

UNIVERSITY HONORS PROGRAM

SENIOR PROJECT - APPROVAL

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PROJECT TITLE: Multisystemic Therapy: Why there is a need for it, what it is, how it works, and an intern's experiences in a mental health agency utilizing multisystemic therapy

I have reviewed this completed senior honors thesis with this student and certify that it is a project commensurate with honors level undergraduate research in this field.

Signed: [Signature], Faculty Mentor

Date: 5-7-82

Comments (Optional):

*Very well written - a shame the surveys did not work out
but the literature review was very well done*

Abstract

Multisystemic therapy is a relatively new therapy that was originally developed to treat juvenile delinquents. Multisystemic therapy is based on empirical research of the multiple causes of juvenile delinquency and psychopathology. Over the past 12 years, multisystemic therapy has done exceptionally well in several clinical trials; however, many in the disciplines of psychology, sociology, social work, and criminal justice have never heard of multisystemic therapy. This paper attempts to explain what multisystemic therapy is, how it is different from other forms of therapy, why there is a need for this therapy model, how successful this therapy has been, and problems in implementing the therapy. In addition, my experiences as an intern working in a mental health agency using multisystemic therapy are discussed.

The Problems of Juvenile Delinquency and Juvenile Mental Health

Over the last 35 years, juvenile and adult crimes have risen dramatically, with the incidence of juvenile violent crimes, such as murder, rape, aggravated assault, and robbery, rising 107% faster than adult violent crimes (Empey, Stafford, and Hay, 1999). Serious juvenile offenders by far are the most likely to commit additional violent and other crimes (Borduin et al., 1995). Property crimes committed by juveniles, such as combining burglary and larceny-theft, motor vehicle theft, and arson, have increased 36 % during the last 35 years (Empey et al., 1999). For all crimes, the juvenile arrest rate has increased 85% since 1965 (Empey et al, 1999). Juveniles in the United States and Canada have similar arrest rates for property crimes, yet the arrest rate for juvenile violent crime in the United States is twice the Canadian rate (Kashani, Jones, Bumby, and Thomas, 1999). Unfortunately, juveniles living in the inner city also have the disadvantage of a disproportionately high rate of the status offence of school drop out (Cunningham and Henggeler, 2001). Furthermore, aside from the emotional and physical pain suffered by victims and the families of the juveniles, the costs of juvenile violence and other delinquencies that society is forced to pay are staggering. It has been estimated that more than \$60 billion is spent each year on victims' medical expenses, lost productivity, and criminal justice system direct costs (Kashani, Jones, Bumby, and Thomas, 1999).

Despite numerous treatment facilities and programs utilizing various therapy models, until recently, nothing has seemed to have significant success upon juvenile delinquency and recidivism rates, especially long term (Borduin et al., 1995). Unfortunately, the high rate of violence in society is expected to continue to increase due to three main factors

(Kashani et al., 1999). The first is that the youth population, which again, has the highest rate of violent crime, is expected to increase by 20% in the next few decades (Kashani et al., 1999). Another factor is that youth committing violent crimes today will most likely continue to do so until they reach middle age (Kashani et al., 1999). Furthermore, the trend in the juvenile justice system has turned from rehabilitation to incarceration, thus leaving these juvenile delinquents untreated. Eventually, they are released back into society, probably having learned more about crime than they knew before entering an institution (Kashani et al., 1999).

Along with several other factors, juvenile psychopathology has been empirically shown to be a cause of juvenile delinquency and is also a problem in itself (Henggeler, Melton, and Smith, 1992). Juveniles who commit violent behavior and violent criminal acts often fit the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM IV) criteria for Conduct Disorder, Attention Deficit/Hyperactivity Disorder (ADHD), depressive disorder, substance abuse, substance dependence, and/or other psychological disorders (Kashani, Jones, Bumby, and Thomas, 1999). This is a serious problem because, as previously stated, the trend in juvenile delinquency is currently incarceration. Even when substance abusing or dependent juveniles are treated, the completion rate in treatment programs is only 10-18% (Henggeler, Pickrel, Brondino, and Crouch, 1996).

The problems with the treatment of juvenile mental health were recently highlighted as a national health priority in the executive summary of the Surgeon General's Conference on Children's Mental Health (Schoenwald and Hoagwood, 2001). Because of this, child mental health professionals are beginning to actively seek treatment models

that are effective for youth and find ways to get treatment agencies and institutions to adopt these models (Schoenwald and Hoagwood, 2001).

A variety of theoretical perspectives have been used to research psychosocial risk factors that contribute to juvenile violence, aggression, and other problems. The perspectives include biological, ethological, anthropological, and sociological viewpoints (Kashani, Jones, Bumby, and Thomas, 1999). Despite the significant amount of research on these juvenile problems, singular theoretical approaches have been largely unsuccessful and inadequate in explaining juvenile problems (Kashani et al., 1999). This is because juvenile delinquency problems have been shown to be caused by and/or related to numerous psychosocial factors, which include individual, family, peer, school, and community/cultural variables (Henggeler, Melton, and Smith, 1992).

Individual and/or biological theories have attempted to treat the numerous individual characteristics that have been associated with juvenile delinquency and other problems. An infant with a difficult temperament, believed by many to be caused by interaction between the infant's genetic predisposition and parent behavior, is more likely to be aggressive in childhood and adolescence (Kashani, Jones, Bumby, and Thomas, 1999). In juveniles that commit aggressive behavior, cognitive deficits have been found, such as lower than average levels of moral reasoning, problem solving skills, abstract reasoning, and verbal IQ scores (Kashani et al., 1999). Aggressive juveniles also frequently make hostile attributional biases, meaning they interpret others' behaviors as intentionally hostile when it is not (Kashani et al., 1999).

In addition, some physiological factors have been linked to juvenile delinquency problems, such as low serotonin activity in the central nervous system, low cortisol

levels, and high testosterone levels. Perinatal difficulties, brain damage, and slight physical irregularities have also been linked to juvenile aggression and violence (Kashani et al., 1999).

Other individual characteristics that are not psychosocial per se but have been linked to juvenile aggression problems are the demographic variables of race and gender. Boys under 18 were arrested 5 times more than girls in the same age group for violent crime, although juvenile female violent crime has been rising faster than male crime over the past few decades, perhaps due to changing societal expectations and norms (Chesney-Lind and Sheldon, 1998). In addition, African-Americans are greatly over represented in the number of arrests for violent crime (Empey, Stafford, and Hay, 1999).

Theories focusing on family structure and interaction as causes of juvenile problems have attempted to treat the numerous familial factors linked to these problems. A family history of criminal behavior and/or substance abuse, positive family and/or parental attitudes toward criminal behavior, and excessive substance use in the family have been connected with juvenile violent behavior (Kashani, Jones, Bumby, and Thomas, 1999). In addition, family management problems, low levels of cohesion and warmth, and high levels of family and marital conflict have been associated with juvenile aggression problems (Kashani et al., 1999). Furthermore, many parents of violent juveniles have failed to reinforce prosocial behaviors by modeling aggressive behavior for their children, allowing high levels of intrafamilial violence, especially multiple forms of violence, disciplining too severely, and/or providing too little supervision (Kashani et al., 1999). The culmination of these problems leads to difficulties in parent-child bi-directional

interaction patterns because the parents and the child, in due course, reinforce maladaptive responding patterns (Kashani et al., 1999).

Numerous school variables have been associated with juvenile aggression. Overcrowded schools have more problems with juvenile violence and aggression than schools that are not overfilled (Kashani, Jones, Bumby, and Thomas, 1999). Within the context of the classroom, lack of classroom management, teacher antagonism, and stringent and rigid classroom rules have been linked with juvenile aggression (Kashani et al., 1999). Moreover, the individual's lack of dedication to school, academic failure, low academic achievement, and school dropout have also been connected to juvenile delinquency and aggression (Kashani et al., 1999).

Consistent with social interaction and social learning theories, peer relations are also linked to juvenile problems. Juveniles with inadequate peer relations demonstrate verbally and physically aggressive behaviors that result in prosocial peer rejection (Kashani et al., 1999). Because of this, the rejected juveniles tend to associate with one another, contributing to the development of further aggressive and other problematic behaviors, such as antisocial behavior (Empey, Stafford, and Hay, 1999). When placed with only nonaggressive peers, aggressive juveniles are much less aggressive, but they revert back to aggressive behavior when in the company of aggressive peers (Kashani et al., 1999).

Various community variables have also been associated with juvenile violence. The availability of firearms influences juvenile aggression (Kashani, Jones, Bumby, and Thomas, 1999). Current research indicates that the number of juveniles carrying weapons, including guns, has dramatically increased during the past 15 years, and youth

who have access to weapons are more likely to commit violent crimes even when they are not carrying the weapons (Kashani et al., 1999). Drugs and alcohol are linked to juvenile aggression problems. Those juveniles who use cocaine and other street drugs commit more violent offences than youth who do not, and those who began drinking alcohol at an earlier than average age are likely to display high rates of aggression (Kashani et al., 1999). For those engaging in violent acts but did not begin using alcohol early, intoxication has been found to have a facilitating effect on their violent behavior (Kashani et al., 1999).

Consistent with social learning theory, although controversial, research indicates that the cultural variable of the media leads to violent behavior and attitudes among those youth who repeatedly view violence in the media (Kashani, Jones, Bumby, and Thomas, 1999). In addition, neighborhoods described as poor, transient, disorganized, and having a low sense of community have a high rate of juvenile violence (Empey, Stafford, and Hay, 1999). Juveniles who have repeatedly been exposed to neighborhood violence, such as witnessing shootings and experiencing beatings, are much more likely to commit violent behavior (Kashani et al., 1999).

Clearly, a wide variety of factors combine to form the complex problems of juvenile delinquency and the problems in juvenile mental health treatment. Treatment models typically only treat one or two variables that have been linked with juvenile delinquency. Cognitive behavioral therapies focus only on the individual. Parenting skills classes focus only on parenting and family interaction. Therapies modeling prosocial behavior by and large focus on peer interactions. By having such a narrow focus, most therapy and treatment models have ignored the multideterminants of juvenile delinquent and

mental health problems and have therefore ultimately failed. Even improvement within the context of a treatment facility or other locations of treatment delivery is often lost once the juvenile reenters the multiple systems in which he or she takes part.

Multisystemic Therapy

Historical and Theoretical Foundations

Home-based family therapy services' roots can be traced to the 19th century when charity organizations would send "friendly visitors" to homes to assess the need for social services and ways to help them overcome their obstacles (Bremmer as cited in Woodford, 1999). By the early 20th century, social workers were beginning to practice in the United States, and many of their methods originated from the "friendly visitors" of the past (Wells as cited in Woodford, 1999). These social workers realized the importance and advantages of home visits for accurate family assessment, and one of their main goals was to use naturally occurring helping networks, such as extended family (Woodford, 1999). They also coordinated social and other services in order to preserve the family and keep the child in the home (Woodford, 1999).

More current home-based family therapy, which began to emerge in the 1950s and more fully in the 1970s, is a theoretical perspective that includes the following features with more or less emphasis on each characteristic depending upon the individual program model: the family of the juvenile is the focus of treatment, the needed services are mostly delivered in the family home rather than a therapist's office or agency, and the services are usually delivered by master's-level therapists with at least some knowledge of systems theory and structural family therapy (Woodford, 1999). Social learning theory, family systems theory, crisis intervention theory, and ecological perspectives, in an effort

to preserve the family, are the theoretical bases for home-based therapy (Woodford, 1999).

Home-based family therapy originates from family systems theory, which includes structural and strategic family therapy (Woodford, 1999). Structural family therapy attempts to change the aversive interactions of family members by changing their interactions as members in a family system (Minuchin as cited in Woodford, 1999). The assumptions of this therapy are that an individual's psychic world is not completely an internal process, changes in the family structure play a role in behavior and internal psychic process changes, and a therapist that enters the lives of the family becomes part of the family system. (Wells as cited in Woodford, 1999). The focus of strategic family therapy is to find a therapeutic intervention that is targeted for each problem presented, according to Madanes (as cited in Woodford, 1999).

Social learning theory views behavior as resulting from "reciprocity between an individual and environmental determinants" with the determinants being "viewed as having the potential to change as a response to an individual's behavior and vice versa" (Bandura as cited in Woodford, 1999, p. 266). Family members learn from one another, and change in behavior results from changes in ways of thinking and feeling (Woodford, 1999).

Crisis theory attempts to redefine a family crisis situation. Intervention procedures are based on the assertions that people who are in crisis are highly motivated to attain help and are exceedingly receptive to change (Wells as cited in Woodford, 1999). The job of the therapist is to respond quickly to a family in crisis, such as a family threatened with having a child removed from the home, mediate each individual's response to the crisis,

and help the family acquire coping skills and social support systems and services to cope with future crises (Woodford, 1999).

Finally Bronfenbrenner's ecological theory "takes the systems metaphor a step further to include much larger systems than the single-family unit" (Woodford, 1999, p. 267). Systems outside the family are interrelated and inter-reliant with the individual and his/her family because the individual is wrought by and reacts to the systems of which he/she is a part (Cunningham and Henggeler, 2001). Links between systems have strengths, such as a good church with prosocial activities, and weaknesses, such as an uncooperative school system, which contribute to the juvenile's development and/or problems (Woodford, 1999). Therapists build upon the strengths and attempt to improve upon the weaknesses in those links (Woodford, 1999).

Attempting to find a therapy model that addressed the empirically based causes and influences of juvenile delinquency and accompanying mental health problems and incorporated the positives of other theories and therapy models already in use while preserving the family using family based interventions, Henggeler and Borduin proposed multisystemic therapy (MST Services, 2001). It was developed in its current form of combining all previously discussed theoretical perspectives in 1990 by the two researchers and is the only therapy model that has shown significant success in treating these juvenile problems long term (Woodford, 1999).

Definition of multisystemic therapy

Multisystemic therapy is an empirically-based treatment that attempts to address the known causes and influences of juvenile antisocial behavior, including aspects of the individual, family, school, peer, and community/cultural systems in a social-ecological

framework (Schoenwald, Brown, and Henggeler, 2000). The ultimate aims of multisystemic therapy are to preserve the family and empower primary caregivers, usually the parents, to independently deal with behavioral and other difficulties in childrearing and to empower the juveniles with skills to cope with obstacles in each system (MST Services, 2001).

Multisystemic therapy program practices

Multisystemic therapy attempts to prevent out-of-home placements by providing home-based therapy in the families' natural environments, like the home, in the tradition of family-based therapy (Woodford, 1999). To effectively preserve the family, therapy must be very inclusive and intensive (Schoenwald, Brown, and Henggeler, 2000). Because of this, caseloads are required to be low, about four to five per fulltime therapist (Stern, 1999). Duration of therapy is also relatively short, usually three to five months per family, depending upon the extent of family problems because, again, one of the goals is to equip families to function independent of the therapist (Schoenwald et al., 2000). Frequency and intensity of therapist-family contact per week is determined by the seriousness of problems in the family and progress made (Schoenwald et al., 2000). In addition, therapists are available 24 hours per day, 7 days per week (MST Services, 2001). Daily contact is often required at the beginning of treatment and usually decreases as the treatment progresses (Schoenwald et al., 2000).

There are nine principles that guide the multisystemic therapy assessment and intervention process (MST Services, 2001):

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context. The therapist attempts to understand the

causes of problems in the social and ecological contexts of the juvenile. Information from all systems, for example, the school, the parents, etc., is obtained and integrated by the therapist to determine the factor(s) contributing to the problem(s). Interventions based on hypotheses from this data are implemented, and these hypotheses are confirmed or refuted based on the outcomes of the interventions. When the hypotheses are refuted, the therapist seeks new information and forms new hypotheses. This attempt to find a “fit” occurs for all problems throughout the therapeutic process. The family and the juvenile are highly involved in this process.

2. Therapeutic contacts emphasize the positive and should use systemic strengths as levers for change. Therapists must focus on the strengths in order to engage the family so they will collaborate with the therapist. Without this collaboration, treatment progress is extremely difficult. Focusing on the positive helps to build positive affect, decrease negative affect, give the caregivers’ confidence in their parenting abilities, and build expectations.

3. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members. Goals of multisystemic therapy include encouraging responsible parental behavior, such as appropriate discipline, expressing love, providing for physical needs, etc., and responsible youth behavior, such as making a commitment to school, helping at home, etc. This principle reinforces a tenant of multisystemic therapy that the family should be able to function well independently when treatment is completed. Encouraging responsible behavior in both caregivers and the juvenile treats common juvenile psychopathologies such as conduct disorder and borderline personality disorder.

4. *Interventions should be present-focused and action-oriented, targeting specified and well-defined problems.* This allows all participants in the treatment to be aware of the direction of therapy and the standards used to measure progress. The principle assumes that all treatment participants will actively work toward present-focused goals, rather than reflecting on the past or looking too far into the future, in order to achieve incremental success and eventually the ultimate goals, such as independent family functioning.

5. *Interventions should target sequences of behavior within and between multiple systems that maintain the identified problems.* Consistent with family systems theory, youth's interactions within his/her natural environment are seen as the keys to changing behavior. This principle stresses that multisystemic treatment is aimed at changing family interactions to encourage responsible behavior and promoting family connections with prosocial support systems, like neighbors, friends, and church. In addition, if psychopharmacological intervention is needed for one or more family members, for example, the youth has Attention Deficit/Hyperactivity Disorder, the therapist aids in setting up appointments with appropriate care providers. If cognitive-behavioral therapy is needed, for example, the mother has depressive disorder and is already on medication, then the therapist provides this therapy.

6. *Interventions should be developmentally appropriate and fit the developmental needs of the youth.* Interventions should be appropriate for the level of development of the family. Families with younger children will have more treatment emphasis placed upon parenting skills, while families with adolescents will have more emphasis placed on peer interactions and youth responsible behavior. This also highlights the individuality of treatment plans allowed by the multisystemic therapy programs.

7. Interventions should be designed to require daily or weekly effort by family members.

It is assumed that families referred to multisystemic therapy have serious and/or longstanding problems. The therapist and the family members must work intensively on these problems. Interventions should be designed to require ongoing effort from all therapy participants. For example, noncompliance with treatment should be quickly identified; positive reinforcement should be quickly given for progress, etc.

8. Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.

Ongoing evaluations of interventions are required. Therapists must evaluate the accuracy of hypotheses concerning “fit,” how well interventions are working toward the ultimate goals, and the efforts of family members participating in therapy. When interventions are not producing expected results, the therapist must analyze these factors and make corrections.

9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts. One of the most important reasons

why multisystemic therapy is effective is that after treatment is over, families should be able to maintain their positive changes and be equipped to handle problems of all family members in multiple systems independent of the therapist. This should occur because family members are heavily involved in the therapy and the treatment goals. Also, the therapists do not take over necessary family functions; rather, they serve as consultants and advocates for the family members and help them build natural support systems,

through extended family, neighbors, etc., and help them acquire coping skills and the ability to seek out resources.

As evidenced by these treatment guidelines, multisystemic therapy provides outcome expectations while allowing the treatment interventions to be highly individualized and pragmatic. Unlike most types of therapeutic treatment, multisystemic therapy gathers information from all relevant systems of which the youth is part, finds problems, such as academic failure, low teacher expectations, few prosocial friends, low family cohesion, psychopathology, etc., and with the family members, formulates interventions and goals to alleviate these problems. These interventions are tailored to the individual, family, and other systems involved so that goals seem attainable and appropriate for the individual and family in the multisystemic context.

For multisystemic therapy to be successful, several factors must work together. One of these is that therapist-family engagement and alignment must be achieved (Stern, 1999). One way to do this is by focusing on the strengths of the family, which gets all therapy participants to have hope that the therapy can work by building upon those strengths (Stern, 1999). Many times, parents or other primary care givers feel blamed by the therapist or blame themselves for problems with their child. Multisystemic therapists focus on getting the family involved in examining all systems to find influences upon problems, and positive reinforcement is immediately given to the caregivers when they have cooperated with therapy goals (MST Services, 2001). This helps to alleviate feelings of blame or being blamed and encourages family members to focus on progress instead of past failures, encouraging caregivers to be comfortable with and trust the therapist (Stern, 1999). Therapist understanding of the stresses of the family, especially

the caregivers, also helps to give the family the feeling that the therapist understands them and further encourages engagement because they feel that the therapist is their advocate in the struggle to have a healthy family (Stern, 1999).

Just as therapists and families develop hypotheses and corresponding interventions for family and youth problems, therapists develop hypotheses about obstacles in family engagement and develop goals and interventions in order to overcome these problem (Stern, 1999). This also reinforces the emphasis on accountability for treatment outcomes, which is an unusual treatment feature relative to most forms of therapy except behavior therapy (Stern, 1999). If therapy and/or engagement outcomes are not meeting expectations, it is the job of the therapist to identify more barriers to progress, develop more hypotheses, etc. (Stern, 1999). It is assumed in multisystemic therapy that therapist-family engagement will happen as long as the therapist is doing his/her utmost to engage the family and is following the principles of multisystemic therapy (Stern, 1999). Evidence of treatment progress will also greatly aid in this process (Stern, 1999).

It may be difficult for therapists to adhere closely to multisystemic therapy practices, especially for those who have previously been trained in other therapy models. This can affect the integrity of the treatment model. Huey, Henggeler, Brondino, and Pickrel (2000) found that higher model adherence was correlated with higher post treatment family functioning quality, family cohesion, and parent monitoring behavior and lower post treatment delinquent behavior and fewer antisocial peer relationships.

To ensure high adherence to the multisystemic treatment model, multisystemic therapy programs use several supervisory practices (Schoenwald, Brown, and Henggeler, 2000). Many of these are not used in other treatment models (Schoenwald et al., 2000).

Therapists who are employed at a multisystemic program agency are required to attend a 5-day orientation/training to learn the principles, practices, and bases of the model before they begin work (Henggeler, Melton, Brondino, Scherer, and Hanley, 1999). In addition, they receive a multisystemic therapy treatment manual and quarterly booster training on the principles of multisystemic therapy and how they apply to actual therapy sessions (Henggeler et al., 1999). Each month, families are asked to fill out a form on therapist adherence to the treatment model. In addition, the therapists document what transpired in every therapeutic contact with the family and other systems on behalf of the family, such as the school or Department of Children's Services (Borduin et al., 1995). Furthermore, the therapists receive weekly supervision sessions, which is probably the most important supervisory practice to ensure multisystemic therapy adherence (Henggeler et al., 1999).

Supervision sessions, or treatment team meetings, occur once per week as previously stated (Schoenwald, Brown, and Henggeler, 2000). At this session, three to four therapists, their supervisor, and a multisystemic therapy expert consultant, who ensures that all treatments are multisystemic therapy based and may join the meeting by conference call, usually meet for ninety minutes (Schoenwald et al., 2000). Prior to this meeting, all therapists have sent treatment notes and treatment plans to the supervisor (Schoenwald et al., 2000). This assures the supervisor that each therapist is working toward overarching/primary goals of multisystemic therapy, intermediary goals (steps toward achieving the overarching goals) are being achieved, barriers to achieving intermediary goals are identified, factors contributing to progress are identified, and new intermediary goals for upcoming weeks that build upon progress and address barriers are formulated (Schoenwald et al., 2000).

In addition, the therapists have selected their most pressing problems, such as stalled progress or difficulty in family engagement, to present at the meeting (MST Services, 2001). Each therapist receives suggestions from the other therapists, the supervisor, and the multisystemic consultant in how to address these problems while remaining consistent with the principles of multisystemic therapy (MST Services, 2001). This weekly group meeting also allows the therapists to brainstorm, learn from others' mistakes and successes, role play interventions in a safe environment, and become familiar with all therapists' cases, which is helpful in the event that a therapist leaves and someone else must take over that person's cases (Schoenwald et al., 2000).

Individual supervision, a therapist-supervisor meeting, is also available as a supplement to treatment team meetings if a case is particularly difficult (Schoenwald et al., 2000). Supervisors are usually involved in all cases and know the families being treated. In addition, most have been therapists before becoming supervisors and are therefore able to draw on their own experiences and have an understanding of the therapists' perspectives (Schoenwald et al., 2000).

Evidence of the success of multisystemic therapy

Multisystemic therapy is one of the few therapies that has demonstrated long-term success with juveniles exhibiting serious clinical, family, and other problems (Schoenwald, Brown, and Henggeler, 2000). Henggeler, Melton, and Smith (1992) randomly assigned 84 serious juvenile delinquents in South Carolina to either multisystemic therapy provided by a community health center or the usual services provided by the Department of Youth Services. Pretests and posttests were administered (Henggeler et al., 1992). As compared to the control group, those who received

multisystemic therapy were less likely to be institutionalized, had lower levels of criminal activity, reported an increase in family cohesion, and reported a decrease in aggression in peer relationships (Henggeler et al., 1992).

Borduin et al. (1992) studied the differences in long-term effects of individual therapy versus multisystemic therapy concerning prevention of criminal behavior among youth offenders who were at high risk for becoming repeat offenders. Pretests and posttests on a variety of aspects of the juveniles' lives, such as family cohesion, peer relations, etc. were administered (Borduin et al., 1992). The researchers found that those who completed multisystemic therapy treatment had increased family cohesion and adaptability, decreased family conflict, decreased parental symptomology, decreased youth behavior problems, and 4 years later, these youths were much less likely to have been rearrested than those who completed individual therapy (Borduin et al., 1992). The most striking result was that even those who dropped out of multisystemic therapy prior to completion had better results than those who completed individual therapy (Borduin et al., 1992).

Henggeler, Schoenwald, and Pickrel (1995), like other researchers, believe that one of the reasons that multisystemic therapy is so successful is that, unlike most other community-based child psychotherapies, multisystemic therapy takes into account all systems in which the child participates. Because of this, multisystemic therapy has been successful, not only in a university-based setting like most psychotherapies are, but also in the community-based setting (Henggeler et al., 1995). For example, multisystemic therapy administered by doctoral students under the directions of a researcher at the University of Missouri in Columbia was successful in improving family relationships and

decreasing juvenile behavior problems (Henggeler et al., 1995). Multisystemic therapy has also been successful in the community. The therapy administered at a South Carolina mental health center improved family and peer relations in addition to doubling the percentage of youths not arrested 2 years after therapy completion (Henggeler et al., 1995). Multisystemic therapy has clearly “bridged the gap between university- and community-based treatment” (Henggeler et al., 1995, p. 711).

Cunningham and Henggeler (2001) implemented several interventions in an inner city school known for violence and bullying problems. This project, known as the *Healthy Schools Project*, employed multisystemic therapy to target juveniles at high risk for receiving court referrals and/or expulsion from school (Cunningham and Henggeler, 2001). They chose multisystemic therapy as an intervention because it addressed all the empirically based causes of juvenile violent, aggressive, etc. problems (Cunningham and Henggeler, 2001). This intervention is expected to be much more successful in deferring criminal and/or violent behavior, reducing court referrals, and reducing the likelihood of school expulsion (Henggeler, 2001).

Multisystemic therapy cost effectiveness

Even with the intensity involved in multisystemic therapy, the therapy is relatively inexpensive when compare to other treatment and/or incarceration options (Henggeler, Melton, and Smith, 1992). The average annual cost of institutionalization in South Carolina is \$16,300 per juvenile; this figure does not even include parole board proceedings, after-care planning, transportation, etc. (Henggeler et al., 1992). Even though the client-therapist ratio is 4:1 and more therapists per agency must be hired, the length of treatment is only about 3 months, so the resulting cost per juvenile is \$2,800

(Henggeler et al., 1992). This amount is approximately the same as a year of the much less intense weekly psychotherapy, a treatment that is not likely to have great efficacy (Henggeler et al., 1992). When considering the costs in time and money of potential future offences committed by those who do not receive multisystemic therapy, multisystemic therapy is clearly much less expensive than traditional juvenile services (Henggeler et al., 1992).

My experiences as an intern with a an agency utilizing multisystemic therapy

During the summer of 2001, I was an intern with Youth Villages, an organization that has been a pioneer in the implementation of multisystemic therapy in mental health services (Youth Villages, n.d.). Youth Villages has residential treatment facilities for juveniles that have been removed from the home either because of their own behavior or because of their parents' behavior. They also have a treatment facility for sex offenders. In addition, they have Intercept, an intense therapeutic program that attempts to keep children in their homes that are in danger of being removed or bringing the children back home if they have already been removed. In addition, Youth Villages has a Families program, the program with which I was an intern, which works closely with the Intercept program to provide multisystemic therapy to children with behavioral and/or psychological problems and their foster families. Intercept and Families' main objectives are to get the homes, families, and children healthy enough to successfully reunite if possible.

For my internship, I was required to attend the same therapy training/orientation as the full-time therapists. In addition, I shadowed two counselors, helped lead therapy sessions, formulated treatment plans, maintained clinical charts, recruited foster families,

and participated in all training and supervision practices. When a therapy program like multisystemic therapy is implemented in a community-based setting, some things follow the program, and some things do not.

The 5-day orientation/training was not really 5 days long; it was 3 days long. The other 2 days were restraining and therapeutic hold training, which interns were not allowed to do. In addition, part of those 3 days was taken up by CPR training and learning to identify sexual abuse. Very little of this time was spent on explaining multisystemic therapy.

After training, I began my internship with the Families program. Interns were handed a manual, as the program specifies. Without having been trained well at orientation, the manual was sometimes difficult to understand. It was meant to be supplementary, but it became my main source of initial information on the historical and theoretical bases of multisystemic therapy.

After becoming more familiar with multisystemic therapy and especially after doing the research for this paper, I realized that many of the practices of the therapists were not truly following multisystemic therapy. While I realize that the program is designed to be highly individualized and pragmatic, I did not find that the therapists closely scrutinized problems in progress with their cases nor did they often look for new hypotheses of causes of problems unless those problems became pervasive. Instead of being accountable for stalled progress like the program emphasizes, behind closed doors, the therapists tended to blame only the families and/or the juvenile when treatment was not progressing. I believe this resulted in a small number of juveniles being under Youth

Villages care for a year or more when the treatment is only suppose to last approximately 3 months.

One of the reasons that the therapists may have displayed relatively low accountability, especially in the office, was that caseloads were almost double the size recommended by the program. As a result, the therapists were typically behind on paperwork, were usually rushed, and did not have as much time as seemed necessary to spend with all the systems, like the schools, in which each of their patients took part. Being able to gather information from all the systems and spend time formulating hypotheses about problems from this information is included in the principles of multisystemic therapy.

Weekly supervision/treatment team meetings occurred without a multisystemic therapy consultant. The program recommends this consultant to aid in suggestions for stalled progress and crises and to ensure that the principles of multisystemic therapy are followed. I believe that therapist accountability would have increased with the presence of a consultant to keep the therapists on track, especially since all but one had previously used other therapy treatment models. In addition, because there was only one supervisor, all six therapists were in one treatment team instead of the recommended three to four. As a result of this and case overload, each therapist divided his/her cases into two groups, which were alternated each week for discussion in treatment team; therefore, instead of each child's progress being analyzed by the supervisor every week as recommended, he/she was only examined twice per month. I believe this also contributed to stalled progress with some of the juveniles. Furthermore, therapists were not able to receive feedback each week on each case from the other therapists and supervisor. These issues

in therapy model adherence are important because, as stated earlier, Huey, Henggeler, Brondino, and Pickrel (2000) found that the greater the adherence to the multisystemic therapy model, the better the outcome for the juvenile and his/her family.

Quarterly training was not always multisystemic therapy focused like it is supposed to be, according to the program model. One training I attended was on the topic of child development. How this topic related to multisystemic therapy was not discussed. The explanation of child development was on an extremely elementary level, especially considering that most of the attendees had masters or bachelors degrees in addition to extensive experience. I found this quarterly training frustrating because I expected to learn more about multisystemic therapy from a supervisor holding a doctorate degree.

Although not everything about the Families program exactly followed the multisystemic treatment model, I learned an immense amount about the program from its practical application and from the therapists. I witnessed how the therapists contacted and looked at all systems when attempting to solve problems. For example, when one child was being aggressive, each system was examined: the foster family, the birth family, school, other children in the neighborhood, etc. This was done by the foster family and the foster child sitting down with the therapist and listing all systems in which the foster child took part. Then, the foster family, child, and therapist discussed every possible cause of the aggressive behavior from each system. It was discovered through this examination that the root of the aggression was that the child was nervous about a visit with his birth family and that he really wanted his foster family to adopt him, which left him feeling guilty about not wanting to be with his birth family. Because multisystemic therapy examined all systems, the child was not punished without question

for the aggression. The true problem was identified, and strategies were implemented to solve the aggression problem, such as drawing the anger and guilt that he felt and talking with his foster mother about what he was feeling when he had aggressive impulses.

Therapists provided information about the success of multisystemic therapy in the Families program. The program had previously used a behavioral model and had only been using multisystemic therapy for approximately 5 years. The therapists repeatedly stated that they now had far fewer critical incidences (crises that required immediate therapist attention). In addition, they stated that they were able to witness faster progress with multisystemic therapy versus behavioral therapy. They also felt that families were much easier to engage because they were actively involved in the therapy. The therapy also focused on family functioning, not just on juvenile behavior, which reduced family conflict and probably encouraged further alignment with the therapist. These assertions by the therapists about the many successes and positives of multisystemic therapy despite Youth Villages straying somewhat from the program model are confirmed by research. A study using a multisystemic therapy program in which there were no quarterly booster trainings or weekly treatment team meetings found that, although this use of the therapy was not as effective as multisystemic therapy utilizing the entire treatment model, this method was more effective than the traditional treatment and therapy services (Henggeler, Melton, Brondino, Scherer, and Hanley, 1997).

My Youth Villages internship introduced me to the multisystemic therapy model. After witnessing the successes of multisystemic therapy and learning about its empirical bases, I have come to the conclusion that multisystemic therapy is the best treatment model currently available. I now no longer believe that a clinician can provide truly

effective therapy resulting in long term success without examining the entire person, and that includes all systems that affect that person. Multisystemic therapy has changed my views on psychology and helped me to realize that more people in the social services and social sciences need to be made aware of what multisystemic therapy could do for children and adolescents and their families in need of help. A need for widespread use of multisystemic therapy has clearly been established.

Problems and suggestions for future research

I believe that one of the chief problems with the current multisystemic therapy research is that most studies have been conducted about inner city children. Youth Villages has offices in both urban and rural areas; therefore, more studies should be conducted in order to examine whether or not multisystemic therapy has the same effects in more rural areas as it does in the inner city. In addition, many of the studies involved training by one of the formulators of multisystemic therapy or one of their closest colleagues. Because they know a vast amount concerning multisystemic therapy, the training they provide to therapists could differ from training provided by a regular multisystemic expert consultant like most mental health agencies use. Perhaps more research could be done on agencies providing multisystemic therapy independent of the scholars who are so well indoctrinated with multisystemic therapy. This could provide more information on how effective multisystemic therapy is in more real-world settings where issues such as money and high employee turnover are more likely to be a problem.

Additionally, more studies should be conducted on the efficacy of multisystemic therapy with adults with problems and children and adolescents with nonviolent,

noncriminal problems. These types of studies would reveal whether or not the successful findings concerning multisystemic therapy could be generalized to other populations.

What about the problems you observed about adherence to the treatment model?

Conclusion

Many other research trials on multisystemic therapy are currently underway in both the university- and community-based settings. This therapy is being examined as a therapy for sexual offenders and others with behavioral and/or psychological problems. Hopefully, as more evidence becomes available, more clinicians, social workers, and those involved in all steps of juvenile justice will realize that multisystemic therapy should be implemented in mental health and social services programs. Hopefully, more money that is currently designated to keep juveniles incarcerated will be allocated in the future to agencies that provide multisystemic therapy.

Multisystemic therapy, I believe, will eventually change the current direction of juvenile justice and child development, hopefully from incarceration and/or individual therapy to rehabilitation and multisystemic therapy. Despite the problems with therapy adherence, my internship provided me with invaluable experiences that changed my perspective on psychology, sociology, and criminal justice. Clearly, multisystemic therapy is a successful form of therapy that could make a difference in the lives of countless youth and their families.

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