FINDINGS **Your selected document**

▶ Therapist behavior as a predictor of black and white caregiver responsiveness in multisystemic therapy.

Foster S.L., Cunningham P.B., Warner S.E. et al.

Journal of Family Psychology: 2009, 23(5), p. 626–635.

Request reprint using your default e-mail program or write to Dr Foster at sfoster@alliant.edu

How to get parents more engaged in becoming a positive influence over their seriously delinquent drug abusing teenagers through family therapy integrated in to a US juvenile drug court. Some of the therapist tactics expected to work did deepen engagement, others did not.

Summary Multisystemic Therapy (MST) is an intensive family-and community-based treatment programme which focuses on the entire world of chronic and violent young offenders – homes, families, schools, teachers, neighbourhoods and friends – in the attempt to reduce antisocial and undesirable behaviour including problem substance use. It targets severe and intractable offenders aged 12–17 with very long arrest histories. MST clinicians are always on call, and work intensively in the home and elsewhere with parents or other caregivers to improve parenting and help focus the child on school and gaining job skills. Therapist and caregivers also introduce the child to sports and recreational activities as an alternative to 'hanging out'. Each therapist has a small caseload of one to five families. On average, treatment lasts four months and the therapist spends several hours a week with the child and/or their family.

The featured study addressed two gaps in research on this approach. First, whether therapist comments and responses expected to deepen the engagement of caregivers and make them feel more positive about the treatment process actually do have this effect. Secondly, whether such skills were more or less important for black families and whether matching these families with a black therapist would deepen engagement and make caregivers feel more positive.

Data for this analysis were drawn from audiotapes of mid-therapy sessions involving 89 of the 94 families/children allocated to Multisystemic Therapy as part of a study of the effectiveness of integrating this approach into a court specialising in young drug-related

offenders. The youngsters aged 12–17 were randomly allocated to be sentenced and supervised by this court with or without also being offered Multisystemic Therapy, which was for some randomly selected children also combined with rewards and sanctions contingent on urine test results ('contingency management'). The original study concluded that in respect of substance use reductions, adding Multisystemic Therapy improved the effectiveness of the court. In this study, two thirds of primary caregivers identified themselves as black or African-American. Of these, 85% were living at or below the poverty level compared to 25% of white caregivers.

In consultation with MST therapists, scales were developed to identify therapist behaviours thought to contribute to treatment success with families in general and black families in particular. For families in general, these were:
- teach: the therapist directs the session, instructs, or educates the client, but not in an authoritarian manner;
- problem solve/collaborate: the therapist suggests an idea or plan of action;
- validate/empathy: the therapist legitimises the client's point of view or feelings; and
- reinforce: the therapist comments positively on a specific client behaviour or statement.

Four other behaviours were deemed especially relevant for black families:
- instrumental support: the therapist offers specific help with practical needs;
- strength focus: the therapist highlights something positive about the client, family, or situation;
- takes responsibility: eg, the therapist admits lack of understanding or acknowledges their possible contribution to a problem in therapy; and
- storytelling: the therapist uses a story or an example to illustrate a point.

The other side of the therapeutic interaction is the caregiver's responses. These were classified along two dimensions:
- positive responses: the proportion of caregiver comments which expressed agreement with the therapist about strategies, plans, or outcomes, or positive opinions, feelings, judgments, or hope.;
- engagement: a general impression of the degree to which the caregiver was involved in sessions, embracing commitment to therapy and agreement on treatment.

These therapist and caregiver behaviours were rated for each of an average eight segments of each audiotaped therapy session.

The key issue was whether generally, and for black caregivers in particular, these therapist and client behaviours were related in such a way as to provide guidance on how therapists can deepen caregiver engagement and promote positive responses to therapy. Relationships were assessed within the same segment of the session and across succeeding segments.

Main findings

Within the same segment of a therapy session, and regardless of race, race-match, or socioeconomic status, of the eight therapist behaviours thought related to better engagement, five actually were: teach; strength focus; problem solve; reinforce; and instrumental support.

Across all clients and therapists, all but the last were also related to more positive responses from the caregiver, but here the picture was complicated by different

relationships for different categories of clients and the match with their therapists. For example, another therapist behaviour − expressing empathy/validation − was only related to more positivity when the caregiver was white and the therapist black or vice versa, not when they were the same colour. Storytelling too was associated with positivity only among the less poor and (once poverty had been taken in to account) the black families.

These relationships might as easily represent an effect of the client on the therapist as the reverse. More indicative of the direction of any causal effects are relationships between how the therapist behaved in one segment and differences in how the client responded in the next. Across all clients and therapists, there was one significant relationship: the more directive ('teach') the therapist had been in one segment of the session, the less engaged the caregiver became in the next. But among the poorer families, being directive also led to more positive responses from the caregiver. The influence was two-way; how the client behaved also seemed to influence the therapist.

Another analysis focused on whether therapists behaved differently with black versus white caregivers. Significant findings were that practical ('instrumental ') support was more often offered to black caregivers, and a strength focus and reinforcing statements were more common when therapist and caregiver were not racially (ie, black v. white) matched.

The authors' conclusions

The findings suggest that in this form of family therapy, relationship-focused strategies (strength focus, reinforcing, instrumental/practical support) on the part of the therapist are associated with greater engagement and positive responses by the caregivers of highly antisocial children, and that some therapist behaviours are more important or felt more relevant for black versus white families.

However, black versus white differences should not be over-emphasised. Though a previous MST study linked therapist−caregiver ethnic match with improved youth outcomes, in the featured study such a match was not associated with caregiver engagement or positive responses. Once poverty had been taken in to account, generally black or white caregivers responded similarly to their therapists. Regardless of caregiver race, two therapist behaviours expected to be especially relevant to black families (instrumental support, strength focus) and three expected to be generally relevant (teach, problem solve, reinforce) were significantly related either to caregiver engagement quality and/or positive responses. These signals or expressions of warmth and genuineness seem influential across racial and socioeconomic divides.

Although many findings were similar for white and black caregivers, a few differences emerged. Among these were that therapists were more likely to offer black families practical support, and that therapist storytelling predicted positive responding from more economically advantaged caregivers and from black but not white caregivers. It could be that offering 'real-life' examples is most helpful with families from economic backgrounds similar to those of their therapists. When therapist and caregiver were not the same colour, therapists tended to (and perhaps needed to) work harder to establish rapport, evident in their greater reliance on a strength focus and reinforcement, and in the fact that expressing empathy or validating the caregiver's perspective was more influential than when both were either black or white.

In terms of deepening caregiver engagement, findings supported Multisystemic Therapy's

focus on building caregiver skills by identifying family strengths, dealing with practical issues, and reinforcing attempts at improved parenting. Complex findings in respect of therapist directiveness (teaching and problem solving) appear to reinforce that done skilfully and in moderation these need not arouse resistance in the client and cause them to distance themselves from therapy, but that this is a risk, at least for some caregivers.

It should be borne in mind that these findings derived only from the middle phase of therapy, and that it is not known whether therapist behaviours which improved caregiver responses also helped achieve the ultimate objectives of the therapy – to improve family and youth functioning. Also, the analyses of matching therapists to caregivers involved mainly a relatively crude black versus white matching. Finally, the significant interactions found between the variables and categories measured by the study only slightly exceeded the number to be expected purely by chance, so the findings should be considered tentative and in need of replication.

FINDINGS The processes probed by the featured study are important partly to the degree to which they show how an effective intervention (one implemented in several parts of the UK) might work and be made more effective. Based on findings generally from child and adolescent psychotherapy, psychotherapy with adults, and couples and family therapy, if Multisystemic Therapy is effective, then deepening the family's engagement in the process in ways suggested by the study can be expected to improve ultimate outcomes. Multisystemic Therapy is widely considered to have one of the best records in fostering more pro-social behaviour among highly troubled and troubling teenagers, but this record is reliant mainly on studies conducted by the approach's developers, studies whose rigour has been challenged. Details below.

For Britain's National Institute for Health and Clinical Excellence (NICE), Multisystemic Therapy is one of a family of programmes which integrate intervention in to several aspects of a child's life and environment which it recommended for children and young people who misuse alcohol who also have other major problems and/or limited social support.

According to the independent US Coalition for Evidence-Based Policy, randomised controlled trials of MST have found sizeable decreases in the amount and severity of criminal behaviour by young offenders. However, they saw the approach as promising rather than proven, and qualified their endorsement by suggesting that effectiveness may depend critically on close adherence to the intervention's key features and the population or setting in which it is implemented. For this their main evidence was a Canadian trial in which the intervention was less well implemented than in other trials, and the sample was less poor and had access to more extensive social and health services than in US studies.

This verdict based on four randomised trials is to some extent challenged by a systematic review of eight randomised trials of the approach, which concluded that it has not been shown to have clinically significant advantages over usual services or other interventions for youngsters with social, emotional or behavioural problems. Though tending to favour MST, pooled results from the studies did not reveal statistically significant advantages in terms of children being removed from home, crime, arrests or convictions, child psychiatric symptoms or family functioning, and when all the sample was included in the

analysis, no study found significant differences in substance use.

Referring to the Canadian study highlighted by the Coalition for Evidence-Based Policy, the reviewers suggested that it might have found MST was equalled by usual services not only because these were relatively extensive, but also because the study was an unusually rigorous test. Specifically, the reviewers saw it as the only trial conducted fully independently of the developers of the approach, and in which results from all the randomised participants could included over a defined follow-up period. A methodological critique of MST studies from the lead author of the review has been contested by the approach's developers and researchers, a rejoinder in turn contested by the reviewer.

The featured study's finding that matching (in terms of black versus white) the race of the therapist and caregiver did not deepen caregiver engagement or positive responses is in line with general findings in couple and family therapy. According to a review commissioned by the American Psychological Association, across these approaches there is no evidence that therapist gender, race/ethnicity, or therapist-family ethnic match are significant factors in the strength of the alliance between therapist and client or affect the degree to which this is related to outcomes.

Last revised 27 March 2012