 2005). While a number of qualitative studies have attempted to redress this by exploring children's and young people's views of participating in family therapy (for example, Lobatto, 2002; Strickland-Clark *et al.*, 2000), the MST literature remains lacking in its exploration of caregiver's and young people's experiences and perspectives.

Lobatto (2002) and Strickland-Clark *et al.* (2000) employed grounded theory methodology (Glaser and Strauss, 1967) to explore children's and adolescent's experience of participating in family therapy. They have discussed how family therapy is experienced by

young people and the factors influencing whether they felt heard and understood in the therapeutic process. They also provide helpful information on the experience of family therapy conducted in a clinic setting. It has been noted that MST is unique in its intensiveness and delivery in a community setting, therefore, perspectives from families and young people participating in a family therapy intervention may not generalize appropriately to the community setting (Ashmore and Fox, 2011)

Tighe *et al.* (2012) aimed to address the gap in current MST research by directly exploring parental and young people's views on what had changed as a result of MST and the aspects of MST which they found helped or hindered this change. The families were interviewed on average at 2 months post-intervention. Their thematic analysis generated two broad themes (i) engagement in MST and the initial processes of change and (ii) the complexity of the outcomes. The therapeutic alliance was of central importance to parents' and young people's experience of MST. Families attributed the majority of change to MST, with improvements noted in relationships between family members, such as reductions in arguments, increased understanding of each other and increased sense of closeness and warmth. The authors concluded that their study confirmed the MST theory of change, which emphasizes the importance of intervening in the multiple systems in the young person's life. They suggested that interviews with families at a longer follow-up period would provide further information on the sustainability of the changes and the longer term impact of MST.

Rationale for the study

Tighe *et al.*'s (2012) study offers an understanding of the processes of change in MST directly from the perspectives of the parents and young people who participated in this intensive intervention. A limitation of thematic analysis is that the information from their study remains largely descriptive and as their interviews were conducted at an average of 2 months post-MST, there is still a gap in the literature on service users' experiences of sustaining positive outcomes over time.

This study aimed to build on Tighe *et al.*'s findings by using grounded theory methodology to provide more detailed information on young people's perceptions of sustaining change over a longer follow-up period, in order to identify their personal meanings and

experiences of what had helped them and their families to maintain positive changes some months after completing MST.

The aim of this research was the generation of a substantive theory of what contributed to sustained improvements for young people following MST, which could then be compared with existing literature on the process of change, highlighting ways in which MST may maximize its effectiveness while considering the challenges young people and their families face when attempting to maintain positive changes. Grounded theory was employed as it generates an emergent theory that can be compared and contrasted with pre-existing theories, exploring previous explanations of a phenomenon and considering what a new theory can add to this knowledge (Glaser and Strauss, 1967).

Method

Participants and setting

The participants were recruited from an outer London MST team. They had received a MST intervention which resulted in positive ultimate outcomes at the time of their discharge. Thirteen young people consented to participate; however, for personal reasons only eight were available at the time of the interview. The reasons given for declining were mainly current family crises or crises since completing MST (for example, divorce). Caregiver's experiences of MST and sustaining change over time were explored by Kaur *et al.* (unpublished).

The basic characteristics of the participants are presented in Table 1. Pseudonyms have been used throughout. Five females and

TABLE 1 *Participants' demographics*

Participant	Age at time of interview (years)	Gender	Ethnicity	Time since completion of MST (months)
1. Jenni	13	F	White British	16
2. Sarah	16	F	Mixed ethnicity	15
3. Craig	15	M	White British	14
4. Sammi	18	F	Black Caribbean	21
5. Louise	14	F	Mixed ethnicity	10
6. David	16	M	White British	5
7. Josh	15	M	White British	15
8. Ruth	18	F	White British	19

TABLE 2 Participant outcomes at time of interview

Participant Number	Any new arrests since MST?	Living at home?	At school/college/working?
1. Jenni	No	Yes	Yes
2. Sarah	No	Yes	Yes
3. Craig	Yes	Yes	Yes
4. Sammi	No	Yes	Yes
5. Louise	No	Yes	Yes
6. David	No	Yes	No
7. Josh	No	Yes	Yes
8. Ruth	No	Yes	Yes

three males were interviewed at home ($n = 7$) or the MST site ($n = 1$). Five participants were white British, two were of mixed ethnicity and one was black Caribbean. Interviews were conducted between 5 and 21 months after completing the intervention.

Eligibility criteria included:

- Completing MST over the prescribed 3–5 month period.
- Meeting all three MST service ultimate outcomes at the time of discharge, defined as (i) no new criminal charges, (ii) still living at home and (iii) in education, training or employment. Information collected from the caregivers and young people indicated that six of the eight participants met all three outcomes at the time of interview (see Table 2).

By focusing on those who reported positive outcomes at the time of discharge it was hoped that information would be obtained on what participants perceived as helpful or unhelpful in sustaining improvements following the completion of MST. The final sample consisted of participants, all with initial positive outcomes, most of whom had sustained improvements at follow up and a minority who had not.

Procedure and analysis

Grounded theory methodology was used to analyse data from the semi-structured interviews (Glaser and Strauss, 1967). A constructivist version of grounded theory was employed (Charmaz, 2006) that acknowledges the researcher's role and relationship with the data and recognizes the co-creation of meaning between participant and researcher. An interview schedule was employed as a guide, with

questions focusing on what enabled or prevented the young people and their families to sustain positive outcomes. In line with grounded theory methodology, the interviews were transcribed verbatim soon after they took place and prior to the first author conducting a further interview.

Data from the interviews were analysed using the constant comparative method (Glaser and Strauss, 1967), where the researcher compares data, codes and categories within and across individuals. The analysis followed initial and focused coding stages, including diagramming, the writing of memos and the abstraction of theoretical codes in the final stage of analysis (Charmaz, 2006). The memos enabled the researcher to identify any gaps or inconsistencies in the data, thus guiding further data collection, and assisted in the further definition and development of categories (Charmaz, 2006). In addition, the writing of memos encouraged the first author to adopt a reflexive stance to her work by reflecting on the assumptions made and insights gained throughout the research process.

In accordance with qualitative research quality guidelines (Elliott *et al.*, 1999), two fellow researchers reviewed the categories and emerging themes of two interviews to ensure that themes had not been overlooked and the interpretations fitted the data. Participant validation was also incorporated into the study and the emergent theory was discussed with two participants to obtain their thoughts and views on whether the theory resonated with them and their experiences.

Following transcription, the interviews were uploaded to the NVivo software package which assists the researcher in qualitative analysis, enabling them to organize and code large amounts of data in a structured and rigorous manner.

Theoretical saturation is a key component of grounded theory research (Charmaz, 2006) and punctuates the end of data collection when the categories developed and their properties offer no new theoretical insights. At the time of the write up no new themes were emerging from the data and theoretical saturation had been reached.

Findings

Young people expressed seven theoretical codes which enhance sustained changes following MST. These were (i) the therapeutic alliance, (ii) improving interpersonal awareness and recognizing responsibility, (iii) increasing systemic awareness, (iv) acknowledging progress and

TABLE 3 *Theoretical codes and sub-codes for young people at 5–21 months post MST*

Theoretical codes	Sub-codes (focused coding)
1. The therapeutic alliance – a model of safe and trusting relationships	(i) Creating a context of safety, trust and collaboration (ii) Revising expectations of MST and therapist (iii) Having choice and control in MST: developing a sense of personal agency
2. Improving self and other awareness and recognising responsibility	(i) Taking personal responsibility for change (ii) Recognising impact of behaviour on self and others
3. Increasing systemic awareness	(i) Increased reflexivity and perspective taking (ii) Identifying unhelpful patterns of interaction and increasing positive communication (iii) Raising other's awareness and understanding
4. Acknowledging progress and celebrating success	(i) Noticing positive changes in self and family (ii) Being realistic about level of change
5. Having alternatives – the continued contribution of strategies and techniques	(i) Having strategies to control emotions (ii) Creating structure and routine
6. Positive peer relationships	(i) Positive influences and support: insights into adulthood (ii) Removing negative influences
7. Identifying and planning for a preferred future	(i) Recognising and pursuing passions: forming an identity (ii) Leaving the past behind (iii) Determination and perseverance (iv) Working on a being a family

celebrating success, (v) having alternatives – the continued contribution of strategies and techniques (vi) positive peer relationships and (vii) identifying and planning for a preferred future. These are presented in Table 3, alongside codes from the initial and focused coding stages.

A model of sustained change in MST for young people

Figure 2 represents a model of sustained change for young people, following their participation in MST, which includes elements associated with the processes of change made during therapy.

The model outlines a continuous process of change, which commenced during therapy. It suggests that improvements are sustained

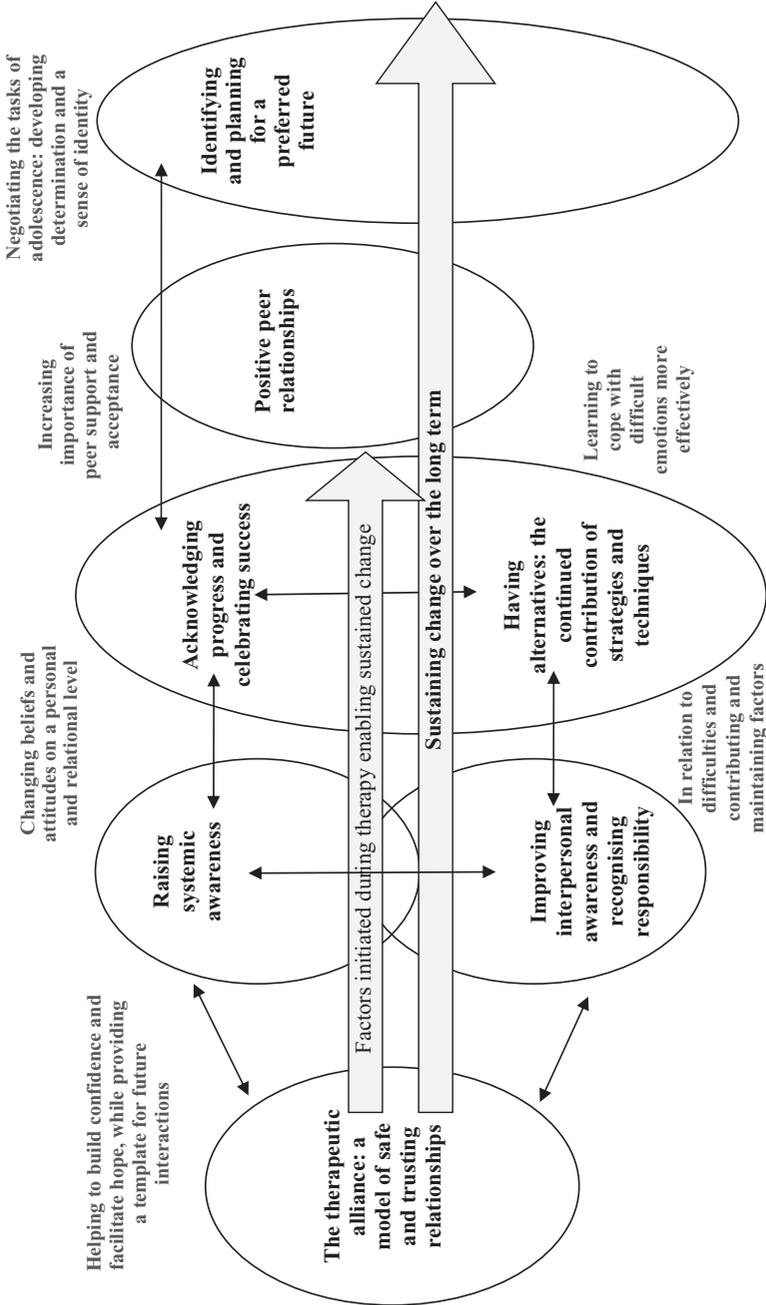


Figure 2. A model of sustained change in MST.

at 5–21 months follow up because of a combination of systemic, relational, developmental, peer and individual factors that interact in order to help sustain change. Young people and their families have to work hard at sustaining change, dealing with subsequent difficulties and maintaining their motivation and commitment to a new, more useful way of being, both individually and interpersonally.

The model was discussed with two participants in order to assess whether it resonated with their experience. The feedback received suggested that the model captured these young people's experiences of MST and what helped them and their family to sustain positive outcomes between 5–21 months after the intervention. Specifically, they commented on how supportive and important their relationship with the therapist was and that without this it would have been difficult to make changes in the first place. The theoretical codes are now presented to illustrate the model in more detail.

Theoretical codes

The therapeutic alliance – a model of safe and trusting relationships. Young people in this study talked extensively about the therapist, and their relationship with them and their parents, as key to the process of change in MST:

In the beginning ... I found it awkward anyway to talk. But she made me feel comfortable as if I can say stuff and that she listened and not only gave – it wasn't like a one-sided thing, she gave her point of view and she saw it from other people's point of view and she saw it from mine which made me feel more comfortable. (Sammi, 18)

Talking to the therapist appeared to be a catalyst for some young people like Josh (15) to 'open up and talk with my parents more':

I suppose building up the trust with [therapist] was helping me kind of build up trust with my mum and dad because every time I was talking to [therapist] they were there and then after [therapist] left we'd sit down and talk. (David, 16)

The young people made connections between the therapeutic alliance and their increased sense of confidence, which they then linked to an increased ability to continue with changes initiated during therapy.

Improving interpersonal and systemic awareness. The young people in this study talked about taking some responsibility for change. Their

accounts showed that the process of engaging in therapy helped them to reflect on the importance of making a contribution towards improving things for them and their family. For example:

If I didn't change how I was then my family would have been like a lot worse off than it is now and I still might be in care or something like that. I don't know but since I've changed a lot of things I found it's got a lot better than it did before. (Sarah, 16)

The young people noticed that having a better understanding of the impact of their behaviour on themselves and others made them more aware of the unhelpful consequences of having arguments, including causing stress to themselves and their parent(s):

Before I was working with MST I didn't think like how my behaviour might have an impact on my mum or my dad. I never used to care. Then it got to the point where I had to sit down and do the meetings with MST and speak about what was going on and it weren't until then that I actually realized, I'm stressing out my mum and my dad just 'cause me messing around at school. Usually I wouldn't have thought that would have any effect on them I would've thought it was just gonna have an effect on me. (Josh, 15)

An ability to see things from another person's point of view and to see an argument from different sides was also highlighted as an important change for these young people. The analysis identified a connection between MST and increased positive communication between family members, which the young people described as helpful in rebuilding their relationships and generating a better understanding of each other:

Me and mum talk more instead of getting angry at each other, 'cause before we was getting angry and just not talking, just arguing straight away, but now we'll talk about it. (Louise, 14)

By adopting a proactive approach to meeting the schoolteachers the therapist appears to have increased systemic awareness of the young person's difficulties. The teachers and tutors were informing parents about their child's progress at school, an area which was often a major source of concern and stress for the family:

The therapist talking to my tutor, my tutor made sure that I was on track and that I wasn't going out of line within those last couple months of school and basically she had an eye on me and then she'd tell my mum when I was doing good. She'd give that praise as well to my mum. (Sammi, 18)

Positive peer relationships. The young people made a connection between spending time with people with similar positive and prosocial ambitions and thinking more about their values and goals in life. They described the importance of identifying with peers with similar values and goals for the future and a sense of unity and camaraderie in relation to the path they had all chosen to pursue:

I suppose the people that I'm with near enough every day now are the people that have exactly the same ambition as me and are not trying to not go college and not do nothing with their lifestyle but trying to actually get somewhere too and understand that everyone's gonna be in the same situation where it's hard to find a job and it's hard to get to university so we're all just trying to get there. (Sammi, 18)

Friendships also helped these young people to keep going, even when this was difficult:

One of my mates actually said 'although you might not be bothered ... if you think back to before you started and how things were with the behaviour and attitude, compared to how they are now and you haven't even finished there's a big difference. So if you carry on going, just keep at it, it's gonna be a lot better for the whole family in the end'. (Josh, 15)

Having alternatives: strategies and ideas for a preferred future. Young people talked about strategies and techniques used during MST and how these were still effective for them in times of need. Making worry boxes and using practical anger management techniques were some of the ideas the young people talked about continuing to use:

It was just the things I was getting told to do like go upstairs, calm down, like write my feelings down and that. (Louise, 14)

Having ideas about their future and a possible career was also talked about as giving the young people some direction in life. The young people said that once they were able to generate goals for their future they felt more able to actively pursue these. They made links between re-instating themselves into school or college and an increased sense of hope and pride in their achievements and they expressed surprise in their ability to persevere with their education and the educational system more generally:

I've stayed in college. I was very surprised about that. I know my mum was surprised at that but I stayed in college for 2 years. I've definitely got my head on my shoulders. I know what I want to do now for a fact so that's really good. (Sammi, 18)

Discussion

At follow up, most of the young people (six) who participated in this study felt that MST had continued to help them and their family improve their functioning in a number of areas such as communication, emotion regulation and flexibility, while helping them to recognize the impact of their behaviour on themselves and others. When MST worked in a sustained way for these young people it appeared to help them to identify and create a preferred future, in which they and others around them were able to acknowledge the progress they had made and celebrate their successes and achievements.

The therapeutic alliance and the way the therapist worked in MST was a key component in how young people experienced the intervention and is in line with findings reported by Tighe *et al.* (2012). The therapeutic alliance appeared to be a catalyst for change and young people were able to use this relationship to facilitate improvements in family functioning and to try out new, and possibly overwhelming, strategies and ways of communicating with others. The therapist's characteristics seemed to be essential in fostering this sense of safety within the therapeutic relationship. The young people particularly talked about the therapist's flexibility, warmth and humour and how they felt respected, listened to and understood throughout the intervention. These are similar to the characteristics and techniques of the therapist highlighted in the review by Ackerman and Hilsenroth (2003) of therapists' attributes that positively impact on the therapeutic alliance in a range of psychotherapeutic approaches.

Research has shown that child and adolescent alliances are particularly relevant to the process of change and outcome in therapy, across individual, parent and family treatments (Shirk *et al.* 2011). As young people rarely refer themselves to therapy, the development of a good working alliance with the therapist becomes vital, particularly in family interventions when the therapist's allegiance with various family members is important. The development of a safe and trusting relationship, where the therapists present themselves as an ally, can positively impact on the building of an alliance which facilitates engagement and positive outcomes (Diamond *et al.*, 1999).

The young people in this study talked about having to revise their expectations of MST and the therapist, based on their past experiences of receiving help. They entered into the therapeutic relationship with low expectations and beliefs that they were going to be respected, supported and cared for by the therapist. They then

appear to have shifted their attitude towards their 'helpers' from a hostile, uninterested and hopeless stance to one of genuine collaboration and hopefulness. Thus their relationship to help (Reder and Fredman, 1996) may have fundamentally shifted throughout and following their experience of MST, helping them to access resources and services more effectively.

Authors, including Henggeler *et al.* (2009b) and Huey *et al.* (2000) have highlighted the lack of focus on and exploration of the impact of peer relationships on young people who participate in MST, despite this being one of the central components of the MST process of change model and one which has been identified as a key mediator of the impact of MST. The young people in this study noted that their peer relationships had an impact on their ability to sustain positive outcomes, attributing some of their success at this to the development of more positive, supportive relationships with peers with similar goals and values in life.

Adapting the MST process of change model

By emphasizing parental change as a precursor to improvements in young people's behaviour, the current model of the process of change in MST (Henggeler *et al.*, 2009a) hypothesizes linear relationships between processes and would benefit from more bi-directionality in order to capture the positive changes young people recognize in themselves. The interplay between first-order and second-order change (Watzlawick *et al.*, 1974), which is conceptualized in family therapy as change in symptomatology versus change in family functioning, is also downplayed, as is the interaction between behaviour and beliefs. The findings of this study suggest there is more of an interplay between first-order and second-order change, suggesting that this is part of a sequential process, with changes in one area leading to changes in another, and also one which is more circular and reciprocal in its nature. This process and sequence is different for different people. For instance, some young people in this study talked about the impact of their initial first-order behavioural changes on family functioning, while others talked more about the changes that family functioning had on their individual behaviour. It could be hypothesized that reductions in antisocial behaviour positively influenced family relationships, rather than improvements in family functioning influencing changes in behaviour, as the current model of the process of MST suggests. Crucially, the second-order change may

therefore be particularly important for sustained change. What is apparent from the findings of this study is that when behavioural changes are difficult to sustain, the second-order changes made in terms of family functioning become important in helping the young person and their family to sustain positive outcomes over time.

In light of these findings, the current model of the process of change in MST needs to more fully consider adolescents' development and how this impacts on outcomes. An understanding and inclusion of the influence of peers more clearly in the process of change is also suggested as an area of further exploration. In this study, reducing the amount of time spent with antisocial peers had a positive, sustaining impact on the young people and was associated with an increase in time spent with prosocial peers and with peers with similar values and ambitions. As such, it could be hypothesized that the reinforcing effect of joining, and being accepted by, a valued peer group may have contributed to a desire to sustain positive outcomes over the long term.

Clinical implications

Qualitative research was used in the current study as it allows for the possibility of new theory, methods and clinical practice by 'shifting the lens of understanding' (Gergen *et al.*, 2004, p. 390). The perspectives of the young people in this study have highlighted clinically and developmentally relevant factors that may be important for clinicians to be mindful of when developing and monitoring a MST intervention. Some clinical implications are set out below.

- Young people are often actively involved in the process of MST alongside parents and make a significant contribution to sustaining therapeutic gains at follow up. This highlights the importance of encouraging young people to actively engage with the therapist and the therapeutic process, alongside their caregivers. This recommendation is echoed in NICE guidelines for the treatment, management and prevention of antisocial personality disorder, which suggest that professionals working with young people with antisocial behaviour should balance the developing autonomy of young people with the responsibility of carers when developing an intervention (NICE, 2009).
- The ongoing utility of strategies and techniques for emotion regulation and structure in the young person's repertoire of coping

skills are particularly important to sustaining change, as they provide useful ways of dealing with future challenges. NICE (2009) recommendations for young people between the ages of 12–17 with offending behaviour suggest MST as an intervention for consideration, specifically focusing on the development of problem-solving approaches in the family.

- The creation of prosocial peer relationships and how these link in with the young person's hopes and dreams for the future are particularly relevant to how positive outcomes are sustained. Although the influence of parents and therapists on who the young person chooses to socialize with may be limited, involving peers in the process of therapy may be useful in generating discussions of the implications of behaviour. Indeed NICE guidelines (2009) recommend that MST involves peer groups in the intervention.
- Continuing to encourage the young person to take a proactive role in therapy is important, as it appears that this impacts positively on the process of therapy and creates a helpful foundation from which young people can develop a sense of autonomy and self-efficacy towards sustaining improvements over the long term. Authors have also talked about the importance of understanding the interplay between developmental stages (for example, the growing desire for autonomy and independence) and demands (for example, increased responsibility) and therapeutic processes, as these are important for clinicians who work with young people (Everall and Paulson, 2002).

Limitations

It is important to note that the present sample predominantly included young people who had achieved positive outcomes at the end of participation in MST ($n = 6$), with limited information on the factors which were perceived as hindering this outcome. One young person had struggled to sustain positive outcomes in relation to offending behaviour. A review of the codes generated from the analysis of this interview suggested that the factors which hindered the ability to sustain improvements (for example, socializing with much older peers, keeping thoughts and problems private, viewing self and future negatively) could be regarded as the opposite of those which the other young people had highlighted as useful in sustaining these.

The study is also limited by the short duration of follow up for some participants. The shortest period of follow up was 5 months and the longest was 21 months. As such, there may be differences between the factors that contribute to sustained change at these different time points and it is important to note that previous findings have indicated that improvements in behaviour and functioning tend to become more apparent at a minimum of 18-months of follow up (Butler *et al.*, 2011).

Conclusions

By exploring young people's views and providing them with an opportunity to reflect on their experiences, an emergent model of how change was sustained following MST was generated. This also provided further information on the process of change in MST, incorporating more detail into the specific processes from an adolescent's perspective, which had been absent from the current model. First-hand accounts of how change was sustained were obtained from what is considered to be a 'hard to reach' group.

This study has contributed to the understanding of what factors assist young people's ability to sustain positive outcomes following MST and how they assist this. It has provided insights into how MST is experienced by young people and the meanings they ascribe to their experiences during and following MST. This fills a gap in the literature which has often overlooked young people's perspectives and which has emphasized the involvement of the parent in relation to initiating and sustaining change. What had been afforded less emphasis in the MST literature were young people's contributions to the process of change and the maintenance of outcomes over time. This study has attempted to address this, suggesting that the young people in this study actively contributed to sustaining positive outcomes over the long term.

The findings suggest that there are therapeutic, relational, systemic and developmental factors that are worth exploring in more detail in future studies on mediators of change in MST. Expanding the exploration of factors to incorporate those suggested by this research, such as the impact of peer relationships on sustained improvements, may provide further information on how these contribute to the process of sustaining change in MST and what may be useful for clinicians to be mindful of when reviewing progress and planning for ending with their clients.

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