

**Mechanisms of Engagement and Change for Minority Ethnic Caregivers with
Multisystemic Therapy: A Grounded Theory**

Fatima Bibi

June 2014

Research submitted in partial fulfilment of the requirements for the degree of Doctor
in Clinical Psychology (DClinPsy), Royal Holloway, University of London.

Acknowledgements

I am very grateful to all the parents who gave up their time to talk with me and who allowed me into their homes in order to do this. I feel very privileged to have been witness to their stories and experiences and appreciate their willingness to allow me to gain insight into these. Without their help, this study would not have been possible.

I would like to thank my research supervisor, Dr. Simone Fox, for all her advice, expertise, and encouragement throughout my undertaking of this research project. I would also like to thank my field supervisors, Dr. Hayleigh Millar and Dr. Amaryllis Holland, for their help with recruitment and support throughout my research. I am very grateful for all their encouragement and advice.

I would like to thank my colleague and fellow researcher, Caitlin Kiddy, for her endless support, humour and inspiration throughout the process of conducting this study, and for sharing the joys and challenges of this journey with me. I would also like to thank my colleagues at UEL for their invaluable support, advice and motivation throughout the process of this study.

Finally, I would like to thank my family and my friends for all their support, patience and encouragement not just throughout the process of my undertaking this research, but throughout the three years of my training. A special thank you to my sisters for their endless encouragement and words of wisdom over the last three years.

Abstract

Evidence has shown that Multisystemic Therapy (MST) an intensive family- and community-based intervention has been particularly effective in the treatment of youth with antisocial behaviour from ethnically diverse backgrounds. Although the process of change within MST has been explored, there is a dearth of research in looking at this for families from ethnic minority backgrounds. The current research aimed to address this gap by exploring the experiences of a sample of London based caregivers who had completed an MST intervention. A qualitative approach was adopted, using grounded theory methodology to explore ethnic minority caregiver experiences of MST and generate a model of the processes of engagement and change based on participants' accounts. Seven semi-structured interviews were carried out with caregivers from two London sites. The emergent model consisted of seven interacting theoretical codes. Three of these codes were organised around the process of engagement; deciding to engage with MST, becoming therapeutically aligned and considering cultural difference, and four related to the process of change; working within a safe and trusting relationship, therapist acting as cultural broker, empowering the parent and increased communication within and outside the family. The author makes novel suggestions relating to the specific mechanisms that are thought to underlie the process of engaging with MST, and highlights the importance of considering cultural difference in the initial stages of the MST intervention.

List of Figures

	Page
Figure 1 MST theory of change.....	25
Figure 2 Recruitment and interview process.....	58
Figure 3 A model of engagement and change for minority ethnic caregivers in MST.....	106
Figure 4 A revised model of the processes of engagement and change in MST	108

List of Tables

	Page
Table 1 Participant demographics.....	54
Table 2 Getting on board with MST; the engagement process.....	69
Table 3 Finding a new way forward; the change process.....	89

Contents

Chapter 1. Introduction	8
1.1 Terminology	9
1.1.1 Ethnicity Race and Culture	10
1.1.2 Black Minority Ethnic (BME)	11
1.1.3 Minority Ethnic Groups	12
1.2 Psychological Interventions for Minority Ethnic Groups	13
1.2.1 Cultural Competence	15
1.3 Evidence Based Family Interventions for Minority Ethnic Groups	17
1.4 The MST Model and its Origins	23
1.4.1 Engagement in MST	24
1.4.2 Change in MST	25
1.5 Evidence Based for MST	26
1.5.1 Outcome Studies	27
1.5.2 Process Studies	28
1.6 MST Studies with Minority Ethnic Group	30
1.7 Proposed Study	34
1.7.1 Aims of Present Study	35
Chapter 2. Method	36
2.1 Research Design	36
2.1.1 Choice of Methodology	36
2.2 Grounded Theory	38
2.2.1 Rational for using Grounded Theory	39
2.2.2 Versions of Grounded Theory	41
2.2.3 Charmaz's Version of Grounded Theory	42
2.2.4 Rational for using Charmaz's Version of Grounded Theory	44
2.3 Position of Researcher	45
2.3.1 Reflexivity	46
2.3.2 Research Sensitivity	47
2.4 Procedure	48
2.4.1 Ethical Approval	48
2.4.2 Distress During or Following Interview	50
2.4.2 Safeguarding Children	50
2.5 Participants and Setting	51
2.5.1 Inclusion Criteria	51
2.5.2 Exclusion Criteria	52

2.5.3	Participants	53
2.5.4	Setting.....	55
2.5.5	Sampling and Theoretical Saturation.....	55
2.6	Recruitment	56
2.6.1	Data Collection.....	59
2.6.2	Interview Schedule.....	59
2.6.3	Piloting the Interview Schedule	60
2.6.4	Interviews.....	61
2.6.5	Adapting the Interview Schedule	62
2.7	Data Analysis Procedure	62
2.7.1	Transcription	62
2.7.2	Initial Coding	63
2.7.3	Focused Coding.....	64
2.7.4	Memo-writing and Constant Comparative Analysis	64
2.7.5	Theoretical Coding.....	65
2.8	Quality Assurance in Qualitative Studies	65
2.8.1	Owning your perspective	66
2.8.2	Situating the Sample	66
2.8.3	Grounding in Examples	67
2.8.4	Providing Credibility Checks	67
2.8.5	Coherence	68
2.8.6	Accomplishing General versus Specific Tasks	68
2.8.7	Resonating with the Reader	69
Chapter 3.	Results.....	70
3.1	Confidentiality	70
3.2	Findings	70
3.3	Getting on Board with MST	74
3.3.1	Deciding to engage with MST.....	74
3.3.2	Becoming Therapeutically Aligned	80
3.3.2.1	Creating a Shared Position.....	80
3.3.2.2	Developing a Therapeutic Alliance.....	83
3.3.3	Considering Cultural Difference.....	85
3.4	Finding a New Way Forward	92
3.4.1	Working Within a Safe and Trusting Relationship.....	94
3.4.2	Empowering the Parent.....	97
3.4.3	Increasing Positive Communication within and Outside the Family ...	100

3.4.4 Therapist Acting as a Cultural Broker	102
3.5 Model for Processes of Engagement and Change with MST for Minority Ethnic Caregivers	108
3.6 Revising the MST Model of Change	110
Chapter 4. Discussion	112
4.1 Overview of Findings.....	112
4.2 Characteristics of the Sample.....	113
4.3 Context for Discussion	114
4.4 The Engagement Process - Getting on Board with MST	115
4.4.1 Deciding to Engage with MST	116
4.4.2 Becoming Therapeutically Aligned	119
4.4.3 Creating a Shared Position	120
4.4.4 Developing a Therapeutic Alliance	120
4.4.5 Considering Cultural Difference.....	122
4.5 Process of Change - Finding a New Way Forward	125
4.5.1 Working Within a Safe Trusting Relationship.....	125
4.5.2 Therapist Being a Cultural Broker	126
4.5.3 Empowering the Parent.....	129
4.5.4 Increasing Communication Within and Outside the Family.....	130
4.6 The Emergent Model in the Context of Existing Theory.....	132
4.7 Critical Review	134
4.8 Implications for Clinical Practice.....	138
4.9 Implications for Future Research.....	140
4.10 Personal Reflections	142
4.11 Summary and Conclusions	143
References	145
Appendices	176
Appendix A: Extracts from Reflexive Journal.....	176
Appendix B: Memo Examples	179
Appendix C: Ethical Approval from National Research Ethics Committee	181
Appendix D: Research and Development Ethics Approval	184
Appendix E: Ethical Approval from RHUL Ethics Committee.....	187
Appendix F: Participant Information Sheet	188
Appendix G: Participant Information Sheet for Young Person	191
Appendix H: Participant Consent Form	192
Appendix I: Interview Schedule	194
Appendix J: Transcript and Coding Sample	198

Chapter 1: Introduction

Engaging minority ethnic populations in mental health services is an area of lively debate within clinical psychology. Guidance on mental health service provision in the UK advocates for mental health workers to be able to deliver culturally sensitive and clinically effective therapeutic interventions (Bassey & Melliush, 2012). Hall (2012) highlights the scientific and ethical imperative for delivering such interventions. Therefore effective, evidence based therapies that consider and address the needs of diverse communities are required. Evidence has shown that Multisystemic Therapy (MST; Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998; Henggeler, Schoenwald, Rowland & Cunningham, 2002), an intensive family- and community-based intervention for high risk juvenile offenders, has been effective in improving outcomes for youth anti-social behavior with ethnically diverse samples (Painter & Scannapieco, 2008). A strong and burgeoning evidence base has contributed to its growing international implementation, including the UK. MST research with minority ethnic groups in the UK however has been limited.

The aim of this research study was to explore minority ethnic caregiver experiences of participating in MST in the UK. The study sought to generate a theoretical understanding of the processes of engagement and change based on participants accounts, with the aim of adding to the existing MST process of change model (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) in highlighting factors to consider when working with minority ethnic families. The study aimed to contribute to the MST knowledge base, and to existing efforts to make MST an equitable treatment model for families from diverse ethnic backgrounds.

This chapter charts the development of the research aims. Starting with a discussion and definitions of terminology in relation to ethnicity, culture and race, the problems of homogenising different ethnic groups in research will be considered. The underrepresentation of minority ethnic groups in mental health services will also be considered. The evidence base for psychological interventions adapted for such groups will then be discussed, with specific reference to systemic models. This will be followed by a description of MST and a review of its evidence base. This review will consider outcomes studies examining efficacy and effectiveness, and process studies examining mechanisms of change in MST. A review of the evidence-base for MST with minority ethnic groups will follow, arguing that qualitative examinations are needed, leading to the aims, objectives and rationale of the current study.

1.1 Terminology

Pursuing precision in the use of terminology specific to a given area of study can be viewed as pedantic or futile (Sewell, 2009). However, terms, concepts and labels are constructed as a means to establish a shared understanding of a given phenomena; a lack of precision in defining them can distort meaning and interpretation, rendering them misrepresentative, meaningless and even dangerous. Indeed, labels are laden with intended and unintended meaning (Sewell, 2009), and can be both helpful and risky. Labels emphasize exclusion or affiliation, and incorporate covert and unacknowledged power hierarchies (McGoldrick & Hardy, 2004). William and Soydan (2005) suggest that language used to construct labels reflects particular theories, values and political ideologies and should therefore be subject to constant review and clarification.

1.1.1 Ethnicity, race and culture

The concept of ethnicity is often used interchangeably with culture as well as race (Fenton & Sadiq-Sangster, 1996). According to Shah, Oommen and Wuntakal (2005) race, culture and ethnicity can be defined in the following way: "Race is a phenomenological description based on physical characteristics. Culture describes features that individuals share and which bind them together into a community. Ethnic minority individuals have been defined as those with a cultural heritage distinct from the majority population" (p.103-104).

Thus of the three terms, race is perceived to be fixed and within the person, and often utilised as a signifier for ethnicity and/or culture. Ethnicity, in comparison, is not as easily definable. It encapsulates a range of factors used to identify individuals and relates to language, geographical origin, skin colour, religion and cultural practices (Sewell, 2009). In comparison to race, ethnicity therefore seems to be more fluid and is based largely on self definition. Sewell (2009) points out that ethnic group and ethnic origin have been defined differently; "Ethnic origin is fixed and pertains to religion, language, geography, physical appearance and the culture associated with these factors. Ethnic group is self-defined though is usually related to the aforementioned characteristics" (Sewell, 2009, p. 17). Like ethnicity, culture is considered to be changeable, and is understood as a fabric of cohesion between individuals. Bhui (2002) defines it as shared ideas, non-material structures, habits and rules that help to circumscribe membership of a group.

Sewell (2009) challenges the accuracy of the dominant understanding of culture as a shared set of ideas adopted uniformly and in the same way by all those from a particular group (i.e. in terms of their race or ethnicity). Culture can be altered with generations, country, language and socioeconomic status (Gelfand & Fandetti, 1980). Thus, both ethnicity and culture should be regarded as concepts which differ greatly between not only countries and communities but also between and within families (Reicher & Hopkins, 2001). Indeed, culture is not a static entity; it is more helpful to think of it perpetually changing through successive phases of definition and redefinition (Fenton & Sadiq-Sangster, 1996). It is beyond the scope of this study to do justice to the intricate relationships between culture, race and ethnicity. What is clear however is that the concepts of ethnicity, race and culture are complex. Claims are frequently made in research about how the behaviour and beliefs of a particular group is informed by their 'culture' and 'ethnicity'. Culture thus appears to be intricately tied to ethnicity and thought of as a determinant of behaviour (Gelfand & Fandetti, 1980).

1.1.2 Black Minority Ethnic (BME)

The term or label BME is widely used in the UK to describe minority groups, particularly those who are viewed to have suffered racism or are in the minority because of their skin color and/or ethnicity (Sewell, 2009). Whilst it has become increasingly popular in government and academic literature, it is important to be critically aware of its problematic connotations. The term BME most reliably conveys disadvantage and, often inferiority (Bhopal, 1997). Referring to people with an acronym is wholly reductionist, dehumanising and depersonalising. Distinguishing between a white majority ethnic group, and a black minority ethnic group is not only

crude, divisive and exclusionary, but inaccurate as it implies that black people do not belong to an ethnic minority. It also implies that white people all belong to a single group, 'the majority', obscuring significant differences within the white population.

Moreover, such homogenizing terminology that groups diverse minority communities in a single group prevents people from defining themselves in all their complexity (McGoldrick & Hardy, 2004). It can thus be viewed as a convenient label placed on minority ethnic groups, rather than how people would identify themselves. Stanfield (1993) maintains that "the reproduction of a singular monolithic identity as objectified reality keeps ethnic minorities oppressed as second and third class citizens, and recognising a range of identities threatens the status quo in that it disturbs the social, political and economic arrangements of the dominant group" (p.13).

1.1.3 Minority Ethnic Groups

The term 'minority ethnic groups' emerged in the 1980s following its inaccurate predecessor 'ethnic minority groups' (still in popular use). The earlier term was contested as it implies that minority groups are 'ethnic', the assumption being that only 'different' people have an ethnic identity (Sewell, 2009). The current reversed description, although grammatically incorrect (with an adjective following a noun), makes it clear that those being referred to are ethnic groups, that together or singularly are in the social minority. McGoldrick and Hardy (2004) point out that the term does not have global transferability in terms of its negative inferences e.g. in some societies, such as in the African continent where white communities are in the

minority. This arguably exposes the unequal power relations inherent in such terms, worryingly masked in the discourse of equality.

Similar to the term BME, the term minority ethnic groups risks homogenizing difference and diversity and encouraging generalizations. Although the term minority ethnic is used in this report to ensure consistency in the context of existing research, it is recognized as problematic and readers are encouraged to be mindful of its limitations.

1.2 Psychological Interventions for Minority Ethnic Groups

The provision of evidence-based psychological interventions for minority ethnic groups that take into account specific cultural values is still a largely underdeveloped and under-researched area (Rathod, Naeem, Phiri & Kingdon, 2008), making it difficult to provide recommendations from which to adapt interventions for such groups (Sass, Moffat, Bhui & Mckenzie, 2009). Indeed, there is a lag in treatment and intervention research that seeks to develop, adapt, and test novel approaches with ethnically diverse populations (Trimble, Scharrón-del Río & Bernal, 2010; Mays & Albee, 1992) and clinical trial samples are typically not characterized by ethnic or cultural diversity (Miranda, Nakamura, & Bernal, 2003). Halliday-Boykins, Schoenwald and Letourneau (2005) highlight that the neglect of minority ethnic groups in treatment research raises serious concerns regarding the effectiveness of mental health treatments and the capability of the mental health services to effectively treat people from ethnically diverse backgrounds (Weisz, Huey & Weersing, 1998).

Research has shown that minority ethnic groups represent a small proportion of mental health service users in the UK (Dowrick, Gask, Edwards, Aseem, Bower, Burroughs & Waheed, 2009), and experience disproportionately poorer outcomes when they do engage in mental health services (Sashidharan, 2003). It has been argued that a key factor in this underutilization of mental health services is the different cultural conceptualizations of mental health problems and their management (Fernando & Keating, 2008). Conventional therapies are grounded in Western ideas and may not be as appropriate for people from different cultures (Benson & Thistlethwaite, 2008). Research has also shown that dominant professional ideas about mental health are experienced as culturally unacceptable for some people from minority ethnic groups (Chew-Graham, Bashir, Chantler, Burman & Batsleer, 2002). Differences in culture may lead to differences in understandings of distress and communication of certain experiences (Fernando, 1991).

Indeed, differences in Western and non-Western values systems are frequently understood to effect attitude orientations to therapy, and cited as a key reason why minority ethnic groups may not take up therapy (Fernando & Keating, 2008). Eastern cultures are understood to be rooted in the principles of collectivism, which implies that an individual's thought and action orientations are largely governed by the group to which he or she belongs, and 'self' is not defined through connection to rather than differentiation from others, that is, through cultivation of the 'we-self' (Seymour, 1999). An example can be found in Chinese cultural values which emphasize collectivism, the centrality of the family, filial piety, academic achievement, hierarchal relationships, respect of authority of elders, humility and emotional self control (Kim, Atkinson & Yang, 1999; Sue & Sue, 2012). Western cultures are thought to be characterized by an individualist orientation, encouraging the development of

autonomy, independent thinking, self-expression and achievement, with the overall aim of trying to develop into inner-directed persons and an emphasis on the 'I' self (Ghuman, 1999). Such values are likely to profoundly shape experiences of self and identity, how individuals make sense of their problems, and manifest in ideas around the appropriateness of therapy, and what to expect from such an endeavour.

However, it is important to take into account that individualist and collectivist values can co-exist within individuals and cultures. There is likely to be enormous variation of behaviour within societies and individuals may adopt both styles (Sinha & Tripathi, 1994). Great heterogeneity is likely within any ethnic group, and huge variation in the degree to which people adhere to the norms and values of their indigenous culture. Key factors such as immigration history, language skills, and degree of acculturation which refers to changes that take place following intercultural contact (Berry, 1997) need to be considered (Kim, Ng & Ahn, 2005; Sue, 1998). Therapists therefore need to be culturally sensitive or responsive when working with clients from minority ethnic groups (Zane, Nagayama Hall, Sue, Young & Nunez, 2004).

1.2.1 Cultural Competence

Indeed, research suggests minority ethnic groups are more likely to continue with interventions modified to take into account their specific cultural needs (Weisman, Duarte, Koneru & Wasserman, 2006). The scarcity of research on the efficacy of different therapeutic approaches for different cultural groups makes it difficult to know exactly how therapy can be made culturally sensitive and appropriate (Jim &

Pistrang, 2007). Sue (1998) argues that the 'cultural competence' of the therapist is necessary although not sufficient in the delivery of culturally appropriate therapies, defining the key characteristic of 'cultural competence' as good knowledge and understanding of the cultural group the client is from. Jim (1997) points out that a critical skill in cultural competence is knowing when to generalize, and when to individualize - that is recognising when cultural characteristics may be relevant to the client's problems, but to see the client as an individual. She highlights that cultural competence stands in contrast to 'cultural encapsulation' (Wren 1962), the unintentional ethnocentrism that can occur when the therapist lacks awareness of the impact of their own culture on interpretations of the client's difficulties.

Patel (2010) points out the importance of going beyond simplistic explanations and recommendations to ensure that the concept of cultural competency is considered seriously, so as to not underestimate or obscure the complexity of "understanding within marginalized communities the relationship between social context, discrimination, inequality, well-being and its neglect within Western psychological approaches" (p.30). Brown (2000) highlights that over emphasizing difference in the name of cultural competence may facilitate a process of 'othering', reinforcing ideas of difference as a disadvantage. This may further disempower and marginalize minority groups, through an inadvertent re-enactment of racist, colonialist and imperialist attitudes in the therapy session (Rober & DeHaene, 2013). The concept and practice of cultural competence thus requires enormous sensitivity, and thoughtful consideration.

Cultural competence has been attended to by some through matching clients with ethnically similar therapists, on the assumption that therapist and client are likely to share similar backgrounds, and are thus likely to possess knowledge, skills and patterns of communication that facilitate the provision of culturally responsive treatment (Tharp, 1991; Sue & Sue, 2012). Consistent with this perspective, findings indicate that client- therapist ethnic similarity is associated with reduced treatment dropout (Maramba & Hall, 2002). However, studies have generally found little or no effect of ethnic match on clinical outcomes (Maramba & Nagayama Hall, 2002). The most popular explanation for the discrepancy between findings for utilization versus clinical outcomes is that the cultural match has a more powerful impact on clinical outcomes than ethnic match and ethnic match does not guarantee cultural match (Erdur, Rude & Baron, 2003; Maramba & Hall, 2002). It has also been suggested that this discrepancy may occur because ethnic match influences engagement, but not the treatment process that leads to improved client functioning (Fiorentine & Hillhouse, 1999; Fujino, Okazaki, & Young, 1994). However, a study examining caregiver-therapist ethnic similarity on youth outcomes in MST found that youth whose caregivers were ethnically matched with the therapist demonstrated greater decrease in symptoms, longer times in treatment and increased likelihood of discharge for meeting treatment goals (Halliday-Boykins, Schoenwald & Letourneau, 2005).

1.3 Evidence Based Family Interventions for Minority Ethnic Groups

Family therapy has been fruitful in incorporating cultural considerations within interventions, spurring growth in research informing clinical practice (Bernal, 2006).

As contextual factors are at the heart of the family systems approach, culture is central in all family approaches (Speigal, 1971). McGolderick, Pearce and Giordano's (1982) seminal publication on ethnicity and family therapy makes recommendations for the inclusion of ethnicity and cultural processes in clinical practice, stating that therapy is more effective when it is congruent with the culture and the context of the service user. They propose that therapy is best understood as an interpersonal process embodying the cultural, social, political, socioeconomic factors (including race relations) that impact upon the daily lives of individuals and families.

Families from minority ethnic groups typically prefer family-focused rather than youth-only focused interventions (Kumpfer, Alvarado, Smith & Bellamy, 2002). Mock (2001) understands this as a result of the collective 'we' family identity fostered by family interventions as opposed to an individual 'I' self-identity. According to Kumpfer et al. (2002), traditional minority ethnic families prefer a systems change approach rather than individual change approaches due to the emphasis on interconnection, reciprocity and filial responsibility. Boyd-Franklin (2006) argues that for such reasons family interventions are culturally more appropriate for ethnic families than individual intervention models. Meta-analyses indicate that family approaches have effect sizes on average nine times larger than youth-only interventions in reducing youth conduct problems for both traditional and acculturated minority families (Tobler & Kumpfer, 2000; Tobler & Stratton, 1997).

Kumpfer et al. (2002) point out that ethnic minority families are difficult to recruit and retain in family interventions, particularly if interventions are not culturally appropriate. One reason for this could be that such interventions are heavily influenced by, and

cater for white middle-class values (McGoldrick & Hardy, 2004). According to Resnicow, Soler, Braithwaite, Ahluwalia & Butler (2000) family interventions should be developed as culture specific and address deep structural values and practices that underpin different cultures, including sensitivity to diverse values of relational orientation (Santisteban, Muir-Malcom, Mitrani & Szapocznik, 2001). Kumper et al. (2002) recommend that deeper cultural adaptations should consider critical values and traditions for within race cultural sub-groups defined by geographical location (rural, suburb), educational achievement, socioeconomic status, language, acculturation level, and the individuals' own interpretation and identity with their race, culture and ethnicity. They argue culturally sensitive programs are essential for the success of family-focused interventions, but are often based on practitioners' perceptions of ethnic community needs rather than research or empirically tested theories.

The lack of research and randomized controlled trials on culturally adapted family interventions makes it difficult to know whether such interventions are more effective than interventions not tailored for minority ethnic groups (Kumper et al., 2002). Sanders (2000) argues there is an ethical imperative to ensure interventions developed for the dominant culture do not negatively impact the individual's own cultural values, competencies or language. He cites the need to identify factors such as family structures, roles and responsibilities, predominant cultural beliefs, child raising practices, developmental issues, sexuality and gender roles within the context of developing culturally sensitive family interventions. For example, collectivist values that embody strong family ties common in Eastern cultures (such as in the Indian culture) have implications for adolescent experiences. It is worth considering that the quest for personal and social identity for British-born minority ethnic young people

can be fraught with more difficulties than their white counterparts due to the potential deep gulf between certain values and social conventions of the home on one hand and of the school and wider society on the other (Ghuman, 1999).

Indeed, it is important to consider different cultural perspectives on the task or developmental function of adolescence as this may have implications for family interventions. Whilst there is enormous variation in any given culture, there are likely to be patterns of normative development that are loosely linked with, and characterise certain cultures (Berry, Phinney, Sam & Vedder, (2006). In Western cultures, individuation from the family is typically seen as the developmental function of adolescence (Havighurst, 1956), and the process of distancing or breaking away from the family is endorsed by the cultural scripts of literature and films (Considine, 1985; Kiell, 1959). In this period, there is a mutual re-negotiation of relationships with parents in which the adolescent is granted more individual autonomy, leading them towards an independent adulthood with more peer-like relationships with their parents (Hauser, Powers & Noam 1991). A period of temporary disharmony between parents and the adolescents as a result of this is often seen as a normal part of this re-negotiation. In contrast to more collectivist cultures, Western culture places a high priority on the development of self resilience in adolescence (Saraswathi & Ganapathy, 2002). In terms of everyday family interactions, this process of change takes the form of reduced daily contact with parents, more autonomy, less time at home and more time with friends (Ghuman, 1999).

The process of distancing, accompanied with a range of emotional experiences seen as the normative developmental pattern in Western cultures has been shown to be

different cross culturally (Berry et al., 2006). For example, a study with African American adolescents showed no decline in amount of time spent with family with age (Larson, Richards, Sims & Dworkin, 2001). African cultures are typically also underpinned by collectivist values placing family at the centre of people's lives (Bharat, 1997). Similar to Eastern cultures, cultural and religious scripts of devotion to the parents and family and increasing commitment and responsibility come to the fore in adolescence (Verma & Saraswathi, 2002). There is less of a cultural imperative to break away. For example, traditional Indian values stress continuity rather than discontinuity in family ties from childhood to adulthood, which are strengthened in adolescence (Larson, Verma & Dworkin, 2003), and subordinating one's own individual needs to the kinship group's interests is perceived as a virtue and encouraged (Saraswathi, 1999). Children are taught respect, trust and deference to elders from an early age and behaviour threatening the co-operative spirit and unity of family is discouraged from surfacing so that close family and kinship ties are maintained (Bharat, 1997). Hence, Ramanujam (1972) noted that inter-dependence is prized, not independence which can be equated with disobedience in such families. Whilst it is important to consider such differences when working with minority ethnic families, any efforts must be balanced against the considerable heterogeneity that exists within a given culture.

Kazdin (1993) recommends deriving principles to guide cultural adaptations of existing model programs rather than developing separate models for minority ethnic groups. Researchers of minority ethnic backgrounds recommend that these principles should include sensitivity to the following elements: (a) the degree of influence of specific cultural family risk and protective factors, (b) level of acculturation, identity, and lifestyle preferences, (c) differential family member

acculturation leading to family member conflict, (d) family migration and relocation history (e) levels of trauma and loss related to experiences of relocation, (f) family work and financial stressors, and (g) language preferences and impediments due to English as a second language, and level of literacy in native language (Turner, 2000). Each specific ethnic group will have special issues that need to be considered when adapting programs (Kumpfer et al., 2002). For example, adaptations for African families should consider their value of education, discipline, religion, extended family support, adaptability of family roles and coping skills in hard times (Boyd-Franklin, 1989; Turner, 2000).

However, the challenge of understanding, specifying and documenting how ethnicity and culture play a role in the treatment process, and how interventions may need to be adapted to meet the needs of diverse families remains (Bernal, 2006). In a review of the evidence base on psychosocial treatments with ethnic minority youth and families, Huey and Polo (2008) propose that treatment models reflecting inherent consideration of cultural differences (even if not specifying culture-specific protocols) produce better outcomes. They cite as an example, the framework of treatment principles provided by MST, which recommends therapists respond to unique circumstances of the individual client and context (Glisson, Schoenwald, Hemmelgarn, Green, Dukes, Armstrong & Chapman, 2010). Indeed, MST has been found to be effective for working with ethnically diverse samples (Brondino, Henggeler, Rowland, Pickrel, Cunningham & Schoenwald, 1997). The origins and application of MST will be examined in the following section.

1.4 The MST Model and its Origins

MST is an intensive, family and community-based therapy for adolescents and their families experiencing difficulties with anti-social behaviour (Henggeler & Borduin, 1990). MST was developed in the 1970s in the US in response to research showing that a number of individual youth, family, caregiver, school and community risk factors contribute to the development and maintenance of anti-social behaviour in young people (e.g. Farrington, 2003). The majority of these risk factors had been overlooked in conventional treatment provision, which typically targeted individual rehabilitation when addressing anti-social behaviour (Henggeler, Rodick, Borduin, Hanson, Watson & Urey, 1986; Ashmore & Fox, 2014). The development of MST sought to target a multitude of risk factors, constituting a more comprehensive and ecologically valid approach (Ashmore & Fox, 2011; Kazdin & Weisz, 1998).

MST is embedded within Bronfenbrenner's (1979) theory of social ecology in which the interactions between the individual, their family and extra-familial systems (e.g. school, community, peers) are conceptualised as functional in the precipitation, trigger and maintenance of clinical problems. It is understood that there is a complex and dynamic interplay between the young person and the different contexts, each having their own unique influence on the individual, and vice-versa. Therefore, MST interventions seek to work with all of these systems to contextualise difficulties and create change, specifically identifying and targeting maintenance cycles within the system (Ashmore & Fox, 2011). This is the guiding principle and focus for intervention.

MST seeks to facilitate change within the young person through supplementing parenting skills of caregivers, improving family relationships and developing more adaptive support networks, ultimately aiming to prevent out-of-home placements, and reduce anti-social behaviours (Ashmore & Fox, 2011). MST interventions are typically carried out with young people and their carers in their homes to overcome the barriers to engagement with traditional services and models of treatment (Ashmore & Fox, 2011). Central to the MST approach is the notion that treatment should be individualised and tailored to meet the needs of the young person and their family.

1.4.1 Engagement in MST

Family engagement is a critical component within MST, and an integral part of the treatment process. Cunningham and Hengeler (1999) propose that engagement can be defined as an active process whereby the therapist and family members make a commitment to work together to accomplish mutually agreed upon treatment goals. They argue treatment can not progress until therapist and family members (i.e. the youth's caregivers, other adults who control family resources or have decision making authority) are prepared to work on important therapeutic tasks, such as defining problems, setting goals and implementing interventions to meet those goals. MST therapists thus utilise a number of core clinical strategies to enhance engagement with families, including identifying strengths across multiple systems, reflective listening, empathy, perspective taking, reframing, authentic, warm and

flexible approach, hope and reinforcement, maintaining a family focus and valuing the family's culture (Tuerk, McCart & Henggeler, 2012).

1.4.2 Change in MST

As stated, caregivers are identified as the main facilitators of change in MST (Henggeler et al., 2009). Empowering caregivers and enhancing parenting skills (e.g. monitoring, affective relations) to improve family functioning is critical in facilitating key changes in the youth's social network. The ultimate goal is to surround the youth with a context that better supports pro-social behaviour. This constitutes the MST theory of change (Henggeler et al., 2009), depicted in Figure 1.

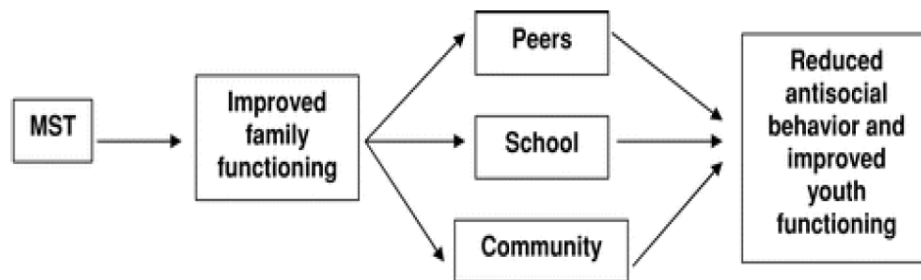


Figure 1. MST Theory of Change

In Figure 1 'Improved Family Functioning' is presented as the umbrella term used in MST encompassing 'parental effectiveness'. Fostering a context that supports pro-

social behaviour and bolstering personal and local resources for the caregivers helps sustain changes achieved during the intervention (Henggeler et al., 2009).

1.5. Evidence Base for MST

MST has been extensively researched, progressing from small scale efficacy studies to multisite trials, which have produced a strong evidence base demonstrating its effectiveness in reducing youth anti-social behaviour, increasing school/training participation, and decreasing rates of out-of-home placements (Henggeler & Sheidow, 2012). MST has been shown to improve family functioning (e.g. Borduin, Schaeffer & Heiblum, 2009), with a variety of troubled youth including violent offenders (Borduin, Mann, Cone, Henggeler, Fucci, Blaske & Williams, 1995). It is a well-validated treatment model, supported by an extensive body of research including 22 published outcome studies (20 of which were randomised controlled trials). A number of research studies have also started to examine the process, and the mechanisms of change within MST.

1.5.1 Outcome Studies

A substantial number of outcome studies have examined the efficacy and effectiveness of MST. Curtis, Ronan and Borduin (2004) conducted a meta-analysis examining the effectiveness of MST, finding a moderate effect size in improving overall functioning in comparison to similar treatments. Young people in receipt of MST showed 70% less offending than those receiving alternative treatments. In addition, MST was found to be effective in reducing aggression and improving emotional and behavioural problems. Treatment effects were sustained for up to four years. The review found the largest effect size on measures of family relations, consistent with the importance MST places on family functioning (Henggeler & Bourduin, 1990). It is noteworthy that 54% of the sample across all studies in the meta-analysis were African American. Although not discussed by the authors, this holds important implications for the utility of MST for this group.

It is also important to take into account that all of the studies included in the meta-analysis by Curtis, Ronan and Borduin (2004) were conducted in the US, thus limiting the generalisability of findings to other countries. Littell, Popa and Forsyth (2005), argue that the meta-analysis findings may have been influenced by estimation errors and bias because the researchers were program developers of MST. These authors highlight that nearly all of the studies included in the meta-analysis (and the vast majority of MST outcome studies as a whole) have been carried out by MST's founders (Littell et al., 2005). They highlight the possibility of 'allegiance effects' and vested interests that may occur as a consequence of being closely affiliated with a particular model. Curtis, Ronan and Borduin (2004) themselves point out that the

involvement of the MST developers as clinical supervisors in the efficacy studies may have contributed to the higher effect sizes that were observed in those studies ($d = .81$) compared to the effectiveness studies ($d=.26$) in their meta-analysis.

In consequence, Littell, Popa and Forsythe (2005) conducted a further meta-analysis of MST effectiveness studies, finding inconclusive evidence of MST effectiveness compared to other interventions. They noted the small study sizes, insufficient review of evidence for other interventions more effective than MST, and inconsistent and incomplete reports on primary outcome studies. However, the first RCT of MST carried out in the US independent of treatment developers, examining outcomes for young people involved with the juvenile justice system, found MST significantly reduced reoffending compared with treatment as usual (Timmons-Mitchell, Bender & Kishna, 2006). Positive outcomes have subsequently been found when comparing MST to 'usual interventions' both in the US, Norway and the UK (Schaeffer & Bourduin, 2005; Ogden & Hagen, 2006; Butler, Baruch, Hicky & Fonagy, 2011).

1.5.2 Process Studies

There have been fewer studies evaluating the processes and mechanisms that lead to change in youth and their families with MST. Studies have begun to identify important moderators e.g. treatment fidelity (Henggeler et al., 1998) and treatment mediators (e.g. improved peer relations; Huey, Henggeler, Brondino, & Pickrel, 2000; family engagement; Schaeffer & Bourduin, 2003) of MST outcomes. Huey et al. (2000) and Henggeler et al. (2009) found that decreasing involvement with negative

peers is mediated by improvement in family relations and increase in caregiver consistency and discipline, identifying processes that facilitate change with MST. Further research on the processes of change in MST has both theoretical and clinical value for MST (Rutter, 2005).

A number of UK studies have recently aimed to fill the gap in the MST literature, examining the processes of change for carers and young people. These have mainly employed qualitative methodology to explore parents and young people's experiences of MST. Such studies have shed much-needed light on the specific mechanisms of change with MST (Tighe, Pistrung, Casdagli, Baruch & Butler, 2012; Paradisopoulos, Pote & Fox, (submitted for publication); Kaur Gomez, Pote & Fox, (submitted for publication).

Tighe et al. (2012) carried out a qualitative study which consisted of interviewing young people and their parents following participation in an MST programme based in London. A thematic analysis generated 10 themes organized around two domains. The first domain, captured the central importance of the therapeutic alliance in families' positive experiences of the intervention. The second domain highlighted outcomes as a more complex construct, with improvements still reported in spite of some repeat offending. A wide range of outcomes were reported, including re-inclusion into the education system and increased communication. Importantly, the data generated indicated an increase in parents' confidence, and improved family functioning as a result of participation in MST. Based on their findings, Tighe et al. (2012) concluded that another key mechanism of change in MST is intervening in the multiple systems in the young person's life.

It is worth noting that although there were minority ethnic participants within Tighe et al's. (2012) study (48% of the total sample), there was no discussion about whether culture or ethnicity specific issues arose, and if so, how they were negotiated within MST. There is a danger in interpreting the absence of the discussion of such issues, as indicative of them not being present or relevant, which in reality may not be the case. In light of the findings from the aforementioned studies that highlight the importance of the therapeutic alliance as key mechanism of change in MST, it becomes ever more important to consider the potential challenges to forming a therapeutic alliance in MST when working with families from different cultural backgrounds, and the impact this may have on engagement and change. The next section will consider studies that have specifically examined MST with minority ethnic groups.

1.6 MST Studies with Minority Ethnic Groups

It has been argued that MST is a culturally competent intervention (Brondino, Henggeler, Rowland, Pickrel, Cunningham & Schoenwald, 1997). Indeed, the effectiveness of MST for minority ethnic groups has been evidenced by several clinical trials in the US that have included relatively high percentages of minority ethnic families (Brondino, Henggeler & Rowland, 1997). One of the pertinent studies supporting this claim was carried out by Scherer, Brondino, Henggeler, Melton and Hanley in 1994. They conducted a three year multisite study in South Carolina to evaluate the outcome of MST across two rural mental health sites, comparing it to treatment as usual for families who had an adolescent at imminent risk of

incarceration. Seventy eight percent of the total sample was of African American origin. Findings showed that families who took part in MST showed significant decreases in aggressive behaviour, and improved family functioning in comparison to usual care services.

Painter and Scannapieco (2008) posed the question, in a review of the literature on MST with culturally diverse families 'if families and children from diverse populations experiencing mental health problems receive MST, will they have similar outcomes across race and ethnicity?'. Ten randomized controlled studies were reviewed, examining the effectiveness of MST with youth who have serious mental health problems, on outcomes of family relations, interactions or functioning; out-of-home placement; psychiatric symptoms; and school functioning. Across the studies reviewed, African American males were over-represented, ranging from 15.5% to 80.6% of the sample. The majority of the studies examined, reported on the effectiveness of MST in improving family relationships, decreased behaviour problems and/ or improved psychiatric symptoms. The authors concluded that MST was a promising intervention in reducing disparities in mental health care for African American children in the child welfare system, in decreasing the chances of out-of-home placements.

It is important to note, however that the over representation of African Americans in the studies reviewed, poses problems for generalisability across all ethnic minority groups. Different cultural groups are likely to have significant structural differences across important dimensions within the family, and within culture specific value systems e.g. acceptability of outside involvement (Hines, Garcia-Preto, McGoldrick &

Weltman, 1992). Moreover, all of the studies reviewed in the Painter and Scannapieco (2008) article were carried out in the US, which once again raises questions about the generalisability of findings for minority ethnic groups outside of the US since there are likely to be major societal and cultural differences across the various ethnic mixes in different countries. Also, only one of the studies reviewed was independent of the founders of MST. So nine of the 10 studies reviewed were carried out by researchers who were affiliated with the development of MST, which brings to the fore issues around 'allegiance' discussed previously.

Butler et al. (2011) published the results of the first independently conducted RCT in the UK, evaluating the effectiveness of MST in a large, ethnically diverse urban sample. They specifically sought to examine whether MST is more effective in reducing youth offending and out of home placements compared to existing youth offending protocols. They also sought to determine whether MST leads to broader improvements in family functioning and youth sociality. One-hundred and eight families from an inner London borough were randomised to MST or the youth offending team and followed up post intervention. Forty one percent of the sample was from an ethnic minority background (mainly black African or Afro-Caribbean). Young people from both arms of the study showed reduced reoffending and out of home placements. However, differences in the mean number of offences from six month pre-MST up to a year after MST were all non significant. Despite this, there was a significant difference between the numbers of non-violent offences at 18 month follow up. There were however no significant group differences post treatment in secondary outcomes of increased parental supervision, increased family communication or reduced deviant peer association. Although the authors propose that secondary outcomes along the dimensions mentioned above are likely to

emerge much later (since reductions in youth offending emerged at the end of the follow up period), such findings raise important questions about whether cultural factors within the significant minority ethnic proportion of the sample may have contributed to the lack of significant secondary outcomes.

It is important to note that the study carried out by Butler et al (2011) does not highlight whether any adaptations were made to the MST model to ensure cultural fit with England. Schoenwald, Heiblum, Sladana and Henggeler (2008) carried out a review of the cultural adaptation process for the transportation of MST in different countries. They highlight the importance of pre-implementation adaptations e.g. programme developers collaborating with local stakeholders to adapt the programme to the structure, procedures culture of the host country. The study describes adaptations that were made to the intervention to ensure concepts were understandable, culturally relevant and appropriate e.g. different norms around 'praise' in the US and Scandinavia. However, the review did not consider whether cultural adaptation was necessary for England. It is important to consider how the MST model originating in accordance with the cultural norms in the US impacts not only a UK population, but minority ethnic groups within the UK.

Butler et al (2011) note that their study does not provide insight into processes or mechanisms of change. Indeed, all of the studies that have examined MST with minority ethnic groups have been quantitative studies that have examined outcomes. There have been no studies to date, either in the US or in the UK, that have qualitatively examined the process of change specifically for minority ethnic groups. It has previously been argued that the social-ecological approach MST adopts inherently addresses some of the key barriers to accessing mental health services for minority ethnic groups (Henggeler et al., 2009), yet there has been no qualitative research to corroborate this.

In light of the common view that minority ethnic groups are typically referred to as 'hard to reach' (Begum, 2006) it seems pertinent to not only examine mechanisms of change specifically for minority groups, but to also consider factors that impact engagement, since this is arguably the precursor to any effective change. Understanding which aspects of a complex intervention such as MST are associated with better outcomes for minority ethnic groups may help to improve clinical practice. It is important to take into account that there is no published research on minority ethnic users perspectives of MST to date, and what they perceive as the advantages and challenges of this treatment. Tighe and colleagues (2012) highlight the potential advantages of exploring service user perspectives, in that it may facilitate insights into how MST may be improved and provide richer, more detailed accounts of the helpful or unhelpful aspects of MST.

1.7 Proposed Study

Since there are no existing studies to the author's knowledge that have qualitatively examined the process of engagement and change specifically for minority ethnic groups, the purpose of the proposed study is to fill a gap in the existing literature through looking at this in a UK sample. The qualitative research mentioned previously examining process of change in MST, and mechanisms that impact outcomes (Tighe et al., 2012) provides a good foundation to build upon in order to understand that factors that facilitate, or hinder engagement and change for minority ethnic groups. Specifically, the current study is interested in finding out how MST accommodates diverse cultural beliefs, and the experience this has on participation in MST for minority ethnic carers and their families.

1.7.1 Aims of Present Study

The aim of the study was to use qualitative methodology to explore minority ethnic caregiver experiences of MST. The study more specifically aimed to:

- Explore factors which are experienced as contributing to or hindering engagement and change with MST from the perspective of minority ethnic caregivers
- Generate a theoretical understanding of the processes of engagement and change with MST for minority ethnic caregivers
- Consider the emergent model in relation to the existing MST process of change model in order to examine whether new factors emerge, and whether the existing model could be adapted to explain the process of engagement and change for minority ethnic caregivers.

Chapter 2: Method

2.1 Research Design

A qualitative study was designed to explore the research questions and grounded theory (GT) was chosen as the qualitative methodology. The following section contains a rationale for using GT and an explanation of what it is. This is followed by an outline of the procedure for gathering data. The final sections focus on the specifics of data collection and data analysis.

2.1.1 Choice of Methodology

The research aimed to construct a theoretical understanding of the mechanisms that underlie engagement and change in Multisystemic Therapy (MST) for minority ethnic caregivers. A qualitative methodology was considered most appropriate to achieve this given its inductive leaning, and emphasis on process and meaning in trying to gain a deeper understanding of experience (Denzin & Lincoln, 1998). Indeed, experiences of the factors that facilitated engagement and change in MST are likely to be constructed by the perceptions and meaning that caregivers ascribe to the various aspects of their MST experience.

Qualitative methodologies typically have a tendency towards constructivist ontology, in which reality is understood to be socially constructed by and between the persons

who experience it rather than being objective and quantifiable (Gergen, 1999), and interpretivist epistemology, in which meaning is understood to be constructed through subjective interpretations of a constructed reality rather than scientific facts and realities (Bryant & Charmaz, 2007). Qualitative methodologies seek to prioritise the voice of the subject as expert of their experiences, as opposed to imposing pre-existing assumptive frameworks held by the researcher (Macran, Ross, Hardy & Shapiro, 1999). Becker (1996) highlights the value of qualitative approaches in helping to gain an in-depth understanding of real world experience in its natural context, “facilitating the development of rich descriptions of phenomena and processes” (Harper & Thompson 2011, p.84). This is particularly useful for generating ideas and theories for further research (Kazdin, 2003; Smith, 2007), which was a primary aim of this study.

Qualitative methods can be particularly fruitful in achieving knowledge about areas that have received limited research attention (Smith, 2007; Strauss & Corbin, 1998). To date, to the author’s knowledge, there have been no qualitative studies that have examined minority ethnic user experiences of MST. It therefore seemed appropriate to employ qualitative methodology. It was thought that quantitative methodologies such as questionnaires run the risk of restricting the exploration of subjective experience (Lyons & Coyle, 2007). Grounded Theory was chosen as the most appropriate qualitative method of analysis.

2.2 Grounded Theory

Grounded Theory is an approach to qualitative research that seeks to explore processes, meanings and perceptions based on individual accounts of lived experience (Payne, 2007), and aims to develop theory that is based in such data (Glaser & Strauss, 1967). Developed by the sociologists Glaser and Strauss in the 1960s, GT originated from the symbolic interactionism movement, which purports that meanings are derived from action and social interactions based on interpretations made by the individuals involved (Schwandt, 1994). GT is based on an inductive approach in which data is gathered and analysed systematically and recursively using a set of rigorous strategies to guide the research and emergent theory (Charmaz, 2006). This is thought to allow researchers to stick closely to the data rather than forcing it to fit pre-existing theory (Glaser & Strauss, 1967). GT thus refers to both the methodology and the theoretical product of the research (Charmaz, 2006).

Glaser and Strauss (1967) developed a number of methodological steps to guide GT research. Central to the GT methodology is the concurrent process of data collection and analysis of data. Meaning making thus begins from the start of the data collection process (Glaser & Strauss, 1967; Charmaz, 2006; Strauss & Corbin, 1990). GT holds that analysis should take place following each piece of data collection, which involves developing codes, which are labels to describe each segment of data. Such codes are developed systematically into conceptual and eventually theoretical categories, and constitute the building blocks of subsequent

theory (Charmaz, 2006). Codes are used to guide theoretical sampling, which is the process of purposefully selecting participants based on the emergent theory. GT stipulates that data collection should stop when no new categories are discovered, referred to as theoretical saturation (Glaser & Strauss, 1967). Glaser and Strauss (1967) identified memo writing as an important part of the analytical process, to not only document ideas and keep an audit trail (Birks & Mills, 2011), but to enable the development of codes, identify gaps, and increase levels of abstraction (Charmaz, 2006).

A core part of the analytical process in GT is the constant comparative method (Glaser & Strauss, 1967) in which data, codes and categories are constantly compared across and within individuals. This process is thought to facilitate the robust development of categories, and the subsequent emerging theory. Also, it ensures that the researcher sticks closely to the data, allowing concepts and categories to arise from the data rather than forcing it to fit a pre-defined concept or theory (Glaser & Strauss, 1967). The theory that emerges can then be compared to the existing knowledge base, to consider in what ways the new theory contributes to this knowledge and understanding (Glaser & Strauss, 1967).

2.2.1 Rationale for using Grounded Theory

GT was considered to be the most appropriate qualitative methodology for this study as it was compatible with the research aim of generating a theoretical understanding of the mechanisms of engagement and change with MST for ethnic minority carers.

GT allows researchers to “examine what is happening, or has happened in studied phenomena” (Morse, 2009, p.13) and is therefore well suited to research questions about processes within therapeutic work. Moreover, existing theories based on Western cultural ideas of therapy might mask and obscure the challenges and complexities of therapeutic work with ethnic minorities. GT was considered well suited to achieve the aim of exploring these issues since it avoids imposing pre-existing theories on data.

Henwood and Pidgeon (1992) propose that GT can be employed where existing research is under defined and patchy. Given the paucity of the studies specific to MST with ethnic minority groups in the UK, this approach was selected to achieve this aim. Furthermore, GT has been successfully applied within family therapy to explore therapy process (e.g. Strickland-Clark, Campbell & Dallos, 2000; Madden-Derdich, Leonard & Gunnell, 2002; Lobatto, 2002) and thus was seen to be suitable for this study.

Other qualitative methods were considered for this study, namely Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) and Discourse Analysis (DA; Potter & Wetherell, 1987). A brief description of these approaches and the reasons for not selecting them for this study are briefly outlined below.

IPA is an approach to qualitative research that is focused on trying to understand individuals' lived experience and how they make sense of these experiences (Smith

et al., 2009). IPA requires the researcher to interpret what they perceive the meanings respondents are ascribing to their experiences, referred to as the 'double hermeneutic' (Smith & Eatough, 2007, p.36). IPA thus requires greater interpretation on the part of the researcher. This was not thought to be best suited to developing an emergent theory which is grounded in what is described by participants'. Indeed, IPA does not usually lend itself to theory construction, which is a primary aim in this research. Also, IPA has a distinct focus on the individual (Smith et al., 2009), whereas GT has more of a social focus given its development from within a sociological context. This seemed to be particularly appropriate to the study of MST in light of its delivery in a multisystemic context, with a family and community focus.

Discourse Analysis (Potter & Wetherell, 1987) examines the way language is used to construct the reality of an individual's world, and was also considered for the current study. The assumption inherent in DA is that there are multiple realities of the world, which are shaped by existing knowledge or discourses. This was of particular relevance to this study in light of the focus on culture and experience. However, it was decided that the wider focus of this approach on broader societal narratives would detract from the task of exploring individual experience and meaning, which was the aim of this study.

2.2.2. Versions of Grounded Theory

There have been a number of revisions of GT since it was originally developed by Glaser and Strauss in the 60s. The evolution of GT has meant that it has now

become an umbrella term representing a constellation of methodologies operating on an epistemological continuum (Charmaz, 2009). Early approaches were based on a positivist epistemology (that seek to discover objective truths and facts in data), whereas more recent revisions are characterised by post positivist, interpretivist epistemology (where reality is understood to be multiple and relative, and meaning is constructed through subjective interpretations of a constructed reality rather than scientific facts and realities (Bryant & Charmaz, 2007)). This study used Charmaz's social constructivist version of GT (Charmaz, 2006), which is described below.

2.2.3 Charmaz's Version of GT

Charmaz (2006) developed her social constructivist¹ version of GT as an alternative to the classic version (Glaser, 1978) and Straussian GT (Strauss & Corbin, 1998). Charmaz purports that her version of GT occupies the middle ground between positivism and postmodernism (Charmaz, 2006). She challenges the way classical GT theorists seek to discover latent and objective truths in data, and argues instead that meaning is created as individuals interact with, and interpret such objects.

¹ It is important to be aware of the differences between constructivism and constructionism in the UK, but not in the US. Tweed and Chamaz note that GT approaches described as constructivist in the US are consistent with the contemporary social constructionist approaches in the UK. Constructivist GT is therefore hereafter referred to as social constructionism for consistency.

At the heart of Charmaz's approach is the assumption that there are multiple social realities, in which knowledge is co-created by the researcher and the participant. Phenomena are thus conceptualised as being produced and understood through social actions rather than being objective truths (Bryman, 2004). Language, discourse, and/or culture are assigned a critical role in the process of construction (Charmaz, 2006). Actions and meaning in participants accounts are viewed as not only reflecting, but also reproducing inequalities, power relationships and discourses (Charmaz, 2009). It is this social constructionist epistemology which frames the lens through which data is understood and treated in Charmaz's approach (Charmaz, 2006).

Charmaz (2006) criticises the original methodology for assuming a distant relationship with participants and retaining the authoritative role of the 'expert' researcher bringing an objective view to the research. Instead, Charmaz advocates a mutual relationship between the participant and the researcher in the construction of a shared reality. Charmaz (2006) places great importance on recognising the role of the researcher in analysing data and constructing theory based on their interpretation of participants language, which is shaped by the researchers own experiences and world views. Researchers are thus seen to be a part of the very phenomena they study, rather than being external to it (Charmaz, 2006).

Charmaz (2006) recommends documenting the research process and engaging in a reflexive process, to enable researchers to take a critical stance towards the impact of their own assumptions on the data collection and theory generation process (Charmaz, 2006). Instead of seeing it as being 'objective' or 'the only perspective',

analyses are understood to be subjective and as offering one of many possible perspectives, filtered through an individual lens (Charmaz, 2009, p.131). Rather than seeking to construct generalisable theories, the aim is to construct tentative theoretical understandings viewed as 'partial, conditional, and situated in time, space, positions, action and interactions' (Charmaz, 2009, p.141).

2.2.4 Rationale for using Charmaz's version of GT

A social constructionist version of GT seemed appropriate as it is consistent with the epistemological position of the study. This approach situates social and psychological processes in their material and cultural context (Charmaz, 2006) and challenges the notion that there is a single, universal reality. On the contrary, it holds that reality can be different for each of us based on our unique understandings of the world and our experience of it (Berger & Luckman, 1966) and aims towards an interpretative understanding of participants meanings. There are likely to be cultural differences regarding minority ethnic parents understandings of concepts fundamental to Western models of therapy, such as emotions and the self in relation to others (Fernando, 1991; Fenton & Sadiq-Sangster, 1996). A social constructionist approach lends itself well to examining such ideas.

Secondly, the overall flexibility inherent in Charmaz's approach made it a particularly appropriate choice in light of the various constraints of a Clinical Psychology Doctoral study. Charmaz (2006) invites researchers to utilise the procedures of GT flexibly, as long as the rationale and analysis process are transparent. Charmaz's version thus

arguably takes a more pragmatic approach than earlier versions of GT (Charmaz, 2006). For instance, earlier versions of GT discourage the researcher from carrying out extensive literature reviews before data collection in order to maintain openness and sensitivity to data (Glaser & Strauss, 1967). Charmaz (2006) acknowledges the practical difficulties related to this; literature reviews can help to ensure that researchers make a novel contribution to the area being researched (Payne, 2007). Since this project was completed as a part of a Doctorate in Clinical Psychology, it was essential to carry out a literature review prior to undertaking the research to fulfil course requirements.

2.3 Position of Researcher

The researcher adopted a critical realist social constructionist position (Guba & Lincoln, 1994). Critical realism ontologically acknowledges that there is a reality or world that exists independent of language, however “we do not make direct contact with the world, rather, our experience of it is mediated through culturally shared concepts” (Harper & Thompson, 2011, p.91-92). Combining this with a social constructionist lens allows the researcher to examine how cultural constructs of mental health problems and therapy impact processes within MST for minority ethnic carers, whilst acknowledging the researchers perspective in co-constructing participants experiences.

2.3.1 Reflexivity

Charmaz's Social Constructionist approach views researchers as 'part of what they study, not separate from it' and emphasises the importance of taking a reflexive stance (Charmaz, 2006, p.21). Researchers are encouraged to reflect on how their interactions, positions and assumptions influence the research process. As mentioned previously, reflexivity was a highly valued part of the research process to elucidate the impact of this interactive relationship between the researcher and participant. The following section outlines reflections on the researcher's position, interests and beliefs.

The researcher was a female Trainee Clinical Psychologist, from a Bangladeshi background (1st generation). During the time of carrying out the research, she was working in a child and adolescent mental health service, and had a clinical interest in working with children and families. Unlike the participants, the researcher was not a mother. She had never carried out qualitative research prior to this study. She had no direct experience of MST.

The researcher had an interest in diversity, culture and systemic practice. Since starting clinical training, she became alerted to the idea of therapy as a construct to specific Western cultures, and the importance of taking this into consideration when trying to understand why certain ethnic minority groups are 'hard to reach'. The researcher commenced the research process with a curiosity about how therapy is constructed and experienced between Western trained therapists and people from

non Western cultures. She was also interested in inequalities in access to resources and power, and the consequences of this on mental health and well-being.

In keeping with the core recommendations of GT methodology, the researcher kept a reflective journal, and actively reflected on her position in to consider its impact in the research process. Thoughts and reflections were discussed in both research and peer supervision at various points throughout the study (see Appendix A and B for extracts from reflective journal and memo keeping).

2.3.2 Research Sensitivity

Acknowledging the researchers sensitivity to the data, and highlighting any existing knowledge in relation to the present study is important in drawing attention to potential biases in the analytical process in GT. As mentioned above, a literature review was submitted in order to meet course requirements for the Doctorate in Clinical Psychology. It was therefore not possible to enter into the research process without pre-existing knowledge, as recommended by Glaser and Strauss (1967). Elliott, Fischer and Rennie (1999) acknowledge that researchers attempts to 'bracket' their prior knowledge is a difficult, if not an unrealistic position to assume and argue that it is more important for the researcher to 'own their perspective' from the outset. Based on the literature review that was carried out the researcher entered the study with a sense that MST was a well-evidenced intervention, and was curious about people's experiential accounts of taking part in it since there was very little literature around this.

2.4 Procedure

2.4.1 Ethical Approval

Since participants for this study were required to have taken part in MST, which is provided by the NHS, full ethical approval was obtained from the National Research Ethics Service (NRES, See appendix C), and local Research and Development committees (see appendix D). Ethical approval was also gained from the Royal Holloway University of London Ethics Committee (see appendix E) prior to commencing the research.

Ethical issues around informed consent, confidentiality, disclosure of risk and distress/discomfort with the process of being interviewed were carefully considered, and addressed in the following ways:

Informed consent

All participants were provided with detailed participant information sheets (see appendix F) to ensure they had an adequate understanding of the research prior to making the decision about whether to take part. The researcher made a concerted effort to discuss any queries with participants in relation to the research, and written consent was obtained from each participant (see Appendix H). All participants were

made aware of their entitlement to withdraw from the study at any stage without this affecting their current or future care. Although young people were not being interviewed as a part of this study, a separate developmentally appropriate participation information sheet was developed to inform them about the study (see appendix G).

Confidentiality

Only the external supervisors were aware of who was being contacted for this study, and verbal consent was obtained before their details were passed on to the researcher.

All participants were informed that the information they shared in the interview would be kept confidential, and that their identities would be anonymised. Participants were informed that the information they shared in the interviews would not be identifiable to their therapist, or the service, with the only exception being around disclosure of risk.

Risk and Disclosure

A clear risk protocol, in line with service procedures was discussed up before interviews were carried out to manage the occurrence of any risk issues. Discussions

took place with site supervisors around the potential types of risk issues that may arise, and how they can be managed. Site supervisors were in a position to be able to screen out families that were considered high risk, which was a part of the exclusion criteria. All participants were informed about risk related issues via the participant information sheet, and a verbal reminder was given at the beginning of the interview.

2.4.2 Distress During or Following Interview

Interviews required participants recalling and reflecting on their experience of MST, which may have been difficult or emotionally challenging. Participants were not asked direct questions about their reason for referral, or details about their particular difficulties to reduce potential discomfort or distress. An opportunity to debrief the participant upon completion of the interview was incorporated into the design of the project. Following discussions with site supervisors, it was agreed that should the researcher feel concerned about a participant in the case that they were very distressed, it would be appropriate to have a conversation about seeking support.

2.4.3 Safeguarding Children

Consistent with NHS guidance, procedures were put in place to ensure child safety and protection. It was agreed that should caregivers disclose any information that indicated that any young person in their care was at risk to themselves, others or

property, relevant professionals would be consulted. This was highlighted in the participant information sheet.

2.5 Participants and Setting

2.5.1 Inclusion Criteria

The following inclusion criteria were applied to recruit participants into the study:

- Minority ethnic caregivers of families who were involved in MST for at least 3 months. This is the minimum a family can participate for in MST for it to be seen as potentially effective (Henggeler, 1999).
- Minority ethnic caregivers of families who have participated in MST in the last 12 months irrespective of outcomes. Positive outcomes at discharge consisted of the 'ultimate' outcomes defined in MST services and in MST research (Henggeler & Schoenwald, 2011). These outcomes capture the main aims of a MST intervention which are:
 1. No new charges.
 2. Young person still living at home.
 3. Young person in education, training or employment
- Minority ethnic caregivers who were not born in the UK in order to capture dual cultured families.

- Minority ethnic caregivers of families with positive outcomes, negative outcomes or no change at the end of treatment in order to try and capture factors that facilitated and/or hindered engagement and change. As such, the sample consisted of both participants who reported positive outcomes and those who had not.

2.5.2 Exclusion Criteria

The following exclusion criteria were applied:

- Non minority ethnic parents/caregivers (including primary minority ethnic parents/cares who were born in the UK).
- Identified current risk, such as risk to others or to self.
- Families who disengaged prematurely, prior to completing the minimum three month prescribed involvement in MST.
- Parents/caregivers who are unable to speak English as it was not possible to pay for an interpreter.

2.5.3 Participants

A total of seven subjects participated in the study. All participants were from minority ethnic backgrounds, and had participated in an MST intervention in the last 12 months prior to taking part in the study. Participant demographics are displayed in Table 1. In light of the small sample size, key participant demographics are not linked up in the table in order to preserve participant and therapist confidentiality.

Table 1: Demographic summary of the sample

	Demographic Information	Number of participants (n=7)
Gender	Male	1
	Female	6
Age	40's	2
	50's	4
	60's	1
Gender of adolescent	Male	3
	Female	4
Age of adolescent at referral	15	4
	16	3
Parent country of origin	Rwanda	1
	Jamaica	1
	Israel	1
	Ghana	2
	China	1
	Ireland	1
Parent ethnicity	Black	1
	Chinese	1
	White	2
Parent religion	Practicing Muslim	1
	Practicing Christian	3
	Non-practicing Christian	2
	Non-practicing Jew	1
Number of years in the UK	10-20	2
	20-30	4
	30-40	1
Time since completing MST	0-3 months	2
	3-6 months	0
	6-9 months	2
	9-12 months	2
	12-15 months	1
Outcomes	Met all ultimate outcomes	5
	Did not meet all ultimate outcomes	2
Therapist Ethnicity	White British	1
	White Romanian	1
	Northern Irish	1
	Black Jamaican	1
Gender of therapist	Male	1
	Female	6

2.5.4 Setting

Six participants were from an outer London MST service, and one from an inner London MST service.

2.5.5 Sampling and Theoretical Saturation

Purposive sampling was initially used to identify participants who fulfilled the inclusion and exclusion criteria. Site supervisors had access to the electronic MST database in each service, which they used to identify potential participants.

Theoretical sampling, which is an important part of the GT methodology, was then employed. This involved transcribing and analysing interviews, and using this information to amend the interview schedules in light of insights gained from previous interviews. Additional data was thus collected in light of categories that emerged from earlier stages of analysis.

Theoretical saturation can be reached through theoretical sampling. Theoretical saturation is reached when additional data does not add further variability to categories. The meaning of saturation and whether saturation should be an aim of GT research has been the object of disagreement amongst GT researchers (Charmaz, 2006). Willig (2008, p. 37) posits that theoretical saturation acts “as a goal

rather than a reality". The term 'theoretical sufficiency', which allows for more flexibility, has been proposed as an alternative to saturation (Dey, 1999). Aiming for 'theoretical sufficiency' instead of 'theoretical saturation' implies researchers can generate categories which explain the data sufficiently without forcing data into predetermined frameworks (Charmaz, 2006). The idea of sufficiency was therefore adopted in the current analysis.

2.6 Recruitment

Service users who fulfilled the inclusion and exclusion criteria were identified by field supervisors via electronic records on the MST database. Telephone contact was then made to potential participants by supervisors to explain the study, and obtain verbal consent for the researcher to contact them. Once this had been obtained, details of the participant were securely passed onto the researcher, who made telephone contact within two working days of receiving their details to further discuss the research.

Participant information sheets (see appendices F and G) were posted out to participants following the conversation on the phone with the researcher, who arranged a call back a week later. Once verbal consent to take part in the study was obtained, the researcher arranged a time to carry out the interview in the participant's home. Written consent was obtained in person, prior to commencing the interview (see appendix H). All participants were offered £10 in cash as a token of appreciation for taking their time to participate in this study.

Participants were recruited in phases to facilitate the process of the researcher being simultaneously involved in data collection and analysis which is central to GT. This allowed the researcher to transcribe, code, constantly compare data and write memos to identify leads and gaps in the data. This was a central part of theoretical sampling in the next phase of data collection. Seven parents were recruited in total, in four stages of one, then two, then two, then two. See Figure 2 for an overview of the recruitment and interview process.

Recruitment and Interview Process

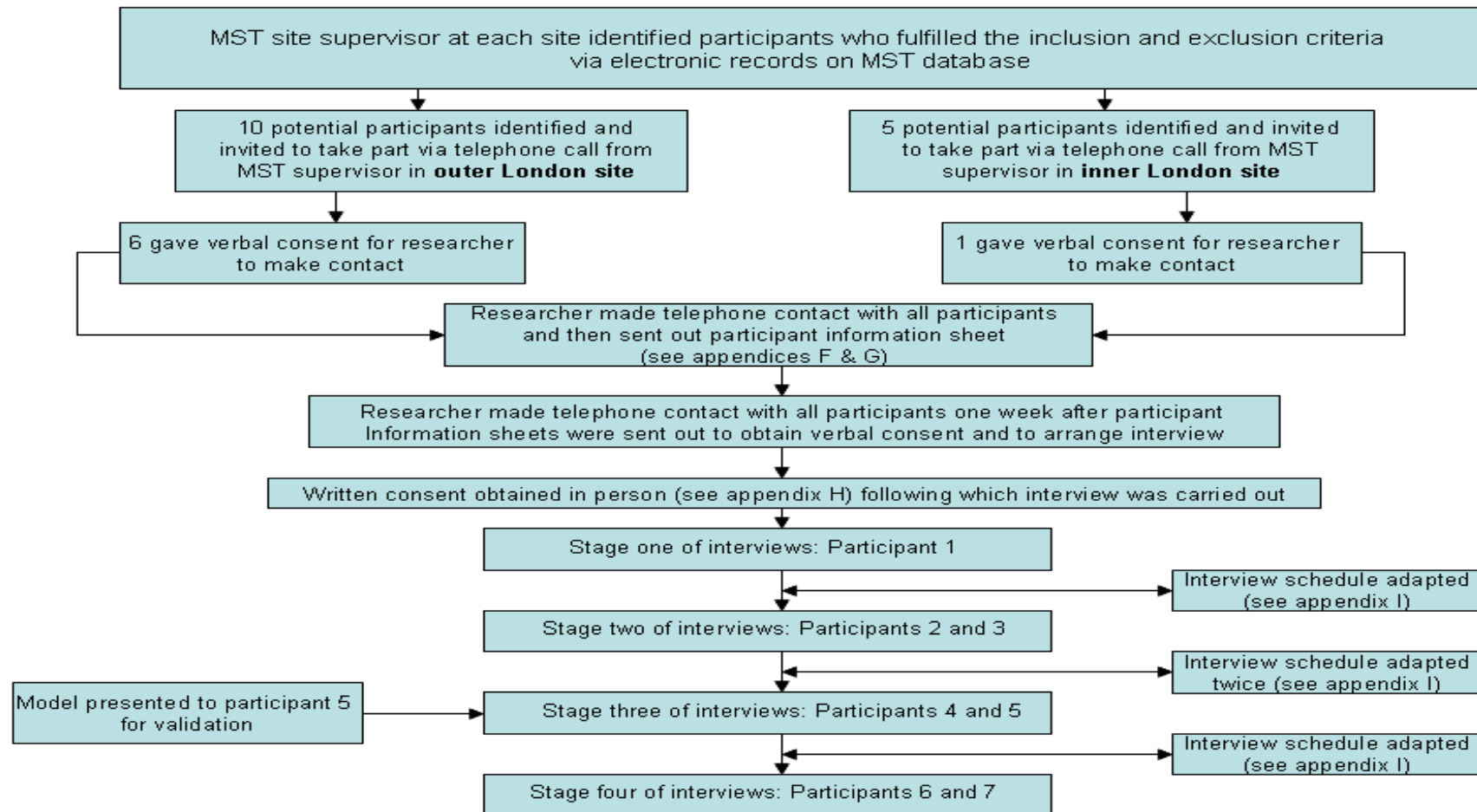


Figure 2. Recruitment and Interview process

2.6.1 Data Collection

Interviews were chosen as the source of data for this study to allow for a rich understanding of parent's experiences of MST. Utilising an open ended interview schedule and direct questions facilitates the emergence of new concepts, as well as addressing specific gaps as the research progresses (Charmaz, 2006). It is important to consider that interviews provide a snapshot in time, that is co-constructed by the participant and researcher within a particular context and relationship (Charmaz, 2005). Charmaz thus highlights the importance of the researcher remaining attuned to how participants perceive them, and to the relationship that is constructed in the interview process.

2.6.2 Interview Schedule

An initial version of the interview schedule (Appendix I) was drafted with the research supervisor prior to conducting the interviews, based on previous qualitative MST studies (Tighe et al., 2012). The aim of the interview schedule was to guide the interviews, starting with structured questions about participants, ethnicity, country of birth and route to MST, followed by open ended questions to allow participants experiences of MST to emerge. General prompts were included to encourage participants to elaborate on their responses and explore ideas they brought. Closing questions and debriefing statements were incorporated to signal the end of the

interview. The research supervisor, who is also an MST supervisor, reviewed the draft interview schedule.

2.6.3 Piloting the Interview Schedule

A pilot interview was carried out with an ethnic minority mother who completed the MST intervention in the last 12 months, in line with the inclusion criteria. She was chosen at random by the field supervisor from the list of families that fulfilled the inclusion and exclusion criteria. The parent received £10 for her time, and her data has not been included in the final analysis.

The purpose of the pilot interview was to identify questions that were not appropriate or helpful. Research has shown that ethnic minority service users are typically hard to reach both clinically (Begum, 2006) and in research (Bernal & Castro, 1994). It was thus helpful to consider with the service user how interviews could be engaging. For example, the parent highlighted that asking parents about their backgrounds conveyed a genuine interest in them as individuals, thus making the interview more engaging for her. Overall, this process was helpful in ensuring that questions were relevant, easy to understand, and that the researcher conducted the interviews at the pace of someone for whom English may be a second language.

2.6.4 Interviews

The interviews with caregivers were conducted by the author in the participants homes. Carrying out the interviews in the participant's home seemed appropriate, and in line with the MST model as much of the work carried out is likely to have taken place in the family home. It was thought that this may also make it easier to participate, and that inconveniences for the participant around meeting in an external location (e.g. travel costs, availability of a quiet location) were minimised.

Interviews varied in duration from 1-1.5 hours which reflected the varying conversational styles. All interviews were recorded on a digital voice recorder, with prior consent. The interview was broadly separated into questions around cultural background, general experience of engaging with MST, the process of change in MST, challenges and the impact of MST on difficulties. Participants were asked to comment on whether the significant aspects of their experiences had been covered at the end of the interview, inviting them to add further thoughts. They were given the opportunity to ask the researcher questions, and thanked for their participation.

The interview schedule was used as a guide and the author was flexible in her questioning to ensure that the interview was a sensitive interaction taking into account individual experiences and preferences (Hugh-Jones & Gibson, 2012). It was important to strike a balance between allowing the interview to be open-ended and yet exploring the area of cultural issues around engagement and change with MST. Description and exploration of process and meaning to the individual were prioritised (Charmaz, 2006).

2.6.5 Adapting the Interview Schedule

Discussion with field supervisors informed the construction of questions for the first stage of interviewing. The interview schedule was then adapted for successive stages of interviews based on the information provide by participants (See appendix I). This was in accordance with the principles of theoretical sampling (Charmaz, 2006). Charmaz (2006) highlights that theoretical sampling is often misunderstood in GT. The usual misunderstandings according to Charmaz (2006) are that theoretical sampling reflects population distributions, finds negative cases and continues until no new data emerges. She argues instead that the purpose of theoretical sampling is to obtain data explicating categories, advance the analysis of tentative categories and defines which directions to take. In accordance with this, adapting the interview schedules (following data analysis) allowed theoretical constructs to progressively emerge through increasing precision of categories, distinguishing between categories, clarifying and explicating analytic links between categories and identifying variations in process.

2.7 Data Analysis Procedure

2.7.1Transcription

The researcher transcribed all the int.erviews as a way of becoming immersed in the data, and to develop an in-depth understanding of it (Charmaz, 2006). Interviews

were transcribed immediately, and prior to the next interview being carried out to allow for theoretical sampling. A denaturalised approach to transcription was adopted. The idea that speech is used to construct meanings of the world underpins this transcription approach, thus encouraging researchers to preserve as many verbatim oral features of spoken language as possible, including utterances such as 'erm' and 'erh' (Davidson, 2009). This was thought to be well suited to GT methodology in which language is seen as a way of exploring constructions, meanings and perceptions of experience rather than reflecting absolute reality.

2.7.2 Initial Coding

Following transcription of the first interview, data analysis commenced with initial coding which constitutes the first step in analysis in GT (Charmaz, 2006). This involved breaking the data down into sentence by sentence segments, closely examining each segment and using gerunds to define and summarise what the researcher considers to be happening in the text. Charmaz purports that coding the data as an action rather than using a theoretical label aims to ensure that the researcher sticks closely to the data, and that the emerging concepts and subsequent theory are *grounded* in the participant's experiences (Charmaz, 2006; Glaser & Strauss, 1967). Close attention was paid to '*in vivo*' codes, where exact terms used by participants to describe their experiences were preserved as they are understood to represent a meaningful experience (Charmaz, 2006).

2.7.3 Focused Coding

Focused coding, which is the next major stage of coding involved synthesising the low level conceptual codes generated during open coding, to develop more abstract codes to describe larger segments of data (Charmaz, 2006). Focused codes were generated from the most frequent or significant codes that were identified during the initial coding stage. These codes are thus more selective and conceptual than earlier codes (Charmaz, 2006).

2.7.4 Memo-writing and Constant Comparative Analysis

Memo-writing, the bridging step between data collection and the final theory, kept the researcher actively involved in the analysis by encouraging early generation of categories from codes and the shift to higher levels of abstraction (see appendix B). This enabled the researcher to remain actively engaged with the data, guided constant comparisons and directed theoretical sampling. The overall aim of this was to “link and integrate categories in such a way that all instances of variation are captured by the emerging theory” (Willig, 2008, p. 36).

2.7.5 Theoretical Coding

The final stage of the coding process involved selectively raising focused codes to tentative analytic categories and sub categories, which were then raised to tentative concepts. Through the iterative process of constant comparisons, memo writing, and theoretical sampling, the researcher was able to engage in successive levels of analysis to construct abstract theoretical understandings of data (Charmaz, 2006). As such, a number of theoretical codes were generated to explain the emergent theory. Once the final stage of coding was complete, the emergent theory was compared with the existing MST process of change theory.

2.8 Quality Assurance in Qualitative Studies

Published guidelines on conducting qualitative research were incorporated into the design of the study and followed closely to increase the quality of the research. The guidelines suggested by Elliott et al. (1999), considered the most comprehensive and clearest statement of best practice currently available in qualitative research (McLeod, 2011), were followed and are outlined in more detail below.

2.8.1 Owning Your Perspective

The researcher's perspective was explicit from the outset described in an earlier section on the researcher's position and reflected upon through memos. This is also explored further in the discussion.

2.8.2 Situating the Sample

Relevant demographic characteristics of participants have been provided in order to situate the sample, and provide a context for this research (outlined in table 1). This also provides an opportunity for the reader to assess the generalisability and applicability of the reported results (Elliott et al., 1999).

2.8.3 Grounding in Examples

Excerpts of data are presented to illustrate the process of the research ranging from a variety of research memos and interview transcripts of the coding process (see Appendix J). Quotations of participants are also presented within the report. Presenting information in this way allows the reader to see the development of the research, the theoretical development of the data and makes clear the analytic strategy.

2.8.4 Providing Credibility Checks

Credibility checks were carried out to validate the categories and the emerging theory. Findings were thus discussed with an experienced GT researcher, and other qualitative researchers. A sample of a transcript was also reviewed and coded by the research supervisor and a Trainee Clinical Psychologist who was also undertaking a GT project to examine whether there was agreement between the categories proposed by the researcher. This helped ensure that codes or themes were not overlooked and that categories fitted the data.

Participation validation was also incorporated through consulting a participant on the emergent theory to obtain their thoughts and views, and whether the theory resonated with their experiences. Strauss & Corbin (1998) point out that the final model may not fit all aspects of a participant's experience but the theoretical concepts should be applicable and recognised by them.

2.8.5 Coherence

A clear description of categories/themes and the relationships between them have been provided to achieve coherence. There has been a concerted effort made to present the emergent model clearly with a verbal narrative supported by a pictorial representation and appropriately named categories that fitted together to form a framework from which to understand the data

2.8.6 Accomplishing General versus Specific Tasks

Elliot et al. (1999) suggest that in order to provide quality research, the research should achieve the level of understanding which was intended at the outset. Strauss & Corbin (1990) describe two levels of theory, grand theory and substantive. Grand theory attempts to account for more global processes. In contrast this study focuses on and seeks to generate substantive theory, that is a theory that evolves from something that occurs in a particular situational context (Strauss & Corbin, 1990). Being clear about this allows the researcher to reflect on the outcome of the data and the scope and transferability of any theory generated, which is reflected upon in the discussion.

2.8.7 Resonating with the Reader

Elliott et al. (1999) suggests that researchers should check that the research represents the subject area accurately. One way this was addressed was through the author contacting a caregiver to consult on the model to ensure it resonated with them in order to provide an authentic account. The author also presents recommendations based on the findings of the report that may be relevant to readers of this study.

Chapter 3: Results

This chapter provides an account of the grounded theory analysis, conducted using the methods detailed in the previous chapter. The model outlined at the end of this chapter represents an understanding of the processes of engagement and change with MST that emerged from the narratives of the participants who contributed to the study.

3.1 Confidentiality

All identifying information such as names, geographical locations and service names have been removed from quotations to preserve the confidentiality of participants and therapists. Each participant was assigned a pseudonym which is used to refer to participants. Participant pseudonyms and key demographics have not been presented together in order to preserve patient confidentiality as doing so could make patients identifiable.

3.2 Findings

Seven theoretical codes emerged from the data. Three of these codes were related to the engagement process, titled 'Getting on board with MST', and six relating to the process of change which is referred to as 'Finding a new way forward'. Each theoretical code was composed of specific and interacting focused codes which capture its key dimensions. Table 3 outlines the properties of the focused codes (or initial codes), and the subsequent theoretical codes that emerged in relation to the engagement process. Table 4 outlines this for the process of change. The theoretical

codes and focused codes will be described individually in further detail. Extracts from the data will be provided to evidence the codes.

Table 2. Getting on board with MST; the process of engagement

Theoretical Codes	Focused Codes	Properties of the codes (initial codes)
Deciding to engage with MST	Having choice over decision to engage	<ul style="list-style-type: none"> • Choosing to participate with MST • Source of referral impacting perceived choice to engage • Not feeling forced to engage
	From uncertainty to renewed hope	<ul style="list-style-type: none"> • Initially being uncertain • Bad experiences with services leading to hopelessness • Being apprehensive but hopeful
	MST making sense	<ul style="list-style-type: none"> • Therapists lack of clarity leading to disengagement • Therapist being specific • Working out a plan • Focusing on present difficulties
	Being willing to try a new way	<ul style="list-style-type: none"> • Needing things to change • Willing to allow for outside help • Previous ways working with siblings of adolescent, but not with him/her
Becoming therapeutically aligned		
Creating a shared position	Therapist 'joining/aligning' with family	<ul style="list-style-type: none"> • Therapist being on family's side • Appreciating therapist valuing collective interest of the family • Distinguishing therapist from other services experienced as unhelpful
	Having shared goals	<ul style="list-style-type: none"> • Agreeing on outcomes • Agreeing to focus on difficulties in the present
Developing a therapeutic alliance	Valued therapist qualities	<ul style="list-style-type: none"> • Empathy

		<ul style="list-style-type: none"> • Sensitivity • Professionalism • Reliability and flexibility
	Developing a positive working relationship	<ul style="list-style-type: none"> • A relationship of mutual respect with therapist • Finding a fit with the therapist • Feeling valued rather than blamed
Considering cultural difference	Being culturally understood	<ul style="list-style-type: none"> • Not feeling judged • Therapist being curious about parents culture, religion and background, • Therapist checking out the meaning behind words
	Therapist taking a culturally sensitive approach	<ul style="list-style-type: none"> • Therapist considering cultural difference within the family • Cultural sensitivity of therapist determining engagement
	Therapist understanding and respecting difference	<ul style="list-style-type: none"> • Professionalism of therapist more important than culture/ethnicity • Feeling better understood by a therapist who is a cultural/ethnic minority
	Considering role of culture in difficulties	<ul style="list-style-type: none"> • Therapist taking into account perceived relationship between culture and difficulties • Being disapproving of certain cultural practices in the UK

3.3 Getting on Board with MST

Getting on board with MST refers the process of engagement, which was constructed as a separate and pre-cursory process to change. Three distinct categories emerged in participants accounts of engagement, which capture the mechanisms that were conceptualised to underpin this process.

3.3.1 Deciding to Engage with MST

This category refers to participants initial encounters with the MST service, encompassing the referral process and initial decision to engage. There was variation in participants experiences in relation to first encounters with MST and decision to engage, ranging from actively not wanting to engage to desperately wanting help. Having a choice over the decision to engage, moving from uncertainly to hope, MST making sense, and being willing to try a new way featured in all of the parents accounts, and constitute the key dimensions of this category.

Having choice over decision to engage

Having choice about engaging was described by all participants to play an important role in their willingness to engage with MST, constituting the first step in the 'getting

on board' process. Most of the parents talked about their initial motivation to engage, and about making a choice to participate with MST.

Pauline: When I heard about it, I thought yeh, this is something I want to try. When Carol told me about it, I thought it would be good and I wanted to try it.

In contrast to this, Joy described her initial resistance to engaging with MST when she felt like she was given no choice.

Joy: My son's Psychologist from CAMHS, I didn't get on with her. I had a very nasty argument with her and I said I don't want to work with her. She said that if I don't work with her, then I have work with this MST. I said that I don't want to work with anybody. She said she will make me if she has to. I said go on, make me. So she put me off in the first place, before I even started working with Mary, I said you can't make me do something I don't want to do. So the probation officer dealt with the case, he referred me to MST as well and he talked me through it. He was nice. I get on with him.

The above quote captures another important dimension of the initial engagement process; the importance of the quality of the parent's relationship with the referrer, and the impact that this had on motivation to engage. As highlighted in the quote, caregivers who were referred by services or individuals they had difficult relationships with described their initial resistance to MST. Caregivers conveyed being more motivated to give MST a try where the referral was coming from a professional they had a better relationship with, or where the referral was coming from a neutral source.

From uncertainty to renewed hope

Participants described their initial uncertainty about engaging with MST. All of the parents talked about their prior negative experiences with services, and how this impacted initial engagement. Themes of uncertainty and feeling hopeless emerged when parents described their journey into MST.

Felicia: I was saying to myself, I've had different organisations, nothing is improving, so I don't need anyone. How is this MST or whatever it is going to help?

Joy: The youngest, was causing too much trouble. I couldn't cope. I needed help. I've been with CAMHS before, I've been the X project before. He had been with all these organisations, not helping, and so they think MST will be something he would benefit from. I didn't know what to think.

Parents described getting to a point where despite the uncertainty MST felt like the last hope. They talked about feeling desperate and fearful if things did not change.

Pauline: I was scared. I knew that things couldn't carry on like this. I felt desperate. Something had to change.

Miriam: We tried everything. We had been everywhere. Over 10 years with CAMHS and they were useless. We didn't know who to turn to. MST was a glimmer of hope.

Not knowing what to initially expect from MST emerged as a common anxiety. There were varying degrees of uncertainty about MST following the referral. Two of the African parents described feeling apprehensive about MST, and were more reluctant

to the idea of having to change. These parents described being ambivalent about an outsider coming in, alluding to a sense of feeling culturally under threat.

Leila: I thought that's just people coming to change your way, who you are, and how you live, new ways, and I don't think that is acceptable in my culture, for anyone to change who you are, how you live, no.

Like Leila, most of the parents made reference to their 'way' of doing things as a means of referring to cultural ideas and practices from their countries of origin.

MST making sense

MST making sense featured strongly in parent's accounts of engaging. It was most apparent in the accounts of the two parents, Joy and Felicia, who described initially not being able to engage with MST. These parents spoke about the therapist not making things clear, generating feelings of confusion, anger and frustration which led to disengagement following the initial meetings.

Felicia: The first time. Sam came, I did not like the way Sam was approaching the thing. It was confusing, and I say no, I don't want to work with SamI couldn't work with Sam, it's the questions, it wasn't clear, it didn't make sense, made me angry you know. So I say no at first.

Once Felicia and Joy re-engaged with MST with a new therapist, like the other parents, they talked about the being able to give MST a chance as the therapist was concrete and specific and was making things clear.

Joy: I wasn't sure about MST after that. But then Mary came. So good. Explaining things properly. It made sense so I thought, yeh I'll give it a try.

Being willing to try a new way

The motivation and willingness to try a new way in spite of uncertainty featured in all of the parents accounts. Parents shared the exasperation they felt having tried lots of approaches with little result. Some parents expressed the relief they felt at the prospect of someone coming into help.

Jin: Oh, great help at last, I have problem with, you know, I see if outside can help because I am running out of ideas already.

Hope as well as a sense of resignation featured strongly in participants explanations for being willing to try a new way.

Pauline: I was ready to try anything. I wanted someone to come in and help. I had tried everything. I gave up. So when I heard about MST I was like, yeh, please.

For some parents, giving up on their way of doing things embodied ideas around culture specific parenting. Cultural differences in the values and behaviour that children should be taught was apparent in most of the participants narratives, with ideas around respect for elders and strict discipline featuring strongly in the African and Chinese parents accounts.

Jin: In Chinese culture, it is important to teach children to be respectful to the adults, we don't talk back to our parents.

The majority of the parents described parenting at least one child in a similar way to how they were raised in their country of origin, who they had no difficulties with, but this not working with the referred adolescent.

Joy: As I was saying, my twins never gave me problems at all. They are 21. No boyfriend as I'm talking to you. They don't even like going out. Because I was brought up that way, the kids have developed that behaviour as well. But things were different with Frank.

For some parents there was a deep sense of frustration around not understanding what had happened, leading them to question what they had done wrong.

Felicia: It was hard because some of the thing I view it as being disrespectful, or you know, thinking maybe did I do something wrong? Didn't I teach them some of the right things?

Some parents considered taking their children back to their country of origin as they blamed influences from outside, including negative peers, for their child's behaviour.

Joy: Martin, when he was younger was very respectful compared to Frank. This one is way out of order. Frank. It was the friends, see..... influences from outside. We were going to send him to Ghana.

Nevertheless, parents talked about being willing to try something different despite their uncertainty. Leila and Joy, who were the more ambivalent parents at the start of MST explained that despite their apprehensiveness, they were willing to allow outside help and give MST a chance for their child's sake.

Leila: Erm, because I thought, to me it felt like I am doing everything right, I don't need anyone to come and tell me what to do, but because I could see how much my daughter was upset, and starting to thinking of running away,

so I thought Ok, I will give it a chance, just for her you know, yeh, that's how I accepted.

3.3.2 Becoming Therapeutically Aligned

This category consists of two sub-categories which captures how the combination of creating a shared position and developing a therapeutic alliance played an important role in getting on board with MST. Together, they seemed to facilitate a process of therapeutic alignment which was distinct from and strengthened parent's decision to take part in MST. Deciding to engage with MST is conceptualised as participant's engaging with idea of taking up the intervention, whereas the therapeutic alignment refers more to the specific relationship between the participant and the MST therapist.

3.3.2.1 Creating a Shared Position

This sub category captures participants accounts of developing shared goals with the therapist, and establishing a sense of the therapist aligning with the family which was described to take place early on in the engagement process. This was most apparent in the accounts of those parents who reported positive outcomes with MST.

Therapist joining/aligning with the family

Parents described the importance of the therapist 'joining' or aligning with the family and being on the same side from the outset of therapy. They alluded to the powerful impact this had on the engagement process.

Joy: The way she got involved, right from the start, it made me think she was a bit like a family, one of the family members. I was very very comfortable with her. Very. Very.

Comparing MST to other services, parents conveyed the sense of disempowerment they felt with services which they experienced as being positioned against them. Social care services in particular were perceived to be interested in, and only on the side of the child. Parents described feeling blamed, intimidated, devalued and angry. Some parents voiced their opinions about social care services 'spoiling' the children and giving them too much freedom, which was perceived to be part of a wider cultural discourse around children in the UK.

Jin: I believe children more strong here, they are free to voice out their opinions and social work backs up the children.

Felicia: The social worker was making things worse. Because you know, they spoil the children, you see, oh you've got no right to do this to him, you've got no right to do that, you know, he's 17, he needs his freedom, just like the way the children behave outside.

Joy: Social workers, they are on the child's side but Mary was on both of our sides. She work with us equally. Equally. Social work don't do that, and it makes things worse. I said I don't want you in my life. I don't want you in my

house. They say we will bring the authorities, I say bring the authorities. Bring them, bring the police, go and bring them. Some children also lie, and the social worker listen to them, you see. They threaten that they will take the child away. I said ok take the child away.

The above quote captures how some parents distinguished between MST and other services; on the premise that MST was there for the family, not just the child. Parents communicated their appreciation of the therapist valuing the collective interest of the family, engendering a sense of being on the same side. They expressed the value of the therapist coming to the house as this enabled the therapist to see the whole picture and gain a better insight into the difficulties.

Joy: She understood that although I had enough of my son, I did not want him to go into care. I feel like that's not what the social worker wanted. But Mary, she understood how important it was to keep the family together.

Felicia: MST, it take us step by step. I like that they come to my house, because I did not want to go to the office. She came here and got to see what the problems were, see the arguments and she can understand better, from both sides.

Having shared goals

Sharing the same goals with the therapist emerged as a key aspect in achieving alignment. Although some of the parents did not entirely agree with the tasks, there was consensus about the end goal.

Leila: Some of the tasks, I did agree, but others, I find very hard even though I agree with what was trying to be achieved.

Parents also talked about the importance of being in agreement with the therapist about what to focus on, prioritising present difficulties.. Two of the parents described the frustration they felt when they disagreed with the things that the therapist chose to focus on, and both disengaged shortly after the initial meetings, citing this as the main reason for disengagement.

Joy: I had one lady Rachel, this lady, when she comes here, she is not interested in what she is supposed to do. She is more interested in my other son being in prison. There was not a single day that she did not come here and mention him. I didn't know why she kept on going on about that. So that's it. I don't want to work with you anymore. Don't come back again I said to her.

3.3.2.2 Developing a Therapeutic Alliance

The quality of the relationship with the therapist featured powerfully in parents accounts of engaging with MST. Some parents talked emphatically about the positive working relationship they developed with the therapist during the initial meetings, and highlighted the qualities of the therapist they perceived to be helpful, which was described to play a key role in the process of engaging. Where this was coupled with developing a shared position, positive outcomes were described.

Valued therapist qualities

Some of the parents talked extensively about valued therapist qualities. The therapist being sensitive, a good listener, empathic and professional were identified as valuable and conducive to the development of a positive working relationship. Parents who achieved positive outcomes alluded to a sense of the therapist being caring and personable, yet maintaining an expert position, featuring as a key dimension of the therapeutic alliance.

Joy: It's the way she dealt with the situation. How she....speak to me. She listening to you. She was professional. The way she approaches. Feels like she cared about us.

Felicia: She understood what I was going through, I felt like she was listening and not judging me. That is what I was afraid of you know. So she dealt with it very you know...sensitively. Yes. She dealt with it in a professional way. That's the word I would use. That made me be able to open up to her.

Developing a positive working relationship

Some of the parents described developing a positive working relationship with the therapist from the outset. They talked about feeling respected rather than judged and valued rather than blamed since problems were not located in individuals, engendering a sense of openness, collaboration and mutual respect from the start.

Joy: She came here the first time, she introduce herself, the first day I saw her, we had a link. I knew I could work with her. It's the way she spoke to me.

Pauline: We were a team. It felt like we were working together. It wasn't about looking for who to blame, but understanding what was happening and making changes together.

Felicia: I felt like she respected us, what we were going through and wanted to help me to do things differently. I was able to be open, put everything on the table you know.

It was also noticeable that the parents who did not describe positive outcomes with MST despite being willing to take part and following the intervention through to the end, spent less time talking about their relationship with the therapist.

3.3.3 Considering Cultural Difference

Cultural difference featured to differing degrees for the parents interviewed in the study. The narratives of some parents were heavily nuanced with references to culture and religion, whereas for others it just formed the backdrop to their story. For the majority however, considering cultural differences facilitated the 'getting on board process', directly contributing to developing a shared position.

The importance of the therapist becoming attuned to where families place themselves on the spectrum of cultural difference and responding accordingly was apparent in the interviews. Considering cultural difference draws on the therapist's sensitivity in being able to balance the act of creating a space for validating cultural

difference without 'othering' the parent. The therapist overplaying or underplaying the role of culture risked entrenching family members deeper in their respective positions. Considering cultural difference appeared to underlie the shift in parents being able to consider taking new perspectives.

Being culturally understood

For some parents, being culturally understood by the therapist powerfully permeated their initial ambivalence to engage, and seemed to facilitate a therapeutic alignment. Parents conveyed a sense of feeling heard, validated and understood in being able to share the differences in their own upbringing. Indeed, all of the parents' accounts were replete with stories about the cultural differences in how they were raised.

Leila: So different, the way I was raised. I was never told twice to do my chores, erm the way you speak to your parents, things like that. How much freedom you want, at that age you do what you're told, in my culture you have a different way of talking to your parents, you don't just come in and be full on, whatever you want to say.

Ola: My parents were very strict. Yes, that is a very African thing.

These parents talked about finding it helpful for the therapist to be curious and find out about their cultural backgrounds, alluding to a sense of their identity being valued and validated in the therapeutic process. This seemed to engender a sense of trust in the therapist and a feeling that the therapist cares, which in turn was described to allow parents to feel more open and less judged.

Joy: It made it helpful to me for her to find out because it made me think that she's er, she cares you see. She cares and that she wants to know more about us. Yeh. And she understood. Without that, I don't think she would have seen the full picture you know.

As expressed in the above quote, parents explained that this enabled the therapist to see the whole cultural picture, thus validating cultural and religious discourses that were important to the parent.

Parents described the importance of the therapist not making assumptions, and checking out the meaning behind words since they can have multiple, and qualitatively different meanings in different cultural contexts.

Miriam: I think it's important to find out the meaning behind the words. Like when people talk about family here, I think they are talking about a different thing.

Joy: In Africa the child is for the whole community it's not just for these two people and that's it. Very different.

Ola: Family is a big part of our Ghanaian culture. Like you see, in this country they say that my family are my husband and my children. No. We...if we say family, it is extended family you see.

Therapist taking a culturally sensitive approach

Most of the parents communicated the importance of the therapist taking a culturally sensitive approach. This was experienced by parents as not feeling judged, and the

therapist amending the intervention to take into account cultural differences within the family. Some of the parents strongly expressed the need for the therapist to consider the intra-cultural and inter-cultural differences that the family embeds and is embedded in and articulated the risk of this not being considered.

Joy: She did respect my culture, she did respect my views. That was important. If she had not gone through that line, I wouldn't have worked with her. So it was a really important part.

For some parents the therapist recognising cultural alignments within the family (i.e. parent being more aligned to their culture of origin and the child being more aligned to UK culture), and adapting the intervention to suit the duality of the culture in the family system was critical to engaging.

Leila: One day I had a heated argument with my daughter, and she was sitting there watching, and I think this was the first time she saw how important this was to me. And that's when she went and come back with bit more different way of change and maybe she thought ok, this has to be dealt with, she asked me what's important about my religion, my background, and, and I wrote all of those down. She asked my daughter too. She did find a way of including those things in, maybe not as much as I want, but she tried to put those into whatever rules that we were making, which was very important to me.

Therapist understanding and respecting difference

Parents described being indifferent to the culture and the ethnicity of the therapist so long as they were professional and respectful in their approach.

Leila: I didn't think that it really made any difference. She was really good. But if even someone else who is English comes in, as long as they consider my background, my culture, my feelings, it would work but if they don't see it that way, it probably would not work. Yeh.

Although this idea was evident in all of the parent's accounts, they all made references to having had a therapist who was not white British, and most perceived this as being helpful in them feeling understood.

Leila : I think it was helpful, because I felt like she could understand more better.

Joy: And I'm telling you, if, though I said before it doesn't matter where she come from, but I'm sure, I'm not being racist, if it was a white person, maybe she wouldn't agree with what I was doing.

For some parents, having a therapist who was also an ethnic minority represented someone who potentially had both personal and professional experience of managing cultural difference, and was well positioned to be able to help them negotiate the cultural challenges within their family.

Jin: If the person coming in has behaved like my child and I'm not accepting my child's behaviour, how is this person going to help my child to change their behaviour, but if you see different person from different place, it gives you a

starting point to think if that person can find a way, it might be ok with me and my child, it would make difference.

It is important to take into account degrees of cultural similarity and difference between the family and the therapist, and the implications of this. A couple of the parents highlighted that although they would prefer a therapist from an ethnic or cultural minority, they would not want a therapist from exactly the same ethnic and cultural background to them as they were more likely to feel judged.

Joy: I don't even like work with someone from my own country. I know I am a Ghanaian, I don't want to work with a Ghanaian. It looks as if she knows where you are from, she knows your background, the culture and your life in Africa, so him being up to a high position, always look down on you. And will prefer someone who is not from my country look down on me more than someone who is. More offensive. Mind you if they are born here, and may have parents from Ghana, they will respect you.

Considering the role of culture in difficulties

Some of the parents contextualized the difficulties they were experiencing within a cultural frame, seeing the existence of dual cultures within the family as the source of their conflicts.

Leila: They should consider what is really causing this, what is the background? You know religion, culture, belief of the parents, 'cos sometimes that could be the problem, as in my kids that was the problem, you know other than that, my daughter was fine, she was going to school, fine, she was

studying hard you know, but because of my religion and my cultural beliefs, it would become like banging heads, so if she didn't deal with that, lets deal with just behaviour, it was not going to work.

Where parents conceptualised their difficulties in this way, a strong narrative emerged casting a deep divide between the parent's culture of origin and UK culture, constructed as unboundaried and individual focused rather than family focused. Some of the parents conveyed a sense of feeling like they had failed to prevent outside influences coming into the family, which was shrouded with suspicion and disapproval.

Jin: I never see, Chinese children in Hong Kong acting or behaving to the parents like this. The children back home, they serve tea, and they take foods for their parents, for their adults, grandpa, grandma, see, but in here, they don't even want to go out with you, they go with the peers you see, and er, talk about maybe their lives, more or less the same thing at home you see, you know I think surrounding is effecting, all the TV they watching you see, bad, and the TV I think has a lot influence, media, and they look at all these things.

The therapist considering the role of culture in relation to the problem was therefore crucial in understanding how difficulties were being conceptualised. The therapist taking into account the perceived relationship between culture and difficulties in the family enabled some of the parents to feel that the therapist understood an important aspect of their difficulties.

Leila: She understood what was important to my culture and how that played a part in the problems with my daughter.

3.4 Finding a New Way Forward

Finding a new way forward refers the process of change with MST for participants in the study. Four distinct categories emerged in participant's accounts of change, which capture the mechanisms that were conceptualised to underpin this process. These are presented below.

Table 3. *Finding a New Way Forward; the process of change*

Theoretical Codes	Focused Codes	Properties of the codes (initial codes)
Working within a safe and trusting relationship	Establishing a trusting relationship with therapist	<ul style="list-style-type: none"> • Being able to trust the therapist • Actively consulting therapist's advice • Feeling safe to experiment with a new way
	Being supported to risk trying new things	<ul style="list-style-type: none"> • Being honest about being apprehensive to try new things • Being supported to take risks • Taking a step by step approach • Being pushed out of comfort zone
	Working collaboratively	<ul style="list-style-type: none"> • Sharing ideas • Working through problems together • Therapist sharing strategies en vivo • Therapist seeing both sides and being neutral
Empowering the parent	Taking a strength's based approach	<ul style="list-style-type: none"> • Identifying strengths in young person and parent • Positively re-framing setbacks
	Focusing on successes to build on progress	<ul style="list-style-type: none"> • Therapist encouragement helpful in trying new strategies • Feeling increasingly confident
	Therapist helping to managing the power differential within and outside the family	<ul style="list-style-type: none"> • Feeling less disqualified through therapist's support • Increasingly feeling more in control at home • Increasingly feeling more in control with other agencies
Increased communication	Increasing positive communication	<ul style="list-style-type: none"> • Being able to talk instead of argue

within and outside of the family	between parent and young person	<ul style="list-style-type: none"> • Thinking about response and impact • Listening to the young person reducing arguments
	Increasing positive communication between the family and other agencies	<ul style="list-style-type: none"> • Therapist attending appointments with parent for moral support • Being supported in relationship with young person
Therapist acting as a cultural broker	Facilitating perspective taking	<ul style="list-style-type: none"> • Being able to see things from child's perspective • Therapist facilitating young person to see parent's perspective • Opening up new perspectives
	Negotiating cultural difference in the family	<ul style="list-style-type: none"> • Being helped to make sense of difficulties in light of dual cultures • Seeing the positives of adapting in spite of being uncomfortable • Being helped to find the threshold for compromising • Finding a way to meet in the middle
	Being helped to contextualise young person's behaviour in UK culture	<ul style="list-style-type: none"> • Therapist helping to distinguish between 'normal' and 'troublesome' teenage behaviour • Therapist appropriately normalising adolescent behaviour in cultural context • Learning from therapist about adolescent behaviour in the UK
	Therapist acting as cultural reference point	<ul style="list-style-type: none"> • Trusting the therapist acknowledges both family cultures • Consulting the therapist about adolescents behaviour in the UK • Therapist accommodating the cultures within the family • Therapist representing possibility of two cultures being able to merge

3.4.1 Working within a Safe and Trusting Relationship

Participants recounted valued aspects of their MST experience, with most referring to their relationship with the therapist as pivotal in creating change. Indeed, parents who achieved positive outcomes associated changes being made possible in the context of a safe and trusting relationship with the therapist, which was described as helping to facilitate moving from conflict to problem solving.

Establishing a trusting relationship with the therapist

Being able to trust the therapist featured as an important precursor to change. Parents talked about how feeling listened to and understood, and the therapist seeing the whole picture in the initial meetings cultivated a sense of trust in the therapist.

Pauline: She really listened, yeh, she saw a lot of it with her own eyes, the arguments and stuff. It was all out on the table. So I think she really understood.

Building trust in the therapist was described to shift the relationship from being given advice, to actively consulting the therapist for advice, contributing to fostering a sense of safety to experiment with a new way of doing things.

Joy: If anything happen in this house, my personal family in this house, I call Mary and she always calls to see how we are doing. I talk to her, she advise

me, let's do it this way, let's do it that way, and when we do it that way, what she's telling me, it works.

Being supported to risk trying new things

Change was described to be facilitated through being supported to risk trying new things. Some of the parents raised their apprehensiveness about trying strategies that the therapist had suggested, and the value of being able to be honest about this with the therapist.

Joy: I said Mary, I am not going to do it. I won't do it. I'm not going to say yes in front of you, and when you leave I won't do it. But then, about a day or two, when I sleep on it, I said no, let me listen, do what she says, let me see. And I'll do it and it will work. And I will call and say, Mary, I did it, what you told me to. Oh good she would say, did it work? I said yes. Oh good. Well done, I'm proud of you. Well done. You see. She was encouraging me to do it. She was encouraging me to do it. It made me try it more, that she tell me to do.

Parents described being pushed out of their comfort zone with support from the therapist, who scaffolded the process of being able to take risks in the context of having established a safe and trusting relationship. Parents valued the therapist taking firm yet flexible stance, and a step by step approach.

Leila: Yeh, seemed to be make sense, but I had, at the beginning, not just one thing but every time I had to change something I was thinking erm, it's not going to work this, I don't feel like I want to do this, but slowly, she help me to break it down and take it step by step, I could try it things you know.

Working collaboratively

Many of the parents alluded to the collaborative nature of the relationship they experienced with the therapist. For such parents, having shared goals and developing alignment at the engagement stage seemed engender a sense of working together from the outset.

Joy: We were working together. Always. Right from the beginning to the end.

Pauline: We were a like a team really.

Parents talked about value of the therapist witnessing arguments as they happened, which was useful in helping to raise awareness in identifying unhelpful patterns that the family were stuck in. The therapist sharing helpful insights and strategies en vivo with the parent and the young person was explained to be instrumental in the process of change, generating shared ownership of the problem and the experience of being able to work through problems together.

Joy: For instance, she did witness so many things in this house, when she came to this house first, there was no peace. Frank and I, we never meet eye to eye. Argument. Nasty argument, he was being rude. She would sit there and watch, and, she says you know what, you know where to push the button, so I should ignore him, I have to tell him what to do, but there are some things he is doing, I shouldn't push it..... See if I shout at him first, he will also shout at me back....so I learn...

Many of the parents talked about the importance of the therapist not taking sides. Being able to maintain a neutral position in the face of intense arguments between the parent and young person was identified as important in helping to reduce conflict.

Joy: Mary was on both of our sides. She listened to us both. Even when we argue, she was on both of our sides. This was very helpful because we both needed someone to listen.

The therapist facilitating the family to work through conflicts together was described as helping to create a fundamental shift in the process of change through equipping parents to take a problem solving approach, which was modelled by the therapist in sessions.

Leila: When she walks in at that point, my head is boiling and I'm about to shout, but I have to remember that it doesn't work good for me or her, so then I have to remember to take another approach, instead of arguing you know, the way the therapist showed me. I never would have done that before. I was doing things differently.

3.4.2 Empowering the Parent

Parents who experienced positive outcomes described a process of becoming increasingly empowered throughout the course of MST. Such parents talked about an increased confidence in their parenting, and ability to interact with the systems around the young person. Redressing the power differential within and outside the family, taking a strengths based approach and building on progress were important dimensions in this category.

Therapist helping to manage the power differential within and outside the family

Parents alluded to an experience feeling disempowered both in the intra and extra familial context before the intervention. Some parents conveyed a sense of feeling marginalised in relation to mainstream cultural discourses around adolescence, perceived to be embodied in services, institutions and the young person's peers.

Jin: My girls just weren't listening to anybody anymore, I can't believe they can treat their father like that. Unrespect. They are shouting at me and talking back and not listening. Learning from the TV and children out there. That's what the children do here. I have no power. The children here, they have more power. And the social services and school, they give them all the power. Being angry teenager and stuff. Not like in China. But we are here.

The therapist supporting the parent in their relationship with the young person and other agencies facilitated the process of the parent feeling less disqualified and more empowered, generating within the parent of sense of being in control.

Pauline: She helped me to get back into the house. Jenny was listening to me again.

Joy: She helped me with lots of things, you know, like with the Psychologist and the Social Worker and stuff. Help me to find my voice again.

Taking a strengths based approach

The majority of parent's made reference to the helpfulness of the MST therapist taking a strengths based approach. Parents talked about how this helped to create a shift from a problem saturated narrative to one in which strengths and resilience could be recognised and built upon.

Pauline: She make me realise that there were things that I was good at, that I could do.

Focusing on the strengths of the parent and the young person was something parents described as unique to MST, experienced as helping to generate change from a more empowered place.

Joy: They don't see the worst in Frank like the Psychologist did. He was so clever, very very brilliant at school, Mary will tell you, so clever. She made us to think about that, which was helpful.

Being able to see strengths in the parent and young person, and positively framing setbacks constituted the core premise of the strengths based approach, which enabled parents risking trying new ways of doing things.

Focusing on successes to build on progress

Parents who noticed a reduction in difficult behaviours and reduced conflict during the course of MST talked about the impact of receiving positive encouragement from

the therapist for trying new strategies. Parents described how this helped them to feel more supported, and risk trying new things. They also talked about feeling increasingly confident when things started to change, and how focusing on this helped to remain convicted in what they were doing.

Joy: And I'll do it and it will work. And I will call and say, Mary, I did it, what you told me to. Oh good she would say, did it work? I said yes. Oh good. Well done, I'm proud of you. Well done. You see. She was encouraging me to do it. It made me try it more, that she tell me to do.

3.4.3 Increasing Positive Communication Within and Outside the Family

Increasing positive communication in the family was described by parents as being a key marker of, and integral in the process of change. The therapist's ability to hold a neutral position without aligning with the parent or the young person was conveyed as instrumental in the process of enabling positive communication between parent and the young person. The therapist facilitating positive communication with systems surrounding the young person was also identified as beneficial.

Increasing positive communication between parent and young person

Where parents reported positive outcomes, a significant shift in communication with the young person was described. For most of the parents they reported being able to talk to their young person instead of arguing.

Felicia: Yeh, I feel like she help us to start communicating before. Before we would just argue. Now we can talk. He will come in to my room, and I will ask him how his day went and he will say it was like this or like that. Before I would be too angry, and we would argue, and there will be slamming doors and all that. But that all changed.

Parents recognised the benefit of not being reactive and approaching things in a calm manner in facilitating positive communication.

Pauline: In another way, I noticed is that, before If she done something wrong, I would straight away jump into it and then it there would be an argument but one thing I learned was to maybe take a step back and let a bit of time, an hour or two pass and then calm down and come back to talk about the issue, whatever is was, then I think that works better for me, and her, and she started to talk to me, but before she wasn't. Before it wasn't like that, so it works better, that's something new I learned which I wasn't doing.

Parents valued the therapist taking a mediator role in that it helped to facilitate both parties feeling heard and validated, opening up possibilities for new ways of communicating.

Felicia: Talking of how to deal with the situation that I'm in and sometimes she comes...um and she wants to see him as well. So we all sit together and then we talk so that everyone can be heard.

Increasing positive communication between the family and other agencies

In addition to increasing positive communication with the family, some of the parents made reference to the therapist facilitating positive communication, and in some cases re-engagement with systems around the young person. Parents alluded to how this was conducted in a supportive and graded way, which enabled the parent to feel more in-control and empowered.

Joy: Mary takes Frank to the appointment with the Psychologist because she knew I did not get along with her. She said to me, come to the appointment, you can sit down and listen, and I will support you. So she came with us. It helped because slowly I was able to start getting involved with the Psychologist again. Before Mary came, I couldn't do that and it was bugging me, but I couldn't even be in the same room as that woman. Nah. But that's changed. She also helped with the X centre too. I didn't have too much of a problem with them before, but she just made it easier you know.

3.4.4 Therapist Acting as a Cultural Broker

For some parents tensions between the culture they grew up in and the cultural context of their child was perceived to play a central role in their difficulties. Discourses around culture, adolescence, identity and parenting were drawn upon. For such parents, the therapist acting as cultural mediator or broker between the parent and the young person, and the wider cultural context emerged as a key facilitator for change in opening up and allowing for constructive conversation about

culture. The core dimensions of this category are explored below. Although a few of the parents made reference to this, it was most apparent in Leila's account who viewed the difficulties with her daughter primarily as a result of cultural differences.

Negotiating cultural difference in family

Some of the parents talked about contending with difficulties around cultural differences in relation to appropriate levels of adolescent autonomy, and the tensions this caused in the family.

Leila: By the time she turned 15 she just want to do her own things, go out when she wants, come in when she wants, and so we were kind of banging heads together because I felt that wasn't appropriate, and erm, I think I wasn't accepting that you know, she's becoming almost mature and she has mind of her own, and I don't agree with some of the things children here do, and she couldn't see where I was coming from, so it was like banging heads together.

The therapist opening up cultural perspective taking within the family was described by some parents as being instrumental in managing cultural difference within the family, creating a powerful shift from being stuck to getting unstuck.

Leila: It was also helpful for my daughter to know that I have my background, and it's as important to me as her background, you know she probably has to start thinking about how do I feel about my own background, just as much as she feel about hers.

Yes, because she see things different, not 100%, but yeh, she doesn't come hard on me thinking why is she doing that, she says ok, that's part of who my mum is, at least you can see the wall has come down a little bit [laughs], it's not up here, I'm not listening, I'm not looking, it's like I understand, the same way I think I understand some of the things now, probably as the same to her.

Some parents talked about being helped to find the threshold for compromising on cultural and religious practices, and seeing the positives of compromising in spite of being uncomfortable. This contributed to the process of change through allowing the parent and the young person a way to meet in the middle.

Leila: Yeh, it was ok, she kind of you know find a point where I had to reduce probably how many days she has to go, and er she has to agree this is important to me because this is who I am and so we find a way, to meet in the middle, to compromise you know. The therapist had to work hard on that point to make us meet in the middle.

Being helped to contextualise young person's behaviour in UK culture

Parents who ascribed their child's behaviour to cultural factors expressed the powerful impact of the therapist being able to help them to distinguish between behaviour that could be conceived as culturally acceptable or unacceptable in the context of UK culture, and strategies around how to manage.

Leila: For example, letting my daughter to go to sleep over to her friends, because I've never allowed any of my children to do that, you know probably, if it was a family member, yes, erm, maybe my sister, my cousin, but I've

never really done sleep over thing, and she wanted to do that, and I was like, no, it's not happening, and the therapist, tried to make me understand that this is the culture here, and perhaps I should look into it and give me guidance to what step I need to take before agreeing for her to go and sleep over somewhere, yeh.

The therapist normalising some of the adolescent's behaviour enabled them to re-evaluate the narrative around the child to be less problem saturated, creating a shift in gradually being able to accept differences.

Leila: Erm, just that showing my child wasn't different to all the other children, Because my question was what's wrong with her? Why is she like this? Why she doing this like? But what MST did, showing me that most of the children in that age group they are doing the same thing, you know this is what children at the age do so I thought it's not that bad as I thought in my head, there was the worst case ever, yeh and that's accepting little little things that I couldn't accept.

Joy: So after that, even when I spoke to Mary, she said you know, that's his age. You know, he needs to go out with his friends. It's not so abnormal.

Leila: Yeh, at the end of the day she's got to have that freedom, she's in a totally different country, but she will have that freedom, but yeh, I mean she still have a bit of...not as much freedom as all the children here have, of her age, that's because of my background and my beliefs, and that's how the therapist find a way to compromise on that, you know, so if you look at the children who are her age, what time they come home, what sort of things they do, she still don't, not allowed to do as much as that, but she at least half of it, yeh.

Therapist acting as cultural reference point

Some of the parents expressed the value of being able to actively consult the therapist about culture and age appropriate behaviour in the context of a safe and trusting relationship with the therapist. Some reflected on the positive impact of the therapist helping to negotiate cultural difference in the family through acknowledging, validating and suggesting ways to accommodate the dual cultures within the family.

Leila: And also there's some question you know you can ask. Just to hear what's gonna come from her, and she will probably say I can understand where you are coming from but this is how things here are, and new ways like this, it's not too bad, it's not bad at all actually but you have to understand the other side is like this and she'll probably give me an example, maybe my mother used to be like that, but she had to understand, look at me, I didn't come out to be bad, you know something like that, it makes you think, lemme just wait until the next time and see how it goes, you can trust it a little bit more, yeh.

As alluded to in the above quote, for some parents, the therapist represented the possibility of two cultures being able to co-exist in a constructive way, which instilled hope in relation to the young person.

Leila: She didn't give me exactly her life story, but she told me that her mother was totally different as well because she come from different background. And she's not ruined [laughs] she's here, she's doing well and she's fine, she's helping people, I shouldn't just think that if you change your ways, your children are going to be ruined.

Parents who framed their difficulties within a cultural lens talked about their initial apprehension about the therapist forming a cultural alliance with the child and privileging the child's narrative at the expense of the family culture. The neutrality of the therapist was considered to create fertile ground to shift from being stuck to start becoming unstuck, and finding a way to meet in the middle.

Leila: I had my guards up at the beginning, they going to change me [laughs] I'm just going to come out of it, you know that's even before I listened to what they are going to say, so I already had that idea, thinking ok, if this is what they want to let, let my child go out, do what they want, come back when they want, I'm not going to do this, but it turn out to be different. She wasn't like that. She help us to find a way, you know, meet in the middle and work things out, respecting both of our ways.

3.5 Model for Processes of Engagement and Change with MST for Minority Ethnic Caregivers

The emergent model for the processes of engagement and change with MST for minority ethnic caregivers is represented diagrammatically in Figure 2. The engagement process is depicted in the arrows and is comprised of three inter-related theoretical categories which enable the caregiver to 'get on board' with MST. Based on participants accounts, deciding to engage with MST, achieving therapeutic alignment and having cultural differences considered must all be present in the 'getting on board' process to achieve good outcomes. The model aims to convey that although 'deciding to engage' is sufficient for engaging with MST, it is not enough to achieve good outcomes.

The sphere represents the change process, titled 'learning a new way', consisting of four theoretical categories depicted in the concentric circles. The aim was to convey the dynamic and interrelated relationship between them, which although discussed individually above, are not mutually exclusive. The therapist acting as cultural broker, empowering the parent, increasing communication within and outside the family and working within a safe and trusting relationship were conceptualised to interact to bring about positive change.

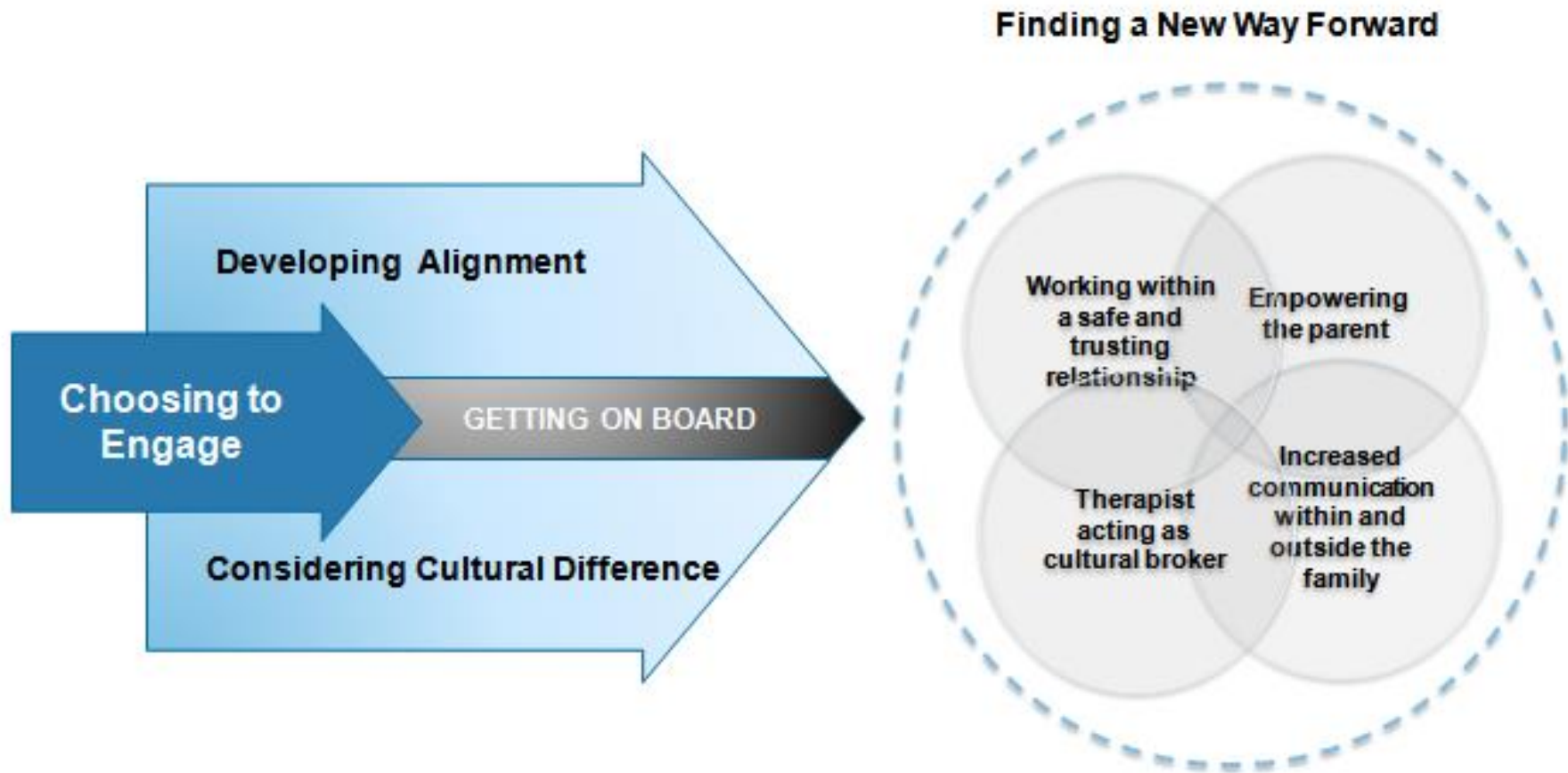


Figure 2. A model of the processes of engagement and change in MST for minority ethnic caregivers

3.6 Revising the MST Model of Change

The final aim of the study was to consider the existing model of the process of change in MST and whether the findings of this study could highlight further factors and provide information on how engagement and change is achieved with minority ethnic caregivers. Caregivers thoughts about how they were able to engage and create change with MST highlighted a number of contributing factors. Furthermore, their reflections on the processes of engagement and change in therapy led to a proposed revised model of the process of change in MST.

This is presented in Figure 3 and will be considered further in the discussion section. Since the original model only depicts the process of change, it was adapted to incorporate the process of engagement that was generated in the emergent model. The process of change in the emergent model outlines the mechanisms that can be understood to facilitate improved family functioning, and have thus been incorporated into the existing model of change.

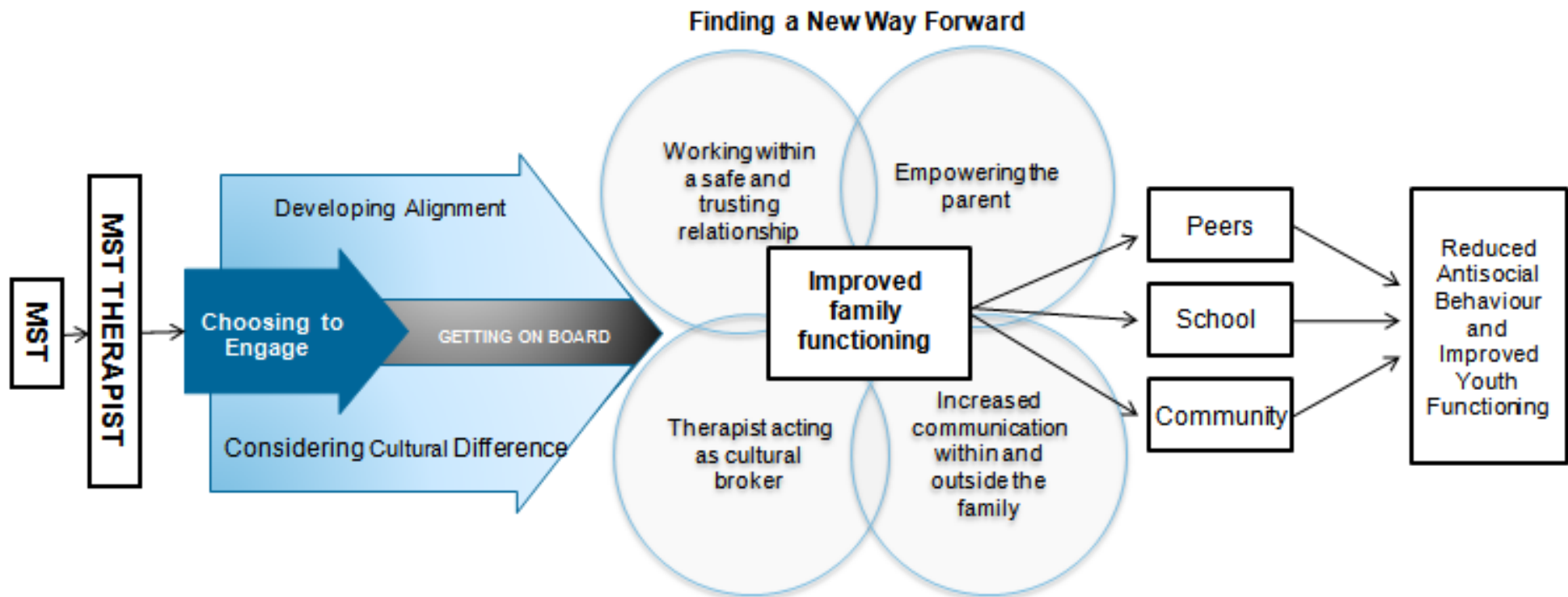


Figure 3. A revised model of the processes of engagement and change in MST for minority ethnic caregivers

Chapter 4: Discussion

This study sought to explore minority ethnic carer experiences of Multisystemic Therapy (MST) and to specifically identify factors that facilitated or hindered engagement and change. This was done with the overall aim of generating a theoretical model of the mechanisms of engagement and change with MST for ethnic minority carers. An additional aim of the research was to consider the findings in relation to the existing MST process of change model in order to examine whether new factors emerged, and whether it could be adapted to explain the process of engagement and change for ethnic minority carers.

4.1 Overview of Findings

A number of theoretical codes emerged to explain the processes of engagement and change for the minority ethnic carers who participated in this study. The theoretical codes that related to the engagement process were (1) choosing to engage with MST, (2) becoming therapeutically aligned and (3) considering cultural difference. The theoretical codes that linked to the change process were (4) working within a safe and trusting relationship, (5) therapist acting as cultural broker, (6) empowering the parent and (7) increased communication within and outside the family. These processes and the interplay between them will be discussed below, with reference to the existing literature to consider how the findings contribute to the knowledge base.

4.2 Characteristics of the Sample

Prior to discussing the results in detail, it is important to take into account the cultural and ethnic diversity within the sample who in no way represented a homogenous group. The term 'minority ethnic group' does not describe a homogenous collective (Sewell, 2004). Stanfield (1993) highlights that homogeneous descriptions of ethnic minority groups in the dominant public culture and in social sciences literature is underpinned by the assumption that such groups have no differential identities. Marsella (2011) argues that homogenizing diversity runs the risk of minimising difference and destroying critical ethnic identity resources. In spite of the small sample size, parents who took part in the study spanned a diverse range of ethnic and cultural backgrounds (see Table 1 for participant demographics).

Moreover, parents varied in terms of the process of acculturation. Although all of the parents had been long term residents in the UK, there was much variation surrounding the purpose of migration to the UK, ranging from political, socioeconomic to educational motives. Research has shown that this has implications for subsequent acculturation (Bhugra & Becker, 2005). Narratives around culture and ethnicity thus varied between participants, featuring strongly and explicitly for some, and more subtly and implicitly for others. A concerted effort has been made to elucidate such differences where they emerged, and the bearing it had on experiences of MST.

It is important to highlight that religion does not feature in the overall findings as this is not something that parents made reference to very much in their accounts. Moreover, religion was not described by participants to be as problematic as perceived cultural differences. Whilst it is important to note that culture may incorporate aspects of religion, and vice versa, in order to try and ensure that the emergent model was grounded in the data and reflected participant experiences, the overall findings place an emphasis on cultural rather than religious differences.

4.3 Context for Discussion

It is worth noting that many of the theoretical codes that emerged in this study overlap with findings from previous studies that have examined the process of change in MST (Tighe et al., 2012), highlighting the common and universal similarities that families are likely to share across all cultures. There were however a number of unique findings, and findings that related specifically to ethnic minority service users. Such findings will be discussed in greater detail, not because they were conceptualised to have played a greater part in the engagement and change process for these families, but because they add new dimensions to the existing model, and shed new insights in relation to working with minority ethnic service users.

4.4 The Engagement Process – Getting on Board with MST

The process of engaging with MST emerged as fundamental precursor to change for the participants in this study. This is in keeping with existing research in family therapy which holds that the therapists capacity to engage and retain the family in treatment is critical in the success of systemic interventions (Thompson, Bender, Lantry, & Flynn, 2010; Stanton & Shadish, 1997). More specifically, this supports the MST literature which holds that treatment cannot progress unless key family members are engaged and actively involved in treatment, and that engagement is a precursor to successful outcomes in MST, thus incentivizing therapists to prioritize strong engagement from the outset (Henggeler & Schoenwald, 1998; Cunningham & Henggeler, 1999).

However, a unique proposition of this study is the conceptualization of engagement as a distinct (albeit inter-related) process to change, underpinned by three interacting theoretical mechanisms. The findings of this study suggest that the engagement process is arguably more complex, and requires greater sensitivity for individuals who may hold alternative beliefs that are not in line with the dominant assumptions around distress and its resolution, and is reflected in the emergent model. While acknowledging the range and diversity of cultures and ethnicities within the sample, participants' cultural contexts are likely to have shaped the findings. Culture has been identified as mediating expressions of distress (Webster & Robertson, 2007) and perceptions of support needs (Stewart, 2008), which is likely to manifest in the engagement process.

4.4.1 Deciding to Engage with MST

Findings indicated that a number of important pre-engagement factors contributed to parent's decision to engage with MST. Research has shown that knowledge of the healthcare system, and available treatments are found to be important factors in determining service utilization and engagement for minority ethnic groups (Rathod, Naeem, Phiri, & Kingdon, 2008). Although the majority of parents described having limited knowledge about MST, the decision to engage was strongly influenced by the activities of MST being made clear and making sense. This is in keeping with existing research which has identified that the therapist's ability to define the aims and activities of therapy in acceptable terms, and with concreteness and specificity, is critical in engagement (Liddle, 1995).

The relationship with the referrer emerged as an important factor in the early engagement process. A difficult relationship with the referrer was described by participants in the study to hinder, and even sever openness to engagement. In contrast, where parents were referred by a trusted source, the decision to engage was characterised by an openness and hope in the possible effectiveness of MST. Attitudes towards services, pre-immigration health beliefs, previous experiences with services have been identified as important factors in the referral pathway for ethnic minority groups (Goldberg, 1999). Mental health professionals attend to their significance infrequently and such domains are rarely researched (Bhui & Bhugra, 2002). The relationship with the referrer is arguably another such domain worthy of further research in seeking to optimise engagement with MST for ethnic minority groups.

Some of the parents expressed ambivalence around the decision to engage, alluding to cultural mistrust around an MST intervention. Cultural mistrust is defined as the tendency to hold a generalised mistrust for individuals and systems that represent mainstream white society (Terrell & Terrell, 1984). It has been linked to poor engagement in therapy in certain African American populations (Biafora, Warheit, Zimmerman, Gil, Apospori, Taylor & Vega, 1993) . Studies have indicated that where cultural mistrust was high, African American clients reported lower expectations for their therapists, perceived their therapists as less credible and were less likely to complete therapy (Thompson, Worthington & Atkinson, 1994). Rasheed (2003) argues that mistrust of mental health services may be entrenched in feelings of mental illness rooted in white oppression, and deeply embedded experiences of discrimination and racism for certain minority groups. He points out that it is impossible to examine the experiences of ethnic minority groups outside of the wider historical, social, political and cultural forces at play. Such forces are likely to have implications for engagement with psychological interventions. Indeed, choice, trust, transparency and control were pertinent themes in some parents accounts of overcoming cultural mistrust to engage with MST.

It is important to highlight that the ambivalence around engagement that some parents referred to was related to cultural differences in value systems in relation to family, parenting and adolescence. This is in keeping with previous research which has found that psychological interventions rooted in dominant ideologies and discourses are unattractive to certain ethnic minority groups, and that they may not be aligned to the ethos of other cultures (McGoldrick & Hardy, 2004). Ghuman (1999) purports that migrants to the UK and US often want to parent their children in line

with the principles, values and assumptions of their culture of origin. It has been argued that a deeper understanding of cultural parenting assumptions can improve the cultural sensitivity of family therapy interventions, which may improve engagement and outcomes (Kumpfer & Alvarado, 1995).

In light of the fact that MST was developed in the US, cultural differences between the US and UK cultures, in addition to cultural differences between mainstream UK culture and culture of origin for minority ethnic service users requires consideration. Some of the participants in the study described having to overcome the initial resistance to share details about their family and difficulties with the therapist, making reference to how this was not the norm in their culture of origin. It is important to consider if such ideas are further perpetuated by UK culture, and whether they would be at odds with an intervention developed in the US. Transportability studies have shown that cultural differences in the US and in other countries in relation to expectations around engagement and building a therapeutic relationship were found to impact on what was deemed an appropriate length and intensity of treatment. For example, in New Zealand a longer time to build engagement was added following feedback around the appropriateness of asking personal questions in early sessions (Schoenwald et al, 2008). The findings of this study arguably point to such adaptations being worthy of consideration for minority ethnic users of MST in the UK.

4.4.2 Becoming Therapeutically Aligned

Forming an alignment emerged as a distinct and important component of the overall engagement process. Where deciding to take up MST is conceptualised in this study as the first engagement step, referring to engaging with the idea of an *MST intervention*, the alignment process refers to the process of engaging with the *MST therapist*. This highlights the complexities of the engagement process in MST, advocating the need to theorise engagement as a multi-level relational process in MST.

Although the MST literature refers to, and makes a distinction between engagement and alignment (Henggeler et al., 1998), no definitions outlining the difference between the two have been made. The concept of alignment within family therapy is used to describe the experiencing of reciprocal interests, attitudes and values between certain members of a family (Wynne 1961). From a structural point of view, the notion of alignment covers a wider field. For example Aponte (1979) sees alignment as the coming together of a member of a system with another or his opposition to that member in the accomplishment of a task. The understanding of alignment based on the findings of this study draws upon both Wynne's (1961) and Aponte's (1979) definition, and refers to creating a shared position and developing a therapeutic alliance. These are conceptualised as two interacting sub-codes within the overall theoretical code (therapeutic alignment) and are discussed below.

4.4.3 Creating a Shared Position

A key dimension of aligning with the therapist was experiencing the therapist as being on the side of the family, prioritising keeping the family together, and agreeing on the same goals as the family. Some parents alluded to the positive impact this had on securing engagement. This is in keeping with the findings from Tighe et al's study, which showed that aligning with families to support rather than criticise them was important in the initial process of change (Tighe et al., 2012). This dimension of the alignment was powerfully illuminated in the comparisons that some caregivers gave between MST and social care services, the primary difference being that the MST therapist was felt to be aligned with the whole family whereas social care services being experienced as aligned with the child, against the parent. Carr (1990) talks about this as an engagement 'mistake' in family therapy, where the therapist forming alliances within the family against other members is detrimental as it allows the therapist to be sucked into a particular role in the family drama which renders them impotent.

4.4.4 Developing a Therapeutic Alliance

Thompson et al. (2007) refer to the importance of the therapeutic alliance in engagement in home-based treatments for adolescents and their families. Indeed, the process of engagement is understood by some as constructing and bedding the therapeutic relationship (Bordin, 1979). Norcross's (2011) definition of the therapeutic alliance in family therapy as the creation of a strong emotional bond as well as negotiation of goals and tasks is resonant with the therapeutic alignment participants

alluded to in this study. Parents talked about the importance of developing a positive working relationship with the therapist from the outset, underpinned by mutual respect, positive regard and feeling understood by the therapist. This is in keeping with previous research in which the therapeutic alliance with key family members is identified as critically important (Friedlander, Escudero & Heatherington, 2006), and that therapist qualities have an impact on engagement (Cunnigham & Henggeler, 1999). A study by Hogue, Dauber, Stambaugh, Cecero and Liddle (2010) found that an early therapeutic alliance relationship with the parent predicted a reduction in youth behaviour problems, which was very much in line with the findings of this study.

A key finding of this study was that where participants described both being engaged with the idea of MST, and therapeutically aligned in the engagement stage, positive outcomes were reported by carers. Participants who described being engaged with the idea of MST but no therapeutic alignment did not report good outcomes despite completing the intervention. This is in keeping with existing ideas and research in MST literature. Henggeler and Schoenwald (1998) point out that slow or stalled clinical progress in MST is indicative of a key family member not being engaged, and that this has negative implications for treatment progress. MST therapists thus prioritise strong engagement from first contact with the family (Cunnigham & Henggeler, 1999). Moreover, they highlight that well thought out strategies will have little value in the absence of a strong therapeutic alliance, which was the experience of some of the parents in this study.

4.4.5 Considering Cultural Difference

Considering cultural difference featured as an important part of the engagement process for many of the parents. This supports findings from previous studies which suggest that talking about culturally salient and meaningful content encourages more active engagement and participation in therapy (Jackson-Gilfort, Liddle, Tejada & Dakof, 2001). The findings indicated that the therapist assessing and responding to cultural difference sensitively in the initial stages of the intervention engendered a sense of being understood by the therapist, contributing to the therapeutic alignment. Importantly, not feeling judged, therapist curiosity, validating difference and sensitively making recommendations were identified as facilitating trust in the therapist. This supports previous research which shows that clients identify culturally competent therapists as those with a mixture of both generic skills that can be adapted to meet individual needs and knowledge of specific issues such as oppression, discrimination and racism (Chang & Berk, 2009). McGoldrick and Hardy (2004) highlight that dealing with cultural diversity is a matter of balancing between validating the differences amongst us, and appreciating the forces of our own common humanity (i.e. diversity and equality).

Falender and Shafranske (2008) argue that “regardless of race, a common therapist barrier to establishing therapeutic alliance or managing ruptures in the alliance is the lack of understanding and appreciation for cultural or value based differences” (p.274). This was very much in keeping with the accounts of some of the parents in the study, specifically those who described disengaging from MST initially. Cunningham and Henggeler (1999) propose that “therapists who have difficulties

empathising with a caregiver – often the result of a lack of cultural understanding – will lead to a therapeutic relationship that lacks trust, collaboration and ultimately has poor outcomes – the impact of cultural non-connect on treatment success” (p.11).

Yi (1995) suggests that by asking clients about their social networks, family relationships, and adherence to their cultural background enables clinicians to consider how culture may or may not influence engagement and thus serves as a guide for culturally sensitive interventions. In keeping with this, some of the parents spoke about finding it helpful for the therapist to enquire about their cultural backgrounds. Brown (2009) highlights that many of the skills required to work with ethnic diversity are similar to those used in therapy generally. Lo and Fung (2003) suggest a range of additional skills to sustain engagement and facilitate a therapeutic alliance for positive outcomes with the ethnically diverse clients. For instance, the therapist must be skilled in actually addressing ethnicity with the client, in terms of conversations about race, spiritual beliefs, religious practices or cultural background (Chang & Berk, 2009). Yarhouse and VanOrman (1999) argue that a therapist cannot hope to comprehensively formulate the importance of a client’s ethnic background without gaining information about it, which was echoed in parents’ accounts. Participants who had been able to have conversations with the therapist about their own cultural up-bringing talked about feeling that the therapist cared, described a strong therapeutic alignment, and overall reported better outcomes than those participants who did not report having such conversations. This supports the evidence suggesting that discussing ethnicity generally leads to a strengthening of the therapeutic alliance (Hill & Knox, 2009).

The therapist understanding and respecting cultural difference was identified as a key feature in taking a culturally sensitive approach. This is well recognised in the MST literature (Tuerk et al., 2012). Adopting a respectful approach when working with cultural diversity in MST has been identified as facilitative to engagement (Cunnigham & Henggeler, 1999). All the parents described being indifferent to the ethnicity of the therapist, providing they were professional and respectful in their approach. However, where given a preference some expressed that they would feel more understood by a therapist who was also from a minority ethnic group. This supports previous research findings that have found that ethnic minority clients prefer ethnically similar therapists to ethnically dissimilar ones (Atkinson and Lowe, 1995).

It is important to take into account that although most of the participants expressed a preference for a therapist who is an ethnic or cultural minority, there were mixed preferences for exact ethnic and cultural matching. Only one parent thought it would have been helpful to have had a therapist from the same cultural background, whereas two of the parents said that they could have potentially felt more judged by someone from exactly the same ethnic and cultural background as them. This illuminates Sue's (1998) suggestion that "the importance of ethnic match may heavily depend on the acculturation level and ethnic-cultural identity of the individual" (p.442) and must therefore be considered carefully.

4.5 Process of Change - Finding a New Way Forward

The findings of the study indicated that successful engagement (i.e. willingness to engage, therapeutic alignment and having cultural differences considered) was a precursor to the process of change entitled 'finding a new way forward'. This title was specifically chosen in an attempt to capture the added dimension of making cultural adaptations or changing their 'way' of doing things as described by these parents, which was identified as an important part of the change process. The theoretical codes which emerged in relation to the change process will be discussed below, with specific emphasis on novel findings.

4.5.1 Working within a Safe and Trusting Relationship

The therapeutic relationship emerged as an integral mechanism in the process of change for participants in this study. This is in keeping with research that shows that the therapeutic alliance is instrumental in change in family therapy (Friedlander, Escudero, Heatherington & Diamond, 2011). Building on the therapeutic alliance that was developed for some in the engagement process, caregivers who reported positive outcomes described a positive relationship with the therapist, and identified it as a key facilitator of change. In accordance with findings from Tighe et als (2012) study, a positive therapeutic relationship was found to facilitate change through improvements in family functioning for participants in this study. Caregivers who experienced positive outcomes reported a positive experience of MST, in which the relationship with the therapist was a central feature.

Despite this diversity of experiences, there was an underlying, central thread common in the accounts of participants who experienced positive outcomes: they valued having a safe place to explore their problems, with someone who they could trust, felt understood them and their family and who was able to help them find a way forward. Parents described being able to work collaboratively, and risked trying out new strategies to make changes in the context of a positive working relationship. This supports Tighe's et al's (2012) hypothesis that the therapeutic alliance has value beyond engagement, implicating it as a contributor to change and sustaining change (Kaur Gomez et al., submitted for publication).

4.5.2 Therapist Acting as a Cultural Broker

The therapist acting as cultural mediator or broker between the parent and the young person, and the wider cultural context emerged as a facilitator for change in families where parents delineated difficulties along cultural lines. The concept of family therapists acting as cultural brokers has previously been identified as helpful in working with migrant families (McGoldrick & Hardy, 2004). There were varying degrees of assimilation and integration with the wider culture on the part of the parents, which varied from family to family, and seemed to shape how parents interpreted their child's behaviour. Rasheed (2003) claims that the culturally attuned therapist must have the clinical skills that allow the therapist to enter into the family's narrative world to uncover with the family the interplay of those ethnic themes and broader socio-cultural narratives. Indeed, the therapist's sensitivity and acknowledgement of this, and ability to collaboratively tailor interventions in line with

the cultural milieu of the family accordingly played an important role in helping to negotiate cultural difference in the family.

Many of the parents talked about striving to preserve fundamental principles and practices from their culture of origin and wanting to teach them to their children, which is consistent with findings from research on parenting in immigrant families (Phinney & Vedder, 2006). Value differences rooted in cultural diversity such as independent versus interdependent self-construal's (Markus & Kitayama, 1991) have been found to be the source of conflict in such families as the adolescents are socialised in multiple cultural contexts (Ghuman, 1999). This was echoed in the accounts given by parents, who talked about feeling 'disrespected' by their children, and interpreted the young person's attempts towards autonomy and independence as a rebuttal of their authority, and as a symptom of the British culture which they were learning from their peers and the media. A lot of the parents talked about their own adolescence in their respective countries of origin, where obedience and respect for elders, and prioritising the family and the community around them was the norm, and alluded to struggling with conflicting cultural values in relation to family structures and expectations of adolescence. McGoldrick and Hardy (2004) point out that the network disruption that follows migration is more readily explicit and salient for families belonging to cultures that favour close knit, extended family and community ties. All of the parents in the study made reference to the absence of extended family and community involvement in managing the difficulties of their child. It is important to take into account that migration unavoidably overloads any family, and that many functions previously fulfilled by members of the extended family, networks, relatives or community remain unfulfilled (McGoldrick & Hardy, 2004).

The therapist's ability to facilitate cultural perspective taking in the family, enabling the parent to see things from the child's perspective of trying to navigate two cultures, and the child acknowledging that the parent is doing the same was described to create a powerful shift. Increasing perspective to facilitate change is well documented in family therapy (Barker & Chang, 2013). The findings of this study are in keeping with this, highlighting the facilitative function of opening up cross cultural perspectives in families with dual cultures. Parents alluded to the impact of this in helping to validate cultural difference within the family. Moreover, it was described to facilitate behavioural change through the parent and young person being able to find compromises and meet in the middle.

An important feature of the therapist acting as cultural broker was in helping the parent to contextualise some of the young person's behaviour in the wider cultural milieu. The normalising function of this was described as powerful in increasing understanding and shifting the narrative around the child as less problem saturated. Walsh (2006) purports through normalising their experience, families can make it manageable and meaningful, as well as use it to strengthen family coherence (Antonovsky & Sourani, 1988), which was resonant in parents accounts. McGoldrick and Hardy (2004) highlight that a key component of the therapist acting as cultural broker and legitimising the experiences of dissonance requires that the therapist maintain an empathic, contextualising and normalising stance, with assumptions of competence and good intent about the participant's behaviours, which was very much in keeping with the findings of this study. The therapist's ability to fulfil this function was reported to consolidate the therapeutic relationship, enabling parents to utilise the therapist as a cultural reference point, which was an important dimension of this theoretical code.

4.5.3 Empowering the Parent

The MST literature holds that the caregiver plays a central role in the process of change, and that focusing on collaborating with and empowering the parent improves their capacity to function as an effective parent (Heneggeler et al., 2000). This was strongly echoed in the accounts of parents who participated in the study. Parents who reported positive outcomes described a process of becoming increasingly empowered throughout the course of the intervention in the context of a supportive relationship with the therapist, which in turn was described to facilitate the process of change. Importantly, the empowerment that some of the parents described was in relation to not only the home, but also the systems surrounding the family. Rasheed (2003) highlights that ethnic minority families may be subject to disempowering socio-political meta-narratives, and consequently may find themselves in multi-system transactions that put them in a position of vulnerability and status of powerlessness. He argues that this reflects a relationship between the family and its broader environment that is unequivocally negative, thus creating a power imbalance between the family and its broader ecological networks. The experience of powerlessness and oppression can become one of the primary themes in the family's identity narrative, which may constrain the family's ability to construct more empowering and potentiating solutions to family problems. The therapist supporting the parent in their relationships within and outside the family system was described as instrumental in re-dressing the power differential to construct a more empowered and resilient narrative.

In line with findings from previous MST studies (Huey et al., 2000; Henggeler et al., 2009), and in keeping with one of the nine treatment principles of MST (Henggeler et al., 1998) the therapist taking a positive and strengths based approach was experienced by parents as empowering. Acknowledging and focusing on successes to build on progress was an important dimension of this theoretical code, and supports previous findings that have identified it as an important feature in the process of sustaining change in MST (Paradisopoulos et al., submitted for publication). In line with De Shazer's (1994) idea of focusing on resources, strengths and solutions or exceptions to the problem rather than problems was reported to be helpful in enhancing parenting skills, which is in keeping with the MST model of change (Huey et al., 2000; Henggeler et al., 2009). Such an approach is arguably particularly important when working with ethnic minority parents, in light of the multiple experiences of disempowerment they may experience in the context of the family and wider society.

4.5.4 Increased Communication Within and Outside the Family

Improved communication within and outside the family emerged as a theoretical code in the process of change. Tighe et al's. (2012) study identifies improved relationships as a positive outcome of MST, which was supported by parents accounts. This is also in keeping with the MST theory of change (Huey et al., 2000; Henggeler et al., 2009) in highlighting the positive impact of improved family relationships. Building on this, increased communication is understood as the mechanism through which family relationships are improved.

Participants talked about how the therapist mediating between the parent and the child helped to reduce conflict, and find more constructive ways of communicating. Communication within the family was described to have improved in two ways; ways of communicating (e.g. talking instead of shouting), and content of communication (e.g. increased affective content). The benefit of this was discussed in increasing understanding, perspective taking and empathy. Such accounts are consistent with family based adolescent interventions which hold that family communication is required to change in order for individual symptoms to remit (Liddle, 1995). Engaging adolescents and parents in new conversations as a way of improving the parent child interaction, and its relationship to change has been demonstrated in previous studies (Holtzworth-Monroe & Jameson, 1994, Schmidt, Liddle & Dakof, 1995).

It is important to take into consideration the added communication complexities that dual cultures can bring in minority ethnic families, which was echoed in some of the parents accounts. Some of the parents talked about feeling deeply offended when their adolescents argued with, or challenged them, and how alien this was in relation to their own upbringing. This is in-keeping with research which has shown that in Western societies, disagreements between parents and adolescents may be considered part of the normal developmental process (Steinberg & Morris, 2001), and therefore not be as disruptive as in non-Western cultures that place greater value on family harmony (Markus & Lin, 1999). Thus in cultures where norms of respect for parents prevail (expressed through obedience and being non-confrontational) differences within the family may be associated with greater problems. The therapist facilitating the process of finding acceptable means of communicating, and contextualising some of the family's communication within cultural norms was described to be powerful in helping to create change. Increasing

communication within the family and the therapist acting as a cultural broker were thus found to be interlinked.

Increasing communication outside the family was an important dimension of this code. The MST model of change identifies that change across the young person's social ecology is likely to lead to sustainable outcomes thus caregivers being helped to develop collaborative relations with teachers and other community professionals (e.g. teachers or youth offending officers) has been identified as an important feature in the MST model (Henggeler et al., 2012). Parents in the study discussed the value of the therapist in helping them to navigate, and in some cases repair relationships with other professionals surrounding the family through increasing and improving communication. Tighe et al. (2012) identified that working with the systems around the young person was an important factor in the process of change. The results of this study support, and further this finding in identifying increased communication and improved relationships between caregivers and other professionals and key figures around the family system as a key mechanism of change.

4.6 The Emergent Model in the Context of Existing Theory

The emergent model highlights a number of factors the parents in the study believe contributed to being able to engage and create change with MST. The existing model of the process of change in MST provides a basic understanding of how change is achieved in MST, a hypothesised process which is regarded to have been supported in studies on the mechanisms of change (Henggeler et al., 2009; Huey et al., 2000).

The findings of the current study suggest additional factors which can explain the process of engagement and change, encapsulating factors that need to be considered when working with minority ethnic families.

The current model does not consider the process of engagement and change as two distinct stages. Indeed, a key feature of the emergent model holds that engagement is a distinct process in itself, and precursor to the process of change. Hayley (1976) and others in different contexts (Prochaska, DiClemente & Norcross, 1992) have noted that it is helpful to think of change as a multi-staged phenomenon. In the context of the current study, engagement can thus be seen as the first stage of change.

The current model of change centralises improved family functioning in the process of change, but lacks specific information about the mechanisms that underpin this. The model presented in this study proposes that working within a safe and trusting relationship, increasing communication within and outside the family and empowering the parent are the mechanisms that enable improved family functioning. The therapist working as a cultural broker is proposed as an additional mechanism of change in minority ethnic families. Incorporating these emergent factors into the existing model would allow for a fuller and more comprehensive understanding of the process of engagement and change for positive outcomes with MST for families from diverse cultural and ethnic backgrounds.

4.7 Critical Review

Representativeness

Qualitative research is often criticised for its limited generalisability (Mays & Pope, 1995). However, consistent with the constructivist critical realist perspective employed in the research, this study did not aim to represent the views of all minority ethnic service users. Rather, it sought to offer a contextualised exploration of this from the perspective of a sample of London-based parents who had completed an MST intervention. Charmaz argues that rather than seeking to construct generalisable theories, the aim of grounded theory is to construct tentative theoretical understandings viewed as "partial, conditional, and situated in time, space, positions, action and interactions" (Charmaz, 2009, p.141). Thus, the results should be situated with respect to participants' contexts, which are likely to have influenced the findings. For instance, all parents reported working with a therapist who was not white British, which may have been a reflection of the overall cultural and ethnic diversity in London. Service users in other parts of the UK may have different experiences of MST, and different experiences of being in the UK as a whole.

This study also excluded ethnic minority parents/caregivers who were born in the UK in an attempt to try and capture the experiences of parents who had migrated from another country, and are thus more likely to have dual cultures within the family. It was thought that such families would most clearly epitomise the cultural tensions that families with two cultures have to navigate, and the impact of this on engaging with

MST. Thus the experiences and views represented in the study constitute a very specific group of ethnic minority caregivers. Also, the study does not include the accounts of those that refused the intervention in the first instance or those did not complete the intervention, and is therefore potentially missing invaluable information about factors that hinder engagement with minority ethnic families.

Youth and therapist perspectives

The findings of this study present only one part of the picture in relation to the process of engagement and change with ethnic minority families. With the focus on the caregivers, the voice of the referred young person is missing. Tighe et al's. (2012) study focused on both youth and caregiver perspectives. Including both caregiver and youth perspective arguably obscures who 'owned' what particular representation, although Tighe et al. (2012) did show who endorsed a particular theme in their summary table in the paper. With respect to working with ethnic minority families, specifically where the parent was born and raised in a different culture to the child, experiences of engagement and change are likely to be more complex. Therefore, it is useful to examine caregiver and young people's perspectives separately. However, Wittenborn, Dolbin-MacNab and Keiley, (2013) have provided a helpful commentary on the benefits of dyadic research and methodological considerations for researchers using dyadic research designs.

Language

Due to the financial constraints of carrying out this research as part of Doctorate in Clinical Psychology, it was not possible to pay for an interpreter to interview non-English speaking caregivers. A number of potential participants were excluded from the study for this reason. Patel (2002) argues that being denied a voice is a form of disempowerment. It is, thus, regrettable that non-English speakers could not participate. Accordingly, the sample used is biased towards English speakers, who perhaps represent a relatively a more integrated and acculturated cohort of minority ethnic parents.

Interviews

A number of factors may have influenced what participants discussed and may have impacted on the interview process (Rapley, 2001). These included cover letters sent to potential participants on service headed paper and the recording of interviews. Although all interviews were carried out in participant's homes, such factors may have been constraining in that participants may have perceived the researcher as affiliated with the respective MST service, which perhaps limited their willingness to voice criticisms.

Similarities and differences

In the methodology section the different positions the researcher held were briefly highlighted, which may have influenced the research process. Focussing particularly on the position of the researcher being a first generation British Bangladeshi, and thinking about the sample, there were similarities with respect to belonging to a minority group in the UK. Some have highlighted the benefit of researchers studying groups of which they are similar to (Egharevba, 2001; Grewal & Ritchie, 2006). Indeed, it was felt that this helped the research process in the sense that participants may have felt more at ease with someone perceived to be similar to them and a shared desire to highlight a group underrepresented in the literature.

However, there were ways that the perceived similarities between the researcher and the participants may have limited some of the discussions. Dwyer and Buckle (2009) highlight that pertinent point that “holding membership in a group does not denote complete sameness within that group. Likewise, not being a member of a group does not denote complete difference” (p. 7). There may have been the assumption that some issues did not require further explaining as the researcher may have been thought to have had previous knowledge about them or could identify with them as a minority ethnic. It was important to consider the implications this might have had for what was shared, and not shared and how this shaped the subsequent research findings. It was also important to be mindful of how much of the researchers “non research self” could be brought to interviews without ‘contaminating’ or ‘distorting’ the interview (Glensne & Peshkin, 1992).

4.8 Implications for Clinical Practice

Exploring ethnic minority carer accounts of the process of therapy and factors that helped or hindered engagement and change with MST has highlighted clinically relevant information which may be useful for clinicians to attend to when working with minority parents, and families. The findings of this study also describe processes of engagement and change which add to the existing MST model of change.

- This study found that the relationship with the referrer had implications for engagement and change with MST. Where parents described being referred to MST by a trusted source, there was less ambivalence and more willingness around engagement. Furthermore, in such cases, parents also reported positive outcomes with MST. Although a number of other contributory factors are likely to have shaped such outcomes, the findings of this study highlight the need for service providers to carefully consider the referral source in MST in order to try and help families to maximise their chances of success with MST.
- There was variability in caregiver accounts in relation to the overall engagement process. The findings of this study draw a distinction between engaging and aligning, which together, are conceptualised to form the optimal engagement conditions to maximise possibility of change with MST. Where parents described developing a strong, positive working relationship with the therapist from the outset of treatment (i.e therapeutic alignment) in addition to

being on board with the idea of MST (i.e. being willing to take up MST), good outcomes were described. In contrast, some parents described being on board with the idea of MST, but there was a marked absence of the therapeutic alignment, and good outcomes were not reported. Such findings have important implications for the engagement conditions necessary to maximise outcomes with MST, where ideally the therapist works to ensure that there is both engagement and alignment. Based on the findings of this study, it may be helpful to incorporate the process of engagement and alignment as a separate and precursory stage to the existing MST model of change.

- As mentioned above, the overall engagement stage emerged as a distinct process to change in caregiver accounts. It is possible to conceptualise this as being related to cultural difference, in that engaging with MST in the context of ambivalence and cultural mistrust may make the engagement process more tentative and delicate. It therefore stands to reason that where there are greater cultural differences, thus allowing more time for engagement and alignment may be beneficial.
- The ability to work sensitively with cultural diversity emerged as a key factor in the engagement and change process. Although *exact* ethnic and cultural matching was not expressed as a preference by most of the parents in this study, working with a clinician who was an ethnic or cultural minority was reported to be helpful. In light of this finding, it may be helpful for service providers to carefully consider the appropriate level of difference for ethnic minority families in MST.

- Most importantly, not making assumptions, tuning into where people place themselves on the spectrum of cultural difference and acknowledging, validating and responding to difference with respect was identified by parents as being a key facilitator for engagement and change. Acknowledging families multiple cultural contexts was found to be useful. Training clinicians around cultural competence, which has been identified as a core competence for mental health practitioners (Pedersen, 2008) and addressing such issues in supervision and consultation therefore becomes essential when working with diversity.

4.9 Implications for Future Research

- This study generated ideas for future research. This study explored minority ethnic accounts of engagement and change with MST from the caregiver's perspective, and generated a theoretical model of the findings. The current study could be extended by exploring the experiences of MST for young people who are from minority ethnic backgrounds, and also the experiences of MST therapists in working with minority ethnic families. This would no doubt provide a more complete picture of the mechanisms of engagement and change in MST for such families.
- A follow on quantitative study to test out the theory generated in this study would be useful. For example, a structured questionnaire incorporating the

key dimensions of the emergent model could be generated and circulated to a larger sample of minority ethnic caregivers who have participated in MST to test out the central tenets of the theory.

- This study was carried out in two London MST sites. Patterns of migration and ethnic diversity are likely to be different in other cities in the UK, and in other countries. This study could be extended by exploring the experiences of minority ethnic groups with MST outside of London.
- The sample group in this study was composed of a collection of participants from different parts of the world. The dangers of assuming similarities and homogenising minority ethnic groups have been discussed above. Further studies exploring the experiences of families from specific ethnic backgrounds would thus be appropriate and illuminating.
- The study highlighted that referral routes into MST are experienced to have implications for initial engagement. Further research examining this for a broader sample (including families from non minority ethnic groups) might be helpful in exploring this in more depth, and potentially draw out important factors in the referral process.

4.10 Personal Reflections

Willig (2008) highlights the importance of researchers' reflecting on their role in the research process. Indeed, reflecting on how the researcher's contexts influenced the research process is central to constructivist grounded theory (Charmaz, 2006). Keeping a reflexive diary and discussing my biases, beliefs and assumptions with my supervisors and peers helped to foster a curious stance towards participants' experiences (see Appendix A). In addition to helping me consider the impact of interviews on me, using a diary facilitated reflection on how my positions shaped the interview dialogue.

My position as a Trainee Psychologist also likely informed participants' expectations of appropriate discussion topics (such as experiences of distress). Moreover, this influenced how I engaged with interviews. I was often moved by participants' accounts and empathised as I would in a therapy session. Nevertheless, I feel this approach, recommended by Charmaz (2006), helped build rapport and was respectful of participants' experiences.

I was particularly aware that I was sensitive to participants' stories of negotiating family life in a dual cultured family as these echoed some similarities to my own family's stories. As a first generation female born to a migrant family with my own experiences of negotiating two cultures, I was aware that I may have pre-formed assumptions from the outset of the research which could shape interviews and subsequent analysis. I noticed that the topic of culture and ethnicity featured strongly

in some of the interviews, which made me curious about how my own ethnicity as a British Bangladeshi female shaped the interviews. I was able to monitor this through the use of the reflexive journal and peer supervision. After each interview, I reflected on the process, the questions I had asked, areas I could have explored further and my feelings coming away from it. In an extract from my diary in Appendix A, I reflect on how I was struck by how participants seemed to relish the opportunity to talk about their own upbringing and cultures.

Being new to the GT approach, the process of coding and constructing a theory that is grounded in the data was at times an intense and overwhelming process. In light of the fact that the participants are typically a hard to reach group and this being the first qualitative study in the UK looking at their experiences of MST, I was aware of my own anxieties around representing the experiences of caregivers as accurately as possible rather than my own pre-conceptions about what was important. Consulting experienced GT researchers, the guidance produced by Charmaz (2006) and Eilliot et al. (1999) and using supervision was instrumental in quality assurance.

4.11 Summary and Conclusions

In spite of its limitations, this study attempts to make a contribution to the knowledge and understanding of the processes of engagement and change through examining minority ethnic caregiver perspectives of MST. The study provides useful insights into what was experienced to help and hinder such processes, and fills a gap in the literature in examining this qualitatively with minority ethnic caregivers. With

reference to novel findings, the study draws attention to the specific mechanisms that are thought to underlie the engagement process, and highlights the importance of considering cultural difference in the initial stages of the intervention. The study points to the complexity of the engagement process for minority ethnic carers participating in MST. The therapist's role in helping to open up meaningful and constructive conversation around culture was identified as an important change mechanism, through helping to negotiate cultural difference in families where difficulties were contextualised within such a frame. The findings of the study were used to suggest ways in which the existing theory of change for MST could be adapted to take into account factors that were identified by minority ethnic caregivers in facilitating engagement and change with MST. It is important to note that outside of novel findings highlighted, the majority of the mechanisms of engagement and change identified in this study are consistent with ideas and findings within the existing MST literature, further evidencing their mediating power. This brings to fore two key points worthy of consideration, the importance of being mindful of cultural differences whilst recognising universal similarities between families, and the value of preserving and maintaining fidelity to the core elements of MST when working with families from diverse cultural backgrounds. It is hoped that the findings of the present study add to the MST evidence base and demonstrates the value of utilising qualitative methods in researching treatment processes and outcomes.

References

- Alexander, J. F., Holtzworth-Munroe, A., & Jameson, P. B. (1994). The process and outcome of marital and family therapy: Research review and evaluation. In *Handbook of psychotherapy and behavior change (4th ed.)*, (pp. 595-630). Oxford, England: John Wiley & Sons.
- Antonovsky, A., & Sourani, T. (1988). Family sense of coherence and family adaptation. *Journal of Marriage and the Family*, *50*(1), 79-92.
- Aponte, H. (1979). Family therapy and the community. *Community psychology*, *79* (1), 176-181.
- Aponte, H. J. (1994). *Bread & spirit: Therapy with the new poor: Diversity of race, culture, and values*. New York: WW Norton & Co.
- Ashmore, Z. & Fox, S. (2011). How does the delivery of multisystemic therapy to adolescents and their families challenge practice in traditional services in the criminal justice system. *The British Journal of Forensic Practice*, *13*(1), 25-31.
- Atkinson, D. R., & Lowe, S. M. (1995). The role of ethnicity, cultural knowledge, and conventional techniques in counselling and psychotherapy. In J.G.Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.), *Handbook of multicultural counselling* (pp. 387-414). Thousand Oaks. CA: Sage.
- Barker, P., & Chang, J. (2013). *Basic family therapy*. Chichester: John Wiley & Sons.

- Bartlett, D. and Payne, Sheila (1997) Grounded theory : its basis, rationale and procedures. In: *Understanding social research : perspectives on methodology and practice*. pp.173-195. London: Falmer Press.
- Bassey, S., & Melluish, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study. *Counselling Psychology Quarterly*, 25(3), 223-238.
- Becker, H. S. (1996). The epistemology of qualitative research. In R. Jessor, A. Colby, & R. A. Shweder (Eds.), *Ethnography and human development: Context and meaning in social inquiry* (pp. 53-71). Chicago, IL: University of Chicago Press.
- Begum, N. (2006). Doing it for themselves: participation and black and minority ethnic service users. Social Care Institute for Excellence and the Race Equality Unit. Available at:
<http://www.scie.org.uk/publications/reports/report14.pdf>.
- Benson, J., & Thistlethwaite, J. (2008). *Mental health across cultures: A practical guide for health professionals*. Oxford: Radcliffe Publishing.
- Berger, P. L., & Luckman, T. T. (1966). *The social construction of reality—A treatise in the sociology of knowledge*. Garden City, NY: Anchor Books.
- Bernal, G. (2006). Intervention development and cultural adaptation research with diverse families. *Family process*, 45(2), 143-151.

- Bernal, M. E., & Castro, F. G. (1994). Are clinical psychologists prepared for service and research with ethnic minorities? Report of a decade of progress. *American Psychologist, 49*(9), 797.
- Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International journal of intercultural relations, 29*(6), 697-712.
- Berry, J. W., Phinney, J., Sam, D. L., & Vedder, P. (2006). *Immigrant youth in cultural transition: Acculturation, identity, and adaptation across national context*. New Jersey: Mahwah.
- Betancourt, T. S., Speelman, L., Onyango, G., & Bolton, P. (2009). A qualitative study of mental health problems among children displaced by war in northern Uganda. *Transcultural Psychiatry, 46*(2), 238-256.
- Bharat, S. (1997). Family socialization of the Indian child. *Trends in Social Science Research, 4*(1), 201-216.
- Bhopal, R. (1997). Is research into ethnicity and health racist, unsound, or important science?. *BMJ: British Medical Journal, 314*(7096), 1751.
- Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry, 4*(1), 18.
- Bhui, K. (1997). London's ethnic minorities and the provision of mental health services. *London's Mental Health, London: King's Fund Institute, 143-166.*

- Bhui, K., & Bhugra, D. (2002). Explanatory models for mental distress: implications for clinical practice and research. *The British Journal of Psychiatry*, 181(1), 6-7.
- Bhui, K., & Bhugra, D. (2002). Mental illness in Black and Asian ethnic minorities: Pathways to care and outcomes. *Advances in Psychiatric Treatment*, 8(1), 26-33.
- Biafora, F. A., Warheit, G. J., Zimmerman, R. S., Gil, A. G., Apospori, E., Taylor, D., & Vega, W. A. (1993). Racial Mistrust and Deviant Behaviors Among Ethnically Diverse Black Adolescent Boys. *Journal of Applied Social Psychology*, 23(11), 891-910.
- Birks, M., & Mills, J. (2011). *Grounded theory a practical guide*. London: Sage Publications.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252.
- Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 996(3), 1.
- Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of consulting and clinical psychology*, 63(4), 569-578.

- Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*(1), 26.
- Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach*. New York: Guilford Press.
- Boyd-Franklin, N. (2006). *Black families in therapy: Understanding the African American experience*. New York: Guilford Press.
- Boyd-Franklin, N., Franklin, A. J., & Toussaint, P. (2001). *Boys into men: Raising our African American teenage sons*. New York: Plume Books.
- Brondino, M. J., Henggeler, S. W., Rowland, M. D., Pickrel, S. G., Cunningham, P. B., & Schoenwald, S. K. (1997). Multisystematic therapy and the ethnic minority client: Culturally responsive and clinically effective. (pp. 229-250). *In: Health-promoting and health-compromising behaviors among minority adolescents. Application and practice in health psychology*. Washington, DC, US: American Psychological Association.
- Bronfenbrenner, U. (1979). Contexts of child rearing: *Problems and prospects*. *American Psychologist, 34*(10), 844.
- Brown, L. S. (2009). Cultural competence: A new way of thinking about integration in therapy. *Journal of Psychotherapy Integration, 19*(4), 340.

Bryant, A. & Charmaz, K. (eds.) (2007). *The SAGE Handbook of Grounded Theory*. London: Sage.

Bryant, A., & Charmaz, K. (2010). Grounded theory in historical perspective: An epistemological account. *Handbook of grounded theory*. London: Sage Publications.

Bryman, A. (2004). *Research methods and organization studies*. London: Routledge.

Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A randomized controlled trial of multisystemic therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child & Adolescent Psychiatry, 50(12)*, 1220-1235.

Carr, A. (1990). Failure in family therapy: A catalogue of engagement mistakes. *Journal of Family Therapy, 12(4)*, 371-386.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of counselling psychology, 56(4)*, 521.

Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis*. London: Sage Publications.

Charmaz, K. (2009). Shifting the grounds: Grounded theory in the 21st century. In: J.M. Morse., P.N. Stern., J.M. Corbin., K.C. Charmaz., B. Bowers., A.E.

Clarke. *Developing grounded theory: The second generation*. Left Coast Press: CA.

Chew-Graham, C., Bashir, C., Chantler, K., Burman, E., & Batsleer, J. (2002). South Asian women, psychological distress and self harm: lessons for primary care trusts. *Health & social care in the community*, 10(5), 339-347.

Considine, D. M. (1985). *The cinema of adolescence*. NC: McFarland.

Cunningham, P. B., & Henggeler, S. W. (1999). Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. *Family Process*, 38(3), 265-281.

Cunningham, P. B., & Randall, J. (2008). Multisystemic approaches to supervision: Tales of woe (cultural nonconnect) in supervision and understanding the fit. Falender, C. A., & Shafranske, E. P. In: *Casebook for clinical supervision: A competency-based approach*. American Psychological Association.

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. *Journal of family psychology*, 18(3), 411-419.

Davidson, C. (2009). Transcription: Imperatives for Qualitative Research. *International Journal of Qualitative Methods*, 8(2), 35-52.

De Shazer, S. (1994). *Words were originally magic*. New York: WW Norton & Co.

- Denzin, N. K., & Lincoln, Y. S (Eds.). (1998). *The landscape of qualitative research: Theories and issues*. CA: Thousand Oaks.
- Dey, I. (1999). *Grounding Grounded Theory. Guidelines for Qualitative Inquiry*. San Diego: Academic Press.
- Dowrick, C., Gask, L., Edwards, S., Aseem, S., Bower, P., Burroughs, H., & Waheed, W. (2009). Researching the mental health needs of hard-to-reach groups: managing multiple sources of evidence. *BMC Health Services Research*, 9(1), 226.
- Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, 8(1).
- Egharevba, I. (2001). Researching an-'other'minority ethnic community: reflections of a black female researcher on the intersections of race, gender and other power positions on the research process. *International Journal of Social Research Methodology*, 4(3), 225-241.
- Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38 (7), 215-29.
- Erdur, O., Rude, S. S., & Baron, A. (2003). Symptom improvement and length of treatment in ethnically similar and dissimilar client-therapist pairings. *Journal of Counseling Psychology*, 50(1), 52.

- Fandetti, D. V., & Goldmeier, J. (1988). Social workers as culture mediators in health care settings. *Health & social work, 13*(3), 171-179.
- Farrington, D. P. (2003). Key results from the first forty years of the Cambridge Study in Delinquent Development. In Thornberry, T. P. & Krohn, M. D. (Eds.) *Taking Stock of Delinquency: An Overview of Findings from Contemporary Longitudinal Studies*. New York: Kluwer/Plenum.
- Fenton, S., & Sadiq - Sangster, A. (1996). Culture, relativism and the expression of mental distress: South Asian women in Britain. *Sociology of Health & Illness, 18*(1), 66-85.
- Fernando, S. (1991). *Mental health, race and culture*. London: Macmillan.
- Fernando, S., & Keating, F. (Eds.). (2008). *Mental health in a multi-ethnic society: A multidisciplinary handbook*. Routledge.
- Fiorentine, R., & Hillhouse, M. P. (1999). Drug treatment effectiveness and client-counselor empathy. *Journal of Drug Issues, 29*(1), 59-74.
- Fox, S., Ashmore, Z. (2014). Multisystemic Therapy as an intervention for young people on the edge of care. *British Journal of Social Work, 1-17*.
- Friedlander, M. L., Escudero, V., & Heatherington, L. (2006). *Therapeutic alliances in couple and family therapy: An empirically informed guide to practice*. American Psychological Association.

- Friedlander, M. L., Escudero, V., Heatherington, L., & Diamond, G. M. (2011). Alliance in couple and family therapy. *Psychotherapy, 48*(1), 25.
- Friedlander, M. L., Kivlighan Jr, D. M., & Shaffer, K. S. (2012). Exploring actor–partner interdependence in family therapy: Whose view (parent or adolescent) best predicts treatment progress?. *Journal of counseling psychology, 59*(1), 168.
- Fujino, D. C., Okazaki, S., & Young, K. (1994). Asian - American women in the mental health system: An examination of ethnic and gender match between therapist and client. *Journal of Community Psychology, 22*(2), 164-176.
- Gallardo-Cooper, M., & Zapata, A. L. (2014). *Multicultural family therapy. APA Handbooks in Psychology.* (pp. 499-525).
- Gelfand, D. E., & Fandetti, D. V. (1980). Suburban and urban white ethnics: attitudes towards care of the aged. *The Gerontologist, 20*(1), 588-594.
- Gergen, K. J. (1999). Agency Social Construction and Relational Action. *Theory and Psychology, 9*(1), 113-115.
- Gergen, K. J., & Gergen, M. M. (2008). Social construction and research as action. *The SAGE handbook of action research: Participative inquiry and practice,* 159-171.
- Ghuman, P. A. S. (1999). *Asian adolescents in the West.* Blackwell Publishing.

Glaser, B. G. (1978). *Theoretical sensitivity*. CA: Sociology Press.

Glaser, B.G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Glisson, C., Schoenwald, S. K., Hemmelgarn, A., Green, P., Dukes, D., Armstrong, K. S., & Chapman, J. E. (2010). Randomized trial of MST and ARC in a two-level evidence-based treatment implementation strategy. *Journal of consulting and clinical psychology, 78(4)*, 537.

Goldberg, D. (1999). *Ethnicity: An Agenda for Mental Health*. London: Sage.

Grewal, I., & Ritchie, J. (2006). Ethnic and language matching of the researcher and the research group during design, fieldwork and analysis. In J.Y. Nazroo., *Health and social research in multiethnic societies*. Routledge.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N. K. Denzin and Y. S. Lincoln (eds), *Handbook of Qualitative Research*. London: Sage.

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69(3)*, 502-510.

- Halliday-Boykins, C. A., Schoenwald, S. K., & Letourneau, E. J. (2005). Caregiver-therapist ethnic similarity predicts youth outcomes from an empirically based treatment. *Journal of Consulting and Clinical Psychology, 73*(5), 808.
- Harper, D., & Thompson, A. (Eds.). (2011). *Qualitative research methods in mental health and psychotherapy: an introduction for students and practitioners*. Chichester: Wiley.
- Hauser, S. T., Powers, S. I., & Noam, G. G. (1991). *Adolescents and their families: Paths of ego development*. Simon and Schuster.
- Havighurst, R. J. (1956). Research on the developmental-task concept. *The School Review, 215*-223.
- Henggeler, S. W. (1999). Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implications. *Child and Adolescent Mental Health, 4*(1), 2-10.
- Henggeler, S. W. (1999). Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implications. *Child and Adolescent Mental Health, 4*(1), 2-10.
- Henggeler, S. W., & Borduin, C. M. (1990). *Family therapy and beyond: A multisystemic approach to treating the behavior problems of children and adolescents*. CA: Brooks/Cole.

- Henggeler, S. W., & Schoenwald, S. K. (1998). *Multisystemic therapy supervisory manual: Promoting quality assurance at the clinical level*. SC: MST Institute.
- Henggeler, S. W., & Sheidow, A. J. (2012). Empirically supported family - based treatments for conduct disorder and delinquency in adolescents. *Journal of Marital and Family Therapy*, *38*(1), 30-58.
- Henggeler, S. W., Letourneau, E. J., Chapman, J. E., Borduin, C. M., Schewe, P. A., & McCart, M. R. (2009). Mediators of change for multisystemic therapy with juvenile sexual offenders. *Journal of Consulting and Clinical Psychology*, *77*(3), 451.
- Henggeler, S. W., Rodick, J. D., Borduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interaction. *Developmental Psychology*, *22*(1), 132.
- Henggeler, S. W., Rowland, M. D., Pickrel, S. G., Miller, S. L., Cunningham, P. B., Santos, A. B., & Edwards, J. E. (1997). Investigating Family-Based Alternatives to Institution-Based Mental Health Services for South: Lessons Learned from the Pilot Study of a Randomized Field Trial. *Journal of Clinical Child Psychology*, *26*(3), 226-233.
- Henggeler, S. W., Rowland, M. D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., ... & Santos, A. B. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis:

Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38(11), 1331-1339.

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. Treatment Manuals for Practitioners*. New York: Guilford Press.

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., Schoenwald, S. K., Rowland, M. D., & Cunningham, P. B. (2002). *Multisystemic Treatment of Children and Adolescents with Serious Emotional Disturbance*. Guilford: New York

Henwood, K. and Pidgeon, N. (1992). Qualitative research and psychological theorizing. *British Journal of Psychiatry*, 83, 97-111.

Hill, C. E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research*, 19(1), 13-29.

Hines, P. A., Garcia-Preto, N., & McGoldrick, A. R., & Weltman, S. (1992). Intergenerational relationships across cultures. *Families in Society: The Journal of Contemporary Human Services* (80), 323-338.

- Hogue, A., Dauber, S., Stambaugh, L. F., Cecero, J. J., & Liddle, H. A. (2006). Early therapeutic alliance and treatment outcome in individual and family therapy for adolescent behavior problems. *Journal of consulting and clinical psychology, 74(1)*, 121.
- Huey Jr, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology, 37(1)*, 262-301.
- Huey Jr, S. J., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of consulting and clinical psychology, 68(3)*, 451.
- Huey, S. J., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology, 68(3)*, 451-467.
- Hugh-Jones, S., & Gibson, S. (2012). *Doing Your Qualitative Psychology Project*. London: Sage.
- Jackson-Gilfort, A., Liddle, H. A., Tejada, M. J., & Dakof, G. A. (2001). Facilitating engagement of African American male adolescents in family therapy: A cultural theme process study. *Journal of Black Psychology, 27(3)*, 321-340.

- Jim, J., & Pistrang, N. (2007). Culture and the therapeutic relationship: Perspectives from Chinese clients. *Psychotherapy Research, 17*(4), 461-473.
- Kaur Gomez, P., Pote, H., & Fox, S. (Submitted). Developing a model of sustained change following Multisystemic Therapy: Caregivers perspectives. *Journal of Family Therapy*.
- Kazdin, A. E. & Weisz, J. R. (1998). Identifying and Developing Empirically Supported Child and Adolescent Treatments. *Journal of Consulting and Clinical Psychology, 66*(1), 19-36.
- Kazdin, A. E. (1993). Adolescent mental health: prevention and treatment programs. *American Psychologist, 48*(2), 127.
- Kazdin, A. E. (2003). *Research design in clinical psychology*. Boston: Allyn and Bacon.
- Kazdin, A.E., & Nock, M.K. (2003). Delineating mechanisms of change in child and adolescent therapy: methodological issues and research recommendations. *Journal of Child Psychology & Psychiatry, 44*, 1116 – 1129.
- Kiell, N. (1959). *The adolescent through fiction: A psychological approach*. International University Press. UK.
- Kim, B. S., Atkinson, D. R., & Yang, P. H. (1999). The Asian Values Scale: Development, factor analysis, validation, and reliability. *Journal of Counseling Psychology, 46*(3), 342.

- Kim, B. S., Ng, G. F., & Ahn, A. J. (2005). Effects of Client Expectation for Counseling Success, Client-Counselor Worldview Match, and Client Adherence to Asian and European American Cultural Values on Counseling Process With Asian Americans. *Journal of Counseling Psychology, 52*(1), 67.
- Kumpfer, K. L., & Alvarado, R. (1995). Strengthening families to prevent drug use in multi-ethnic youth. *Drug abuse prevention with multiethnic youth, 255-294*.
- Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science, 3*(3), 241-246.
- Larson, R. W., Richards, M. H., Sims, B., & Dworkin, J. (2001). How urban African American young adolescents spend their time: Time budgets for locations, activities, and companionship. *American Journal of Community Psychology, 29*(4), 565-597.
- Larson, R., Verma, S., & Dworkin, J. (2003). *Adolescence without family disengagement: The daily family lives of Indian middle class teenagers. Cross-cultural perspectives in human development: Theory, research and applications*. London: Sage.
- Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multisystems engagement strategy in family-based adolescent treatment. *Psychotherapy: Theory, Research, Practice, Training, 32*(1), 39.

- Littell, J., Popa, M., & Forsythe. (2005). *Multisystemic Therapy for social, emotional, and behavioural problems in youth aged 10-17*. Nordic Campbell Centre.
- Lloyd, K., & Moodley, P. (1992). Psychotropic medication and ethnicity: an inpatient survey. *Social Psychiatry and Psychiatric Epidemiology*, 27(2), 95-101.
- Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry*, 48(3), 161-170.
- Lobatto, W. (2002). Talking to children about family therapy: A qualitative research study. *Journal of family therapy*, 24(3), 330-343.
- Lyons, E., & Coyle, A. (Eds.). (2007). *Analysing qualitative data in psychology*. London: Sage.
- Macran, H. Ross., G. E. Hardy., D. A. Shapiro, S. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 8(4), 325-337.
- Madden-Derdich, D. A., Leonard, S. A., & Gunnell, G. A. (2002). Parents' and children's perceptions of family processes in inner-city families with delinquent youths: A qualitative investigation. *Journal of Marital and Family Therapy*. 28, 355–369.
- Maramba, G. G., & Nagayama Hall, G. C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural diversity and ethnic minority psychology*, 8(3), 290.

- Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological review*, 98(2), 224.
- Markus, H. R., & Lin, L. R. (1999). *Conflictways: Cultural diversity in the meanings and practices of conflict*. London: Sage.
- Marsella, A. J. (2011). The challenges of ethno-cultural diversity in an era of asymmetric globalization. *Dynamics of Asymmetric Conflict*, 4(1), 52-58.
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *BMJ: British Medical Journal*, 311(6997), 109.
- Mays, V. M., & Albee, G. W. (1992). Psychotherapy and Ethnic Minorities. In D.K. Freedheim & H.J. Freudenberger (Eds.), *History of psychotherapy: A century of change*. Washington, DC: American Psychological Association.
- McCallin, A. M. (2003). Designing a grounded theory study: some practicalities. *Nursing in Critical Care*, 8(5), 203-208.
- McGoldrick, M., & Hardy, K. V. (Eds.). (2004). *Re-visioning family therapy: Race, culture, and gender in clinical practice*. Guilford Press.
- McGoldrick, M., Pearce, J. K., & Giordano, J. (1982). *Ethnicity and family therapy*. New York: Guilford.

- McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: Sage.
- Miranda, J., Nakamura, R., & Bernal, G. (2003). Including ethnic minorities in mental health intervention research: A practical approach to a long-standing problem. *Culture, Medicine and Psychiatry, 27(4)*, 467-486.
- Mock, M. (2001). Working with Asian American families. In interventions with multicultural families (Part 2). *The Family Psychologist, 17(3)*, 5–7.
- Morgan, C., Dazzan, P., Morgan, K., Jones, P., Harrison, G., Leff, J., & Fearon, P. (2006). First episode psychosis and ethnicity: initial findings from the AESOP study. *World Psychiatry, 5(1)*, 40.
- Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., ... & Leff, J. (2005). Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission Report from the AÆSOP study. *The British journal of psychiatry, 186(4)*, 281-289.
- Morse, J. M. (2009). *Developing grounded theory: The second generation*. London: Sage.
- Naeem, F., Ayub, M., Kingdon, D., & Gobbi, M. (2012). Views of depressed patients in Pakistan concerning their illness, its causes, and treatments. *Qualitative health research, 22(8)*, 1083-1093.

- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy, 48*(1), 98.
- Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behaviour problems in youth: Sustainability of effectiveness two years after intake. *Child and adolescent mental health, 11*(3), 142-149.
- Painter, K., & Scannapieco, M. (2009). Part I: a review of the literature on multisystemic treatment within an evidence-based framework: implications for working with culturally diverse families and children. *Journal of family social work, 12*(1), 73-92.
- Paradisopoulos, D., Pote, H., & Fox, S. (Submitted). Developing a model of sustained change following Multisystemic Therapy: Young people's perspectives. *Journal of Family Therapy*.
- Patel, N. (2002). Speaking with the silent: addressing issues of disempowerment when working with refugee people. In R. Tribe & H. Raval (Eds.). *Working with Interpreters in Mental Health*. East Sussex: Brunner-Routledge.
- Payne, Sheila (2007) *Grounded theory. In: Analysing Qualitative Data in Psychology*. London: Sage.
- Pedersen, P. (Ed.). (2008). *Counselling Across Cultures*. London: Sage.

- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (2002). *Introduction: Multicultural awareness as a generic competence for counseling. Counseling across cultures* (5th ed). Thousand Oaks, CA: Sage.
- Phinney, J. S., & Vedder, P. (2006). *Acculturation, identity, and adaptation across national contexts*. London: Sage.
- Potter, J. and Wetherell, M., (1987). *Discourse and social psychology: Beyond Attitudes and behaviour*. London: Sage.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). *In search of the structure of change*. New York: Springer
- Ramanujam, B. K. (1972). *The Indian Family in Transition. The Indian Family in the Change and Challenge of the Seventies*. New Delhi: Sterling Publishers.
- Rapley, M. (2001). *Understanding prejudice, racism and social conflict*. London: Sage.
- Rasheed, J. M., & Rasheed, M. N. (2003). *Family therapy with ethnic minorities*. London: Sage.
- Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and cognitive psychotherapy*, 38(05), 511-533.

- Rathod, S., Kingdon, D., Weiden, P., & Turkington, D. (2008). Cognitive-behavioral therapy for medication-resistant schizophrenia: a review. *Journal of Psychiatric Practice, 14*(1), 22-33.
- Rathod, S., Naeem, F., Phiri, P., & Kingdon, D. (2008). Electronic letter. Cultural adaptation of cognitive behaviour therapy. *British Journal of Psychiatry, 192*(5), 326.
- Rathod, S., Naeem, F., Phiri, P., & Kingdon, D. (2008). Electronic letter. Cultural adaptation of cognitive behaviour therapy. *British Journal of Psychiatry, 192*(5), 326.
- Reicher, S. D., & Hopkins, N. (2001). *Self and nation: Categorization, contestation and mobilisation*. London: Sage.
- Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of community psychology, 28*(3), 271-290.
- Rober, P., & De Haene, L. (2013). Intercultural therapy and the limitations of a cultural competency framework: about cultural differences, universalities and the unresolvable tensions between them. *Journal of Family Therapy, (36)*, 3-20.
- Rutter, M. (2005). Environmentally mediated risks for psychopathology: Research strategies and findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(1), 3-18.

- Sanders, M. R. (2000). Community-based parenting and family support interventions and the prevention of drug abuse. *Addictive Behaviors, 25*(6), 929-942.
- Santisteban, D. A., Mena, M. P., & Abalo, C. (2013). Bridging diversity and family systems: Culturally informed and flexible family-based treatment for Hispanic adolescents. *Couple and Family Psychology: Research and Practice, 2*(4), 246.
- Santisteban, D.A., Muir-Malcom, J.A., Mitrani, J.B., & Szapocznik, J. (2001). Integrating the study of ethnic culture and family psychology intervention science. In H.A. Liddle, D.A. Santisteban, R. F. Levant, & J.H. Bray (Eds.), *Family psychology: Science-based interventions* (pp. 331-351). Washington, DC: American Psychological Association.
- Saraswathi, T. S. (1999). *Adult-child continuity in India: Is adolescence a myth or an emerging reality?*. London: Sage Publications.
- Saraswathi, T. S., & Ganapathy, H. (2002). Indian parents' ethnotheories as reflections of the Hindu scheme of child and human development. Between culture and biology. *Perspectives on ontogenetic development, 79-88*.
- Saraswathi, T. S., & Ganapathy, H. (2002). The Hindu world view of child and human development: Reflections in contemporary parental ethnotheories. Biology, culture, and development. *Integrating diverse perspectives, 80-88*.

- Sashidharan, S. P. (2003). *Inside outside: improving mental health services for black and minority ethnic communities in England*. Department of Health. London. England.
- Sass, B., Moffat, J., Mckenzie, K., & Bhui, K. (2009). A learning and action manual to improve care pathways for mental health and recovery among BME groups. *International Review of Psychiatry*, 21(5), 472-481.
- Schaeffer, C. M., & Borduin, C. M. (2005). Long-term follow-up to a randomized clinical trial of multisystemic therapy with serious and violent juvenile offenders. *Journal of consulting and clinical psychology*, 73(3), 445.
- Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic Family Preservation Therapy Preliminary Findings From A Study Of Rural And Minority Serious Adolescent Offenders. *Journal of Emotional and Behavioral Disorders*, 2(4), 198-206.
- Schmidt, S. E., Liddle, H. A., & Dakof, G. A. (1996). Changes in parenting practices and adolescent drug abuse during multidimensional family therapy. *Journal of Family Psychology*, 10(1), 12.
- Schoenwald, S. K., Heiblum, N., Saldana, L., & Henggeler, S. W. (2008). The international implementation of multisystemic therapy. *Evaluation & the health professions*, 31(2), 211-225.

- Schwandt, T. A. (1994) Constructivist, Interpretivist Approaches to Human Enquiry, In: N. K. Denzin & Y. S. Lincoln (Eds) *Handbook of Qualitative Research*. Thousand Oaks: Sage.
- Sewell, H. (2008). *Working with ethnicity, race and culture in mental health: A handbook for practitioners*. Jessica Kingsley Publishers.
- Seymour, S. C. (1999). *Women, family, and child care in India: A world in transition*. Cambridge University Press.
- Shah, A., Oommen, G., & Wuntakal, B. (2005). Cross-cultural aspects of dementia. *Psychiatry*, 4(2), 103-106.
- Sinha, D., & Tripathi, R. C. (1994). Individualism in a collectivist culture: A case of coexistence of opposites. In Individualism and collectivism: Theory, method, and applications. *Cross-cultural research and methodology series. Vol. 18.*, (pp. 123-136). CA, US: Sage Publications.
- Smith, J. A. (2010). Interpretative phenomenological analysis. *Existential Analysis: Journal of the Society for Existential Analysis*, 21(2).
- Smith, J. A. (Ed.). (2007). *Qualitative psychology: A practical guide to research methods*. London: Sage.
- Smith, J. A., & Eatough, V. (2007). In E. Lyons, & A. Coyle. *Analysing Qualitative Data in Psychology*. London: Sage.

- Smith, JA, Flowers, P. and Larkin, M. 2009. *Interpretative phenomenological analysis: Theory, method, research*. London: Sage.
- Spiegel, J. P. (1971). *Transactions: The interplay between individual, family, and society*. Science House.
- Stanfield, J. H. II.(1993). *Epistemological considerations. Race and ethnicity in research methods*. Routedledge.
- Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition, and family–couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological bulletin*, 122(2), 170.
- Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Journal of Cognitive Education and Psychology*, 2(1), 55-87.
- Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. *International Journal of Health Promotion and Education*, 46(2), 49-56.
- Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: grounded theory procedures and techniques*. Newbury Park: Sage.
- Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research (2nd Ed.)*. London: Sage Publications.

- Strickland-Clark, L., Campbell, D. & Dallos, R. (2000) Children's and adolescent's views on family therapy. *Journal of Family Therapy* 22, 324-341. 192
- Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice*. John Wiley & Sons.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53(4), 440.
- Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. *Journal of Counseling Psychology*, 31(3), 371.
- Tharp, R. G. (1991). Cultural diversity and treatment of children. *Journal of Consulting and Clinical Psychology*, 59(6), 799.
- Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology*, 41(2), 155.
- Thompson, S. J., Bender, K., Lantry, J., & Flynn, P. M. (2007). Treatment engagement: Building therapeutic alliance in home-based treatment with adolescents and their families. *Contemporary Family Therapy*, 29(1-2), 39-55.
- Tighe, A., Pistrung, N., Casdagli, L., Baruch, G., Butler, S. (2012). Multisystemic therapy for young offenders: Families' experiences of therapeutic processes and outcomes. *Journal of Family Psychology*. 6(2), 187-97.

- Timmons-Mitchell, J., Bender, M. B., Kishna, M. A. & Mitchell, C. C. (2006). An independent effectiveness trial of Multisystemic therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychology, 35*(2), 227-236.
- Tobler, N. S., & Kumpfer, K. L. (2000). *Meta-analysis of family based strengthening programs*. Report to the Center for Substance Abuse Prevention.
- Tobler, N. S., & Stratton, H. H. (1997). Effectiveness of school-based drug prevention programs: A meta-analysis of the research. *Journal of Primary Prevention, 18*(1), 71-128.
- Tobler, N., & Kumpfer, K. L. (2000). *Meta-analysis of effectiveness of family-focused substance abuse prevention programs*. Rockville, MD: Center for Substance Abuse Prevention.
- Trimble, J. E., Scharrón-del Río, M. R., & Bernal, G. (2010). Cultural perspectives on women's depression: Self-silencing, psychological distress and recovery. Routledge.
- Tripathi, R. C., & Leviatan, U. (2003). Individualism and collectivism: in search of a product or process?. *Culture & Psychology, 9*(1), 79-88.
- Tuerk, E. H., McCart, M. R., & Henggeler, S. W. (2012). Collaboration in family therapy. *Journal of clinical psychology, 68*(2), 168-178.

- Turner, W. L. (2000). Cultural considerations in family-based primary prevention programs in drug abuse. *Journal of Primary Prevention, 21*(2), 285-303.
- Verma, S., & Saraswathi, T. S. (2002). *Adolescence in India. The Worlds Youth: Adolescence in Eight Regions of the Globe*. London: Sage.
- Walsh, F. (2006). *Strengthening family resilience*. Guilford Press.
- Webster, A., & Robertson, M. (2007). Can community psychology meet the needs of refugees?. *Psychologist, 20*(3), 156-158.
- Weisman, A., Duarte, E., Koneru, V., & Wasserman, S. (2006). The Development of a Culturally Informed, Family-Focused Treatment for Schizophrenia. *Family Process, 45*(2), 171-186.
- Weisz, J. R., Huey, S. J., & Weersing, V. R. (1998). Psychotherapy outcome research with children and adolescents: *The state of the art. Advances in clinical child psychology, 23*(9), 193-197.
- Willig, C. (2008). *Introducing Qualitative Research in Psychology*. (2nd Ed.). Maidenhead: Open University Press.
- Williams, C., & Soydan, H. (2005). When and how does ethnicity matter? A cross-national study of social work responses to ethnicity in child protection cases. *British Journal of Social Work, 35*(6), 901-920.

- Wittenborn, A. K., Dolbin - MacNab, M. L., & Keiley, M. K. (2013). Dyadic research in marriage and family therapy: Methodological considerations. *Journal of Marital and Family Therapy*, 39(1), 5-16.
- Wynne, L. (1961). The study of intrafamilial alignment and splits in exploring family therapy. *Exploring the Base for Family Therapy*. Family Service Assn. Amer. New York.
- Yarhouse, M. A., & VanOrman, B. T. (1999). When psychologists work with religious clients: Applications of the general principles of ethical conduct. *Professional Psychology: Research and Practice*, 30(6), 557.
- Zane, N., Nagayama Hall, G.C., Sue, S., Young, K., & Nunez, J. (2004). Research on psychotherapy with culturally diverse populations. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed)*. New York: Wiley.

Appendices

Appendix A: Extracts from Reflexive Journal

The researcher kept a reflexive journal throughout the course of the research to capture thoughts, process ideas and reflect on assumptions and values. Charmaz (2006) advocates the use of reflexivity, and defines it as “the researchers scrutiny of his or her research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interest, position and assumptions influence enquiry (p.188).

Reflections during interview and transcribing

Extract 1:

Following the first interview, I was moved by Jin’s stories and reflections. I was able to get a sense of how deeply distressing the situation around his children had been for him, and I found myself having to refrain from slipping into a therapeutic role. Ethically, I felt it was appropriate to convey empathy and acknowledge the sensitivity of what he was sharing whilst maintaining my position as a researcher. The semi-structured interview schedule was particularly helpful in drawing me back to the purpose of the interview.

I was struck by the amount of time, and how emphatically Jin spoke about his culture and background. In addition to what he was saying, being sat in Jin’s living room, which was full of Chinese decorations, newspapers and with the Chinese channel muted in the background conveyed to me the importance of Jin preserving his culture was to him. I re-thought my decision of refusing the tea that he had offered me, (which in my culture of origin likes Jin’s is likely to be perceived as rude) and the subtle implications this may have had for building rapport. Jin spoke very highly of Chinese culture and emphasised the central role of authority figures and the respect they were granted. His description of UK culture was in contrast very negative, expressing his view that there was an absence of a respect for authority. My impression was that Jin had constructed a very split, opposite and polarised view of these two cultures, with one being idealised and the other being denigrated. Jin explicitly talked about how the British culture, media and institutions had played an important part in ruining his children. I found myself intrigued by, and motivated to understand how Jin had arrived at this polarised construction. Having membership within two cultures, I am aware of the difficulties that young people face when negotiating two cultures and during the course of this interview I was able to understand better the perspective of the parent. Jin talked a lot of the incompatibilities of his culture, and the mainstream culture in the UK and the implications this had for child rearing. This alerted me to the importance this may have when taking part in an MST intervention, and a question around this was added into the interview schedule.

Whilst transcribing I also noticed a number of areas that Jin had drawn on during the interview that I had wished to follow up on. I was aware that it would not be possible to follow up on every topic raised in the interview. On reflection however, I wondered if I could have balanced my engagement with maintaining some distance to enable me to notice more of these issues during the interview, instead of afterwards. After interviews, I also decide to ensure that I recorded memos of issues I would have liked to explore further in order to shape theoretical sampling when adopting the semi structured interview for the next wave of data collection.

Extract 2:

I found myself thinking a lot about the ideas and issues that Miriam raised in the interview I did with her yesterday. Miriam was bemused by the term Black Minority Ethnic meant, and strongly expressed that she did not identify herself as 'black' or an 'ethnic minority'. I felt slightly embarrassed at my own use of the term, since I myself do not identify with it, or like to be referred to as a 'BME'. I was left thinking about this, and how within the field of Clinical Psychology it is well accepted and taken for granted term that has been placed on a huge group of people. It put me in touch with how reductionist and homogenising this term was, and how depersonalising it is to refer to people in this way. Following this interview, I chose to take the term BME out all of the study related material.

As I was transcribing the interview, I was reminded of how misunderstood she described feeling, both by services (including MST) and wider society as a whole. A specific excerpt of her interview stuck out in my mind, as it seemed to capture the essence of what she was trying to convey. She said that it is important that therapists "check out the meaning behind words" as they can have different meanings for people from different cultures, with specific reference to the word 'family'. This was something the other parents had referred to in their interviews too. Miriam depicted in detail the richness of family life in Israel, and the support that she felt she missed out on. She said that she wished she had raised her children in Israel, and questioned whether her daughter would have ended up becoming so unwell had she stayed in Israel. I could sense the deep regret in her voice. I wondered how much of this the MST therapist had been aware of. Based on what Miriam told me, it was clear that this was a conversation that she had not been able to have with the MST therapist, thus cultural differences had not been validated. Miriam said that she felt as though the therapist was 'lovely, but was on a completely different page'. I got the sense that this became a big obstacle in them building a working relationship. This was in stark contrast to Joy, who talked about feeling as though the therapist 'understood and respected' her culture. Indeed, a strong and positive working alliance stood out in Joy's interview. This seems to point to a link between being able to validate cultural differences, feeling understood, being able to build a good working relationship and having a positive experience of MST with good outcomes.

Extract 3:

I was pleased with today's interview and feel as though updating my interview schedule for the second time has enabled to ask more relevant questions and gather rich data. Leila's interview was particularly useful in helping to consider taken for granted, culturally specific ideas around adolescence. Although the developmental period of adolescence is a universally accepted stage of life (marked by physiological changes), perhaps the purpose of it is socially constructed. Leila talked about her experience of adolescence being different in Chad where she grew up where young people are expected reintegrate to more responsible positions within the family, rather than separate and individuate as is the norm here. She shared that it was difficult to accept her daughters 'demands' for independence and talking back, which she viewed as deeply disrespectful. I was struck by the descriptions of the therapists role in helping her to contextualise this differently.

Extract 4:

In all of the interviews I have done so far, I've noticed whilst transcribing and in the process of coding how long the parents have wanted to speak about their own

backgrounds. All of the parents interviewed so far have wanted to talk in a lot of depth about where and how they grew up sharing fond memories and stories of growing up in extended families. Although at times I had to move the interview on to focus on the research questions, I felt as though taking the time to genuinely listen to parents experiences and stories about their own upbringing helped to build rapport, as the interviews have flowed very easily. I wondered how this played out in the engagement process with the MST therapist and whether this was an important part of the engagement process in the MST intervention, as it had been in the interview.

Reflections during initial coding

I found analysing the first wave of interviews particularly challenging. I had never coded qualitative data before, and was overwhelmed by the amount of data that required processing. Charmaz's (2006) recommendations were clear and helpful although I was still unsure about whether I was coding properly. Sharing my concerns with fellow trainees who were also doing a grounded theory projects was extremely helpful in ensuring I was on the right track. I found it particularly challenging at first to find the balance between describing and conceptualising the data, however as the research progressed I became increasingly more familiar with and confident in the coding process.

Reflections during theoretical coding

The number of initial codes and focused codes I had generated after coding the final interview left me feeling both pleased and overwhelmed. The very structured approach to data analysis that GT outlines helped me to break the data analysis down into more manageable steps. The process of collecting and analysing data simultaneously was also helpful in achieving a sense of moving through the analysis process in a systematic way. Constantly comparing codes between and within interviews was particularly useful in consolidating emerging codes. Focused coding had helped to provide a useful bridge between initial line by line coding and developing categories. However, there was a sense of 'stuckness' I felt when I had to take the leap from focused codes to theoretical categories. My biggest fear was that I would risk not doing justice to, and represent the experience of my participants. However, having paid careful attention in the initial coding and focused coding stages to ensure that codes were grounded in data (and in the words of the participant as much as possible) made it possible for me to move towards theoretical coding as I was reassured that my the bidding blocks of the theory (codes) were evidenced in the data. Also, one of my GT colleagues reminded me of Charmaz's point that there are numerous possibilities held within data, and each individual researcher is likely to construct it in a unique way. Providing that the emergent theory is grounded in, and evidenced by the data, there is no 'right' or 'wrong'. This reminder was particularly helpful in me being able to start generating my model.

During the construction of theoretical categories, I struggled with the interconnectedness of the data. It was difficult to fully distinguish different categories as there was much overlap between them. I collapsed the 12 categories that I initially constructed to a total of 7 through a systematic process of examining how similar and unique they were. Constructing a way of presenting the analysis that captured the interconnectedness of the categories and circular movements between categories was a considerable challenge, rather than presenting fragmented categories, interweaving concepts throughout the analysis was also felt to be useful to create a sense of interconnectedness between the categories.

Appendix B: Memo Examples

Raising initial codes to focused codes – ‘MST making sense’

Parents have talked in detail about the early engagement process with the MST. There is a variation in participant's experiences of initially engaging with MST. The theme of ‘things making sense’ was apparent in all parents narratives, and was described to have implications for whether people chose to follow through with MST or not. Parents who initially disengaged with MST provided rich detail about the important aspects of initial engagement. The initial codes ‘therapist being concrete and specific’, ‘working out a plan’, ‘focusing on present difficulties’ were apparent in all parents accounts of the initial engagement process, and could be subsumed in to a broader focused code that relates to ‘MST making sense’ as it was these processes that seemed to help parents understand and makes sense of MST, which then seemed to impact their willingness and commitment to engage.

Memo to guide theoretical sampling (informing changes made to interview schedule 2): asking about cultural differences within the family

Jin frames the difficulties he is having with his daughters as a product of cultural differences within the family. He drew distinctions between western culture, which he perceives to be individualist and Chinese culture, depicted as collectivist. He conveyed how important it is to him to preserve the values of his culture (e.g. respect for authority figures, obedience, centring life around family) and how mainstream society works against this. He said he thought that peers, agencies and media were a powerful force in instilling western values within his children. Jin gave the impression that he had not discussed this with his MST therapist. Further questions around whether parents see their difficulties as a product of cultural incompatibilities and if so, whether this was discussed with the therapist will be incorporated into the interview schedule.

Memo to guide theoretical sampling (informing changes made to interview schedule 2): asking about the therapeutic alliance

The theme of having a positive working relationship with the therapist is apparent in the narratives of those parents who have described having positive outcomes with MST. It is absent in those parents who did not report good outcomes. The two parents who disengaged with MST initially describe a difficult relationship with the therapist from the outset. Indeed, there is a sense that where there was a good working relationship with the therapist, it started very early on in (perhaps even in engagement). Is the working relationship with the therapist seems to be instrumental both the process of change? This requires to be explored further in the interview. Additional questions will be added to the interview schedule around the therapeutic relationship to gauge how it facilitates change.

Memo to guide theoretical sampling (informing changes made to interview schedule 3): asking about reasons for moving to the UK

There is a distinct variation in participants accounts of their initial thoughts about MST, and how culturally appropriate it would be. Some parents were noticeably more suspicious about MST at the outset, their concerns being centred around having people come in to change their cultural practices. These parents were also more critical of UK culture. It is worth considering whether their reasons and early experiences of coming to the UK has shaped their ideas about the culture here, and

subsequently their trust and willingness to engage with MST, specifically in relation to their intimate family life. Leila said that she was initially in the UK as a refugee, and Joy had been brought over by her uncle (under the impression that she would be going back). They said that they were both very unhappy here and desperately wanted to go back in the early years. They also spoke proudly about how they strived to preserve their cultural heritage (through food, rituals and parenting). Questions around reasons for migration to the UK and early adjustment will be added to the interview schedule to explore impact on early engagement with MST.

Therapist managing cultural differences (raising a focused code to a theoretical category) to therapist acting as cultural broker

The therapist's role in helping to negotiate cultural difference in the family has emerged as important to helping to bring about change in some parents accounts. Where parents have made sense of their difficulties as being a result of incompatibilities between eastern/collectivist cultures and western/individualistic cultures, it was apparent that the therapists ability to acknowledge, validate, and address this was instrumental in helping the parent to frame their difficulties in a more helpful way. The therapist helping to manage cultural difference was conveyed to include the therapist being able to hold a neutral position, in that they were not aligned with the parent and their culture, or the child and their culture. So being on none, and on both of their sides at the same time.

The skill of the therapist in helping to encourage cultural perspective taking so that the parent could acknowledge that the child was navigating two cultures (a necessary and important part of the development of a self identity), and the child acknowledging that the parent is trying to preserve cultural practices that they value was experienced as helpful in helping to create a shift in previously entrenched and strongly held positions. Thus the therapist found a way to help them 'meet in the middle', through mediating between the parents and child's cultural alignments.

The ethnicity and cultural background of the therapist stood out as an important factor, contributing to how credible parents perceived the therapist to be in being able to address cultural issues. For a couple of the parents, therapists with lived experience of negotiating such cultural differences themselves were perceived to be able to help them with such difficulties better (i.e. therapists who were also ethnic minorities). There was a sense that by these therapists having been educated and in a 'good job' represented negotiation of, and adjustment to the mainstream culture. Leila talked about being able to use the use the therapist as a cultural reference point, to differentiate between 'normal' and 'abnormal' behaviour, which was described to have a powerful normalising effect. The therapist was thus able to act as a sort of cultural broker within the family, and between the family and the wider cultural milieu to help create change.

Appendix C: Ethical Approval from National Research Ethics Committee Service (NHS)



NRES Committee London - Fulham

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

Telephone: 0161 625 7821
Facsimile: 0161 625 7299

30 July 2013

Miss Fatima Bibi
239b Archway Road
London
N6 5BS

Dear Miss Bibi

Study title:	Experiences of Engaging in Multisystemic Therapy – A Qualitative Investigation with Black Minority Ethnic Parents/Carers
REC reference:	13/LO/0978
Protocol number:	N/A
IRAS project ID:	126784

Thank you for your letter of 30 July 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chairman.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator, Miss Shehnaz Ishaq, nrescommittee.london-fulham@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

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

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

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

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

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

Sponsors are not required to notify the Committee of approvals from host organisations

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

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity		01 August 2012
Interview Schedules/Topic Guides	1	19 April 2013
Investigator CV	Fatima Bibi - 1	19 April 2013
Investigator CV	Gary Brown	
Participant Consent Form	2	24 July 2013
Participant Information Sheet	2	24 July 2013
Participant Information Sheet: Information Sheet for Young Person	1	24 July 2013
Protocol	1	19 April 2013
REC application	3.5	26 June 2013
Response to Request for Further Information	Cover letter detailing the response	30 July 2013

Statement of compliance

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

After ethical review

Reporting requirements

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

A Research Ethics Committee established by the Health Research Authority

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

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

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/LO/0978	Please quote this number on all correspondence
-------------------	---

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

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

Yours sincerely



Signed on behalf of:
Dr Charles Mackworth-Young
Chairman

Email: nrescommittee.london-fulham@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Andrew McLeod, Royal Holloway University of London
A.Macleod@rhul.ac.uk

Ms Enitan Eboda, South West London & St Georges Mental Health NHS Trust
Enitan.Eboda@swlstg-tr.nhs.uk

Appendix D: Research and Development Ethics Approval

South West London and St. George's Mental Health NHS Trust

Miss Fatima Bibi
Department of Psychology
Royal Holloway, University of London
Egham Hill
Egham
Surrey TW20 0EX

Research and Development

R&D Director: Dr Niruj Agrawal
c/o SECTION OF MENTAL HEALTH, PHSE
DIVISION
HUNTER WING
CRANMER TERRACE
LONDON SW17 0RE

R&D Co-ordinator: Ms Enitan Eboda
E-mail: eeboda@squ.ac.uk

Direct Line: 020 8725 3463/2783
Fax: 020 8725 3538/2914

28 August 2013

Dear Fatima,

Research Title: Experiences of engaging in multisystemic therapy – a qualitative investigation with Black Minority Ethnic parents/carers.
Principal Investigator: Miss Fatima Bibi
Project reference: PF570
Sponsor: Royal Holloway, University of London

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

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

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

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

Terms and conditions of Approval, version 1.1 28/08/2013

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

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

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact Enitan Eboda, R&D Co-ordinator, on 020 8725 3463 (St. George's), e-mail: eeboda@sgul.ac.uk.

Yours sincerely,



Dr Niruj Agrawal
Research & Development Director
Chair, Research & Development Committee.

Cc: Dr Amaryllis Holland, South West London & St George's Mental Health NHS Trust.

Terms and conditions of Approval, version 1.1 28/08/2013

Joint Research Management Office
Queen Mary Innovation Centre
5 Walden Street
London
E1 2EF

FINAL R&D APPROVAL

01 November 2013

Miss Fatima Bibi
Royal Holloway, University of London
Trainee Clinical Psychologist
Department of Psychology
Royal Holloway, University of London
Egham,
Surrey
TW20 0EX

Tel: 020 7882 7260
Fax: 020 7882 7276
Email: Sponsorsrep@bartshealth.nhs.uk

Dear Miss Bibi,

Protocol: BME Parents/Carer Experiences of Engaging in multisystematic therapy

ReDA Ref: JB1308/3
REC Ref: 13/LO/0978

I am pleased to inform you that the Joint Research Management Office for Barts Health NHS Trust and Queen Mary University of London has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project, on behalf of East London Foundation Trust. Approved study documents are as follows:

Type	Version	Date
Protocol	1	19 April 2013
Participant Information Sheet	2	24 July 2013
Information Sheet for Young Person	1	24 July 2013
Interview Schedule		

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BH and QMUL policies that reinforce them, you can obtain details from the Joint Research Management Office or go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

You must stay in touch with the Joint Research Management Office during the course of the research project, in particular:

- If there is a change of Principal Investigator
- When the project finishes
- If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is **essential** that you inform the Sponsor within 24 hours. If patients or staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Risk Management Unit on 020 7480 4718.

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely



Gerry Leonard, Head of Research Resources

Copy to: Sponsor Organisation

Appendix E: Ethical Approval form from RHUL Ethics Committee

Ref: 2013/084 Ethics Form Approved

Psychology-Webmaster@rhul.ac.uk
Mon 11/4/2013 3:38 PM

To: mwj075@rhul.ac.uk; Brown, Gary;
Cc: PSY-EthicsAdmin@rhul.ac.uk; Leman, Patrick; Lock, Annette;

Application Details: View the form click [here](#) Revise the form click [here](#)

Applicant Name: **Fatima Bibi**

Application title: **BME Parents/Carer Experiences of Engaging in Multisystemic Therapy**

17:57
27/05/2014

Appendix F: Participant Information Sheet

Participant Information Sheet



Title: Experiences of Engaging in Multisystemic Therapy – A Qualitative Investigation with Minority Ethnic Carers

You are being invited to take part in a research study. Before you decide whether you want to take part or not it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Part 1 tells you about the purpose of this study and what will happen if you decide to take part; Part 2 gives you more detailed information about the how the study will be carried out.

PART 1

What is the purpose of the study?

My name is Fatima Bibi and I am a 3rd Year Clinical Psychology Trainee at Royal Holloway University and I am conducting this research for my 3rd year Doctoral research project. I am interested in following up Minority Ethnic families who have taken part in Multisystemic Therapy (MST). I am interested in finding out about your experience of MST, how well suited you found MST to your specific cultural and/or religious beliefs, and what MST related factors and other factors you felt impacted engagement and change

From this I hope to develop an understanding of your experience of engagement and the change process. I hope this may help other therapists and MST teams working with families to understand the experience of families from different cultures in more depth.

Why have I been chosen?

You have been invited because you took part in Multisystemic therapy and you are from a Minority Ethnic background.

Do I have to take part?

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

What will happen to me if I take part?

If you would like to participate you would be asked to take part in one tape-recorded interview lasting around 1 hour in a comfortable setting, which could be your home. The meeting will involve talking to the researcher about your experiences of MST, how appropriate you felt the treatment was for your specific cultural and or religious needs and what you felt the advantages and disadvantages of this treatment were. You will also be asked to complete a short questionnaire asking you about you ethnicity, religious beliefs, age and gender. If you consent, you may be contacted at a later date to ask if you wish to comment on the research findings. You are able to decline this offer without giving a reason.

What are the possible disadvantages of taking part?

It is possible that you might feel upset about talking about your experiences. If this does occur you can take a break or stop the interview at any point. You will be given further information about resources and help that are available to you should you need them after the interview.

What are the possible advantages of taking part?

I cannot promise this study will help you. However, this research project will allow you to have time and space to reflect on your experiences. Potentially, this research will help other therapists and practitioners understand your experiences in depth, and what aspects of MST are more or less helpful with minority ethnic groups, which in turn will help improve MST delivery in the future.

Expenses

You will be offered £10 in cash as a thank you for taking time to talk to me.

PART 2)

What if there is a problem?

If you have any worries about any part of this study you should ask to speak to the researcher who will do their best to answer your questions. If you are still unhappy and want to complain you can contact the project Research Supervisor, Dr Gary Brown.

Will anyone else know I am doing this?

We will keep your information in confidence. This means we will only tell those who have a need or right to know. On my sheets I will remove your name and anything else that may identify you. I will then write a thesis about the interviews and all your identifying information will be removed.

I will ask you if it is ok for me to tell people who are involved in your care that you have said yes to take part in the study. The MST team, including your therapist, will not be given any information on what you have said to me. The audio-taped recording of our talk will be typed up word for word and this document will be kept in safe place at Royal Holloway University of London and may be looked at by authorised persons from Royal Holloway, University of London. They may also be

looked at by authorised people to check that the study is being carried out correctly. All these people will have a responsibility to keep your information private and we will do our best to make sure this is done. The audio-taped recording will be destroyed immediately once our talk has been typed up.

What will happen if I share information about possible risk to myself or others?

If during our talk we have any worries for your safety, worries for other people's safety, or you tell us something which is against the law we have a responsibility to tell someone else about this. Should this happen, I am required to contact the relevant site supervisor (either Dr Amaryllis Holland or Dr Hayleigh Millar at the Merton and Kingston site, or Dr Jenny Taylor at the Hackney site). They will then contact a professional who is still involved in your care so that they can check that you and/or others are okay. If you are not involved with any other professional, then I will contact the local Safeguarding Team and they will contact you to make sure that you and/or others are okay. We will try to talk about this with you first to explain our reasons and what will happen next.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. Your project has been checked by the Royal Holloway University of London Research Committee and the NRES Committee London - Fulham.

Further information and contact details

If you would like to take part in this study then please contact me via email (Fatima.bibi.2011@live.rhul.ac.uk) or at the address below.

Researcher

Fatima Bibi
Clinical Psychology Department
Royal Holloway University of London
Egham
Surrey
TW20 0EX
Tel: 01784 414636

Research Supervisor

Dr Gary Brown
Clinical Psychology Department
Royal Holloway University of London
Egham
Surrey
TW20 0EX
Tel: 01784 414636
Email: gary.brown@rhul.ac.uk

You are also able to contact the relevant field supervisors on the emails below:

Merton and Kingston MST Service

Dr Amaryllis Holland
Amaryllis.Holland@swlstg-tr.nhs.uk

Dr Hayliegh Millar
Hayleigh.Millar@swlstg-tr.nhs.uk

Hackney MST Service

Dr Jenny Taylor
jenny.taylor@eastlondon.nhs.uk

Appendix G: Participant Information Sheet for Young Person

Information Sheet for study - Experiences of ethnic minority parents or carers of taking part in Multisystemic Therapy



My name is Fatima Bibi and I am studying to become a psychologist. I am doing a project as a part of my studies.

I am really interested in hearing about your parent's or carer's experience of Multisystemic Therapy, and what they thought was helpful or not helpful for your family and you. This is what my project is about.

The reason your parent or carer has been chosen is because your family took part in Multisystemic Therapy and are from an ethnic minority background (meaning that your family may be from a different culture or of another race).

It is up to your parent or carer whether they want to take part. They do not have to, and can say yes or no at any point. If they decide not to take part, this is not a problem and it will not affect your care or support in any way.

If your parent or carer does decide to take part in my project, I will arrange to talk with them where they live. I will tape record the interview, and then type it up so I can remember what we talked about. I will then delete the taped interview. I will make sure that your parent or carers name, your name or the name of any other member of your family or anybody who has been involved with your family is not included anywhere.

Our talk will be private, and I will not be telling anybody else about what they say.

But if they tell me something that makes me feel worried about their safety, your safety or someone else's safety I will have to tell someone about this.

Your parent or carer is able to stop the interview at any time if they want to. They will be offered £10 in cash as a thank-you for taking part.

Appendix H: Participant Consent Form

Consent Form

Title: Engagement and Process of Change for Black Minority Ethnic (BME) carers in Multisystemic Therapy

Researcher: Fatima Bibi

Please initial statements:

1. I confirm that I have read and understood the information sheet which describes this study.

2. I have had an opportunity to consider the information, ask questions and discuss this study.

3. I have received satisfactory answers to all my questions.

4. I understand that relevant sections of my data collected during the study may be looked at by individuals from Royal Holloway University of London, from regulatory authorities or from the NHS trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

5. I understand that my participation is voluntary and I am free to withdraw at any time, without giving a reason and without my care or rights being affected.

6. I understand that all my personal data is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

7. I have read and understood the remits of confidentiality regarding risk.

8. I agree to being contacted for my comments on the findings of the study.

9. I agree for anonymised quotes from my interview to be used in publications.

10. I agree for my interview to be tape recorded.

11. I agree to current professionals involved in my care being informed of my participation in the study.

12. I agree to take part in the above study.

Name of participant

Signed

Date

Appendix I: Interview Schedule

The interview schedule was used to guide interviews. The researcher used it flexibly. The interview schedule was used to guide theoretical sampling, and was updated in each stage of the interview process to follow up emerging ideas and lines of enquiry. There were 4 versions of the interview schedule. The numbers at the end of the question represent which interview schedule the questions were added in.

General background information

- Can you tell me a bit about your cultural and religious beliefs? (1)
- Can you tell me a bit about your child's cultural and religious beliefs? (1)
- Where were you born? (1)
- Where was your child born? (1)
- Why did you come to the UK? (3)
- What was it like for you when you first came here? (3)
- Can you tell me about any tensions there are between your culture and the British culture? (2)
- What is the impact of this on your child? (2)
- What is it like to live in a family with two cultures? Was it part of your difficulties? (2)

General open ended questions about MST

- How did you come to be involved in MST? (1)
- What was it like to be involved in it? (1)
- What did you make of your child's behaviour? (1)
- What would have happened if you had behaved like this where you grew up? (1)
- What were your initial thoughts about MST? (1)
- Were there things that you were worried about before you took part? (2)
- What made you give it a chance? (2)
- How important was it for the MST therapist to take your background into account? (2)
- What would have been different if they hadn't? (3)

Cultural appropriateness of MST and engagement

- How suitable do you think MST was for you and your family? (1)
- What did you think when you first heard about it and the way it works? (2)
- How did your child feel? How willing were they to take part initially why? (1)
- How willing were you to try it? Why did you try it? (1)
- Which factors influenced your decision to take part? (2)
- Tell me about how suitable you felt it was for your cultural or religious beliefs? (1)
- How suitable do you think your child thought it was? (2)
- How would your community view this type of treatment? (2)
- Could you explain what help/interventions would be available for the difficulties with your child? How might this differ? (3)
- How did you manage sharing that you were involved in this treatment with member of your extended family and/or community if there are any? (2)
- Do you think it is helpful to have others involved in your help? (4)
- What were the particular challenges of MST in relation to your beliefs? (4)
- What were the advantages of the model in relation to your beliefs? Can you give me examples? (2)
- Who did the therapist work with? Just you or child also? Can you describe how that was for you? (3)
- How well do you think the therapist/model took into account specific cultural and/or religious beliefs that you have? (2)
- How well do you feel you were understood/ your way of doing things and why? (3)
- Tell me about the therapist you worked with (2)
- How would you describe the relationship (2)
- What was the ethnicity (and gender) of the therapist you had? (if therapist was of a different/same ethnicity) What were the benefits and challenges of that? (2)
- Were there things about this approach that you felt were appropriate/inappropriate in relation to you specific values? (4)

Process of change

- Can you tell me about any changes, if any, you noticed (in your child, family and you) throughout and/or since finishing MST? (1)
- What do you feel brought about these changes? Anything else? (1)
- What would your child say? (1)
- What part of MST do you think helped change you, your child, family the most? (1)
- How did you manage any cultural/religious beliefs that were challenging for you throughout the process? Examples (1)
- How much did you have to adapt your beliefs to work in this way? What was that like for you? (2)
- Do you think it was the same for your child? (3)
- How much do you think the treatment was adapted for your specific beliefs? How did this impact any change? (2)
- How helpful was the therapist in helping you to manage any cultural difference in the family? (3)
- What are your thoughts about the therapists culture ethnicity and impact on the work you did together? (2)
- What are your thoughts about matching families with therapist from similar backgrounds? (2)
- Is this something you would choose if you had a choice? (2)
- If you could change the treatment in some way to make it more effective for your family and people from your community, what would that be? (1)
- Have you learnt anything from doing MST? (1)
- What was it like to talk about your experience of MST in this interview? (4)

General interview prompts

- What do you think your child's perspective on that would be?
- Anything else?
- Can you tell me about that experience?
- What was that like for you? Can you give me an example?
- What was the impact of that on you? Your child?

Appendix J: Transcript and Coding Sample

Appendix 12. Interview transcript with initial and focused coding stages

How well do you think the therapist took into account specific cultural and/or religious beliefs that you have?	Initial coding	Focused coding
<p>Yeh, she had to because that was a part of the problem, yeh she had to find out, because of things that I needed done differently, erm, you know like drinking, smoking, I wasn't accepting that because I don't do that, and erm, attending maybe religious study for my kids is important to me, and at the time, my daughter didn't want to, so that was like the point where I will not give up and she doesn't want to do it, so the therapist had to work hard on that point to make us meet in the middle.</p>	<p>Therapist finding out about her culture, seen as part of the problem, wanting things to be different, wanting to incorporate cultural and religious practices, not accepting some British practices, wanting children to find out about religion, conflicting with daughter over this, Not giving up, conflicting with daughter Therapist working hard to make them meet in the middle</p>	<p>Culture seen as part of problem</p> <p>Wanting to preserve cultural and religious practices</p> <p>Therapist facilitating a way to meet in the middle</p>
<p>How did that go?</p>	<p>Finding a compromise</p>	<p>Therapist helping to find the threshold for compromising</p>
<p>Yeh, it was ok, she kind of you know find a point where I had to reduce probably how many days she has to go, and er she has to agree this is important to me because this is who I am and so we find a way, but I could see that at the beginning she probably didn't know how am I going to sort this out, you know, and she had to go back and think hard to how because I did say I'm not budging on this one, and yeh. I think culture, background is very important to lot of people and if you doing this, you don't include that it's not going to work, I think, that's for me, if she didn't include that in and see that as important to me and just think ok, you know I'm not listening to that, this is a very a</p>	<p>Wanting daughter to understand that it is an important part of who she is</p> <p>Seeing therapist having to figure out how to sort it out Seeing therapist have to think hard to Not compromising on certain things Culture and background being very important to her Emphasising importance of MST therapist recognising culture and religion or</p>	<p>Therapist needing to recognise importance of culture to parent</p> <p>Cultural sensitivity of therapist determining engagement</p>

<p>different culture, different country and this is what kids have to do, it would not have worked, no.</p> <p>So that was important?</p> <p>If she didn't probably find a way to include those things in, I could have probably just left it. So it was a really important part.</p> <p>What was it like to be involved in MST?</p> <p>Everything is open, on the table, you know everything about your life, I am not like that, I am a very private person, I could even be going through something and maybe I wouldn't even be telling my sister, that's a big example I'm giving, you know that my sister my blood, you know somebody really close to me, erm, I'm a kind of person who deal with things by myself, and I was terrified to think that I am going to start talking about everything openly, the therapist really helped me to start opening up, you know but I had to do it, cos I feel like this is probably my last chance to make things work with my daughter so I had to do it.</p> <p>Do you think it was helpful to have a therapist who was an ethnic minority?</p> <p>I didn't think that it really made any difference. She was really good. But if even someone else who is English comes in, as long as they consider my background, my culture, my feelings, it would work but if they don't see it that way, it probably would not work. Yeh.</p>	<p>it not working</p> <p>Deciding that if culture not incorporated, then would not work</p> <p>Feeling like everything is in the open with MST Venturing out of comfort zone, Not allowing others to know when she is struggling</p> <p>Trying to deal with things by herself Being terrified at prospect of having to talk about everything openly, therapist helping her to be open Feeling like she had to do try Feeling like MST was last chance to make things work with daughter</p> <p>Ethnicity of MST therapist not making a difference As long as her background is considered, it would work.</p>	<p>Considering culture critical to Engagement/alignment</p> <p>Open communication and sharing identified as important</p> <p>Being pushed out of comfort zone</p> <p>MST feeling like the last chance to make things work</p> <p>Being indifferent to ethnicity of therapist providing culture is considered</p>
---	---	--