Multisystemic Therapy Supervisory Manual

Promoting Quality Assurance At the Clinical Level

SCOTT W. HENGGELER
SONJA K. SCHOENWALD

Multisystemic Therapy
Supervisory Manual

Promoting Quality Assurance
At the Clinical Level

Scott W. Henggeler, Ph.D.
Sonja K. Schoenwald, Ph.D.

August, 1998

Acknowledgments

We greatly appreciate the support of Shay Bilichik and the Office of Juvenile Justice and Delinquency Prevention (Grant Number 97-JN-FX-0016) who provided the resources needed to develop this manual. In addition, we owe special thanks to the following MST supervisors and consultants whose constructive feedback helped to shape the form and content of this manual: Laura Artino, Stephanie Blanks, Cindy Borgognoni, Phillippe B. Cunningham, Jon M. DeActis, Christine Hamel, Susan G. Pickrel, Melisa D. Rowland, Marshall Swenson, Barbara A. Trout, and Greg Winterburn.

Table of Contents

Introduction

This manual is the second in a series of three documents that explicate the multisystemic therapy (MST) intervention model and corresponding quality assurance mechanisms (i.e., supervisory process and consultation protocol). The clinical foundation of MST is detailed in a volume titled, *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). The present supervisory manual delineates the MST approach to clinical supervision. The overarching objective of MST clinical supervision is to facilitate therapists' acquisition and implementation of the conceptual and behavioral skills required to achieve adherence to the MST treatment model. These skills are critical to attenuating or eliminating identified problems and achieving positive, sustainable outcomes for children and their families. The MST consultation protocol (Schoenwald, 1998) discusses the role that MST expert consultants play in promoting treatment fidelity and child outcomes in MST programs.

This manual is structured to orient supervisors to processes that are important to the success of MST supervision, therapist adherence, and child/family outcome. The first section describes the rationale for the structure and process of MST supervision–a rationale that emphasizes the efficiency and goal-oriented nature of supervision. The second section describes the establishment of overarching treatment goals. The third section notes the key indices of family engagement and suggests avenues for the supervisor to pursue when these indices are absent. Similarly, the fourth section provides criteria for evaluating whether clinicians understand the "fit" of identified problems and recommends strategies for determining the barriers to understanding this concept and corresponding solutions. The fifth section provides guidelines for implementing interventions, and addresses barriers to effective implementation. Finally, we stress that the development of the therapist's capacity to implement MST effectively is a developmental process in which the supervisor plays a critical role.

Throughout these sections, the underlying assumptions of the MST approach to clinical supervision guide both the analyses of difficulties that clinicians may be having in attaining favorable outcomes and the development of solutions to overcome such difficulties. The underlying assumptions of MST supervision include:

- The purpose of clinical supervision is to enable clinicians to adhere to the nine principles of MST in all aspects of treatment–engagement of families, case conceptualization, intervention design and implementation, and evaluation of outcomes.
- Each clinician implementing MST is a hard-working, competent professional who brings unique personal strengths and professional experiences to the treatment process. Nevertheless, ongoing clinical supervision is necessary to monitor adherence to MST and to achieve positive, sustainable outcomes with youth presenting serious clinical problems and their families.
- The process of clinical supervision should mirror the process of MST. That is, supervision is present-focused, action-oriented, and targets specific problems that the clinician appears to be having in (a) engaging families in the treatment process, (b) conceptualizing the "fit" of referral problems with the family's ecological context, (c) identifying and using

strengths as levers for change, (d) designing interventions, (e) implementing interventions adequately, and (f) overcoming barriers to intervention implementation or success. Supervision also should enable clinicians to sustain MST-like conceptualization and intervention skills across families (generalization).

- Clinicians, supervisors, and the provider organization that houses the MST program are accountable for outcomes.

As suggested by these assumptions, a clear theme throughout this manual is the critical importance of the supervisor to the MST treatment process. We know clinicians' adherence to the MST principles are linked with favorable outcomes (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997), and supervisors are primarily responsible for helping clinicians adhere. As such, and analogous to the role of therapists with families, supervisors must be able to identify and address any barriers to therapist adherence. Although the identification of barriers to treatment adherence may be difficult at times, the supervisor has responsibility for struggling with this issue. Moreover, assistance in identifying and addressing barriers is available from the MST consultant. Again, low clinician adherence can not be ignored, it must be addressed for the good of the families who are being served, the MST program, and the community and policy context in which the program is embedded.

When the barriers to therapist adherence are elusive (i.e., supervision is unsuccessful for a particular therapist with a particular family for some unknown reason), the supervisor should obtain more direct, first-hand, information regarding the clinician's interactions with the family. Several avenues are available in this regard. Going into the field with the clinician and sitting in on (not leading or directing) treatment sessions can provide invaluable information about the strengths and weaknesses of the therapist and family– as well as about the therapist-family interface. Similarly, audio or videotapes of treatment sessions can be reviewed. Hence, just as therapists are encouraged to "do what it takes" to achieve treatment goals with families, supervisors should be prepared to extend considerable effort in promoting clinicians' adherence to the MST protocol.

The Structure and Process of Supervision

MST supervision takes place within a structure and uses a process that is intended to promote high quality assurance–especially with regard to therapist adherence and child/family outcomes. Supervisory sessions are the "fuel that drive the engine." That is, through these sessions, therapist adherence to the MST model is optimized, which, in turn, leads to better outcomes for children and families as well as programmatic success. As such, the supervisory sessions are critical to the MST treatment process and are treated very seriously–although they should be made as enjoyable as possible (not necessarily a contradiction). This section describes key elements of the structure and process of MST supervision, providing rationales for each and guidelines for ensuring that appropriate structure and process are implemented.

Key Components of MST Supervision

Small Group Format

The MST supervisor meets with the members of each treatment team, which typically includes 2 to 4 other practitioners, in a group. Group supervision provides several advantages, including:

The opportunity for team members to learn from each others' successes and mistakes.
When providing home-based services to families with complex clinical needs, many practitioners make similar mistakes. For example, fathers (or male caregivers) are often allowed to be absent from sessions after they, or their wives, provide a rationale for such absences (e.g., He has to work late, He's too tired from the night shift, He doesn't really care about his son, He's out fishing with his buddies). When such difficulties are addressed in a group format, a variety of solutions may be generated, thus increasing the probability that the practitioners will possess a greater repertoire of responses when faced with similar barriers to engagement. Similarly, when a successful strategy is implemented by a practitioner, the other practitioners can learn from and share in the success. For example, when approaching the father as "the key" to helping his son develop into a responsible person leads to greater engagement with the father, an important lesson might be learned by the team members.

The opportunity for team members to practice (role play) clinical interventions in a safe setting.
Certain clinical interventions can be difficult to implement, even for experienced clinicians. In such cases, the group supervisory context provides an excellent opportunity to practice and rehearse planned interventions with confederates who are usually superb at playing client roles. For example, the clinician may need to address a parent's substance abuse problem because it clearly contributes to a youth's problems, but the clinician may suspect that the parent will respond with great hostility upon receiving such feedback. Here, the group context can be used to practice the initial therapist-parent dialogue as well as therapeutic responses to possible reactions of the parent (e.g., anger, denial).

The opportunity for team members to work as a cohesive unit.
Attempting to understand and delineate the "fit" of problems and developing and implementing effective interventions are often very challenging tasks. Tremendous advantage is afforded by the fact that team members can call on the experiences of each other when attempting to understand and empower families. Although the supervisor must always ascertain whether proposed solutions to "fit" and intervention de-

sign and implementation questions are based on the MST treatment principles, discussions that "brainstorm" these issues are often useful. In particular, the supervisor should become adept at tapping the strengths that each practitioner brings to the supervisory context to the advantage of the team.

Supportive collaboration.
In addition to the experiential and informational resources that team members bring to supervision, the group supervisory process can become a source of encouragement and social support for team members. Practitioners can become discouraged when faced with challenging families that may not always be making progress. Group support for therapeutic effort to overcome barriers to obtaining outcomes can promote continued effort in the face of adversity. Moreover, the group supervisory process can facilitate the types of collaboration among team members that lead to better outcomes for families. For example, when progress has been slow and barriers to advancements are elusive, another team member might attend one or more treatment sessions to attain direct family contact. This second practitioner often develops new hypotheses about the barriers to progress as a result of having a fresh perspective.

Quality coverage during time off and vacations.
By definition, families in MST programs are at high risk of out-of-home placement, and the clinician-family relationship is driven by the mutual desire to make the types of ecological changes that will prevent out-of-home placements in the future. Until these changes are made, however, risk of placement is high–which is one reason why clinicians are available 24-hours-a-day, 7-days-a-week (i.e., to respond immediately to crises that risk out-of-home placements). Practitioners, nevertheless, deserve and have earned time off and vacation time. Hence, MST programs must be prepared to meet the needs of families in crisis (a) who have not yet made the necessary ecological changes, and (b) whose therapist is not available. To address this important issue (i.e., a family in crisis whose primary therapist is unavailable), MST programs have incorporated at least two strategies. First, team members have helped to conceive and develop interventions for all families through group supervision. Hence, therapists who are on-call for the team or who are covering for a colleague who is unavailable have considerable background information regarding the family in crisis. This information increases the probability that the clinician will make good decisions during the crisis. Second, MST practitioners are encouraged to meet the families of the other team members. Hence, in time of crisis, the family has at least met the MST clinician who is substituting for their primary therapist. Such familiarity should enhance the capacity of the therapist to work effectively with the family.

When is Individual Supervision Indicated?

Individual supervision is not the norm in MST programs for the reasons discussed above. Individual supervision is warranted, however, in several situations.

Practitioner personal problems are interfering with performance.
The supervisor is not and should not become the practitioner's "therapist." Nevertheless, the supervisor is responsible for treatment adherence, and, as such, steps must be taken when a practitioner's personal problems are interfering with adherence. In such cases, the supervisor should schedule private meetings with the practitioner (in addition to regularly scheduled group meetings) to identify, discuss, and develop strategies conjointly that solve personal problems, thus increasing therapist effectiveness. If therapist effectiveness has become impaired because of personal psychosocial difficulties (e.g., marital distress, substance abuse, clinical depression), the supervisor should refer the clinician to an appropriate source of help. Again, the supervisor's job is to help clinicians achieve adherence, not to "therapize" the clinician. Thus, the supervisor evaluates the therapeutic progress of the referred clinician from the vantage point of improved adherence to the MST protocol. In other words, if clinicians are adhering to the MST treatment protocol and obtaining good outcomes for their families, a therapist's personal problems may not be a concern to the supervisor. On the other hand, if adherence is low and outcomes are poor, therapist per-

sonal problems might explain the poor outcomes and should be considered.

Specific competencies must be developed.
Few clinicians begin their work in MST programs possessing all the requisite clinical skills. MST training, the booster sessions, MST consultation, and group supervision are intended to promote the development of skills needed to implement MST effectively. In some cases, however, a practitioner requires more intensive training/consultation regarding certain clinical procedures than can be provided during the extant training opportunities. For example, individual work with a parent or youth may require proficiency in the use of cognitive-behavioral interventions to promote problem-solving skills. Although the clinician may have been exposed to cognitive-behavioral intervention strategies during training, such exposure may not have been of the intensity needed to develop the clinician's proficiency in the technique. Here, the supervisor (in collaboration with the MST consultant if necessary) should provide the clinician with the resources (e.g., clinical writings) needed to acquire a more "in depth" knowledge of the clinical procedure. The clinician, as a practicing professional, is responsible for attempting to understand and integrate the knowledge, and the supervisor is subsequently responsible for facilitating such understanding and integration. Thus, the clinician may study the material him/herself, and then meet periodically with the supervisor to gain clarification on sticking points. The supervisor should have the clinician demonstrate the newly learned competence through role-playing exercises.

Alternatively, a situation may arise in which the entire treatment team, supervisor included, requires information regarding a clinical issue or particular problem. For example, knowledge of childhood autism may be limited in the MST program prior to the referral of a child with such a diagnosis. With the supervisor assuring the quality of the information received, team members must acquire information about autism that will be pertinent to the family and development of MST treatment plans. Respected colleagues with a particular expertise in the community and the MST consultant can be tapped for such information. As with many areas of mental health, however, misleading and erroneous information is plentiful–so, again, the quality assurance role of the supervisor is important. That is, the supervisor should ensure that professionals regarded as local experts on a topic are in command of information that is empirically derived and practice according to empirically-based guidelines. They must be sure that the "expert" has a successful track record with respect to treatment outcomes.

Practitioner and Supervisor Preparation Before, During, and Following Supervision

For increased efficiency and continuity of care, the clinician and supervisor must arrive at supervision prepared to discuss pertinent issues regarding each family. To facilitate this process, clinicians delineate key issues on paper and provide copies for the supervisor before each session. In addition, to facilitate task accomplishment between supervisory sessions, the therapist and supervisor note "next steps" in progressing toward the overarching goals for each family, and the supervisor rates important aspects of therapeutic progress for each family and therapist. These processes are described in detail in corresponding sections of this manual, but are noted here briefly because of their relevance to preparation for efficient use of time during supervisory sessions.

Initial contacts–understanding the "fit" from the practitioner.
Prior to supervisory sessions that follow new referrals, the practitioner briefly describes on appropriate forms (see Figure 1) information that describes:

- The past mental health/juvenile justice history of the youth and family
- The treatment goals of the parents, youth, and referring agencies
- The strengths and barriers in the adolescent, family, peer group, school, neighborhood, and social support context

- The family structure and history (genogram)

This information provides the foundation for initial hypotheses regarding the fit of referral problems and serves as the conceptual basis of the initial set of interventions.

Weekly progress updates from practitioner.
The MST treatment process entails interrelated steps that connect the ongoing assessment of "fit" with the development and implementation of interventions. This ongoing and iterative process, depicted in Figure 2, has been dubbed the "MST Do-Loop." Throughout the course of treatment, clinicians summarize key aspects of **family progress** in terms of these steps prior to each supervisory session in the format indicated subsequently (see Figure 3):

- The overarching/primary goals of MST are listed.
- The intermediary goals (i.e., goals that represent steps toward achieving the overarching goals) established at the previous supervisory session are listed and progress toward achieving each goal is noted.
- Barriers to achieving the intermediary goals that were not met are presented.
- Advances in treatment are provided.
- The new understanding of fit, in consideration of advancements and barriers, is described.
- New intermediary goals are set for upcoming sessions, with interventions designed to address the described barriers.

Monitoring of therapist-family progress by the supervisor.
Following supervision, the supervisor notes each **therapist's status** with respect to each of the following for each family (see Figure 4):

- The ongoing engagement of key players
- The ongoing MST "fit" conceptualization
- How the intermediary goals are logically linked with overarching goals
- How interventions will achieve intermediary goals
- How implementation of interventions and attainment of goals will be measured
- Identifying factors contributing to and strategies to overcome barriers

Supervisors also note strategies recommended in supervision to enhance clinician and family progress with respect to these steps in the MST treatment process.

Duration and Frequency of Supervision

The overriding purpose of MST supervision is to achieve treatment fidelity and favorable outcomes for children and families. Hence, MST supervisory sessions are held as often as needed to accomplish this task–but not more frequently than is productive.

LENGTH OF SESSIONS

Supervisory sessions are scheduled for a set duration of time, and all efforts should be made to keep within the time frame to maximize efficiency. Depending on the nature of the clinical populations and the number of sessions held per week, the length of supervision may range between 1 and 2 hours, with the typical duration lasting about 1.5 hours. After 2 hours, supervision usually has limited benefit for time expended because the energy of team members is often drained and concentration levels are low.

Figure 1

Initial Contact Sheet

Summary of Mental Health, Juvenile Justice, and Placement History

Participant

Youth

Parent Figures

Others

Initial Goals/Desired Outcomes

Participant	Goals
Primary Caregiver	
Secondary Caregiver	
Youth	
Referral Agencies	

Overarching MST Goals

1.

2.

3.

4.

5.

Therapist	Date	Supervisor	Date

Figure 1
Initial Contact Sheet
(Page 2)

Date of Intake: _____ Referral Agency: _____

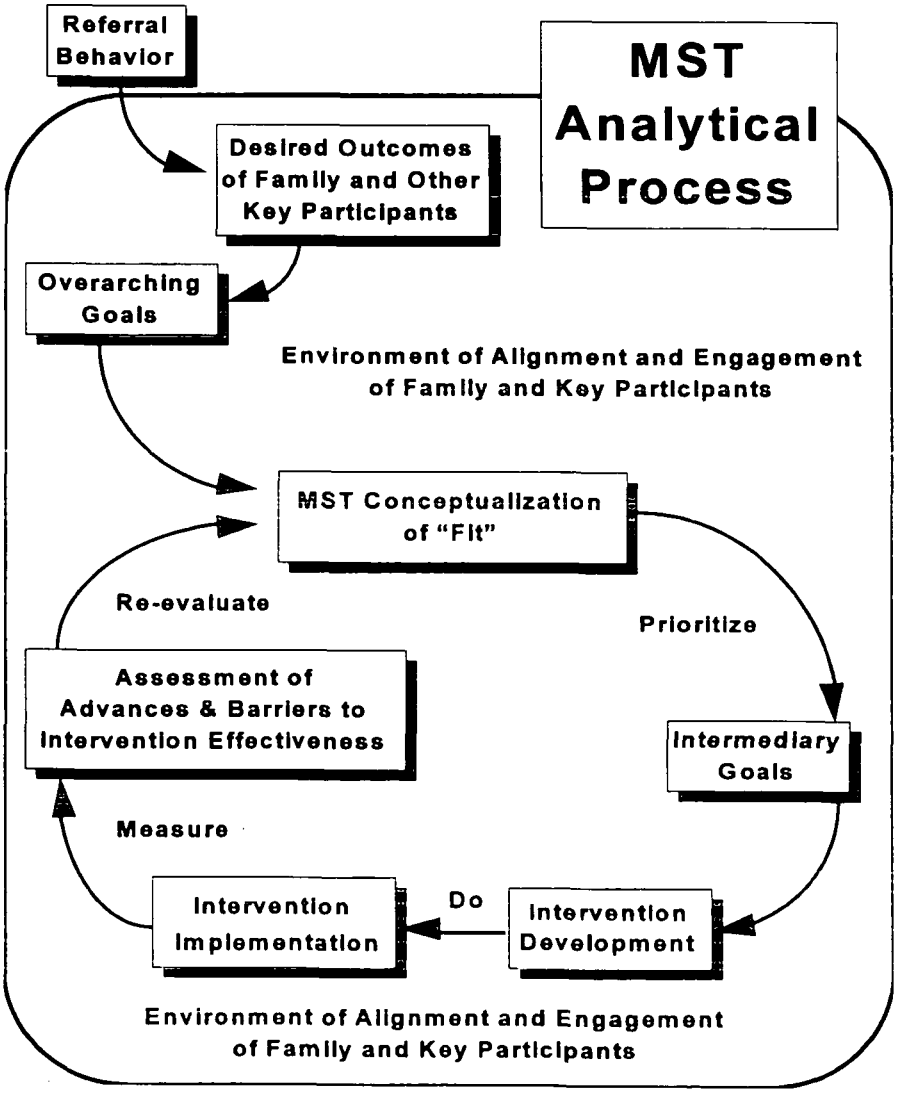
Reasons for Referral: 1. _____ 2. _____ 3. _____ 4. _____

STRENGTHS	NEEDS/BARRIERS
Family	
School	
Peers	
Individual	
Neighborhood/Community	

Genogram

Figure 2

MST Assessment and Intervention Process (AKA, MST Do-Loop)



If sessions extend beyond the time limit, be it 1, 1.5, or 2 hours, one of two circumstances have probably come into play. Perhaps the supervision time is not being used efficiently (see below). For example, the supervisor is allowing many interactions that are not pertinent to the task at hand–story telling for its own sake, extended debate without coming to closure, asides that are not relevant to outcomes, and so forth. Alternatively, if supervision time is being used efficiently, the complexity of the cases may require more frequent supervisory sessions each week for a time-limited period.

FREQUENCY OF SESSIONS

The weekly frequency of supervisory sessions may vary with the maturity of the MST program and nature of the clinical population. In new MST programs, supervision may occur more often than in mature programs because the therapists (and supervisor) are just beginning to "learn the ropes." With in-

Figure 3

MST Weekly Case Summary Form

Family: _____ Therapist: _____ Date: _____

Weekly Review

I. Overarching\Primary MST Goals

II. Previous Intermediary Goals Met Partially Not

III. Barriers to Intermediary Goals

IV. Advances in Treatment

V. How has your assessment of the fit changed with new information/interventions?

VI. Goals/Next Steps for the Week

Figure 4

Weekly Supervision Notes

Supervisor _____ Clinician _____

- Supervision notes are designed to help the supervisor assess clinician progress with each case. In supervision, label which step you are addressing. Gather evidence during supervision that clinicians understand recommendations and next steps.

SEE ANALYTICAL PROCESS ("DO-LOOP") DIAGRAM

1. Overarching goals
    - referral behaviors
    - desired outcomes of key players
2. Ongoing Engagement of Key players
    - evidence of engagement
    - barriers to engagement
    - recommended strategies to overcome
3. Ongoing MST "Fit" Conceptualization
    - multiple determinants
    - fit circles
    - evidence of fit factors
4. Are current intermediary goals logically linked to ultimate goals?
    - link intermediary goals to overarching goals
    - prioritize intermediary goals
5. Development and Implementation of Interventions
    - link interventions to intermediary goals
    - adherence to 9 MST Principles
    - empirically validated techniques
    - clinical skills
    - complete implementation and monitoring of implementation
6. Measure Outcomes of Interventions
    - measure intervention success
    - obtain multiple perspectives
7. Identification, "fit" of, and strategies to overcome barriers to intervention success.

(Return to #2)

creased experience and program maturity, however, team members generally develop greater capacity to address complex clinical problems independently and require less feedback and consultation.

In a "typical" MST program that treats youths presenting serious antisocial behavior and their families, new programs often will have two supervisory sessions per week, whereas mature programs might require only one session per week to maintain fidelity. On the other hand, changes in the nature of the client population may require changes in the frequency of sessions. For example, in our first study with youths presenting psychiatric emergencies (Henggeler, Rowland, et al., 1997), the seriousness of the family crises (e.g., youth was suicidal, homicidal, or psychotic) required daily supervisory sessions– 8:00 a.m. to 9:00 a.m. each morning–with the MST team to assure the quality of care needed to stabilize the crises safely. After this program matured (in about 8 months), the number of supervisory sessions gradually was reduced to three per week, which is three times the frequency of group supervision sessions held in studies using MST with chronic juvenile offenders. Importantly, decisions to reduce (or increase) the frequency of supervision are driven almost entirely by demonstrated adherence levels and outcomes. Sessions, however, should never be less frequent than once per week.

Attendance At and Use of Time During Supervision

ATTENDANCE

In light of the importance of supervision to the success of MST programs, attendance is mandatory with few exceptions. Those exceptions pertain to important clinical tasks or personal emergencies that the team member has no control over (e.g., a court hearing scheduled for a family, an expulsion hearing at the adolescent's school, a family crisis that risks out-of-home placement, or a personal emergency). Exceptions do not pertain to regularly scheduled meetings with clients, personal dentist appointments, and so forth.

Sessions should begin and end on time. Arriving on time is considered a sign of respect for the professional colleagues who are attending and for the goals of the sessions. Moreover, considerable professional time is wasted when a meeting begins even 15 minutes late (4 attendees x 15 minutes = 1 hour of lost productivity). The supervisor must take the lead in promoting efficient use of time by personally arriving on time, rarely canceling supervisory sessions, ending on time, and so forth.

USE OF TIME DURING SUPERVISION

The supervisor should strive to make efficient use of time during supervision. Efficiency requires that more time be devoted to families who are in the beginning stages of treatment–when "fit" is still being determined–and to families who are not progressing satisfactorily. For the latter, the efforts of team members are aimed at trying to understand the barriers to clinical progress and to designing interventions aimed at overcoming them. Extended time may also need to be devoted to a family that is in an immediate crisis. On the other hand, in families where progress is satisfactory and the family and clinician are on the intended trajectory for favorable outcomes, relatively little time will be devoted to discussion of the family.

ALLOCATION OF TIME TO FAMILIES

Concretely, supervision usually begins with the supervisor taking inventory of the families that will need some extended discussion from the perspectives of each clinician. Thus, for example, each clinician might identify one to three families who he or she wants to discuss for the reasons noted above (i.e., still trying to understand fit, progress is not being made, family in immediate crisis). The supervisor then allots time proportionate to need. For example, the first 15 to 20 minutes of a 90-minute session might be devoted to briefly touching base regarding the 10 families who are progressing satisfactorily. The five families who require extended discussion might be allotted about 15 minutes each, assuming the requisite flexibility. At the end of the 90 minutes, each therapist should have a plan to put into place until the next session. If all

families haven't been covered, however, the supervisor might meet with the pertinent clinician for a short time longer, and excuse the other team members from the session.

EFFICIENT USE OF TIME

Based on the above description and the overriding purpose of supervision, the goal-oriented and task-oriented nature of supervision should be evident. MST supervision is not a time to chitchat or to discuss administrative issues: The task of supervision is to facilitate therapist adherence and family outcomes. If supervision ends early because the tasks are completed, that is fine, and the team members can enjoy a cup of coffee or soda together. Supervision, itself, should remain focused on the goals of the MST program.

Supervision Should Be Enjoyable

Though time should be used efficiently and the goals of supervision are serious, the supervisor should endeavor to make supervision as enjoyable as possible. Optimally, therapists should look forward to supervision rather than dreading that time in their weekly schedule. Therapists who dread supervision are apt to be less productive clinicians, less satisfied employees, and less likely to contribute to the goals of the MST program. Supervisors can follow several guidelines for engaging therapists in supervision.

FOCUS ON THE POSITIVE

As therapists should focus on the positive when working with families, supervisors should emphasize the positive when consulting with clinicians. The development of clinical skills largely entails the reinforcement of strengths and the building of competencies in areas of weakness. Just as families are more responsive to a strength-focused approach, so, too, are clinicians. Hence, supervisors should search for, identify, and label the positive aspects of each clinician's work. Similarly, clinical deficits should be viewed as opportunities to become more effective at implementing a complex clinical model. All clinicians will have areas in need of improvement. The supervisor's job is to identify those areas collaboratively and to provide the types of experiences that build clinical competencies.

EXPRESS AN APPRECIATION FOR THE FOIBLES OF THE HUMAN CONDITION

Many of the experiences that clinicians view as frustrating when working with families who present complex clinical problems can be viewed as humorous from a certain, offbeat, perspective. For example, the therapist may not see the humor in the family hiding in a back bedroom while he or she is knocking at the front door for a scheduled appointment. On the other hand, the supervisor and other team members might get a chuckle out of imagining the scene. An important supervisory skill is to help clinicians take their work seriously, but not too seriously–to be able to laugh at themselves, laugh with their families, and appreciate the absurdity of certain circumstances–while still developing strategies to address barriers that may be equal in absurdity (e.g., while waiting for the family to come out, ordering a pizza to eat and completing paper work on the front steps). Taking a job too seriously can lead to burnout, staff turnover, program inefficiency, and failure.

Supervision Helps to Effectively Analyze Problems and Generate Solutions

Few things make people more satisfied with their work than success. In the context of an MST program, success is defined as favorable outcomes for youth and families. Most mental health practitioners entered their profession, as least in part, because they truly wanted to help others overcome difficulties–to have a positive effect on the world. The MST program, the treatment team, and the supervisor can all help clinicians realize the goal of "helping others." Supervision can assist clinicians to realize this goal by helping them to become more effective and efficient in their analyses of clinical problems and develop-

ment of solutions. Thus, supervision assists clinicians with all aspects of the MST Analytic Process (AKA, "Do Loop"), depicted in Figure 2.

The ongoing MST assessment and intervention process begins with a clear understanding of the reasons for referral. The next task is to develop overarching treatment goals. Once the goals are identified, a preliminary multisystemic explication of the fit of identified problems is developed. This initial explication of fit encompasses strengths and weaknesses observed in each of the systems in the youth ecology; it becomes more detailed as the clinician gathers information and observations about interactions within and between each system that directly and indirectly influences the referral behavior.

Next, the treatment team delineates intermediary treatment goals–those goals that are achievable in the short term and reflect direct movement toward the overarching goals. With the intermediary goals defined, the team identifies the range of treatment modalities and techniques that might be effective toward meeting the intermediary goals and tailors these to the specific strengths and weaknesses of the targeted client system (e.g., marital, parent-child, family-school).

As interventions are implemented and their success is monitored, barriers to favorable outcomes may become evident at several levels. For example, at the family level, previously unidentified parental difficulties, such as drug abuse, weak parenting skills, and so forth, might emerge. Likewise, clinician limitations (e.g., inexperience in marital therapy) may impede progress. The supervisor's responsibility is to help the clinicians to identify these barriers at the case and clinician level, as well as the factors contributing to the barriers. Then, in an iterative process, strategies for overcoming the barriers are developed and implemented. Refinement continues until the desired results are achieved. Throughout this process, the supervisor ensures critical thinking and adherence to the MST principles.

FACILITATING HYPOTHESIS DEVELOPMENT AND TESTING

Hypotheses are hunches or theories that can be expressed in terms that are concrete and measurable. Hypotheses are initially developed on the basis of therapist observations of interaction patterns and interviews with key participants in the youth's ecology. As indicated in Figure 2, hypothesis development and testing begins at the moment a clinician or family member uses a piece of information or an observation to generate an idea about what-causes-what. A clinician should be able to describe evidence from direct observations and interview information that supports or refutes the hypothesis. For example, a clinician who thinks that permissive parenting is a family-level factor contributing to an adolescent's physical aggression toward classmates should be able to describe: (a) sequences of parent-child interaction that illustrate permissive parenting (i.e., evidence that parenting is permissive); and (b) the ways in which these sequences relate to the aggression toward peers (i.e., evidence that permissive parenting contributes directly or indirectly to the adolescent's aggressive acts). Evidence refuting the hypothesis could emerge at either juncture. For example, information indicating that the parent usually punishes aggressive behavior could constitute evidence refuting the permissive parenting hypothesis. Faced with such evidence, the supervisor may suggest that the therapist gather more evidence to support or refute the permissive parenting hypothesis before designing parenting interventions. Strategies for gathering such evidence include having the parent monitor daily discipline efforts and the youth's response to these efforts, observing parent-child interactions, and talking with family members and teachers about what happened at home after the youth engaged in aggressive behavior at school.

The process of developing hypotheses, gathering evidence to support and refute them, and designing interventions to test them continues throughout the ongoing assessment and intervention process depicted in Figure 2. Supervisors should model and reinforce the practice of hypothesis development, evaluation of evidence, and hypothesis testing. To this end, questions commonly asked by supervisors include the following:

- What repeated, predictable patterns of family interactions have you observed that might explain the problem behavior?
- What repeated, predictable patterns of interaction between family members and key figures in the school, neighborhood, and community have you observed that might explain the problem behavior?
- What is your evidence that [any clinician's hypothesis about why things do or do not happen in a family, at school, etc.] is contributing to the referral problems?
- How can you test the hypothesis you have about what contributes to what?
- When interventions are partly implemented, not implemented at all, or not successful, what are the barriers to success? What is the evidence supporting your assessment that these barriers are the ones that interfered with the intervention's implementation or success? How can you test which ones are the greatest barriers to change?

Initially, hypotheses should pertain to the most proximal causes of behavior. Proximal causes are interactions and events in everyday living that seem to be directly connected with the problem behavior. MST therapists should be able to detect among everyday interactions between parents and their children, teachers and students, peer groups, etc., the sequences of interaction that seem to precede and follow the occurrence of a particular problem. A parent's use of harsh and inconsistent discipline, for example, is often one proximal cause of aggressive behavior. In one family, the factors that contribute to the harsh discipline practices may include long work hours, marital problems, and lack of knowledge about parenting. In another family, the parent may have the necessary knowledge and skills but suffer from depression and lack the social support needed to implement them. In both families, the parent's discipline style is a direct and proximal cause of the aggressive behavior. The work hours, marital problems, depression, and so on, have an indirect or more distal effect on the boy's aggressive behavior but a direct effect on the parent's discipline style.

Early in their work as MST therapists, clinicians often identify numerous distal factors (e.g., divorce that occurred 7 years ago, parent who has been in prison for 5 years) they believe are related to referral problems but fail to articulate how these more distal factors are linked with more proximal factors (e.g., permissive parenting) and the target behavior (e.g., doing drugs with antisocial peers). Supervisors should ask clinicians to provide evidence that links indirect influences with direct influences, and direct influences with one or more target behaviors. The fact that a father is in prison, for example, does not explain a youth's drug use. To be relevant to "fit," and therefore to develop intervention plans, the clinician would need evidence that the father's prison term directly or indirectly influences interactions at home, school, or with peers that sustain the youth's drug use. Did father's imprisonment necessitate mother taking a second job, and therefore not monitor her son's whereabouts? Did father act as primary disciplinarian? If evidence suggests that monitoring decreased and discipline became more lax as a result of the prison sentence, the sentence could be seen as a distal influence on drug use. The more direct influences, however, and those amenable to change (a prison sentence is not) are the monitoring plans and parenting style of the mother.

Hypotheses are generally tested by evaluating the effects of interventions derived from those hypotheses. If interventions designed to increase consistency and decrease the use of harsh punishment were implemented and measurable decreases in the child's aggressive behaviors followed, the team would have some evidence to support the hypothesis that inconsistent and harsh discipline strategies were direct contributors to the child's aggression. Similarly, if interventions to address maternal depression and increase social support were required to enable the parent to use more consistent and less harsh discipline, the team would have evidence that these more distal factors were directly related to the discipline and

indirectly related to the aggressive behavior.

IDENTIFYING PROCESS BARRIERS TO PROGRESS

The Analytic Process (AKA, Do Loop) (Figure 2) can be used in supervision to help locate sources of progress and problems in terms of tasks in the ongoing assessment and intervention process. Indeed, the Weekly Case Summary Form (Figure 3) completed by clinicians is designed to capture information about each step in this process. Supervisors generally report that referring to the "Do Loop" in supervision helps clinicians to:

- Prepare for supervision more proactively by organizing the week's experiences with client families in terms of implications for one or more of the tasks (e.g., fit, intermediary goal revision, barrier detection, etc.).
- Identify the sources of their difficulties when case progress is slow (e.g., a therapist realizes he or she implemented new parenting interventions before analyzing the barriers to success of previously implemented interventions).
- Reduce "random acts of intervention," and thus the frustration and discouragement that can build when clinicians and families perceive that they are spending considerable energy trying many different things with little effect.

In addition, supervisors report using the "Do Loop" to help manage unproductive narrative or storytelling. When the purpose of narrative is unclear, supervisors often ask clinicians to label the information conveyed in terms of its relevance to one or more tasks on the loop.

Team Building: The Culmination of MST Structure and Process

Virtually all aspects of the structure and process of MST teams should contribute to team building, and the supervisor is primarily responsible for assuring such. The advantages of the small group format (e.g., learning from each other, providing support, practicing interventions, covering for each other during vacations) require professionals to come together as a team under the leadership of the supervisor. The preparation required (e.g., completion of goal-oriented paperwork prior to meetings) and structures for meeting (e.g., rules regulating attendance, scheduling of supervisory sessions) are similar to those of other team-oriented organizations (e.g., corporate, athletics). Teams do not develop overnight. As individual professionals support each others' development, facilitate each others' capacity to achieve favorable outcomes for children and families, and develop a collaborative history, they will become a team.

For supervisors, the leadership skills needed to develop a team are comprised, in large part, of the skills needed to maintain the structure and process of supervision. That is, by definition, a successful MST supervisor is someone whose team is maintaining the structure and process of MST supervision, which will lead to favorable outcomes. The next section presents common reasons for problems in maintaining the structure and process of supervision, with corresponding suggestions for addressing the problems.

Common Reasons for Difficulties in Maintaining the Structure and Process of Supervision

Difficulties in maintaining the structure and process of supervision are often evidenced by low morale during sessions, team members missing sessions or coming late to sessions, and a lack of productivity during sessions. Such difficulties may reflect fundamental and programmatic problems in understanding and implementing the MST treatment protocol. For example, team members may have limited understanding of the engagement process, the analysis of fit and hypothesis development, the design and implementation of interventions, or the process by which barriers to implementation are identified and over-

come. In such cases, the supervisor should refer to the corresponding sections of this manual.

On the other hand, problems in maintaining the structure and process of supervision might reflect an underlying difficulty in the supervisor-clinician relationship. Essentially, the supervisor is not in control of supervision or is not fulfilling the supervisory role effectively. If such is the case, a critically important component of MST quality assurance is lost, and the integrity of the program is threatened. Well-functioning MST programs require a series of checks and balances, in which adherence is promoted at several levels (i.e., by other practitioners on the team, the supervisor, and the MST consultant). Low supervisory effectiveness may reflect several circumstances, each of which is serious and must be addressed.

The Supervisor Possesses the Requisite Expertise, But Lacks Management Skills

The supervisory role requires both clinical expertise and leadership (management) skills. A professional can possess strong clinical expertise, but not necessarily have the skills to effectively manage other practitioners. In other words, highly skilled clinicians do not necessarily make strong supervisors. Two skills essential to the efficient functioning of supervision should be developed by individuals who wish to retain the supervisory role but lack management skills.

SETTING THE OBJECTIVES OF SUPERVISION

A critical strategy in managing group interactions involves labeling the objectives and rationale underlying supervisory feedback. For example, a supervisor often will begin asking a series of questions related to clinician engagement, or to the clinician's understanding of the "fit," without indicating that these are the topics being pursued. Other members of the team, also developing questions as the clinician speaks, often "chime in" with their questions once the supervisor has begun a line of inquiry. Usually, the questions are related to the supervisory objective and useful. Sometimes they are not, as occurs when one or more team members focus on interesting but unimportant details. As a result, clinicians may spend a considerable amount of time trying to answer a variety of questions without either addressing the supervisor's concerns or having a clear understanding of next steps to be taken with the family. Hence, supervisors should label the underlying purpose of a line of questioning on the front end (e.g., "Even though you're 8 weeks into the case, I'm asking about alignment because . . ."), thereby priming the clinician and team to the topic of interest and managing potentially unproductive interactions. Similarly, the supervisor can ask team members to ask or comment only on the issue or topic identified by the supervisor or to hold questions until a particular point of clarification has been made or objective has been met. Finally, such labeling conveys respect for the team and may enhance clinicians' ability to generalize from supervisory feedback on one family to similar dilemmas in other families.

STAYING ON TASK

Balancing the task- and goal-directed nature of supervision with collegial give-and-take and enjoyment requires active management of the interpersonal processes during group supervision. As noted earlier, the supervisor has the ultimate responsibility for managing this process. Thus, when clinicians provide extensive narrative about details, events, conversations, and treatment sessions that were particularly interesting, amusing, or disturbing, the supervisor will need to help the clinician evaluate the utility of the narrative in regard to MST case conceptualization and intervention design. To assist in this endeavor, the supervisor should try to identify whether the narrative: (a) conveys new information that changes the team's overall case conceptualization or understanding of the "fit" of the identified problems with the ecology; (b) provides new information about potential strengths that can be used as levers for change, or about barriers to change previously unknown to the family and therapist; or, (c) provides new information about the extent to which interventions have been specified, implemented, or monitored adequately. If the narrative does not convey such new information, the supervisor should label such and return to the pri-

mary goals of supervision (i.e., promoting therapist adherence and youth outcomes).

The Supervisor is Knowledgeable, But is not Fulfilling the "Teaching" Role

Group supervision is a forum in which participants teach and learn from one another continuously through discussion, brainstorming, problem-solving, and so forth. Additional learning takes place as the supervisor models professional demeanor and behaviors during supervision. Thus, for example, supervisors who disparage families and complain about community agencies teach therapists to belittle and complain. For these reasons, supervisors should use positive reinforcement liberally with colleagues, avoid the use of pejorative language, and discourage complaining among team members. The supervisor leads team efforts to solve problems and applauds the efforts and successes of team members.

In addition to modeling an optimistic problem-solving approach, the supervisor also might teach more directly on occasion. At times, short "lessons" might be needed about a particular MST principle, treatment technique, or conceptual problem to help clinicians generalize lessons learned with one family to others, learn the steps of an intervention, or break through a conceptual impasse. Thus, it often becomes apparent that a few minutes of didactic "teaching" about a particular principle, treatment modality, or intervention technique would benefit one or more clinicians on the team. For example, a clinician who, across several families, seems to "do for" families instead of designing interventions that enable families to do for themselves, may need a brief reminder about the rationale underlying MST Principle 9 (generalization). Similarly, the supervisor may briefly describe some aspect of cognitive behavioral or marital interventions if one or more members of the team have little background or experience in these areas but need to consider the possibility of implementing these interventions with a current family. Although the point of Principle 9 and the central features of behavioral interventions may have been made many times previously, the supervisor should not assume that the clinician always understands these issues, especially when evidence is to the contrary. Hence, the supervisor should be aware and take advantage of "teaching moments" that arise during supervision.

The Supervisor is Too Directive or Too Nondirective

When clinicians are new to MST, supervisors may rely more heavily on directive methods of facilitating clinician adherence to MST principles because clinicians ask for and need such assistance. As clinicians gain more experience with MST, however, supervisors must balance participatory methods with directive feedback.

TOO DIRECTIVE

Some supervisors frequently tell clinicians what to do, or what to do differently, without first understanding what the clinician has done to date or why the clinician had planned to pursue a particular course of action. When supervisors consistently tell without asking, and rely too heavily on directive methods of cultivating clinician understanding of MST principles and practices, they run the risk of breeding clinician compliance in the absence of understanding. Such compliance is not conducive to generalization, and may lead to clinician dissatisfaction with supervision and with MST.

Signs that clinicians are complying in the absence of understanding include:

- Clinician passively accepts supervisory advice.
- Advice repeatedly given is not implemented by the clinician.
- Advice is implemented in one family, but not in others where it seems obviously applicable and useful (i.e., does not generalize).

- Clinician reports doing what the supervisor wants, without owning the interventions (e.g., "I did what you said").
- Advice is openly rejected.

When faced with any of these clues, supervisors should resist the temptation to continue to tell or give advice and recommendations, and instead elicit the clinician's perspective on the recommendations. Again, the supervisor's objective is to understand the "fit" of the clinician's behavior–in this case, failure to implement recommendations–before either persisting in ineffective supervision strategies or changing those strategies. In addition, supervisors should assure that clinicians have understood, and see the necessity for, implementation of a recommendation by asking them to describe the recommendations in their own words and how they plan to put the recommendation into action. In short, supervisors should ascertain what clinicians are taking away from supervisory recommendations and group supervision sessions. Subsequent case summaries provide another glimpse into the clinician's understanding of the family and extent to which supervisory feedback is incorporated.

TOO NONDIRECTIVE

Other supervisors are reluctant to use any directive strategies in supervision. For example, when aware of an objective the supervisor wishes the clinician to meet, the supervisor may ask a series of questions about the as yet unstated objective in the hopes that the clinician will arrive at the answer independently. Although approaches that encourage individuals to arrive at conclusions for themselves can facilitate learning and generalization, this process can be frustrating and inefficient for all team members if closure is not reached in a reasonable duration of time. Signs that the supervisor is too nondirective include:

- Supervisory sessions meander and seem confused.
- Little is accomplished during supervision.
- Team members are bored during supervision as irrelevant case details abound.
- The structure of supervision is falling apart, with absences, poor punctuality, and inattention among team members.

If these signs are observed in a context in which the supervisor knows what interventions should be occurring with the families, the supervisor is likely not communicating this knowledge in a sufficiently directive fashion. On the other hand, if these signs occur in a context where the supervisor is uncertain of clinical direction in the families, the difficulty most likely pertains to other therapist-level or supervisor-level difficulties discussed in this manual.

AIM FOR A BALANCE

Parallels are evident in the parenting, teaching, and management literatures with respect to the balance between demandingness and responsiveness in interpersonal interactions that contribute to positive outcomes for youth, students, and employees. Essentially, when the nature of work requires the responsible exercise of autonomy, expertise, and creativity, supervisory and organizational structures that are too directive, rigid, and hierarchical are likely to breed resentment and limit productivity. Conversely, supervisory and organizational structures can be so loosely defined and lax that accountability for performance and outcome are difficult to achieve, and productivity is hampered.

We have not yet conducted formal evaluations of the nature of supervision and the extent to which variations in the process or style are associated with therapist adherence and youth outcomes. Nevertheless, we suspect that supervisors who are unable to strike a balance between being overly directive and overly lax may not be effective facilitators of treatment adherence, or, alternatively, may achieve adherence but at

the cost of high clinician turnover. Hence, we recommend that supervisors who find it difficult to "push" a clinician to make needed changes, or, alternatively, who are inflexible in their directiveness and suspect that clinicians are complying (or not!) rather than learning, should enlist the assistance of the MST consultant working with the team. Based on experience with the team gleaned during weekly telephone consultations, quarterly booster sessions, and ad hoc consultation, the consultant should be able to help the supervisor identify and alter patterns of interaction that might be contributing to ineffective management of the group supervision process.

The Supervisor May Lack Clinical Expertise in General and MST Expertise in Particular

Clinicians are unlikely to follow the leadership of a supervisor who seems less skilled and knowledgeable than themselves. Clinicians care about the outcomes of their families, are being held accountable for outcomes by program administrators, and, consequently, will discount the consultation of supervisors who are not viewed as credible. In cases where the clinicians' perceptions of low supervisory expertise are accurate, two solutions seem viable.

INCREASE SUPERVISOR EXPERTISE

The supervisor may need to take "crash courses" to develop the repertoire of skills and breadth of knowledge needed to be an effective supervisor. In collaboration with the program administrator and MST consultant, we recommend that the advantages and disadvantages of this plan be weighed. If pursued, an individualized "supervisory training"" program should be developed with clear goals by which to judge the supervisor's progress.

CHANGE PROFESSIONAL POSITIONS

Courage is needed for a supervisor to admit that he or she may not be a good fit for the supervisory position. A voluntary move to a different position, however, is greatly preferred to the slow "twisting in the wind" that supervisors who lack expertise are likely to experience as complaints flow up the administrative hierarchy and those in charge address the "problem."

The Clinician Does not Appreciate His or Her Role on a Team

A subset of clinicians believe that "they know best," irrespective of feedback from supervisors, families, and outcome measures. Interactions with clinicians who "know it all" can be extremely taxing for the supervisor and unpleasant for other team members as well.

In such cases, we recommend that the supervisor and program administrator have a serious discussion with the clinician regarding the job description of an MST therapist, the job for which the clinician is being paid. Included in the job description are: providing MST, as defined by adhering to the treatment protocol; collaborating with and supporting colleagues on the team; and following rigorous quality assurance mechanisms, of which supervision is an essential part. The meeting should emphasize that MST clinicians, regardless of their amount of experience in the field, participate actively in supervision to promote treatment fidelity. Indeed, our anecdotal and research data (Schoenwald, Henggeler, Rowland, & Hoagwood, 1998) clearly support the importance of supervision even for highly experienced MST therapists. Following this discussion, the clinician may or may not wish to continue working on the team. If continued employment by the MST program is desired, clear performance criteria should be specified and tracked (e.g., attendance and demeanor during supervision, evidence of progress on weekly case summary forms, adherence scores based on family ratings on the MST process measure). Alternatively, the supervisor and administrator may decide that the clinician has low potential for engaging in such collaboration, and act accordingly.

From Referral Problems To Goal Setting

Clarifying Reasons for Referral

Generally speaking, youth referred to MST programs are at imminent risk of out-of-home placement and engaging in antisocial behavior in the community, school, and/or home. If a referred youth is not at risk of placement or displaying serious antisocial behavior, the clinician should contact the referral agency to clarify the reasons for referral. In one community, for example, school personnel who heard about the MST program began referring youth who were chronically truant but had no involvement with other agencies and were not at risk of placement. After receiving two such referrals, the supervisor met with the director of the provider organization that housed the MST program to discuss the nature of the referrals and the extent to which they were appropriate for MST. If parameters regarding referral criteria and target populations for MST are not clear to the supervisor, she or he should clarify them with the organizational leadership, community organizations providing referral and reimbursement to the MST program, and MST consultant.

Developing Overarching Goals

An overarching goal is an ultimate aim of treatment that:

- Eliminates or greatly reduces the frequency and intensity of a referral behavior
- Incorporates the desired outcomes of key participants (e.g., primary and secondary caregiver, teacher or principal, probation officer, judge, etc.)
- Can be measured directly
- Is written so that any outside observer would interpret the goal the same way and could determine whether or not the goal was met

For example, "no further arrests," and "no further involvement with the juvenile justice system" are goals that can be objectively documented through probation, arrest, and court records. In contrast "increased self-control," cannot be observed or documented in similarly concrete terms, and opinions regarding the extent to which self-control has increased may vary among family members, teachers, and legal authorities. Alternatively, if a child referred for MST has not yet committed a crime but frequently starts physical fights with peers and siblings and destroys others' property, an overarching goal may read, "Decrease antisocial behavior as evidenced by decreased frequency of fights with peers and siblings and no further destruction of property." Without the "as evidenced by" clause, the nature of the behavior to be changed is ambiguous (i.e., lying, stealing, fighting, car theft, assault and battery are all antisocial behaviors) as is the extent to which observers could determine whether the goal was met.

In most cases of youth referred for serious antisocial behavior, there are three or four overarching goals of MST treatment. Jeff, for example, was referred by juvenile justice following his third arrest for assault and car theft. The county child protection agency also had an open case for Jeff's family because Jeff had pulled a knife on his father during a domestic violence incident. In addition, Jeff was frequently truant and occasionally suspended from school. Thus, the overarching goals of MST treatment were:

- Eliminate criminal activity resulting in contact with the juvenile justice system.
- Attend school all day, every day unless physically ill or having an excused absence.
- Decrease suspensions to one this semester and zero next semester.
- Decrease family violence sufficiently to end child protective service involvement.

Well-written overarching goals developed by key participants establish clear criteria for treatment success, and therefore, for treatment termination. To establish such goals, clinicians should be able to pull from the desired outcomes of each key participant (each caregiver, referral agencies, teachers, etc.) the common threads of an overarching goal. In Jeff's case, mother, father, the judge, and Jeff's probation officer all stated that they wanted Jeff to stop criminal activity and stay in school. Thus, the clinician was easily able to achieve consensus on the first three overarching goals. In contrast, the clinician had difficulty identifying a common goal from among the desired outcomes of family members and the child protection agency regarding family conflict. Jeff's mother said she needed "peace in the household." Jeff's father wanted to "get these government agencies out of our family's personal business." Jeff wanted permission to defend himself and his mother when his father became physically threatening. The child protection agency wanted evidence that Jeff and his father would not physically harm one another before it would close the case. The clinician's first strategy was to try to get the family members to agree to "reduce the amount of family conflict," but an argument quickly began regarding the amount of conflict experienced by various family members and who was at fault for the conflict. Jeff's mother said the conflict was rare but intense, Jeff said his parents argued all the time, and Jeff's father said that there would be no conflict at all if Jeff simply did as he was told. When the clinician presented the case to the team, the supervisor pointed out that the father's desire to get agencies out of his family's business could be seen as consistent with the mother's desire for peace in the household. The team brainstormed about ways to phrase the goal that would incorporate the desires of both parents and be measured objectively. Thus, to accommodate all parties, the goal was framed in terms of reducing family violence sufficiently to end child protective services involvement.

Overarching goals often need to be prioritized. When a referred youth is both at imminent risk of physical abuse and truant from school, assuring safety in the home would most likely be seen as more critical than assuring regular school attendance in the early days of therapist involvement with the family. In the case of Jeff, preventing further criminal activity and reducing family violence were seen as equally important in principle. Practically speaking, however, Jeff's criminal activities occurred more frequently than incidents of family violence. As importantly, the team and family knew that the negative consequences of the criminal activity would be swift, immediate, and long lasting because the judge ordered that any violation of Jeff's probation terms result in his immediate incarceration. In contrast, incidents of family violence had been reported twice in one year, had not resulted in injury to any family member, and had not involved weapons until the most recent incident in which Jeff threatened his father with a knife. Thus, the team and family implemented several intervention strategies to monitor Jeff's whereabouts (a step toward reducing opportunities to engage in criminal activity) and to remove all weapons from the home within the first week of treatment. Intermediary goals and interventions to reduce family conflicts were introduced in subsequent weeks.

Overarching goals may be added or eliminated in accordance with information obtained as the clinician and family continue the assessment process. In Jeff's case, part of the parental monitoring plan put into place during the first week of treatment involved having a neighbor who worked in the school cafeteria keep an eye out for him. The neighbor said she had seen him with people she believed to be gang members. Jeff's mother contacted the arresting officer to find out if he could verify this information. The officer did so and also described Jeff as a "gang wanna-be." Thus, the overarching goal "Eliminate association with gang-affiliated peers and increase association with prosocial peers" was added.

Engagement Of Family Members

Treatment can not progress unless key family members are engaged and actively participating in the treatment process–helping to define problems, setting goals, and implementing interventions to meet those goals. The MST team may have developed a "brilliant" set of intervention strategies, but such strategies will have little value in the absence of a strong therapeutic alliance. Team members must remember that parents and other family members are essential to achieving positive outcomes, and such outcomes are almost always accomplished through hard work by the family members. Family members (and clinicians!) who are not engaged in treatment are unlikely to put forth the effort needed for favorable outcomes. Hence, concomitant with a thorough assessment process, practitioners should be working to achieve strong engagement from the time of their first contact with the family.

Before discussing the signs of engagement and solutions to difficulties in engaging family members, we should emphasize that low engagement is virtually always a solvable problem given the necessary desire and commitment of the MST program. For example, individuals with substance abuse problems have historically had extremely high dropout rates. Yet, in a randomized trial of MST with diagnosed substance abusing and dependent juvenile offenders, 98% (57 of 58) of families randomly assigned to MST treatment were fully engaged in the treatment process (Henggeler, Pickrel, Brondino, & Crouch, 1996) and completed a full course of treatment. Because engagement is a bi-directional process, this section of the manual focuses on both practitioner-level and family-level reasons for poor engagement, and recommendations for verifying and addressing such barriers are presented.

Evidence of Engagement versus Non-Engagement of Family Members

When clinical progress is slow or progress seems to have stalled, a common reason is that key family members (i.e., the child's caregivers, those adults who control family resources or have decision-making authority) are not truly "on board" with the treatment plan. Although the therapist may have believed that the family was engaged, a closer look might reveal otherwise. Often, we (therapists, supervisors, consultants) assume that family members are committed to a particular treatment goal that seems logical to us, but may not be viewed in the same way from the perspective of family members. In any case, engagement is a precursor to successful outcome, and, fortunately, the behavioral signs of engagement are available for observation.

SIGNS OF ENGAGEMENT

Indicators of engagement include, for example:

- **High rates of attendance at sessions**–Assuming that sessions are scheduled at convenient times for family members.
- **Completion of homework assignments**–The provision of daily and weekly assignments linked with treatment goals provides an excellent opportunity to track participant engagement and efforts. Hard work, whether successful or not, almost always reflects family engagement.

- **Emotional involvement in sessions**–Engagement is indicated when family members are lively and energetic during sessions, actively debating and planning intervention strategies. Although the absence of emotional involvement does not necessarily mean that family members are not engaged (i.e., some families have a very low-key style, but are sincerely motivated), the presence of emotional energy generally reflects engagement.
- **Progress is being made toward meeting treatment goals**–Almost by definition, families who are progressing toward their goals are engaged in the treatment process.

SIGNS OF ENGAGEMENT PROBLEMS

Several sets of behaviors can reflect a lack of engagement of family members in the treatment process. That is, a lack of engagement should be considered as one of the possible explanations of the "fit" of the following behaviors.

- **Difficulty scheduling appointments**–If the family is only willing to schedule, for example, one appointment per week, they are probably not engaged in the treatment process.
- **Missed appointments**–When a high rate of appointments are missed after family members have agreed, a priori, on meeting times, a lack of engagement is often indicated.
- **Intervention plans are not being followed**–Plans may not be followed for a number of reasons (e.g., members don't understand or agree with the plan), one of which is low engagement.
- **Goals of the family contain little of substance**–In some cases, families will "go through the motions of treatment" as a strategy to eliminate social service involvement from their lives in the shortest time possible. A clue to this strategy is that the family targets difficulties that are minor in nature, while choosing to ignore far more serious problems identified by the therapist and referral sources.
- **Treatment progress is very uneven**–Treatment progresses slightly and then stalls, progresses slightly and then stalls, and so forth. Such outcomes often reflect the ambivalence of family members toward the treatment process, and, concomitantly, a lack of engagement.
- **Family members lie about important issues**–Family members provide important information that is directly contradicted by other credible sources (e.g., parent says the child was not expelled from school, whereas the principal says that he or she was expelled).

Practitioner-Level Reasons for Low Engagement–and Possible Solutions

In many cases, the primary reason for low engagement pertains to therapist characteristics and training history. Few graduate training programs place great emphasis on developing engagement skills, but such skills are critical for MST. Hence, as discussed in *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* (Henggeler et al., 1998), supervisors and therapists are expected to understand and ably execute several processes that facilitate family engagement in treatment, which include:

- Articulating the rationale, possible benefits, and structure of treatment
- Emphasizing the identification, acknowledgment, and enhancement of family strengths
- Taking a collaborative approach with families and viewing families as full partners in the treatment process
- Having treatment goals set primarily by the family
- Making appointments and providing services at times that are convenient to the family

- Assuming responsibility for, and overcoming any barriers to, engagement

Again, competence in the above processes is essential to MST practitioners and supervisors, and the specifics of these processes are delineated in the aforementioned treatment text. Here, attention is devoted to other therapist-level barriers to family engagement that supervisors may encounter, and recommendations are made for addressing these barriers.

CHILD-CENTERED VERSUS FAMILY-CENTERED

Many practitioners decided to specialize in working with children because they truly enjoy interacting with and helping children to develop. Conversely, some of these practitioners do not particularly enjoy or possess the requisite skills to implement treatment with adults, especially when the adults are not very effective with their children (e.g., too harsh, permissive, or neglectful). An underlying assumption of MST, however, is that favorable child outcomes are gained primarily by developing the capacity of caregivers to be more effective parents. Thus, MST clinicians work primarily with parents to overcome barriers to their effectiveness, and devote relatively little time to working with children individually.

When therapists are spending a larger than usual amount of time providing individual treatment to children, a "red flag" should go up for the supervisor. Even if progress seems satisfactory with the family and the caregivers are engaged, the therapist's individual emphasis likely will attenuate chances for long-term maintenance of change. Moreover, if the family is not progressing, caregivers likely are not engaged in the treatment process, and the therapist is unaware of or choosing to ignore the issue of engagement.

To assess the possible problem of child-centered practice by an MST clinician, the supervisor should ask the clinician to justify the fit of the individual child-based interventions and describe the plans to assure that resulting treatment gains will be maintained. The supervisor must then judge whether the descriptions and plans adhere to the MST treatment principles or appear to reflect an unchecked preference for child-centered practice on the part of the clinician. If the latter, the supervisor should further examine the clinician's assumptions and beliefs about the processes that drive clinical change. For example, the clinician might believe that favorable outcomes are primarily determined by increasing a child's self-esteem, and, therefore, the therapist is personally attempting to raise the self-esteem of a child who receives little positive feedback from the family. Although such assumptions regarding clinical change have legitimacy in some mental health circles, they do not fit an MST perspective.

Basic differences in the theoretical assumptions that underlie MST programs and those of individual practitioners in the program can lead to difficulties in achieving treatment fidelity and outcomes. The supervisor must address these differences, as stressful as such may be. Although the MST training protocol attempted to explicate the research literature on the causes of serious clinical problems in children and adolescents and the favorable long-term outcomes achieved by MST in randomized clinical trials, the clinician might not have followed the logic of the linkages between theory (i.e., social ecology), empirical support for the theory (i.e., the causal modeling literature for delinquency and substance abuse), treatment implications of the theory (i.e., MST), and empirical tests of the implications (i.e., MST outcome studies). The supervisor should carefully help the practitioner to understand these linkages, with the assistance of the training materials. Hopefully, the clinician's understanding of the logic of MST will increase, and the therapist will commit to a family-focused approach. Additional strategies for facilitating convergence between clinicians' previous training and experience with MST are described in the discussion of common barriers to clinicians' understanding of fit, and of clinician development in Sections 4 and 6 of this manual, respectively. If convergence between clinician's previous training and the requirements of MST can not be resolved, a fundamental schism between the MST program and the practitioner will be clarified. The supervisor and program administrator might then help the therapist appreciate that he or she is ill-suited for the role of MST therapist.

CULTURAL NON-CONNECT

Clinicians are typically middle class and the majority of families receiving MST tend to be economically disadvantaged. Irrespective of race, a common therapist barrier to engaging a family is a lack of understanding of and appreciation for cultural or values-based differences. For example, a middle class therapist of any race may have difficulty with the apparent low regard for education evidenced by a father who periodically keeps his eldest daughter home from school to help care for her younger siblings. Similarly, the clinician might express bewilderment with a mother with five children, each having a different father and none of whom are involved in the family's life.

To assess the possibility that a cultural non-connect (because of differences in racial background or socioeconomic status) is associated with engagement problems, the supervisor might have the therapist describe circumstances from the caregiver's point of view. If the clinician has significant difficulty putting himself or herself in the caregiver's shoes, the likelihood is high that critical components of MST are not being communicated effectively from the clinician to the family (i.e., identifying family strengths, viewing families as full partners in treatment). The failure to communicate these components will negatively impact engagement. Several processes can be used to prevent a cultural non-connect or to address one that appears.

- The best prevention strategy is to hire clinicians who have broad cultural experiences and value cultural diversity. MST programs should endeavor to recruit staff from a variety of cultural backgrounds. We favor professionals who grew up in the communities that are being served or have had extensive prior experience working in those communities. Similarly, flexibility is a highly valued quality in therapists, and rigidity should be avoided.
- The supervisor might turn to different members of the MST team when a clinician's personal prejudices are affecting clinical judgments or the engagement process. Team members may help the clinician to appreciate better the life circumstances of people with serious psychosocial problems. For example, occasional opportunities for emotional intimacy may be worth the downside of an alcoholic boyfriend for a lonely mother with little adult support in her life.
- A fundamental characteristic of successful MST programs is respect–respect for families, for colleagues, for professionals from other agencies, and so forth. Clinicians can disagree adamantly with parents about the benefits/costs of certain parental actions. Discussions, however, must be conducted within a context of mutual respect. Otherwise, the clinician will not be capable of effecting positive change, even if he or she prevails in the discussion. Supervisors are instrumental in promoting this value of respect through their own interactions with clinicians, families, and other colleagues.
- When the requisite expertise for cultural understanding does not exist within the MST program, the supervisor is responsible for identifying this gap and for determining appropriate resources in the community. For example, many families of the hearing impaired have a distinct culture and social network that differs from the networks of the hearing. Community resources may need to be tapped to gain an understanding of that culture if a lack of understanding seems to be associated with low engagement of a family with hearing impaired members.

DISCOMFORT WITH THE ISSUE NEEDED TO BE ADDRESSED

Certain types of "private" issues can be difficult for some clinicians to address, and failure to assess key aspects of the social ecology can lead to low engagement and negligible clinical progress. For example,

inexperienced therapists often are hesitant to assess the couple's satisfaction with their sexual relations (an important index of their emotional intimacy) or inquire about the history of spousal abuse in situations that warrant such determination. In such instances, the supervisor can have the therapist practice intimate lines of questioning with team members to gain greater comfort. Similar to graduated exposure procedures for decreasing client anxiety, the therapist's discomfort will decrease eventually with continued exposure and practice dealing with the sensitive issue.

In other instances, the therapist's discomfort may relate to issues that hit too close to home. For example, a therapist was not addressing parental and youth substance abuse effectively because his own daughter had recently been arrested for drug dealing and the therapist felt overwhelmed by the challenges the family was presenting around this issue. As the supervisor began to recognize that the therapist was having difficulty dealing with drug-related problems, she met privately with the therapist to evaluate any special barriers in this regard. During the private discussions with the therapist, the supervisor learned about the therapist's problems, and individualized plans were made to help the therapist overcome his feelings of ineffectiveness. These plans emphasized (a) that individuals can be effective as therapists in spite of problems in their personal lives, and (b) that the therapist now was doing everything within his power to help his daughter with her drug problem.

REPULSED BY THE BEHAVIOR OF A FAMILY MEMBER

Certain types of human behavior (e.g., sexual abuse, physical abuse, domestic violence) are naturally repulsive to therapists and other caring people. Although these behaviors normally evoke negative emotions and possible desire for retribution, therapists who display such reactions will usually have difficulty engaging key family members in treatment. Without doubt, for example, fathers who are sexual perpetrators of their children deserve a certain level of disdain. If such disdain is delivered by the family's primary change agent, however, the clinician's effectiveness will be clearly compromised.

If the therapist's repulsion causes low engagement, it is usually not difficult for the supervisor to detect. The supervisor can track (a) his or her own feelings about the family (i.e., if the supervisor is repulsed, the therapist is probably repulsed), (b) observe the verbal and nonverbal cues of the therapist when discussing the family and especially the perpetrator, and (c) observe the reactions of other team members to the family. If an attitude emphasizing punishment of a family member prevails, it's a good bet that engagement and treatment outcome will be compromised, unless, of course, the perpetrator has been removed from the family by legal authorities or other family members. In most cases, however, perpetrators will retain an important and often powerful role in the family.

Therapists who can not align and collaborate with perpetrators will have only modest success working in MST programs because many of the families include individuals who have engaged in illegal, distasteful, and harmful behaviors. Given that collaboration with all family members is the most reliable and productive way to decrease the probability of future victimization of children, the supervisor must help the therapist find a way to collaborate. Collaboration does not equal condoning, and the therapist is not expected to "like" each family member. Rather, as with all MST interventions, the therapist must be able to identify the strengths of the systems and help the family to change their social ecology in ways that make future abuse less likely (e.g., opening communication channels, developing indigenous support systems, helping the family set rules and limits effectively for both child and adult behavior).

Thus, supervisors must help therapists to control their negative affect in such cases and to identify the strengths in the family. One strategy for motivating oneself to engage and collaborate with someone viewed negatively is to focus on the larger goals–that is, reducing the chances of reabuse by promoting the development of child and caregiver competence. Expressing anger toward the perpetrator might feel good to the therapist, but such expressions will block opportunities for collaboration, and, consequently, be of

little value to the children and other family members.

Another strategy for helping therapists to control their negative affect has been coined the "cup of coffee" intervention. Here, the therapist puts clinical assessments and interventions on hold and spends considerable time with the family member who is evoking the negative affect (e.g., the perpetrator). The therapist's goal during this time is to gain an understanding of the caregiver's view of the world and to examine the fit of the behavior that is annoying the therapist. Usually, as the therapist appreciates the caregiver's own social ecology, negative affect decreases and the development of a therapeutic alliance is promoted.

Finally, it must be emphasized that child safety is always a high priority in MST programs. Guidelines presented in the MST treatment volume (Henggeler et al., 1998) and legal statutes should be followed if a child is at risk of harm from others. The preceding discussion about working with perpetrators assumes that the present risk of maltreatment is minimal and that the perpetrator is actively working to prevent reoccurrence of the maltreatment. If such is not the case, the development of safety plans is one of the therapist's first priorities.

THERAPISTS' PERSONAL PROBLEMS

Families may not be engaged because therapists' personal problems are interfering with clinical effectiveness. Such problems include, for example, drug abuse, mental health difficulties (e.g., depression, bipolar disorder), marital discord, financial problems, and so forth. The provision of MST is a complex process, and practitioners need all their resources to be successful.

As an experienced mental health professional interacting with the therapist on a regular basis, the supervisor is in an excellent position to identify whether personal problems are linked with difficulties in engaging families. Most likely, treatment progress will be suffering across the clinician's caseload. As indicated earlier in this manual, the supervisor is responsible for promoting adherence to the MST protocol among clinicians, but the supervisor should not be functioning as a personal "counselor" to the clinician. Rather, the role of the supervisor in this situation is to help the clinician to determine whether personal problems are interfering with his or her effectiveness. Then, if so determined, the supervisor can help link the therapist with appropriate mental health or substance abuse resources. Thus, the supervisor's role is to examine the fit of poor therapist performance (engagement included), and if personal problems are identified as contributors to poor performance, the supervisor should link the therapist with appropriate resources. The supervisor is not responsible, however, for monitoring the therapist's personal progress in treatment. The supervisor's primary responsibility and concern pertain to the outcomes that the clinician is obtaining with his or her caseload, which should be judged based on practitioner adherence to the MST protocol and the degree to which youths and families are meeting their identified goals.

STRESS AND BURNOUT

Providing intensive in-home services to families with multiple needs is clearly stressful and can lead to therapist burnout. Therapists who are overly stressed and disheartened are likely to have low rates of engagement and effectiveness. Families who are under considerable stress are not likely to be energized by clinicians who are burned out.

Again, the supervisor, as an experienced mental health professional, is in an excellent position to identify this difficulty. In addition to lack of clinical progress, cues that a therapist is overly stressed include high rates of sick leave, lethargy and a lack of enthusiasm during supervision, difficulty focusing on the positive, and difficulty developing and implementing interventions.

Verification of therapist stress as a barrier to engagement and effectiveness usually can be obtained by the supervisor through direct questioning in a private meeting with the clinician. In attempting to understand the determinants of stress for the therapist, the supervisor should examine possible contributors across the

therapist's ecology. For example, individual cognitive variables might include the self-defeating belief that the therapist is a failure unless all families improve, or irrational feelings that family treatment gains should be much more dramatic than are being achieved. In addition, the supervisor should examine the possibility that the MST team and program, supervision included, are not functioning in a sufficiently supportive manner. For example, perhaps team members are not providing requisite support and backup during "off" hours (i.e., the therapist's personal time off), or the clinician is not benefiting as needed and intended from supervisory sessions. The possibility should also be explored that the provision of intensive home-based services as a career path does not meet the personal needs of the therapist at this time (e.g., the therapist has young children at home and the irregular hours of home-based services are disruptive to his or her own family life).

In collaboration with the practitioner, the supervisor should develop and implement interventions that address the identified determinants of stress. For example, in one MST program in which the clinicians were refusing to go off call for their personal caseloads (i.e., consequently, they were always on a 24-hour call schedule, and had no guaranteed time off), the administrators compelled the clinicians to adhere to a schedule in which they regularly relieved each other from being on call 24 hours a day, 7 days a week. Similarly, the supervisor may be assuming that clinicians are learning more from supervision than they actually are. This problem is common for experienced supervisors who quickly recognize the determinants of clinical problems and move rapidly to the corresponding solutions. Therapists who are less experienced than the supervisor, however, may need help "walking through" the sequence from fit to hypotheses to interventions to understand the complete clinical conceptualization. Finally, stress and burnout can be contagious, or rather, program-wide factors that contribute to stress for one therapist are probably contributing to stress for others as well. Hence, every effort should be made to create an environment in which clinicians feel supported, valued, and have the resources needed to accomplish their job.

FEAR FOR PERSONAL SAFETY

In general, therapists who have a pervasive fear for personal safety terminate their position after spending a few days or weeks in the field. The field for MST includes homes in high crime and drug-infested neighborhoods, and many mental health professionals are not capable of working effectively in such settings. Usually these individuals self-select out or are screened out of the therapist position before being hired, but sometimes they don't realize the severity of the challenges facing MST families until after being hired.

A more frequent concern is therapists who are fearful with a particular family and that fear is impeding engagement and clinical progress. For example, an abusive or alcoholic parent may keep the therapist at a distance through implicit or explicit intimidation. The therapist, fearful of confronting the situation, may "dance around" the key clinical issues without ever addressing these issues in a substantive manner. In such cases, we usually recommend that the supervisor and team members help the therapist develop strategies to directly address the fear with the client, while taking a one-down position. For example, the therapist might say, "I'm not sure what's going on, but I'm feeling very afraid of you. In fact, so afraid that I'm having a hard time doing what I think is best for your child and family because I think you might get mad at me. I'm not sure what to do about this, what do you think?" If intimidation is being used as a control tactic by the parent, the team must develop and implement a counter ploy that does not aggravate the situation or "up the ante," but does deal with the barrier to change.

Alternatively, if the fear is based on clear threats to personal safety (e.g., gang members have warned the therapist not to return to the neighborhood) the issue needs to be problem solved with the team and MST consultant. In some cases, the program administrator may need to be informed. For example, a father once pulled a shotgun on the first author and informed him that the family no longer required his services. The therapist concurred fully and immediately departed. Such circumstances go beyond the confines of

the MST adherence and supervisory protocols and require a well-conceived response from the MST program.

A VIEW THAT THE FAMILY'S SITUATION IS HOPELESS

Low engagement is occasionally due to the therapist's perception that favorable outcomes will be impossible to obtain. MST therapists must be capable of engendering hope and taking a long-term view of the clinical situation. If the therapist feels hopeless, the probability for positive outcomes is near zero.

In such cases, the supervisor should examine the fit of the therapist's feelings of hopelessness. In effect, the determinants of hopelessness reflect the barriers that the therapist has observed in the family. Delineation of these barriers and the determinants of the barriers are pivotal steps in the design of effective interventions. Thus, determination of barriers on the therapist's part should be reframed as a positive advance. Subsequently, the barriers to effective child functioning should be addressed as described in the MST treatment volume (Henggeler et al., 1998), and the supervisor should help the therapist to set small achievable family goals on a weekly basis.

Alternatively, the MST therapist may have a pervasive feeling of hopelessness that cuts across all families. If this feeling reflects the therapist's generally pessimistic view of life, the personal characteristics of the therapist are a poor fit for the position. MST therapists clearly need high degrees of optimism and hope. If, on the other hand, the therapist is normally quite productive, a pervasive feeling of hopelessness might reflect burnout or personal problems (see the preceding sections).

Family-Level Reasons for Low Engagement–and Possible Solutions

Several family-related factors are commonly implicated in low therapist-family engagement. The supervisor's responsibility is to examine the possibilities, determine the likely reasons for low engagement (develop hypotheses), and help practitioners to design and implement strategies that address these reasons (test hypotheses). The following are several family-level hypotheses for low engagement and corresponding solutions that should be considered by the supervisor.

MISTRUST

Family members may mistrust the MST clinician. For example, the clinician may be viewed as similar to case managers from other agencies who may have made life more difficult for the family (e.g., removing a child from the home, requiring compliance with agency directives). Mistrust may be evidenced by minimal self-disclosure by family members and efforts to keep the clinician "at a distance."

We may be overstating the case, but a lack of trust can be overcome in only one way–through honesty, reliability, and advocacy by the practitioner over an extended period of time. Hence, several steps are recommended to overcome this barrier to engagement.

- The clinician should affirm the family's lack of trust when clinically appropriate (not all mistrust is appropriate), indicating that the lack of trust is completely reasonable given the family's prior history with service agencies.
- The clinician should indicate that he or she does not want the family's trust until it is earned. Early in treatment, trusting the therapist completely would be unrealistic. Eventually, however, after demonstrating "trustworthy" behaviors, the clinician hopes that the family will come to trust him or her.
- The clinician promises to be honest and straightforward with the family and in return asks the family to give periodic feedback regarding their confidence in his/her honesty (i.e., an index of trust).

- The clinician communicates and acts with complete integrity for the duration of treatment. If a practitioner acts in some way that threatens the family's trust (e.g., engages in coercive behavior to gain the family's compliance with a court order, loses neutrality in a family-school meeting, distorts messages being communicated by the family), the practitioner acknowledges the behavior, apologizes, and develops plans to rebuild the lost trust.

FAMILY MEMBERS DON'T LIKE OR DISCOUNT THE COMPETENCE OF THE THERAPIST

Therapists are sometimes disliked or disregarded because they are too old, too young; White, Black; male, female; too much like doctors, not enough like doctors; don't have children of their own and so forth. The key for the therapist is not to take dislike or disregard by family members personally or to try to prove that he or she really is a likable person and a competent professional. Both strategies are doomed to failure: The former alienates the therapist from the family and the latter restricts the therapist's repertoire of interventions as he or she acts the "nice guy or gal" role. The following strategy is recommended for overcoming "dislike" and "disregard" as barriers to engagement and change.

- The practitioner should have a heart-to-heart conversation (i.e., openly discussing the issues at hand without being afraid to mention and say the things that are being avoided) with the pertinent family members, during which he or she expresses a modest degree of regret that the family has reservations about his or her ability to be of assistance. Such reservations are especially disappointing in light of the fact that the therapist likes and values many things about the various family members and sees considerable hope in achieving treatment goals.
- One can not always be liked or immediately respected by the people one works with, even if those people are valued by the therapist–c'est la vie (that's life). Nevertheless, being able to work with individuals who have reservations about you is critical to the success of the task at hand (e.g., building family capacity to prevent out-of-home placement). Therefore, with great humility, the therapist asks the family members if anything about him or her precludes working together in a professional capacity. The majority of family members will strongly deny that they don't like the therapist or have reservations about the therapist's competence, and their behavior toward the therapist will improve immediately.
- If, however, the family identifies qualities of the therapist that are not likable or indicate low competence, the therapist should affirm the family's perspective and gain their cooperation in working to improve those qualities. For example, the family might indicate that the therapist acts too bossy. Here, the therapist would acknowledge the possible difficulty, indicate that he or she has no desire to act that way and that being bossy is counterproductive, and gain the family's consent in signaling the occurrence of bossy therapist behavior. Similarly, if the family identifies an area of possible low therapist competence, the therapist should not get defensive, but should thank the family for their honesty and develop a plan to address the identified area.

FAMILY SECRETS AND SECONDARY GAIN

Sometimes what appears as mistrust (i.e., minimal self-disclosure, keeping the therapist at a distance) actually reflects self-serving parental interests. Common family secrets that are kept from the therapist include sexual abuse, physical abuse, criminal activity (e.g., fencing, prostitution, drug dealing) perpetrated or supported by adults in the household, and parental drug abuse. An example of secondary gain includes the financial benefits that the family may receive for having a child with a disability. That is, if the disability is rehabilitated, the family may no longer receive the benefits.

Uncovering family secrets or secondary gain that accounts for the lack of engagement is an extremely difficult clinical process–a process in which the supervisor might have to provide considerable guidance to the clinician. Guidelines and strategies that have been useful in uncovering secrets and secondary gains include the following.

- The clinician should have "heart-to-heart" conversations separately with the parent figures, in which the clinician explains that he or she is at a loss in understanding the lack of progress in the family. The therapist explains that he or she has a gut feeling (actually based on a thorough examination of the child and family's social ecology) that something important is not being told to him or her, and without understanding the complete situation, the design of effective interventions will be impossible. The clinician also might suggest some possible explanations (e.g., abuse), along with the evidence that supports the hypotheses. Here, the key is to observe and follow-up the reactions of the family members to the possibilities. Critically, the clinician should be nonjudgmental about the secrets or secondary gain and convey such by tone of voice and behavior.
- If and when the secret emerges, the clinician should be extremely appreciative of the family's forthrightness and maintain a nonjudgmental stance. Legal mandates must be followed (e.g., reporting abuse), but the thrust of clinical interventions should be pragmatic (i.e., the nine MST treatment principles continue to apply).

CAREGIVERS HAVE OTHER PRIORITIES

For some caregivers, meetings with the practitioner and the needs of the children are not at the top of their priority list. Procuring drugs, hanging out with friends, a romantic relationship, or accumulating wealth might be more important endeavors for that parent. Evidence of the caregiver's priorities can be obtained by examining the preferred activities of the caregiver in the context of having a child with serious mental health problems who is at risk for out-of-home placement. That is, the therapist makes observations and gathers information from the caregiver and others regarding the caregiver's availability to the child and the nature of the activities that interfere with adequate availability.

The intervention for overcoming this barrier usually requires that the caregiver be oriented to the gravity of the situation and that the clinician develop an understanding of the fit of why the caregiver has other priorities. Regarding the gravity of the situation, in clear and unambiguous terms, the therapist explains the short- and long-term implications of not placing the youth's needs near the top of the family's priorities (e.g., for youths presenting serious antisocial behavior, the implications are incarceration, failure in the primary tasks of life, and premature death). Occasionally, understanding the seriousness of the situation will impact parental behavior. More frequently, however, the therapist will need to examine the fit of the child being a relatively low priority for the caregiver and intervene accordingly (see Henggeler et al., 1998). For example, an extremely lonely single mother stopped monitoring her son and greatly decreased her frequency of keeping appointments with the therapist when she became romantically involved and spent almost all of her free time at her boyfriend's apartment. The therapist engaged the boyfriend to support the mother's monitoring efforts and re-engagement in the treatment process.

THE CAREGIVER IS NOT BONDED WITH THE CHILD

As discussed more extensively in the family intervention chapter of *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*, a caregiver may not participate in the treatment process because he or she is not bonded with the child. Caregivers have little motivation to engage in a long and difficult treatment process to help their child if, basically, they do not love him or her. Evidence of this barrier to engagement includes: a history of little positive interaction between the caregiver and child

from early childhood to the present; a lack of positive affect when the caregiver talks about the child; and, sometimes, a report by the child of feeling unloved by the caregiver. Therapists and supervisors are cautioned, however, against prematurely concluding that bonding is inappropriate or lacking when a parent first regains custody of a child after years of separation or limited contact (e.g., while the child lived with a relative, was in foster care, etc.) or in the context of surrogate caregiving. That is, a relative or family friend who has had little contact with the youth prior to gaining guardianship or custody should not be expected to develop an unwavering affective bond instantaneously, and interventions designed to build affective relations are often required to forge such a bond. Similarly, caregiver expressions of frustration, anger, and hopelessness about a youth's behavior, or a wish to have a youth removed from the home should not be interpreted as evidence of low bonding, as many caregivers of youth with serious problems have such feelings at times despite the fact that they love their children.

Strategies to identify minimal parent-child bonding are discussed in the aforementioned chapter of Henggeler et al. (1998). Most pertinent is that the therapist be nonjudgmental and essentially give permission for the parent to not love the child. Acknowledging a lack of caring for the child by the parent has very low social desirability, and few parents who are not bonded to their child would ever admit such. Thus, the therapist must be nonpejorative and focus on the clinical implications of the circumstance (i.e., an alternative caregiver must be identified to provide the nurturance and structure that the child needs to address the problems that have resulted in referral to the MST program). Treatment can progress in earnest only after the barrier of low bonding is identified and acknowledged.

CAREGIVER PSYCHOPATHOLOGY AND/OR SUBSTANCE ABUSE

Low engagement can be a product of serious clinical problems in the caregiver. For example, if the father has bipolar disorder that is not under control, the likelihood of effective therapist-father collaboration seems low. Similarly, if the mother is addicted to cocaine, the development of an effective therapeutic alliance will be nearly impossible. In such cases, addressing serious parental psychopathology is the immediate priority of treatment, because such parents can not address child difficulties successfully until the severe psychopathology is attenuated. Henggeler et al. (1998) describe the strategies for addressing serious clinical problems in caregivers.

SUMMARY AND COMMON THEMES

Several common themes emerge for supervision when evidence suggests that engagement is low because of family level factors.

- Team members review the available evidence with the supervisor to develop hypotheses regarding the particular barriers to engagement for a given family (i.e., analyze the fit). The barriers are prioritized, and the key barrier is addressed first.
- Supervisors help the clinician to develop plans to confront the hypothesized key barrier directly with the pertinent family members in a gentle, but firm, and honest manner. We strongly recommend that the supervisor orchestrates role-playing exercises during group supervision to develop and refine strategies for such confrontations.
- Supervisors help the clinician decide whether to be direct with the family or to take a one-down position in addressing the barriers. That is, certain issues are worth relatively firm (but never pejorative or judgmental) confrontation–clarifying caregiver priorities and pursuing family secrets, for example. Other issues are not worth arguing about, and can be overcome by accepting criticism, whether valid or not (e.g., mistrust of the therapist, not being liked), and using the criticism to further the therapist-family relationship (e.g., gaining family consent to identify the therapist's deficits as they emerge throughout treatment).

- Finally, "the proof is in the pudding" (an odd expression when you think about it). That is, one of the strengths of MST is the cycle of hypothesis generation, testing, and confirmation (or disconfirmation) that is based on observable and verifiable data. Correct hypotheses will lead to clinical progress in one form or another, and incorrect hypothesizing will lead to new information that helps the supervisor and clinicians reconceptualize possible barriers to engagement, test those reconceptualizations, and move on.

Understanding The Fit Of Problems

Helping therapists to understand the fit of identified problems is one of the supervisor's primary responsibilities. The delineation of fit provides the fundamental basis for hypothesis development, and hypothesis development leads directly to the design of interventions. Hence, favorable outcomes are unlikely in the absence of an accurate analysis of fit.

Teaching clinicians to think systemicly and use "multicausal" analyses of behavior is often a difficult task. This section provides the supervisor with guidelines for judging the clinician's ability to develop complex (and logical) understandings of fit and notes several common barriers to such understanding with corresponding recommendations for addressing these barriers.

Signs that Reflect Clinicians' Understanding of Fit

STRONG UNDERSTANDING

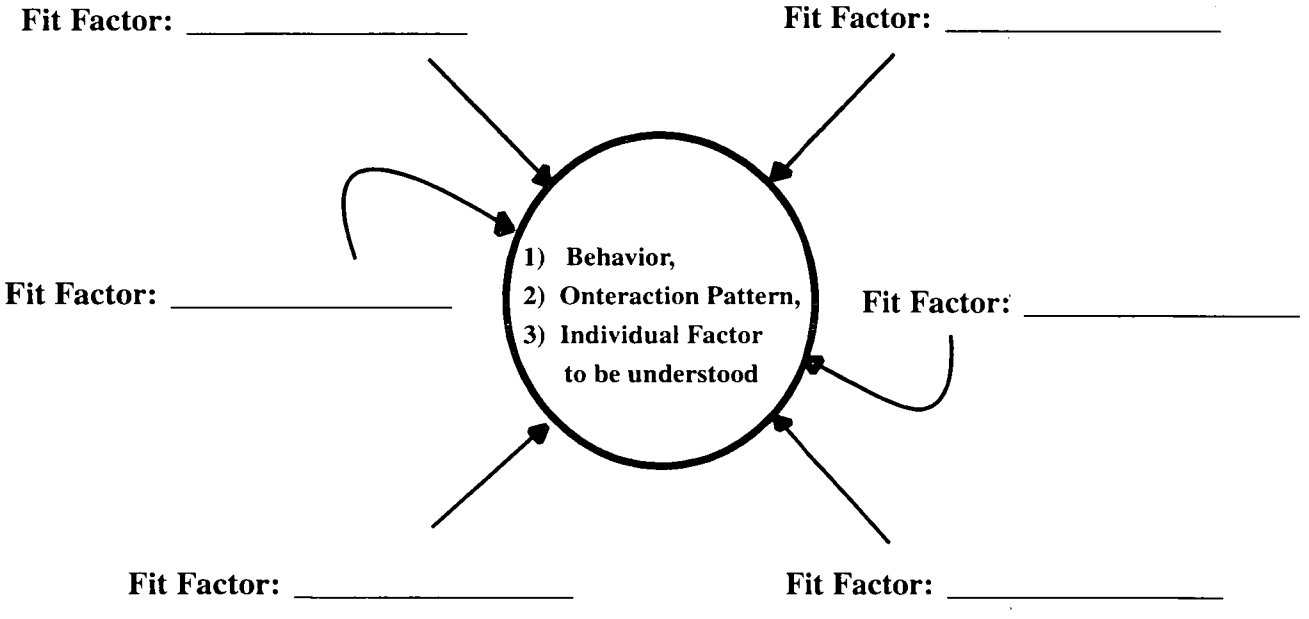
Several therapist behaviors during supervision and with the family reflect a solid understanding of fit.

- **Analyses of fit are logical**–The practitioner's analysis of the factors contributing to the identified problems makes common sense. For example, with truancy as an identified problem, the clinician reports that the analysis of fit shows that (a) the single-parent father works the night shift and is sleeping when it's time for his son to go to school; (b) while father is at work, the boy watches television and smokes marijuana until late at night with deviant peers; (c) the boy has a long history of academic failure and is not involved in activities at school; and (d) the father provides little structure and few consequences for his son's behavior.
- **Analyses of fit are multidimensional**–The vast majority of serious problems are multidetermined, and the analysis of fit should reflect this. Using the preceding example, important aspects of the youth's biology (i.e., low motivation linked with chronic marijuana use), family, school, and the family's social support network (i.e., no one is monitoring this youth while the father is at work) are contributing to the identified problem. Thus, analyses should integrate some combination of individual, family, peer, school, neighborhood, and social network variables.
- **Analyses lead to interventions that can effect change in the problem**–The preceding analysis suggests several starting places. The most important place is to help the father develop strategies for providing greater structure and consistent consequences for his son's behavior, while enlisting help from the indigenous support network for monitoring the son's activities during evening hours. Developing plans to eliminate the boy's marijuana use and determining a school/vocational trajectory that fits the boy's strengths and weaknesses are additional priorities.
- **The therapist can depict the interplay of causes graphically**–Essentially, the therapist can use the assessment data to determine the factors contributing positively and negatively

to the identified problem. The capacity to delineate these factors reflects a strong grasp of the preceding three points (i.e., analyses of fit are logical, multidimensional, and lead to interventions). A simple graphic, which has come to be known as a "fit circle" by MST practitioners, provides a starting point for depicting the factors that contribute to and attenuate identified problems (see Figure 5).

- **The therapist has obtained consensus among stakeholders regarding the relevance of the identified problem**–Understanding the fit of a problem is not fruitful if the key stakeholders do not regard the identified problem as a problem. For example, if the boy and his father are not concerned about the truancy (which was a concern to the school and referring agency) because the boy was planning to leave school at age 16 and apprentice in his uncle's shop as a carpenter, the therapist would be wasting precious time by focusing on this issue. Thus, part of understanding fit is the capacity to recognize, using information from across the systems, which problems are actually problems and from whose perspective.

Figure 5
"Fit Circle"



1) Behaviors can be: (a) referral problems (e.g., truancy, aggression at school, criminal acts), (b) behaviors of key participants (e.g., father's lack of monitoring)

2) Examples of interaction patterns include: Parent-child conflict; marital conflict; interparental inconsistency; permissive, neglectful, or authoritative parenting style, etc.

3) Examples of individual factors include: Mother's depression; stepfather's alcohol abuse

Note: Clinicians should be able to provide evidence that each "fit factor": (a) exists; (b) is contributing to the targeted behavior of interaction in the circle. When such evidence is lacking, recommendations should be made regarding how to gather evidence to support or refute the hypothesis that the factor contributes to the targeted problem.

WEAK UNDERSTANDING

Several therapist behaviors and activities reflect a poor understanding of fit.

- **Problems are viewed with little complexity**–The therapist's analysis of the determinants of problems often focuses on factors within one or two systems. For example, the boy's truancy is attributed primarily to the demotivating effects of chronic marijuana use or to the depression he experienced following the death of his mother.
- **Unidirectional interpretations of causality dominate**–The problems embedded in social relations have bi-directional influences (i.e., reciprocity), yet many mental health professionals adhere to unidirectional models of behavior. For example, one unidirectional interpretation is that low self-esteem has caused the boy's problems with marijuana use, truancy, and social isolation. Alternatively, the father's lack of disciplinary competence is the basic cause of the identified problems. The first interpretation fails to consider the effects of chronic failure on self-esteem (and the roles of ecological factors in the problem), and the second interpretation fails to consider the effects of the boy on his father (as well as the effects of other variables influencing paternal behavior).
- **Analyses don't lead to effective interventions**–A solid understanding of fit leads directly to logical interventions, though the interventions still need to be prioritized (as discussed later in this manual). A poor understanding of fit will be reflected by analyses that are difficult to link with effective interventions, as defined by the MST treatment principles. For example, if truancy is attributed to maltreatment experienced from 1 year to 6 years of age for the boy, effective interventions that are grounded in the MST treatment principles are difficult to develop. Similarly, if the range of problems is attributed to low self-esteem, how exactly should interventions be targeted to raise self-esteem?
- **The goals of stakeholders are conflicting**–A reasonable consensus regarding the targeted problems must be achieved among stakeholders before interventions can move forward. A therapist who reports conflicting goals among stakeholders often has not examined fit with sufficient depth. For example, if the goal of eliminating truancy was changed to "facilitating school/vocational functioning," the therapist could probably gain an agreement for this goal among the family, school, and referral agency.

Barriers to Understanding Fit and How to Overcome Them

Barriers to obtaining an accurate understanding of fit pertain to the therapist, family, and supervisor. The following are the most common barriers encountered during supervision.

THE THERAPIST IS NOT ATTENDING TO THE ENTIRE ECOLOGY

A therapist may fail to develop complete and accurate understandings of fit because he or she favors certain aspects of the ecology over others. For example, the therapist may have a complete understanding of how child and mother variables are linked with the identified problems, but have little sense of how the father plays into the equation. Similarly, the therapist (a former teacher, for example) may have developed a comprehensive understanding of the youth's academic and social strengths and weaknesses in the school context, but have little appreciation for the role that the mother's contentious relationship with her boyfriend plays in the identified problems.

Identification of this therapist barrier requires the supervisor to notice trends in therapist reports over time. That is, the therapist frequently emphasizes certain aspects of the ecology in his or her analysis of fit, and rarely emphasizes other aspects that may be important. Several factors may be contributing to the therapist's difficulty in attending to the entire ecology.

- The therapist may simply be more comfortable in some systems than in others, and consequently, may emphasize the characteristics of that system in his or her analyses. In such cases, the supervisor should routinely assign the therapist explicit tasks and assessments to be conducted with the systems that he or she usually ignores. For example, a therapist who tends to ignore peer influences should be required to interview the child's peers and gain information about the child's peers from parents and teachers for every family (i.e., overlearning). Eventually, with supervisory support, the therapist will develop increased comfort in that system and gain a greater appreciation of the role that the particular system can play in problem analysis and hypothesis development.
- The therapist may be overwhelmed by the complexity of the task, that is, simultaneously attending to and integrating the multiple characteristics of many aspects of the youth and his or her social ecology. In such cases, the supervisor should help the therapist to break the analyses down into smaller steps. For example, use of forms that denote each system and allowing the respondent to delineate the strengths and weaknesses of each system may be helpful. The therapist can rely on the visual aid to make sure that all parts of the ecology have been reviewed and to determine the key factors that are linked to the identified problems.
- Despite his or her participation in MST training, the therapist may not be fully aware that problems are multidetermined and that a fundamental assumption of MST is that addressing difficulties across the systems increases the probability of favorable outcomes. Although the proposed solution may seem rudimentary, the supervisor may save considerable time by having the therapist study the chapters in *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* (Henggeler et al., 1998) that pertain to each system (i.e., individual, family, peer, school, social network). The supervisor can then "test" the therapist's knowledge of the material on an ongoing basis.

THE THERAPIST IS FOLLOWING NON-ECOLOGICAL THEORETICAL MODELS

MST requires that clinicians use a social ecological theoretical model, which assumes that behavior is multidetermined and reciprocal. A therapist may have difficulty understanding the fit of problems because his or her underlying conceptual model (or at least the conceptual model that the therapist is using with a particular family) is not systemic in nature. Several types of difficulties in this regard have been observed by MST supervisors.

- **Prior training**–The therapist, for example, may have had years of experience providing cognitive behavior therapy to children. Although cognitive behavior therapy is an empirically based approach like MST, cognitive behavior therapy contrasts with MST in its relatively linear and child-focused emphases. As an even more problematic example, the therapist may have been trained extensively in theoretical models that are basically nonempirical in nature (e.g., the aesthetic family therapies, humanistic approaches, psychodynamic therapy).
- **Underlying personal philosophical beliefs**–Many theories of how the world works have little to do with formal training in mental health interventions. For example, belief in the power of crystals and pyramids do not lead to MST-like conceptualizations of fit.
- **Effects of stress**–A common observation among MST supervisors is that clinicians will revert to treatment approaches learned earlier in their careers during times of difficulty when working with families. Thus, rather than attempting to analyze a complex social ecology to understand fit, the clinician might refer the child for a psychiatric evaluation,

> work individually with the child, or advocate for an out-of-home placement. In such cases the clinician is usually not able to delineate how his or her proposed interventions are based on fit or how these interventions will facilitate the attainment of treatment goals.

Supervisors can learn about a therapist's underlying theory of behavior by inquiring about the hypothesized change mechanisms with a family. Thus, supervisors question the validity of proposed interventions, requiring conceptual justification by the practitioner. Thus, the supervisor might ask the therapist to explain the rationale behind referral of a youth to a Big Brothers program. What goal is such a referral aiming to accomplish, and how might that goal be addressed in the family's natural ecology? Similarly, the supervisor might question the rationale behind anger management training. Is aggression driven primarily by internal mechanisms or by environmental circumstances? If the latter, why is the therapist focusing intervention resources on the former. Such justifications provide the raw data for assessing the possibility that the therapist is basing the design of interventions on non-ecological (and non-MST) theories of behavior.

Often, when supervisors provide well-articulated feedback showing that the therapist's implicit model of change is not ecological, the therapist can gain a level of "insight" that almost immediately improves his or her ability to conceptualize problems ecologically. On the other end of the continuum, a percentage of therapists are very rigid in their philosophical/theoretical beliefs and will never be able to grasp the complexity of ecological analyses. Most likely, these therapists should not be working in MST programs. In the mid-range of this continuum, the majority of clinicians who occasionally rely on non-ecological models of change to inform the design of interventions in their cases, require ongoing feedback from the supervisor–feedback delineating the ecological nature of the identified problem. For some clinicians, the supervisor will be required to "re-educate" them over many months and even years. The beauty of the quality assurance mechanisms built into MST, however, is that the therapist can make conceptual errors, and if the supervisor is doing his or her job, these errors will be identified and addressed on an ongoing basis. Moreover, the MST consultant provides a second check regarding the capacity of team members to understand fit.

THE THERAPIST HAS COGNITIVE LIMITATIONS IN UNDERSTANDING THE COMPLEXITY OF BEHAVIOR

Multidimensional models of behavior are fundamentally more difficult to understand than unidimensional models. In multidimensional models, the interplay of several factors is considered simultaneously. The increased complexity of multidimensional models (and families with complex problems) requires that therapists be capable of formal operational thought, that is, capable of abstract reasoning and the generation of potential solutions with logical assessments to obtain needed information. Unfortunately, not all clinicians have developed formal operational thought. Such clinicians are overly concrete in their analyses of problems. That is, conceptualizations tend to focus on the available information, little attention is devoted to alternative explanations, and solutions to complex problems tend to be simplistic (e.g., just say "no").

Being overly concrete in thought processes is definitely a handicap for an MST clinician, the team, and the supervisor. In a favorable scenario, the clinician may be able to compensate for this weakness through his or her other strengths (e.g., high motivation, strong ability to engage families, high knowledge of the community). In a less favorable scenario, clinicians who are overly concrete and can not compensate for this relative weakness will provide little benefit to MST programs.

In the majority of cases where the understanding of fit is limited by a clinician's cognitive abilities, the team and supervisor will have to compensate by providing increased structure and support. That is, the supervisor will need to help the clinician to identify ecological factors that have not been assessed and may be contributing to the identified problems. Likewise, the therapist will need regular assistance from

the team in considering alternative explanations for behavior. Depending on the individual clinician, improvement in understanding fit may or may not improve over time.

FAMILY MEMBERS ARE NOT PROVIDING PERTINENT INFORMATION

In the absence of pertinent information regarding the parameters and possible determinants of the identified problems, fit can be difficult to specify. The supervisor should consider the possibility that all information is not being revealed when (a) the therapist has attempted to obtain all pertinent information across systems and (b) the problem still does not make sense in light this information. Not understanding fit because of a lack of information from family members is one of the situations in which the "instincts" of clinicians and supervisors are important to consider. That is, their "gut feeling" that family members are not being forthright is often accurate.

Three general circumstances usually account for the failure of family members to reveal all pertinent information: honestly not understanding what information might be helpful, family secrets, and low family engagement (discussed previously). Regarding an honest lack of understanding, family members are usually being forthright, but much more detailed questioning by the therapist is required. For example, the clinician may be asking about how the parents disciplined their adolescent who came home intoxicated on Friday evening, and the parents may have said they "grounded" him. The clinician might have concluded that the parents disciplined effectively, when further questioning would have revealed that "grounding" did not apply to the subsequent evening (Saturday) because the youth had a special school event. Moreover, when the boy was grounded, he could still listen to music in his room and talk with his friends on the phone. Similarly, family members may have been confused by or not understood the therapist's question, but failed to acknowledge such out of embarrassment. For example, the therapist may have used language or words the meaning of which was not clear to family members (e.g., sexually active, mental retardation).

Family secrets (e.g., dad is alcoholic, mom is physically abusive) sometimes account for difficulty in understanding fit when other explanations have been ruled out. Guidelines for attempting to uncover family secrets are discussed in the section of this manual that describes possible barriers to therapist-family engagement. Considerable clinical acumen is needed to inquire about family secrets effectively, and supervisors should usually role-play these scenarios with team members before the clinician confronts the family.

THE SUPERVISOR IS CONFUSED IN INTEGRATING INFORMATION

Supervisor confusion is easy to identify. If the supervisor is feeling confused, he or she is confused. Confusion in integrating the information needed to understand fit can come from two sources:

- The therapist is presenting unclear or contradictory information.
- The family and others in the ecology are presenting unclear or contradictory information.

In either case, the therapist should review the information slowly and methodically, system by system, with the supervisor and team. Areas of confusion and contradiction should be flagged, and concrete plans should be made to seek clarification from the pertinent sources of information. For example, another team member or the supervisor might obtain information directly by accompanying the therapist on home visits or observing the youth in school. In any case, additional sources of information are tapped and the analytic process is repeated until a reasonable level of clarity has been obtained. Reasonable level is defined by that level of understanding of fit needed to develop hypotheses that lead to clinical interventions.

Ensuring Implementation Of Effective MST Interventions

The purpose of this section is to describe the supervisor's role in the development, implementation, and refinement of effective intervention strategies. Although all team members provide valuable perspectives on case conceptualization, development of effective and creative interventions, and problem-solving strategies to overcome barriers to intervention success, the supervisor has the added responsibility of facilitating and monitoring each clinician's adherence to the MST treatment principles. Following the explication of the fit of identified problems, the next task of the treatment team is to delineate intermediary treatment goals–those goals that are achievable in the short term and reflect direct movement toward the overarching goals. With the intermediary goals defined, the team identifies the range of treatment modalities and techniques that might be effective toward meeting the intermediary goals and tailors these to the specific strengths and weaknesses of the targeted client system (e.g., marital, parent-child, family-school). As interventions are implemented and their success is monitored, barriers to favorable outcomes may become evident at several levels. For example, at the family level, previously unidentified parental difficulties such as drug abuse, weak parenting skills, and so forth might emerge. Likewise, clinician limitations (e.g., inexperience in marital therapy) may impede progress. The supervisor's responsibility is to help the clinicians to identify these barriers as well as the factors contributing to the barriers. Then, in an iterative process, strategies for overcoming the barriers are developed and implemented. Refinement continues until the desired results are achieved, with the supervisor providing the key role in quality assurance.

Developing Intermediary Goals

Once overarching treatment goals are identified by the family-clinician team (see Section 2 of this manual), clinicians attempt to understand the "fit" of the referral problems (see Section 4). On the basis of the preliminary assessment, intermediary treatment goals are developed. Intermediary goals should (a) be logically linked to overarching goals, (b) address aspects of the systemic context that contribute to the referral problems, and (c) be achievable over a period of days or weeks. Often, several intermediary goals related to a single overarching goal are pursued simultaneously, as the systems and interactions they target reciprocally influence one another. At other times, intermediary goals may need to be pursued in sequential order. Thus, for example, "increase interparental consistency" and "increase the frequency and quality of parent-school contact" are two intermediary goals often established when a juvenile offender is on the verge of school expulsion and evidence indicates that interparental inconsistency is contributing to problematic school and criminal behavior. In some families, interparental consistency would need to increase before the family-school linkage could improve, because the inconsistency directly contributes to family-school conflict (e.g., one parent agrees to meet with a teacher, the other protests the meeting and cancels). In other families, both goals could be pursued simultaneously, because the inconsistency does not interfere directly with school-family communications (e.g., parents disagree about what should happen at home in response to misbehavior at school, but each can and does talk with the school, albeit infrequently and with some frustration and anger).

Across cases and clinicians, the supervisor should assure that intermediary treatment goals are logically linked with overarching goals. Without evidence of such linkage, there is little hope that attainment of the intermediary goals will ultimately lead to achievement of the overarching goals. The nature of the linkage between intermediary and overarching goals should be apparent on the weekly case summaries and in

group supervision discussions. For example, an intermediary goal that reads "reduce arguments between father and Jeff" is logically linked with the overarching goal of reducing violent incidents in a family referred after Jeff pulled a knife on his father. This intermediary goal, however, is not obviously linked with a second overarching goal of decreasing Jeff's association with gang-affiliated peers. When the peer-related overarching goal is targeted for intervention, the team and supervisor would expect to see intermediary goals that reflect parental efforts to monitor and sanction peer contact, provide opportunities for prosocial peer contact, and so on. On the other hand, the intermediary goal "increase parental monitoring of Jeff's whereabouts" could be directly linked with the peer-related overarching goal and with the school-related goals. Thus, a single intermediary goal is often directly or indirectly linked to more than one overarching goal.

Each goal may remain on the case summary form for several weeks, although the specific interventions needed to achieve the intermediary goals often vary weekly in response to evidence that the interventions are more or less effective. As clinicians implement interventions to meet an intermediary goal (e.g., increase interparental consistency), they learn that other aspects of individual, family, or extra-familial functioning present barriers to goal attainment. Such information often leads to the identification of additional intermediary goals. Let us return, for example, to the intermediary goal, "increase interparental consistency." In one family, major differences in parenting style (authoritarian father and permissive mother) appeared to be the major contributor to inconsistent discipline and monitoring, and the clinician had tried several interventions to help each parent develop more authoritative discipline strategies. Homework assignments related to this effort were rarely completed, however, and it became clear that ongoing marital conflicts were the major barrier to each parent's willingness to make changes in his or her parenting practices. Thus, an additional intermediary goal–reduction of marital conflict–was developed, and marital interventions were put into place. Intermediary goals, therefore, can change as treatment advances are made and barriers to intervention success are encountered.

Guiding Intervention Development: Supervisory Focus on MST Principles

As noted previously, the supervisor has the primary responsibility of facilitating and monitoring each clinician's adherence to the MST treatment principles. It is often helpful to post these principles wherever group supervision occurs. Supervisors should be able to evaluate the information provided in case summaries and group supervision in terms of its consistency with each of the principles. The foundations of MST interventions and guidelines for their implementation appear in the practitioner manual, *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* (Henggeler et al., 1998), and are introduced in the 5-day introductory MST training. Weekly telephone consultation between the team and an MST expert and quarterly booster training sessions provide ongoing opportunities for clinicians and supervisors to hone their skills in MST case conceptualization and intervention strategies.

Ideally, individuals who become MST supervisors will have had experience doing MST as a clinician. When organizations first develop MST programs, however, this is seldom possible. Thus, individuals acting as MST supervisors should at least have a solid understanding of and some clinical experience implementing the major empirically based treatment approaches described in the practitioner manual, namely pragmatic family therapies (strategic, structural, behavioral family systems approaches), parent-child behavior management, and behavioral and cognitive behavioral treatment. In addition, the supervisor should collaborate closely and early on with the MST consultant regarding mastery of the supervisory process. Consultants dedicate additional telephone consultation time to supervisors for this purpose, with more frequent contact occurring as teams and supervisors are first learning MST and less frequent contact occurring as the team and supervisor become more skilled in implementing MST and using on-site supervision effectively.

Guidelines for implementing these empirically based approaches in the context of a treatment model

(MST) that includes the whole ecology, rather than just the family, a family subsystem, or an individual, are described in the manual. When a specific treatment approach with empirical support (e.g., cognitive-behavioral treatment for depression in adults, behavioral anxiety management techniques) is described in detail in other texts, key features of the approach are summarized in the manual and clinicians are referred to these other texts for further details about the treatment techniques in question. As illustrated by example in the manual, however, the specific treatment approach is rarely, if ever, imported wholesale into MST. Instead, the supervisor and team consider together how to tailor the treatment techniques to the particular case–that is, how the technique can be used in a way that fits the needs of the youth and family's social ecology.

Because treatment strategies such as cognitive behavior therapy are often validated with target populations having a specific clinical problem (rather than several co-occurring problems), who are seen weekly (rather than almost daily) in office-based (rather than home-, school-, and neighborhood-based) settings, significant adjustments are often made when implementing specific treatment approaches in the context of MST. Thus, for example, techniques for resolving persistent parent-adolescent conflicts described in behavioral family systems manuals are typically implemented in weekly outpatient family therapy sessions with youth experiencing relatively minor problems. These techniques would probably be implemented more frequently and augmented by homework assuring frequent practice in the context of MST, and other interventions previously put into place to address the topics that give rise to conflicts (e.g., curfew, deviant peers, discipline strategies) would continue.

In deciding on the optimal treatment strategies for each case, the supervisor should encourage the development of creative ideas by team members that are consistent with the MST treatment principles. Some ideas, however, will be more consistent with the principles of MST than others, at least until the team has had considerable experience conducting MST. Similarly, some intervention suggestions will be more consistent with empirically validated treatment techniques than others. For example, in response to a clinician who suggests that a 10-year-old boy who hits and kicks his siblings be encouraged to "express his anger" by hitting pillows instead, the supervisor might point out that (a) "catharsis-based" interventions are not effective with children and (b) the suggested intervention does not address the sequences of interaction that contribute to angry outbursts (MST Principles 1 and 4). The supervisor ultimately is responsible for decisions to use particular treatment techniques. Nevertheless, the team's MST consultant can be accessed for assistance helping clinicians tailor specific interventions for use with a particular family.

Helping Clinicians Identify and Overcome Barriers to Intervention Success

In spite of significant efforts, interventions with children and families presenting serious clinical problems often fail. Importantly, examination of the reasons for failure (i.e., barriers to change) should provide clues to the types of interventions that will have a higher probability of succeeding. As such, the supervisor has several functions in helping team members develop more effective interventions following failure. These functions include:

- Identifying and making sense of barriers that contributed to intervention failure
- Determining which aspects of the intervention should be changed in light of information obtained about the barriers
- Developing strategies for helping the therapist implement the revised intervention
- Consulting with the MST consultant, as needed, to verify the viability of the analysis of barriers and plans to overcome them

Given the complexity of the cases referred for MST, teasing out the fit of failed interventions is sometimes

difficult. When a clinician struggles consistently to assist families in making even small gains, the supervisor and team should assure that each step on the "Do Loop" preceding intervention design and implementation is adequately addressed, that the understanding of barriers to intervention success is as multisystemic as it should be, and that interventions were actually delivered properly. Common barriers to intervention success include:

- Faulty or incomplete conceptualizations of the "fit" of the problem targeted for a particular intervention (ranging from the referral behavior of the youth to a parent behavior that interferes with intervention success)
- Intermediary goals that do not reflect the most powerful and proximal predictors of the target behavior, such that interventions designed to achieve these goals miss the mark
- Intermediary goals are appropriate, but interventions did not follow logically from the goals
- The clinician did not implement the intervention correctly or completely, or did not assure that the individuals (parent, grandparent, teacher and parent) who were to implement the intervention had sufficient understanding and competency to do so

Each of these factors, in turn, may be influenced by a combination of case-specific, clinician-specific, and supervision-specific issues. That is, at any juncture of MST, it may be helpful–indeed necessary–to consider not only the details of the particular case, but the extent to which the clinician, team, and supervisor are engaging in the behaviors necessary to help families achieve their treatment goals.

Situations in which intervention failure is a result of incomplete or faulty conceptualizations of fit (e.g., a clinician does not know a parent uses drugs; a clinician's theoretical perspective interferes with multisystemic conceptualization) were addressed previously, as were situations in which intermediary goals are inappropriate. Thus, the remainder of this section focuses on assuring that interventions follow logically from one or more intermediary goals and are adequately specified, implemented, and monitored. Indeed, sometimes interventions appear to be ineffective when, in fact, they have not been implemented adequately.

MISMATCH BETWEEN INTERMEDIARY GOALS AND INTERVENTIONS

Sometimes, a clinician's understanding of the "fit" of the referral problems is multisystemic and comprehensive and intermediary goals target several of the most powerful and proximal factors sustaining a problem, but one or more interventions proposed to achieve the goals do not follow MST principles or logic. Thus, for example, the family and clinician in the case of 15-year-old Jake identified several overarching goals–keeping Jake in school (he was often suspended), out of criminal activity (he had several misdemeanor charges), and away from deviant peers and involved with prosocial peers (his crimes were often committed with peers). Interactions within and between the parent-child and marital subsystems of the family and between the family and school were initially identified as major contributors to the referral problems. Specifically, Jake often stayed out all night with deviant peers following intense family conflicts that culminated in physical violence between Jake and his stepfather. Jake had been arrested during one all-night outing, and the physical altercations between Jake and his stepfather had been reported to Child Protective Services by neighbors. Thus, one of the family's intermediary goals was to "reduce verbal and physical conflict between Jake and his stepfather." The clinician told the team she planned to teach Jake anger management skills to reach this intermediary goal.

The supervisor and team pointed out that this individually based intervention (a) implied that Jake's "anger" was both a stable attribute and the primary contributor to the verbal and physical altercations, and (b) would not address the multiple interactions within and between systems known to contribute to the

verbal and physical conflict. The team recommended that interventions targeting the related problems of interparental inconsistency, marital conflict, and weak boundaries between the parent-child and marital subsystems would be more likely to reduce the number of opportunities for conflict between Jake and his stepfather. The team identified several broad intervention strategies to be implemented simultaneously, and each of these general strategies entailed multiple steps and techniques. The general strategies were to (a) change each parent's discipline strategies (e.g., help mother become less permissive and stepfather become less authoritarian) thereby decreasing interparental conflict about discipline (which often led to arguments in which Jake became involved), (b) address marital issues that exacerbated parenting difficulties, and (c) clarify boundaries around the marital and parent-child subsystems so Jake would not be present for and involved in arguments about his discipline. Thus, although the clinician's intervention idea–anger management for Jake–may appear to a non-MST practitioner to directly address the problem of verbal and physical altercations, the intervention in this context did not conform to MST Principles 1 (multisystemic fit with broader context), 5 (targeting sequences of behavior within or between systems), or 9 (generalization by empowering caregivers to address family members' needs). In short, the anger management route does not address the multiple factors that give rise to the altercations in which verbal and physical conflict occur, and thus has a low probability of helping the family meet their intermediary goal. When little progress is being made, supervisors should assure that intervention strategies logically follow from intermediary goals and conform to MST principles. In this case, anger management skills training for Jake met neither criteria.

INADEQUATE SPECIFICATION OF INTERVENTIONS

Sometimes intervention strategies are inadequately specified. Thus, a clinician who reports that particular interventions are not working should be prompted to describe in further detail the nature of the therapeutic interactions. That is, the objectives of each treatment session, the strategies the therapist is using within sessions, the homework assigned between sessions, and the evidence that sessions are or are not leading to change should be reviewed. When inquiring about the nature of intervention strategies, supervisors should be particularly wary of such responses as "we're working on it," "we talked about it," or "I told them about it." Such phrases are not descriptors of interventions, and supervisors should seek clarification of the terms upon hearing them.

An example of weak specification is "recommend parents provide more structure." Increased structure may be a reasonable intermediary goal, though a better operational definition of "structure" is needed (e.g., "Parents will provide consistent rules, rewards, and consequences, and monitor the youth's whereabouts"). Interventions, however, are the how and wherefore of achieving such goals. Specification of interventions indicate what will be needed for the parent to provide structure, what should be said and done differently by the parent(s) and the child, and how the clinician plans to facilitate these events. Thus, intervention strategies to help parents and youth identify rules, rewards, and consequences that are meaningful to the youth may be the first step toward achieving the intermediary goal related to structure. Additional steps may include specification of which parent will deliver the consequence when rules are broken, and what each parent will do if the youth complains, appeals for leniency, or berates the parent who doled out the consequence. Essentially, intervention strategies should specifically describe what each participant in the ecology will do and when and how they will do it.

In addition, the clinician and supervisor should specify what actions the clinician must take to enable participants to implement the intervention. In some cases, clinicians will have to complete several complex tasks before family members are prepared to implement an intervention. For example, the therapist may need to make the connection between specific behaviors indicative of permissive parenting and a child's bullying of the parent; introduce the idea that alternative discipline strategies may be more effective; cultivate the parent's interest and willingness in trying the alternative strategies; describe, model, and

role-play the strategies; and be present when the parent first attempts to implement the intervention. Each of these steps could be, in and of itself, an intervention. Taken together, the multiple steps are precursors to changing a parent's discipline strategy. In other cases, clinicians might need to engage a couple in marital sessions targeting specific instrumental and/or affective issues that interfere with goal attainment; actively structure and manage the interactions between the couple during the sessions; and develop, assign, and monitor homework to facilitate continued changes in interaction on a daily basis.

INCOMPLETE IMPLEMENTATION OF INTERVENTIONS

An example of incomplete implementation is that of a clinician who helps parents develop a set of rules, but does not list rewards and consequences. Or, the clinician helps a parent set a curfew, but does not examine the possible strategies the youth might use to circumvent the curfew and help the parent develop and practice counter-responses. In such instances, the clinician may simply need to complete the steps that comprise a complete intervention. In the curfew scenario, the therapist would help the parents identify the variety of protestations and strategies the youth might use to thwart the curfew plan and rehearse their responses to these protests. A parent also may ask the therapist to be present when the intervention is enacted, either for moral support, or to help identify and remedy potentially problematic aspects of implementation. Therapists should be prepared to accommodate such requests until the parent is able to manage the curfew implementation comfortably or identify indigenous sources of support to help.

Providing opportunities to practice the proposed intervention also is part of intervention implementation, and such practice can occur in the context of role-played rehearsal or in vivo. In one case, for example, a clinician and parent had agreed upon a series of changes to be made in the household morning routine to get a chronically truant youth to school. The clinician, however, did not assure that the parent had sufficient practice to execute the steps in the face of her son's protestations. After the first attempt to implement the new morning routine fell apart when the son began cursing his mother and threatening to punch a hole in the wall, the mother and clinician role-played the scenarios the mother dreaded most. In this case, the mother felt that role-played practice was not sufficient to prepare her to manage her son's verbally abusive response to the new morning routine. Consequently, the clinician helped the mother get her son out of bed and to school each morning until the mother had the practice and indigenous support needed to stand firm in the face of her son's protests.

INADEQUATE MONITORING OF INTERVENTIONS

Interventions may fail because implementation is not monitored adequately by the family or clinicians. As a common example, the clinician reports that a parent has implemented rules and consequences for several days, but that the contingencies are having no effect on the adolescent's behavior. However, no system was put into place to track whether the consequences and rewards were being implemented consistently, and other family members provide conflicting reports as to whether rules are being enforced. In such cases, the supervisor and team should assure that the clinician and family track implementation using observable measures (e.g., checklists, behavior charts, etc.) and obtaining information on intervention outcomes from multiple perspectives (parent, teacher, neighbor), in accordance with MST Principle 8.

WHEN BARRIERS REMAIN ELUSIVE

If the reasons for the ineffectiveness of interventions remain elusive, the supervisor should obtain first-hand information about the case. Tools such as audio tapes of treatment sessions and field supervision (attending sessions with clinicians) can quickly illuminate the nature of the challenges a particular case presents with respect to engagement, "fit" of particularly problematic interaction patterns, and barriers to intervention success. Clinicians often report that such tools are most helpful when the clinician and supervisor clarify problem areas to be targeted in advance of the audiotaped or field supervision sessions (e.g.,

assessing the engagement of family members). Thus, consistent with MST Principles 4 (interventions are present focused, action oriented, and target well defined problems) and 5 (targeting specific sequences of interaction) discussion of audiotaped and field supervision is focused on case-related challenges for the clinician jointly identified by the supervisor and clinician. As always, and consistent with MST principles, supervisory feedback should focus on clinician strengths as well as weaknesses or challenges observed in clinician-client interactions, as these strengths can be useful in changing clinician behavior.

Developmental Goals Of Supervision

Supervision sessions are the primary forum in which supervisors obtain evidence of clinicians' development and implementation of the conceptual and behavioral skills required to implement MST effectively. As such, supervision serves three interrelated purposes:

- Development of case-specific recommendations to speed progress toward outcomes for each client family
- Monitoring of therapist adherence to MST treatment principles in all cases
- Advancement of clinicians' developmental trajectories with respect to each aspect of the ongoing MST assessment and intervention process (Figure 2)

Several sections of this manual addressed the means by which supervision facilitates adherence to MST principles and treatment progress. The following sections describe strategies that supervisors can use to detect and advance the developmental trajectories of MST therapists and teams.

Developmental Progression of Teams and Supervision

When clinicians are new to MST, each referral tends to prompt numerous questions about each step of the assessment and intervention process and about the concrete application of the nine treatment principles. Accordingly, supervision for new teams tends to focus with almost equal emphasis on: clinician engagement/alignment with the family, collection of sufficient information and observations from multiple respondents to understand what combination of factors contribute to the major referral problems, development and prioritization of intermediary treatment goals, and design of interventions. As well, simple interventions that facilitate alignment and engagement (e.g., bringing pizza for dinner or interviewing a parent while giving him a ride to the employment office) and/or success experiences (e.g., establishing a short-term morning routine in which the therapist helps the parent get a persistently truant adolescent to school on time) are implemented as the initial assessment of fit is occurring, and thus are discussed in group supervision.

As cases progress from the point of referral to ongoing assessment and intervention, group supervision sessions tend to focus more selectively on those aspects of each case that present particular challenges to the clinician (e.g., difficulty implementing particular interventions effectively or problems understanding the barriers to intervention success). As teams become more seasoned, the productivity of supervision can be enhanced when supervisors develop a sense of case-specific objectives prior to the supervision session. By virtue of being removed from day-to-day clinical interactions, but in command of information contained in case summaries, exchanged during group supervision, and logged in their supervisory notes and recommendations, supervisors can help clinicians anticipate developments before they would have become apparent to, or priorities for, the clinician. Such ongoing review of case materials can assist supervisors in detecting trends and anticipating case developments that are sometimes elusive to clinicians who are "in the thick" of case-related activities all day, every day. For example, a clinician whose initial interventions successfully increased interparental inconsistency may overlook signs that inconsistency is resurfacing because she is focusing more intensively on contentious family-school and family-kinship

interactions. Thus, the supervisor would recommend that parental consistency be monitored and barriers to sustainability identified while the clinician is targeting interactions between the family and other systems. In this way, the supervisor can serve as an additional, and perhaps more objective, case historian, and one who can help the team "see the forest for the trees" on a regular basis.

Clinician-Specific Developmental Objectives

Supervision should facilitate clinician adoption of and adherence to MST in the field, across all cases, outside of the supervision context. As clinicians meet, or struggle to meet, case-specific objectives on a weekly basis, supervisors begin to identify the relative strengths and weaknesses of clinicians' performance across cases with respect to (1) each of the nine MST treatment principles and (2) each step in the ongoing assessment and intervention process represented on the MST Do Loop (Figure 2). Some clinicians, eager to effect change quickly (a strength), implement interventions before having established a working alliance, a sufficient understanding of strengths to use as levers for change, or a clear understanding of the multisystemic "fit" of the referral problems. Other therapists are quick to develop a multisystemic understanding of the fit of referral problems, but fail to use the same analytic process (understanding multiple factors contributing to a behavior) to analyze barriers to intervention success (e.g., why a parent figure did not implement an intervention). Some clinicians can identify barriers easily, but struggle to identify strengths in the family and other systems to build interventions upon, or routinely fail to see their own contribution to an intervention failure (e.g., the clinician did not assure a parent could enforce curfew when establishing it; did not role-play a parent-teacher conference with a parent whom the teacher chastised; did not clarify the exact nature of the consequence and reward associated with curfew violation and adherence). Some clinicians are comfortable implementing parent-child interventions but fail to appreciate the contribution of marital or other adult interaction patterns to the parent-child interaction problem.

Supervisors should be able to identify those MST-related tasks that each clinician is able to perform well in most cases, those which present consistent challenges for a clinician, and those on which clinician performance seems to vary considerably from case to case. This information can be used to develop individualized objectives for clinician performance with respect to a particular task (e.g., engagement/alliance building, case conceptualization, identification and prioritization of intermediary goals, development and implementation of interventions that are consistent with the nine MST principles, problem-solving strategies to overcome barriers). Supervisory strategies are individualized accordingly and can include individual supervision sessions, homework assignments, repeated audiotaped or field supervision, and training activities tailored to the individual clinician (e.g., reading about and role-playing cognitive-behavioral treatment techniques, marital intervention strategies, etc.).

Take, for example, a clinician who consistently identifies barriers to intervention success but relies primarily on the team to generate hypotheses about the "fit" of the barrier and to develop interventions to overcome the barriers. This therapist often seems to get "stuck" when interventions are only partially implemented, saying either that she doesn't know why this occurred or giving a single-factor explanation (e.g., the grandmother isn't motivated to do it) without taking the next step, namely identifying factors that might contribute to the barrier (e.g., how does the grandmother's lack of motivation make sense or what factors contribute to low motivation?). The supervisor noticed that this pattern characterized several of the clinician's cases, despite the team's best efforts to make sense of various barriers and develop intervention strategies to overcome the barriers. Because one of the main objectives of supervision is to assure that clinicians have a multisystemic understanding of the "fit" of barriers to intervention success and can design strategies to overcome barriers, the supervisor decided to talk with the clinician individually. Consistent with MST treatment principles, the supervisor's first task was to try to understand the "fit" between the clinician's difficulty understanding why interventions failed and or her apparent inability to generate and test multisystemic hypotheses about barriers to intervention success.

In this case, three factors emerged as primary contributors to the clinician's behavior:

- Failure to apply the process of generating a multisystemic "fit" of a child's behavior to the behavior of adults (generalization problem)
- Limited clinical experience with adults
- Limited repertoire of intervention strategies

For 2 weeks, the supervisor and clinician met individually to help the clinician develop a multisystemic conceptualization of the "fit" of specific barriers in each case and to generate a more extensive repertoire of interventions that might address these barriers. Following a brief discussion of these topics, the supervisor asked the clinician to rewrite the description of the fit accordingly in case summaries. The supervisor tracked the clinician's efforts to understand barriers to intervention success and revise intervention strategies in subsequent case group supervision sessions. The clinician continued to have difficulty identifying multiple contributors to barriers, so the supervisor offered to accompany her to treatment sessions to observe firsthand potential barriers to intervention success. The supervisor observed that the clinician was very directive with the adults in most cases, and the supervisor made specific recommendations regarding the development of a more collaborative approach to the design and implementation of interventions. The supervisor then monitored the implementation of such an approach through periodic review of audiotaped treatment sessions.

In summary, the MST supervisor must be able to detect patterns of clinician behavior across cases and time that signal adherence to each of the nine treatment principles and facility in executing each step of the iterative MST assessment and intervention process. This assessment of clinicians' strengths and needs enables clinicians and supervisors to track the "developmental trajectory" of clinicians with respect to mastery of MST. At times, supervisors may need to individualize some supervisory strategies to the particular needs of a clinician, as illustrated above. As well, the supervisor elicits team feedback with respect to presenting problems, client populations, or intervention strategies with which the entire team struggles. Importantly, this feedback can guide the selection of topics for booster training with the MST consultant.

Clinicians who consistently adhere to the MST treatment model, achieve positive outcomes and support team members' efforts to do so may seek opportunities to further their professional development. Such clinicians can be great assets to families, MST programs, and service systems. Thus, supervisors should be open to discussing professional development opportunities with them. The nature of professional development activities should follow logically from specific professional goals. The development plan should incorporate the strengths and needs of the clinician as well as the goals and resources of the MST program and organization that houses it. Thus, the supervisor should consult with organizational leadership and the MST consultant before developing the plan with the clinician. The extent to which goals in a professional development plan can be met entirely within the organization may vary across programs. For example, MST programs that have obtained funding to expand have been able to offer MST clinicians who performed particularly well positions as MST supervisors for new teams. MST programs with a fixed number of teams and no plans for expansion have not been able to do so.

From an MST perspective, almost any activity (conference, workshop, training experience) that enhances a clinician's experience with ecological practices and empirically tested family and community-based treatments could potentially enrich the experience of the clinician and the MST program. On the other hand, workshops, conferences, and training courses that feature services or treatments that have never been evaluated or have been shown to be ineffective would probably not be seen as promoting the professional development of an MST clinician. If supervisors are unsure about the extent to which a particular activity would enhance the clinician's contribution to the MST team, or the organization housing the program, a brief discussion with the MST consultant who has been working with the team may be helpful.

Finally, as noted earlier in this manual, activities that approximate psychotherapy for the clinician should not be seen as the obligation of the supervisor or MST program. If personal problems are interfering with the clinician's effectiveness at work, however, the supervisor should be prepared to discuss the evidence that this is the case with the clinician. In addition, the supervisor should be willing to discuss strategies the clinician might use to manage his or her problems more effectively while on the job. If psychotherapy is a desired option, the supervisor can provide instrumental support (e.g., covering the case during the clinician's therapy appointment times) and encouragement.

Barriers to Clinician Development

In some instances, despite the efforts of the team and supervisor to assist a particular clinician with the principles and process of MST, little change is evidenced in a clinician's developmental trajectory. A variety of case-related, clinician, and supervisory factors may contribute to this state of affairs, and should be explored. Identification of case-specific challenges and supervisory strategies to address them have already been discussed, as have barriers to effective supervision. At the level of the individual clinician, anecdotal experience suggests that several factors may hamper clinician acquisition of MST case conceptualization and intervention skills. Chief among these are clinician loyalty to theoretical orientations or professional practices that are incompatible with MST.

Clues that a clinician subscribes to theoretical perspectives inconsistent with MST seem to arise most often during discussions about the "fit" of a particular referral problem (or of newly identified barrier to intervention success) and during intervention implementation. Some clinicians consistently use diagnostic and characterological terms when asked to help "make sense" of a youth's delinquent behavior, describing the behavior as a function of a mother's dependency, father's passive-aggressive tendencies, and adolescent's anger problem. Others continue to rely on insight-oriented techniques to change the behavior of a parent or adolescent. Clinicians with extensive experience in structural family therapy may not appreciate the value of parent-child behavior management techniques, whereas clinicians with a strong behavior management background may struggle to identify family interaction patterns that contribute to a youth's aggressive behavior. Clinicians with significant experience conducting individual treatment with children and adolescents may seek to establish an alliance with the referred youth rather than with the caregivers, or quickly abandon family sessions in favor of individual sessions with youths when interventions targeting adult interactions have been ineffective or sessions have been interpersonally challenging.

Other aspects (besides theoretical orientation) of an individual's professional experiences also may be inconsistent with MST and interfere, at least temporarily, with adherence to the treatment principles. For example, individuals who join MST teams with significant experience as case managers often seek to coordinate formal services rather than cultivating the capacity of the family's indigenous environment to engage in the activities offered by the services. Or, former case managers may wish to refer a parent to individual or marital treatment rather than providing such treatment themselves in the context of MST.

If case-specific supervisory recommendations redirecting the clinicians' activities are not incorporated, supervisors may need to schedule an individual meeting to discuss the incompatibility of some aspects of the clinician's past experience with MST. The purpose of such a meeting is to develop a shared understanding between the supervisor and clinician of the "fit" of the clinician's persistence in activities inconsistent with MST. Such shared understanding is more likely to facilitate the joint (supervisor and clinician) development of effective strategies to increase clinician adherence to MST. In preparation for such a meeting, the supervisor should have specific evidence of clinician activities that are inconsistent with MST, and examples where recommendations made by the team and supervisor related to these activities have not been followed. If the supervisor is not familiar with the variety of the clinician's previous professional experiences, she or he should inquire about these experiences and explain the rationale for raising

this topic (e.g., "I'm trying to understand why these recommendations aren't being followed and wonder if it's because you had lots of experience doing X or Y in other ways before you joined our team"). The meeting should conclude with a plan delineating specific changes to be made by the therapist, the supervisor's role in helping make these changes, how both individuals will know whether the changes have been made, and the time frame in which the changes should occur.

References

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford Press.

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65, 821-833.

Henggeler, S. W., Rowland, M. D., Pickrel, S. G., Miller, S. L., Cunningham, P. B., Santos, A. B., Schoenwald, S. K., Randall, J., & Edwards, J. E. (1997). Investigating family-based alternatives to institution-based mental health services for youth: Lessons learned from the pilot study of a randomized field trial. *Journal of Clinical Child Psychology*, 26, 226-233.

Henggeler, S. W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry*, 153, 427-428.

Schoenwald, S. K. (1998). *Multisystemic Therapy Consultation Guidelines*. Charleston, SC: MST Institute.

Schoenwald, S.K., Henggeler, S.W., Rowland, M.D., & Hoagwood, K. (1998). *Getting Outcomes with MST: Implications for Dissemination*. Symposium presented at the Eleventh Annual Research Conference, *A System of Care for Children's Mutual Health: Expanding the Research Base*, Tampa, FL: Research and Training Center for Children's Mental Health, The Louis de la Parte Florida Mental Health Institute, University of South Florida.

THE AUTHORS CAN BE CONTACTED AT THE FOLLOWING ADDRESS:

Scott W. Henggeler, Ph.D.
Sonja K. Schoenwald, Ph.D.
Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, South Carolina 29425-0742