

**Processes of Engagement and Change in Multisystemic Therapy for Minority Ethnic
Young People**

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Abstract

Multisystemic therapy (MST) has been shown to be an effective family- and community-based treatment for antisocial behaviour problems with young people from minority ethnic backgrounds. A number of studies have examined the processes of change for individuals in MST, however only one study to date has examined the processes of engagement and change for minority ethnic groups in MST, which focused on the caregiver perspective. The current research aimed to address this gap in the existing literature, by exploring the experiences of minority ethnic young people living in London, who had completed, or dropped out of a MST intervention. A qualitative approach was adopted, using grounded theory methodology to explore minority ethnic young peoples' experiences of MST, and generate a model of the processes of engagement and change. Seven semi-structured interviews were carried out with young people from three London sites. The emergent model consisted of seven interacting theoretical codes. Three of these codes were organised around the process of engagement; making the decision to engage with MST, understanding family culture and considering cultural differences, and four related to the process of change; having a positive relationship with the MST therapist, making relational family changes, empowering the young person and recognising and reflecting on cultural differences. The author makes novel suggestions relating to the mechanisms that are thought to underlie the process of engagement and change for minority ethnic young people in MST, emphasising the reciprocal and circular nature of these processes. Furthermore, the author highlights the importance of considering cultural difference within the family and in the therapeutic relationship throughout a MST intervention, utilising young peoples' involvement as a resource.

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Chapter 1: Introduction

Engaging minority ethnic populations in evidence-based treatment and improving outcomes is increasingly becoming a prominent area within clinical psychology research. Guidance on mental health service provision in the UK advocates culturally-sensitive and clinically effective therapeutic interventions (Bassey & Melliush, 2012). However, with alarming mental health disparities, and researchers stating that the majority of data generated from existing clinical research cannot be generalised beyond European-American samples (Huey & Polo, 2008), there is an urgent need for research considering the needs of diverse communities. 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 young people, is effective in improving outcomes for antisocial behaviour with ethnically diverse samples (Painter & Scannapieco, 2009). Nevertheless, the majority of these studies have been quantitative studies, examining outcomes, which do not provide insight in to specific processes of engagement and change. A recent research study examining processes of engagement and change for minority ethnic caregivers in MST (Bibi et al., 2014), contributed novel suggestions, however further research focusing on the unique experience of minority ethnic young people would advance the literature.

The aim of this research study was to recruit minority ethnic young people, whose antisocial or vulnerable behaviour had led their families to receive an MST intervention, and explore their experiences of MST. The study recruited second-generation young

people (whose parent(s) had immigrated to the UK), in order to specifically explore the unique experiences of young people in dual-cultured families within MST. 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 et al., 2009, amended Henggeler, 2015) by highlighting additional factors to consider when working with dual-cultured minority ethnic families. The study aimed to contribute to the MST literature, and to further existing efforts to make MST an equitable treatment model for families from diverse ethnic backgrounds.

This chapter summarises the development of the research aims. Beginning with a discussion on terminology and then considering the underrepresentation of minority ethnic groups in mental health services, alongside the evidence-base for psychological interventions adapted for such groups, 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

There are five terms commonly used interchangeably in research related to ethnicity, including; race, ethnicity, culture, black and minority ethnic (BME) and minority ethnic

groups. There has been much debate regarding the definitions of these concepts in the literature (Shah, Oommen & Wuntakal, 2005; Sewell, 2009; Bhui, 2002; Reicher & Hopkins, 2001). As a result of these debates, the concept 'minority ethnic' has been adopted in academic literature, which Sewell (2009) defines as ethnic groups that together or singularly are in the social minority.

As the current study focuses on young people whose parents were born outside the European Union, we have used the term 'second-generation immigrants'. Clare and Abdelhady (2016) argue that by virtue of being born and raised in the country of destination, these individuals should not be referred to as 'immigrants'. However, a person can be considered a migrant even if born in the country (UNESCO, 2016).

Traditionally, researchers have described 'immigrants' as persons who have uprooted themselves and face the painful process of incorporation in to a different society and culture (Handlin, 1973; Takaki, 1993). However, Schiller, Basch, and Szanton-Blanc (1995) argue that contemporary immigrants are 'trans-migrants' who maintain multiple linkages to their homeland, including having children cared for in country of origin, visiting at regular intervals, and owning homes and businesses. The exact definition of migrant is contested (Migrant Clinicians Network, 2006), but in this study we utilise the term immigrant to refer to these families who have moved to the UK from outside the European Union, in order to find work or better living conditions.

Sewell (2009) argues that labels are constructed as a means to establish a shared understanding, however as the language often reflects particular theories, values and political ideologies, terminology is frequently the subject of much debate. Many of the

terms outlined above have been found to be unhelpful for both service providers and the individuals being classified in other research (Page, Whitting, & Mclean, 2007). Lloyd and Rafferty (2006) argue that these terms can be impersonal and reductionist, and indeed any classification is open to criticisms around assuming or exaggerating homogeneity within each group, and focusing on contrast between groups (Bradby, 2003). Nevertheless, in order to ensure consistency in the context of existing research, the terms 'minority ethnic' and 'second-generation immigrant' are used in this report, however we acknowledge that these definitions do not capture the full essence of the constructs to which they refer.

1.2.Potential challenges faced by minority ethnic young people from immigrant backgrounds

Understanding some of the specific challenges faced by immigrant parents can illuminate a range of factors which impact their adolescent children. Robila and Sandberg (2011) highlight that immigrants often experience a decrease in the quantity and quality of their social support (Robila, 2008; Rumbaut, 1994), increasing their risk for depression and anxiety. Due to the fact that some of their capabilities, such as professional or language skills, might not be transferable (Robila and Sandberg, 2011), this can increase the likelihood of unemployment and living in poverty. In many cases, a family can immigrate in stages, resulting in marital strains caused by long-distance relationships (Robila & Sandberg, 2011). Other factors pertaining to immigration that could impact marital relations include, struggling with economic stress, conflicts regarding different cultural perspectives between the country of origin and the new

environment regarding marital/gender roles or parenting (Falicov, 1988; Falicov & Karrer, 1984; Fuligni, 2003).

As MST is a family and community intervention, it is important to consider the factors affecting the parents in immigrant families. Nevertheless, adolescents from immigrant backgrounds face their own complex issues of adaptation (Berry, 1997; Rumbaut, 1994). Growing up in an ethnic group within a larger society, adolescents develop an ethnic identity, which can be understood as the subjective sense of belonging to an ethnic group and the feelings and attitudes that accompany this (Phinney et al., 2001). The issue of ethnic identity is particularly salient for adolescents whose parents are immigrants (Rumbaut, 1994). On the one hand, these young people have grown up with, and been socialised by, parents who carry with them the language, values, and customs from their country of origin and are likely to retain these characteristics throughout their lives (McCoy, 1992). On the other hand, the adolescents have been educated in the British school system, which emphasises English proficiency and English customs. Phinney et al. (2001) highlight that differences between the two cultures present these adolescents with many choices in areas such as cultural practices, language use, and friendship. Both the values and attitudes expressed by their parents and those they encounter among their peers are likely to play a role in the formation of ethnic identity.

Robila and Sandberg (2011) highlight that immigrant parents are usually concerned about the transmission of ethnic/cultural identity to their children, supporting them in their adaptation process, maintaining a balance between their own child-rearing views and the ones belonging to the new environment (Fuligni, 2003; Parra-Cardona, Cordova,

Holtrop, & Villa, 2008; Portes & Rumbaut, 2001; Rumbaut, 1994). Nevertheless, in terms of parent-child relations, sometimes conflicts based on cultural differences and growing up in different environments are reported (Robila & Sandberg, 2011). Immigrant children tend to adapt faster to the new country than their parents, requiring the latter to keep up with their children's involvement in the new social, educational, and cultural environment (Baptiste, Hardy, & Lewis, 1997; Portes & Rumbaut, 2001). Robila and Sandberg (2011) recommended that services working with immigrant families should be knowledgeable about the potential impacts of migration at the family levels, different rates of acculturation and be able to communicate these ideas with the family.

1.2.1. Acculturation

Redfield, Linton and Herskovits (1936) defined acculturation as the changes that occur as a result of individuals from two distinct cultures coming into continuous first-hand contact. However, in today's satellite-internet age acculturation can occur via internet without any first-hand contact, therefore Berry (1997) describes acculturation as changes that take place following intercultural contact. Acculturation has been conceptualised as a process of adaptation along two dimensions: (a) adopting ideals, values, and behaviours of the receiving culture, and (b) retaining ideals, values, and beliefs from the person's culture of origin (Phinney et al., 2001). Berry (1997) outlines four acculturation strategies people utilise including, assimilation, separation, integration and marginalisation, each of which are suggested to have unique implications for mental health (Cuéllar, 2000). By definition, acculturation is a relational process and depends on social interaction to unfold (Martinez, 2006) and is

operationally indicated by factors such as; language proficiency, language use, nativity status, culturally-related behavioural preferences, and ethnic identity. Rudmin (2003) argues acculturation is a normal, universal human process that occurs regardless of minority or majority status. Nevertheless, it is widely acknowledged that a process of adaptation is typically one aspect of immigrants' experiences. Nevertheless, such definitional and operational complexity has led to wide variability in acculturation measurement strategies in the literature (Cabassa, 2003).

Acculturation is important to consider when thinking about second-generation young people, as Berry (2005) suggests that acculturation occurs at both a group level (changes in social structures, institutions and in cultural practices) and individual level (changes in a person's behavioural repertoire), and that often these cultural and psychological changes are part of a long-term process sometimes taking years, or generations. Berry argues that there are often variations in acculturation within families, sometimes leading to an increase in conflict and stress, and to more difficult adaptations. Indeed, McGoldrick, Giordano, and Garcia-Preto (2005) argue that "members of the next generation, particularly during adolescence, are likely to reject their parents' 'ethnic' values and strive to become 'Americanised.' Intergenerational conflicts often reflect the families' struggles over values in adapting to the United States. The third and fourth generations are usually freer to reclaim aspects of their identities that were sacrificed in previous generations because of the need to assimilate" (p. 26).

Research has suggested that differences in how individual family members navigate acculturation stress may contribute to family difficulties, which increases susceptibility

to psychological symptoms (Cuéllar, 2000). Fang and Wark (1998) argue that when parents and their children acculturate differently, intergenerational conflicts are almost inevitable, which can result in low family cohesion (Tseng & Fuligni, 2000) and may lead to adolescent internalisation and externalisation of emotional problems (Crane, Ngai, Larson & Hafen, 2005). Martinez (2006) found a link between acculturation differences, the effect of this on parenting practices, and Hispanic youth substance-use. Crane et al. (2005) suggest that opening up conversations about acculturation differences, normalising these differences and reframing them as an intercultural problem rather than an intergenerational one, can be effective for familial relationships (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984). As acculturation differences are most likely to emerge between parents and children in their teenage years (Szapocznik & Kurtines, 1993), at an individual level, this can impact on adolescents' identity formation. Montgomery and Briones (2006) argue that immigrant adolescents are faced with the challenge of creating a cultural identity that incorporates both the heritage and receiving cultures, in addition to confronting the normative personal identity issues that characterise this developmental period (Arnett, 1999; Schwartz, 2005).

Nevertheless, there is debate around whether second-generation acculturation is a positive process (Crane et al., 2005). Some studies show a positive relationship between acculturation and academic performance (Skinner, 2000), whereas others have found a positive association between acculturation and delinquency and social incompetence (Florsheim, 1997; Wong, 1999). However, these studies did not consider parental acculturation, or acculturation discrepancies between parents and adolescents. These studies were also based in the US, and so the generalisability of these findings is

debatable. Therefore, this is an area which requires further investigation to establish more conclusive results.

1.3. Behavioural problems in second-generation minority ethnic young people

Research has tended to focus on first-generation immigrants and their psychological adjustment (Abouguendia & Noels, 2001), however some studies suggest that children of immigrants may be at greater risk of psychological distress (Hovey, 2001; Heras & Revilla, 1994; Rumbaut, 1994). Abouguendia and Noels (2001) found that second-generation individuals were more likely to experience in-group hassles than first-generation immigrants, as well as out-group hassles and minor family hassles which may account for increased psychological distress. Being a second-generation immigrant has been linked to a variety of mental health issues (Bhugra et al., 2014), as well as lower self-esteem (Rumbaut, 1994) and self-concept (Heras & Revilla, 1994). In the UK, rates of psychosis are particularly high among second-generation Caribbean young men (Kirkbride & Jones, 2011; Liu & Cheng, 2011), and suicide rates are high among young South-Asian women (Soni-Raleigh & Balarajan, 1992; Nazroo, 1997). However, as MST is a family intervention, specifically where there is a high risk of family breakdown, for example adolescents going in to custody or care, this section will focus on evidence regarding minority ethnic populations and problem behaviours including, numbers of looked after children, offending rates and risky sexualised behaviours.

Chand and Thoburn (2005) highlight that minority ethnic children, as a combined group, are more likely than white children to be receiving an 'in need' service in the UK.

Additionally, Mixed and Black or Black British groups make up 9 per cent and 7 per cent

of looked after children respectively (Harker, 2012), despite making up only 3 per cent of the child population. Hovey (2001) reported greater levels of maltreatment in immigrant children, however Dogra, Karim, and Ronzoni (2011) question these findings and other research indicates that children of immigrants did not differ from comparable non-immigrant children (Alati, Najman, Shuttlewood, Williams, & Bor, 2003; Georgiades, Boyle, & Duku, 2007).

With regards to offending behaviours, Bersani (2014) highlights that whilst first-generation immigrants exhibit low rates of offending, crime among second-generation immigrants is significantly higher (Bersani, 2012). Bersani (2014) suggests a number of theoretical arguments for this difference including; conflicting family and social norms and expectations, growing up in resource-deprived contexts where they are exposed to a variety of risk factors, or that being born and socialised in the US means second-generation immigrant parallel native-born youth and display similar offending rates. Bell and Machin (2011) also highlight that immigrants may experience discrimination at various points in the criminal justice system.

Harris (1999) found that the children of immigrants in America had a greater propensity to engage in risky behaviours than foreign-born young people, including having sex at a younger age. Furthermore, Jeltova, Fish and Revenson (2004) found that intergenerational discrepancies could contribute to risky sexual behaviours, such as, when a second-generation teenage girl perceived her levels of acculturation and attitudes towards women as being very different from that of her parents, she was more

likely to engage in risky sexual behaviours. However, Harris (1999) argues that socio-economic factors also influence risky sexual behaviour in second-generation immigrants.

Stevens and Vollebergh (2008) highlight that research exploring problem behaviours in second-generation young people is of variable quality, as the terminology used is unclear and the groups studied vary hugely. Furthermore, there may be disproportionate cross-sectional designs and questionable cross-culturally valid and reliable measures (Liu & Cheng, 2011). This is further complicated by the argument that not all self-identified minority ethnic people are immigrants, and not all immigrants continue to identify with their original ethnic background (Dogra et al., 2011). Dogra et al. (2011) highlight that problem behaviours have a multifactorial aetiology, therefore considering migration effects is only one part of the whole picture.

1.4. Evidence-base for psychological interventions for minority ethnic families

Given some of the unique challenges faced by young people from minority ethnic and immigrant backgrounds, researchers are keen to develop effective, evidence-based treatments for these individuals. Turner and Bhugra (2011) suggest that therapeutic approaches with people from immigrant communities may require modification, from those used with people from the ethnic and cultural majority. As Ingleby (2011) states that descendants of immigrants are not often classified as 'migrants' but as minority ethnic individuals, therefore this study will focus on the evidence-base of psychological interventions for minority ethnic individuals.

Rathod, Naeem, Phiri and Kingdon (2010) suggest that research focusing on evidence-based psychological treatments, which take in to account ethnic, cultural and religious interpretations, is an underdeveloped area. Furthermore, the underrepresentation of minority ethnic groups in research (Miranda, Nakamura, & Bernal, 2003), questions the effectiveness of treatments for service users from ethnically diverse backgrounds (Halliday-Boykins, Schoenwald, & Letourneau, 2005). This argument is supported by Dowrick et al. (2009) who found that minority ethnic groups consistently represent a small proportion of mental health service users, and experience disproportionately poorer outcomes when they do engage (Sashidharan, 2003). Caution must be exercised when interpreting the underrepresentation of minority ethnic groups in research and mental health services, as this is not indicative of a lack of need. Fernando and Keating (2008) argue that a key factor in this underutilisation of services is cultural differences in the conceptualisation of mental health problems, and their management. Research has shown that dominant Western ideas about mental health are experienced as culturally unacceptable for some minority ethnic individuals (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).

It has been argued that cultures can be divided into socio-centric and egocentric (Hofstede, 2001). In egocentric societies, ties between individuals are relatively loose, and it is supposed that individuals look after themselves and/or their immediate family. In collectivist societies, individuals integrate into kinship-based structures and have very strong in-groups. There is a clear difference in the I-consciousness in egocentric societies

(where the individual shows autonomy, independence, individual initiative, pleasure-seeking and financial independence) in contrast to the we-ness seen in collectivist societies (Bhugra, Wojcik & Gupta, 2011). Nevertheless, individualist and collectivist values can co-exist within individuals and cultures (Bhugra et al., 2011). These values shape experiences of self and identity, how individuals make sense of their problems, the severity of these problems, and the kind of help needed.

Begum (2006) argues mental health services have tended to label people who are marginalised from services as 'hard to reach', implying difficulties are associated with the individuals rather than the agencies who find certain groups harder to engage with. Nevertheless, the scarcity of research on the efficacy of different therapeutic approaches for different cultural groups, makes it difficult to know exactly how treatments can be made more accessible, culturally sensitive and appropriate for minority ethnic groups (Jim & Pistrang, 2007).

Turner and Bhugra (2011) highlight that therapists should be aware of how differences in the ethnic and cultural background of both therapist and client can influence the therapeutic relationship in subtle ways. Zane, Nagayama-Hall, Sue, Young, and Nunez (2004) stress that when working with minority ethnic clients therapists need to be culturally sensitive or responsive, and cultural competence has been suggested as one way of achieving this. Lo and Fung (2003) define cultural competence as an ability to obtain positive clinical outcomes in cross-cultural encounters, which Sue (1998) suggests involves a good knowledge and understanding of the cultural group the client is from. Sue (1998) points out that a critical skill in cultural competence is knowing when to

generalise and when to individualise, that is, recognising when cultural characteristics may be relevant to the client's problems, but to see the client as an individual. Matching clients with ethnically similar therapists has also been suggested, based the assumption that similar backgrounds will result in a combination of knowledge, skills and patterns of communication that facilitate the provision of culturally responsive treatment (Tharp, 1991; Sue & Sue, 2012). Nevertheless, research focusing on matching therapists and clients has produced inconclusive results (Maramba & Hall, 2002).

1.5. Family interventions for minority ethnic families

Consideration of context is the hallmark of the family systems approach; therefore, by logic, culture should be a key aspect of all family approaches (Bernal, 2006). Relatively early in the family therapy movement, proposals were made to consider culture (Kluckhohn, 1958; Kluckhohn & Strodtbeck, 1961; Speigal, 1971). Yet it was not until 1982, with the publication of the now seminal work on ethnicity and family therapy, that specific recommendations and guidelines for the inclusion of cultural processes in clinical practice were proposed (McGoldrick, Pearce, & Giordano, 1982).

Kumpfer, Alvarado, Smith and Bellamy (2002) argue that families from minority ethnic groups typically prefer family-focused interventions, because of their collective 'we' family identity as opposed to an individual 'I' self-identity (Mock, 2001). Indeed, Mock (2001) argues that in close traditional minority ethnic families, individual change which is not sanctioned by family elders will be squelched through shame, guilt, a focus on duty, obligation, and respect for the authority of elders. Furthermore, it is suggested that

changes in the child would be unlikely to continue if the family system remains unchanged, regardless of ethnic orientation (Kumpfer et al., 2002). Boyd-Franklin (2006) argues that for such reasons family interventions can be more culturally-appropriate for minority ethnic families. This argument has been reinforced by meta-analyses indicating 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).

The lack of research and randomised 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 (Kumpfer et al., 2002).

Kumpfer et al. (2002) use the term culturally-adapted (appropriate, tailored and sensitive) in which culture refers to the sum total of ways of living of a group (e.g., traditions, rituals, values, religion). Kumpfer et al. argue that difficulties engaging and retaining minority ethnic families, may relate to the cultural-appropriateness of the family intervention. McGoldrick and Giordano (1996) argue that ideas around the melting pot of cultures, has resulted in few culturally-specific models, and therefore interventions are heavily influenced by, and cater for white middle-class values (McGoldrick & Hardy, 2004).

Resnicow, Soler, Braithwaite, Ahluwalia, and Butler (2000) argue that family interventions should incorporate the cultural, social, historical, environmental, and psychological forces that influence the target health behaviour, which in the current study would be antisocial behaviours. Resnicow et al. (2000) suggest that peer

influences may exert a greater influence on substance-use initiation among Hispanic youth, while parental influences may be stronger among African-Americans.

Furthermore, cultural sub-groups should be considered when making adaptations to interventions, as geographical location, educational achievement, socioeconomic status, language, acculturation level, and the individuals' own interpretation and identity with their culture all play an influential role on individuals of the 'same' minority ethnic group (Kumpfer et al., 2002). Additionally, cultural variations in family structures, roles and responsibilities, child-raising practices, developmental issues, and sexuality and gender roles need to be considered for any culturally-adapted family intervention (Sanders, 2000). Nevertheless, research on the effectiveness of culturally-adapted interventions is required, to ensure these adaptations are not simply based on therapist's perceptions of cultural sensitivity.

Cultural perspectives on adolescence also need to be considered in family interventions with minority ethnic families. Kagitcibasi (2005) described adolescence as a period where autonomy and relatedness dynamics assume special significance, and argued that close ties and attachment to parents, rather than detachment, is associated with adolescent health and well-being in diverse cultures (Chirkov, Kim, Ryan, & Kaplan, 2003; Chou, 2000; Ryan & Deci, 2000). In contrast, self-resilience in adolescents is encouraged in Western cultures (Saraswathi & Ganapathy, 2002), through a mutual re-negotiation of relationships with parents, increased autonomy, and the establishment of more mature peer and romantic relationships (Kerig & Schulz, 2012). In different cultures such as Latino and Chinese, there is an emphasis on family solidarity, parental authority, respect for elders and obedience as desirable traits in children (Fuligni &

Zhang, 2004; Halgunseth, Ispa, & Rudy, 2006; Phinney, Ong, & Madden, 2000), and similarly African cultures have been found to emphasise firm limits, as opposed to encouraging independence (Smetana & Chuang, 2001). Second-generation females have described more stringent rules for female adolescent socialisation, and perceived a high social cost to protest and dissent (Talbani & Hasanali, 2000), which may contribute to familial stress and behavioural problems. Furthermore, there are cultural differences in how acceptable outside involvement is for adolescents with behavioural problems (Hines, Garcia-Preto, McGoldrick & Weltman, 1992). For minority ethnic young people growing up in the UK, different cultural ideas around adolescence may lead to confusion and conflict at home, and therefore need to be considered in any form of family intervention.

In a review of evidence-based psychosocial treatments with minority ethnic young people and their families, Huey and Polo (2008) proposed that interventions which considered specific cultural differences produced better outcomes. Huey and Polo (2008) refer to the treatment principles of MST, which recommend that therapists respond to unique circumstances of the individual and context (Glisson et al., 2010). The origins and application of MST will be examined in the following section.

1.6. Origins of the MST model

MST is an intensive, family and community-based therapy for adolescents and their families experiencing difficulties with antisocial behaviour (ASB) (Henggeler & Borduin, 1990), for example, violent offenders, sexual offenders, substance-abusing offenders, and youth with serious emotional disturbance (Henggeler & Sheidow, 2012). MST was developed in the 1970s, in response to emerging theories that ASB was multi-determined (outlined in Henggeler, 1991), with important correlates pertaining to the individual (e.g. low cognitive functioning, poor social skills), family (e.g. low warmth, ineffective discipline, parental criminal behaviour), peers (e.g. association with deviant peers), school functioning (e.g. poor academic performance, dropping-out), and community (e.g. a criminal subculture). Therefore, unlike previous approaches (Curtis, Ronan & Borduin, 2004) the intervention aims to address a comprehensive list of systemic and contextual risk, rather than focusing on individual symptomatology (Ashmore & Fox, 2011).

This concept comes from Bronfenbrenner's (1979) theory of social ecology, which suggests that interactions between the individual, their family and extra-familial systems are functional in the precipitation, trigger and maintenance of clinical problems. Consistent with the social-ecological model, decades of research have shown that serious clinical problems, including criminal activity and drug abuse, are influenced by the interplay between the young person and those systems around them. It is recognised that each context has its own unique influence on the individual, and vice-

versa, therefore, MST interventions seek to work with all of these systems, specifically identifying and targeting maintenance cycles within these (Ashmore & Fox, 2011).

Caregivers are considered in the MST model as being the main facilitators of change (Henggeler et al., 2009), therefore MST aims to create change 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 ASB (Ashmore & Fox, 2011). MST interventions are typically carried out in the family home to overcome the barriers to engagement experienced by traditional 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.

1.6.1. MST and engagement

Family engagement is an essential component towards achieving targeted outcomes in MST (Cunningham & Henggeler, 1999). Tuerk, McCart and Henggeler (2012) suggest that MST therapists utilise core clinical strategies, culled from various theoretical orientations, to create a climate of engagement while behavioural, cognitive and systemic interventions are being implemented. These strategies include; identifying strengths across multiple systems, reflective listening, empathy, engendering hope, perspective-taking, reframing, providing authenticity and flexibility, and positive communication whilst maintaining a family focus and valuing the family's culture.

Cunningham and Henggeler (1999) argue that treatment cannot 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. However, Paradisopoulos, Pote, Fox, and Kaur (2015) found that when young people did actively get involved in the MST process they found it valuable, and this engagement with sessions also contributed to sustained change. Therefore, taking time to ensure adequate engagement with all family members should be an aim for MST therapists.

1.6.2. MST and change

Henggeler et al.'s (2009) theory of change for MST assumed that adolescent ASB was driven by the interplay of risk factors associated with multiple systems, and identified caregivers as the main facilitators of change. Therefore, according to this theory empowering caregivers and enhancing parenting skills (e.g. monitoring, affective relations) to improve family functioning, fostering a context that supports pro-social behaviour, and bolstering personal and local resources for caregivers, are seen as critical in obtaining positive outcomes. This model of change (Henggeler et al., 2009), was amended by Henggeler (2015) to highlight the bi-directionality of change, through altering the arrows to be two-way.

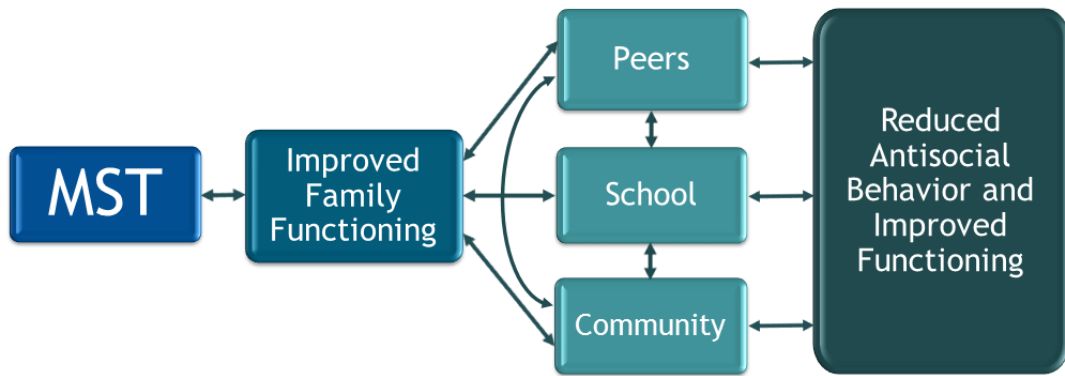


Figure 1: MST Theory of Change

In Figure 1 ‘Improved Family Functioning’ is presented as the umbrella term used in MST encompassing ‘parental effectiveness’. Crane et al. (2005) argues that family functioning has been studied predominantly in association with family structure, communication, adaptability, cohesion, and problem-solving, however acculturation is an element of family functioning that should also be considered for immigrant families.

1.7. Evidence-base for MST

MST has a strong evidence-base demonstrating its effectiveness in reducing youth ASB, increasing school/training participation, and decreasing rates of out-of-home placements (Henggeler & Sheidow, 2012). In recent years, there have been 22 published MST outcome studies, and delivery to more than 17,000 families annually, making MST one of the most extensively validated evidence-based psychosocial treatments (Henggeler & Sheidow, 2012). Research interest is now focusing on processes of engagement and change within MST.

1.7.1. Outcome studies of MST

Outcome studies have been a useful way to evaluate the overall effectiveness of MST. A meta-analysis of all eligible MST studies, found a moderate effect of MST in improving overall functioning, and 70% less offending than those receiving alternative treatments (Curtis et al., 2004). Specifically, MST was found to be relatively effective in reducing aggression and deviant peer association, improving parent-child relations, and individual family members emotional and behavioural problems. The review found the largest effect size on measures of family relations, rather than individual adjustment and peer relations, which appears to fit with the importance MST places on family functioning (Henggeler & Bourduin, 1990), and Henggeler's (2015) theory of change. In Curtis et al.'s (2004) study 54% of the overall sample was African-American, which despite not being discussed by the authors, suggests important implications for the utility of MST for African-Americans. Nevertheless, as this meta-analysis took place in the US, the applicability of these findings to the UK is limited. Also, given the relatively small number of outcome studies available for inclusion in the review, the authors highlighted that conclusions were somewhat tentative. Additionally, this meta-analysis was further criticised for being influenced by estimation errors and bias, because the researchers were involved in the development of MST (Littell, Popa & Forsythe, 2005).

Nevertheless, the first randomised control trial (RCT) of MST carried out independently of the treatment developers, found MST significantly reduced reoffending in young people compared with treatment as usual (Timmons-Mitchell, Benda & Kishna, 2006). Subsequently, MST has been found to have positive outcomes when compared to

treatment as usual in the US, Norway and the UK (Schaeffer & Borduin, 2005; Ogden & Hagen, 2006; Butler, Baruch, Hicky & Fonagy 2011).

1.7.2. Process studies of MST

Reviewers increasingly argue for research on factors that mediate and moderate treatment outcomes (Kazdin, 2007), as this permits investigators to evaluate the mechanisms through which clinical improvement occurs and whether such mechanisms are consistent with the “theory of change” posited by particular treatment models (Huey & Polo, 2008).

A number of studies have attempted to illuminate some of the mechanisms which promote engagement and change in MST. Henggeler et al. (1998) identified treatment fidelity as an important moderator of MST outcomes, whilst other studies have illuminated significant mediators of MST outcomes, for example, improved peer relations (Huey, Henggeler, Brondino, & Pickrel, 2000). Huey et al. (2000) and Henggeler et al. (2009) found that decreasing delinquent peer association is mediated by improvement in family relations and increased caregiver consistency and discipline. Furthermore, Halliday-Boykins et al. (2005) found that the relationship between therapist–client ethnic match and achieving positive outcomes at discharge was partially mediated by higher therapist adherence to MST. Findings from these studies are encouraging and suggest that clinical change for minority ethnic youth may occur via theory-consistent mechanisms (Huey & Polo, 2008). Nevertheless, Rutter (2005)

suggests that further research on the processes of change in MST has both theoretical and clinical value.

A recent UK study examining processes of change in MST (Tighe, Pistrung, Casdagli, Baruch, & Butler, 2012) interviewed young people and their parents, and found therapeutic alliance played an important role. Tighe et al. (2012) also highlighted outcomes as a more complex construct than previously acknowledged, as even if the young person had reoffended, families often reported a wide range of other beneficial outcomes, such as, inclusion in education and increased communication. Tighe et al. (2012) concluded that a key mechanism of change in MST is intervening in the multiple systems around the young person. Nevertheless, the average interview time was two months' post-intervention, therefore it is difficult to generalise about sustainability of change. Additionally, despite Tighe et al. (2012) having an ethnically diverse sample (only 38% of the sample identified themselves as White British) the authors did not discuss whether cultural or spiritual issues arose, and if so how the MST model worked with these beliefs or if these were barriers to engagement or change.

Kaur, Pote, Fox and Paradisopoulos (2015) and Paradisopoulos et al.'s (2015) studies extended the MST literature by exploring processes of change which contributed to sustained change over a longer follow-up period. Caregivers identified parental efficacy, positive therapeutic relationship and positive family relationships as contributing towards sustained change (Kaur et al., 2015). Young people identified therapeutic alliance, increases in systemic awareness, recognising responsibility, positive peer relationships, acknowledging and celebrating success, continued use of specific

strategies (e.g. worry boxes) and the identification and creation of a preferred future, as factors contributing towards sustained change (Paradisopoulos et al., 2015). However, the variation in follow-up times for participants (5 -21 months) may be indicative of different factors sustaining change, as other studies suggested improvements in behaviour and functioning became more apparent at a minimum of 18-months follow-up (Butler et al., 2011). A further limitation of these studies is that their sample predominantly included families who had achieved positive outcomes in MST, thereby limiting the information on perceived factors hindering sustained change, or even engagement in the first place. Paradisopoulos et al. (2015) also had some minority ethnic participants, however there was no discussion regarding culture and sustained change. Bibi et al. (2014) highlight that there is a danger in interpreting the absence of the discussion of such issues as indicative of them not being present or relevant.

1.8. MST and minority ethnic groups

It has been argued that MST is a culturally competent intervention (Brondino et al., 1997), due to its effectiveness being demonstrated in studies which have included relatively high percentages of minority ethnic families. Scherer, Brondino, Henggeler, Melton, and Hanley's (1994) study, which found significant decreases in aggressive behaviour and improved family functioning in the MST group, had a sample in which 78% was of African-American origin. Furthermore, Painter and Scannapieco (2009) found that MST was effective in improving family relationships, decreasing behaviour problems and/or improving psychiatric symptoms in a sample where African-Americans were over-represented. Nevertheless, the applicability of these findings across other

minority ethnic groups, and to the UK is questionable, as there is likely to be major societal and cultural differences across the various minority ethnic groups in different countries.

Schoenwald, Heiblum, Saldana, and Henggeler (2008) reviewed some of the challenges to transporting MST internationally, considering the political, legal, economic, and cultural contexts in different nations. They argued that MST must be adapted to suit the structure, procedures, and culture of the service provider, to ensure therapist and supervisor adherence. MST principles are thought to be internationally applicable, however Schoenwald et al. (2008) argue certain tweaks must be made to ensure concepts are culturally relevant, for example in Scandinavian countries praise is typically used sparingly. The review did not explore how cultural adaptations would be relevant for an MST intervention implemented in the UK, and whether further adjustments need to be made for minority ethnic groups within different countries.

To address these concerns, MST research in the UK has developed. Butler et al. (2011), conducted the first independent RCT in the UK, and in this sample had relatively high percentages of families from minority ethnic backgrounds, making up 41% (mainly African or Afro-Caribbean). Young people receiving both MST and youth offending team (YOT) interventions showed reduced offending, however the MST group showed significantly reduced nonviolent offending at 18-months. There were no significant group differences post-treatment in secondary outcomes of increased parental supervision and family communication or reduced deviant peer association, however Butler et al. (2011) indicate that because of their relatively small sample size, they may

not have been able to detect more modest effects. The authors did not explore whether these non-significant results may have been associated with the high number of minority ethnic families in the study.

Butler et al. (2011) acknowledge that the study does not provide insight into processes or mechanisms of change, and therefore they were unable to determine why, as time progressed, MST was increasingly superior to YOT in terms of nonviolent offences, showing what looked like a delayed treatment effect. Indeed, only one study to date has explored processes of engagement and change in MST with minority ethnic caregivers (Bibi et al., 2014). With huge gaps being highlighted between estimates of young people suffering from psychological disorders and the number accessing services (La Greca, Silverman, & Lochman, 2009), Henggeler and Sheidow (2012) highlight that researchers focus has turned to understanding mechanisms of change, including the role of diversity, and factors which influence the implementation of treatments.

1.8.1. Processes of change with minority ethnic groups

McGoldrick et al. (1982) recommend the inclusion of cultural processes in clinical practice, stating that therapy is more effective when it is congruent with the clients' culture and context. In their study of minority ethnic caregivers' experiences in MST, Bibi et al. (2014) adopted a qualitative approach using grounded theory methodology to generate a model of processes of engagement and change for minority ethnic caregivers. The results of this study suggested ways in which the existing theory of change for MST could be adapted, including; the therapist's role in considering culture at

the initial engagement stage and the therapist acting as cultural broker throughout treatment. Bibi et al. (2014) suggested that considering cultural difference (the therapist validating cultural difference and sensitively responding) may have engendered a sense of being understood, contributing to therapeutic alliance. She also suggested that the therapist acting as a cultural broker (facilitating cultural perspective taking in the family), enabled parents to see the child's experience of navigating two cultures (and vice versa), and helped the parent to contextualise some of the young person's behaviour.

Cunningham and Randall (2008) highlight that a common therapist barrier to establishing a therapeutic alliance is lack of understanding of cultural or value based differences. Similarly, contextualising people's behaviour and increasing perspective taking to facilitate change are well documented in family therapy (Barker & Chang, 2013) hence these factors are not necessarily unique to minority ethnic families. Nevertheless, 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, given that minority ethnic families are considered 'hard to reach' (Begum, 2006). Bibi et al.'s (2014) qualitative research provides some unique insight into the factors which might facilitate or hinder engagement within MST, however further research with young people is needed to corroborate this.

1.9. Proposed study

Since there is one study, to the author's knowledge, which has qualitatively examined the process of engagement and change for minority ethnic groups in MST, which

focused on the caregiver perspective, the purpose of the proposed study is to fill a gap in the existing literature through exploration of young peoples' perspectives.

Paradisopoulos et al. (2015) found that young people identify their own specific mechanisms of change in MST, which highlights the importance of including ethnic minority young peoples' views. Specifically, the current study is interested in finding out how MST accommodates diverse cultural beliefs in dual-cultured families, and the experience this has on participation in MST for minority ethnic young people.

1.9.1. Aims of present study

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

- a. Explore the factors which are experienced as facilitating or hindering engagement and change in MST from the perspective of minority ethnic young people.
- b. Generate a theoretical understanding of the processes of engagement and change in MST for minority ethnic young people and utilise this, in combination with previous related research (Bibi et al., 2014), to contribute towards and develop the existing MST process of change model.
- c. Contribute towards existing efforts to make MST an equitable treatment model for families from diverse backgrounds.

Chapter 2: Method

2.1. Research design

A cross-sectional qualitative design was chosen to explore the research questions. A Grounded theory (Charmaz, 2014) methodology was used to collect, analyse and report data. The following section outlines an explanation of Grounded Theory (GT) and the rationale for using GT. Subsequently, the procedure used to gather and analyse data is outlined.

2.1.1. Choice of methodology

The research aimed to construct a theoretical understanding of the mechanisms underlying engagement and change in MST for minority ethnic young people. A qualitative methodology was considered most appropriate to achieve this given its emphasis on process and meaning in trying to gain a deeper understanding of experience (Willig, 2013). Indeed, experiences of the processes that influence engagement and change in MST are likely to be constructed by the perceptions and meaning that young people ascribe to the various aspects of their MST experience, and quantitative methodologies, such as questionnaires, run the risk of restricting the exploration of subjective experience (Lyons & Coyle, 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). Qualitative methods can be particularly useful in achieving knowledge about areas that have received limited research attention (Smith, 2007), considering the relatively limited research in this area (Bibi et al., 2014), it seemed appropriate to employ qualitative methodology. GT was chosen as the most appropriate qualitative method of analysis.

2.2. Grounded theory

GT (Glaser & Strauss, 1967) is a qualitative method of analysis that seeks to explore processes, meanings and perceptions based on individual accounts of lived experience (Payne, 2007). Through the study of how participants construct meanings, intentions and actions (Charmaz, 2003), the aim is to produce an explanatory framework which allows an understanding of a particular phenomenon (Willig, 2001). GT was developed to discover contextualised theories which are 'grounded' in data (Willig, 2001) and differs from other research methods in that data is gathered, and analysed, simultaneously using rigorous strategies to ensure the theory is 'grounded' in the data (Charmaz, 2014; Willig, 2013). GT thus refers to both the methodology and the theoretical product of the research (Charmaz, 2014).

Glaser and Strauss (1967) developed a number of methodological steps to guide the simultaneous process of data collection and analysis, which begins with the study of

individual experiences and progresses towards the development of conceptual categories, which explain the data (Charmaz, 2003). Initially, 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. The fundamental process of coding the data, systemically develops from a descriptive to analytical level, where conceptual and eventually theoretical categories are created. These categories constitute the building blocks of subsequent theory (Charmaz, 2014). Glaser and Strauss (1967) identified memo writing as an important part of the analytical process, to document the researcher's ideas and keep an audit trail. Writing memos also allows the researcher to define categories, to make comparisons between data and between codes and categories, to elaborate processes, assumptions and actions. It also helps to identify gaps in the analysis that need to be addressed (Charmaz, 2014).

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 at each level of the analysis, across and within individuals, allowing the development of robust categories. Also it ensures that researchers stick closely to the data rather than forcing it to fit pre-existing theory (Glaser & Strauss, 1967). The theory that emerges can then be compared to the existing knowledge base, to consider how it contributes to this knowledge and understanding (Glaser & Strauss, 1967).

Other fundamental considerations in GT are theoretical sampling and theoretical saturation (Glaser & Strauss, 1967). Theoretical sampling, the process of purposefully selecting participants to refine and clarify theoretical categories, is used to develop the theory and reach theoretical saturation. According to Strauss and Corbin (1998) theoretical saturation is reached when: a) 'no new or relevant data seem to emerge

regarding a category, b) the category is well developed in terms of its properties and dimensions demonstrating variation, and c) the relationships among categories are well established and validated' (p. 212). Therefore, it is not possible to know how many participants you will use at the out-set (Birks & Mills, 2011). Due to the requirements of the clinical psychology doctorate, a proposed sample size of ten (minimum) to twelve (maximum) participants was set at the out-set. However, given that the specificity of the phenomenon and sample under study, it was felt that there was a reasonable chance that theoretical saturation would be achieved with the majority of categories with this sample size.

2.2.1. Rationale for using grounded theory

GT was considered to be the most appropriate methodological approach for developing a theoretical understanding and model of the processes of engagement and change in MST for minority ethnic young people. Existing theories of engagement and change in therapy may be based on Western ideas and cultures, which might obscure the challenges faced by minority ethnic young people. As the methodological processes of GT avoid imposing pre-existing ideas on the data, this was considered to be the most appropriate methodology. Furthermore, given the scarcity of studies exploring ethnic minority views of MST, Henwood and Pidgeon (1992) propose that GT is often useful where existing research is patchy. Furthermore, GT has been successfully applied within family therapy to explore therapy process (Strickland-Clark, Campbell & Dallos, 2000;

Madden-Derdich, Leonard & Gunnell, 2002; Lobatto, 2002), and thus was viewed as suitable for this study.

Other qualitative methods considered for this study, included Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). IPA aims to capture the quality and texture of individual experience, including how the participant perceives and experiences the world (Smith, Flowers & Larkin, 2009). This requires the researcher to interpret what they perceive to be the meanings respondents are ascribing to their experiences, referred to as the 'double hermeneutic' (Smith & Eatough, 2007, p.36). As IPA requires greater interpretation on the part of the researcher, it was not thought to be best suited to developing an emergent theory. Also, IPA has a distinct focus on the individual (Smith, Flowers & Larkin, 2009) whereas GT has more of a social focus given its development from within a sociological context, which seemed appropriate to the study of multisystemic intervention like MST. Furthermore, IPA documents individual experiences and changes in these, but does not aim to provide an explanatory account of changes (Willig, 2013), as the aim of the current study was to study a process and the changes within it, it was thought that GT would be better able to achieve this.

Discourse Analysis (DA), which examines language in terms of construction and function (Georgaca & Avdi, 2012), was also considered as a potential methodology (Potter & Wetherell, 1987). In DA, language is considered to mediate and construct multiple realities (Starks & Trinidad, 2007) and is a form of social action (Georgaca & Avdi, 2012). Starks and Trinidad (2007) explain that using DA to analyse language can provide insight in to how social norms are created and maintained and how personal and group identities are constructed. While constructed societal discourses and their impact are likely to be of importance in the study of cultural experience, DA's wide focus on societal

narratives detracts from exploring individual experiences and meaning, which did not fit with the aim of this research to explore individual psychological processes, albeit from a constructionist position.

2.2.2. Versions of Grounded Theory

Since GT was introduced by Glaser and Strauss (1967), its evolution has meant that it has now become an umbrella term representing a constellation of methodologies (Charmaz, 2009). The two original authors disagreed about the nature of the approach and went on to author divergent versions of GT. Willig (2001) notes that while GT took an inductive rather than deductive approach, allowing categories and theories to emerge from the data, it accordingly failed to acknowledge the role of the researcher and to take a reflexive stance. Charmaz (1990) proposed a social constructionist version of GT that recognised the researchers active role in interacting with the data, influenced by their past and present experiences, assumptions, knowledge and disciplinary perspectives (Charmaz, 2014).

2.2.3. Charmaz's version of grounded theory

Charmaz (2014) developed her social constructivist version of GT as an alternative to the earlier approaches (Glaser, 1978; Strauss & Corbin, 1998), which she viewed as seeking

to discover objective truths in data. Charmaz suggests that earlier approaches created a distant relationship with participants, and relied on the authoritative or objective voice of the researcher. 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). Charmaz (2014) assumes that there are multiple social realities which are constructed through interactions of language, discourse, and/or culture. 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. Charmaz (2014) 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 researcher's own experiences and world views. Research acts are viewed as 'constructed' between the researcher and the participant, rather than discovered by the researcher. Charmaz recommends documenting the research process to facilitate a reflexive process, assessing the impact of the researchers' own assumptions on the data collection and theory generation process.

2.2.4. Rationale for using Charmaz's version of grounded theory

Charmaz's (2014) constructionist version of GT states that 'we are the part of the world we study and the data we collect' (p. 17). This seemed appropriate given the

epistemological position of the study, exploring social and psychological processes in their cultural context. Cultural beliefs may influence how minority ethnic young people understand some of the 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.

Furthermore, given the requirements of the Clinical Psychology Doctorate, such as providing a literature review prior to the study commencing, Charmaz's (2014) approach offers a set of practices and guidelines that can be used flexibly. Charmaz acknowledges practical research difficulties; literature reviews can help to ensure that researchers make a novel contribution (Payne, 2007). Glaser and Strauss (1967) proposed that the literature review should be delayed until after the analysis due to concerns around the researcher imposing preconceived ideas on the data. However, adopting a constructionist approach allowed the researcher to be aware of and reflect on this.

2.3. Position of researcher

Charmaz (2014) highlights that 'grounded theorists, like other researchers may, and do, unwittingly start from their own preconceptions...that emanate from such standpoints as class, race, gender, age, embodiment, culture and historical era...without the researcher's awareness' (p. 156). Elliott, Fischer, and Rennie (1999) acknowledge that researchers' attempts to bracket their prior knowledge is an unrealistic position to assume, suggesting it is more important for the researcher to own their perspective.

Taking a reflexive stance and thinking about the researchers' sensitivity to the data was important given the diversity of topic of culture, and given that the researcher of this study is from a different culture to where the research was taking part.

2.3.1. Theoretical sensitivity

Theoretical sensitivity is the ability to recognise data that has relevance for the emerging theory (Birks and Mills, 2011). While a constructionist approach acknowledges the interactive role between the researcher and the research process, it is important that the researcher's assumptions and beliefs do not unduly influence the analysis (Birks & Mills, 2011). Therefore, acknowledging the researcher's sensitivity to the data, and highlighting any existing knowledge is important in drawing attention to potential biases in the analytical process in GT.

As a literature review was completed prior to research beginning, it was not possible to enter into the research process without pre-existing knowledge (Glaser & Strauss, 1967). Based on the literature review that was carried out, the researcher entered the study with a sense that MST had a substantive evidence-base developed in various Western countries, and had some ideas of the processes which had facilitated engagement and change for caregivers from minority ethnic backgrounds (Bibi et al., 2014).

2.3.2. Reflexivity

Reflexivity is a highly valued part of the research process to elucidate the impact of this interactive relationship between the researcher and participant (Charmaz, 2014). The following section outlines reflections on the researcher's position, interests and beliefs.

The researcher was a female trainee clinical psychologist, from a White Irish background, and research participants were minority ethnic young people. Therefore, continuously reflecting on the similarities and differences between the researcher and participants, and how these might impact on the analysis of the data, was important.

At the outset of the study, the researcher had limited knowledge of MST, but was working in a child and adolescent mental health service and had an interest in working with children and families. After writing a literature review as part of the doctorate research process, with her own experiences of growing up with intergenerational differences and tensions, the researcher had her own ideas about factors which may have been relevant to young people who had taken part in MST. She had never carried out qualitative research prior to this study.

The researcher had an interest in diversity, culture and systemic practice. Before starting clinical training, she carried out research with young people considered 'hard to reach', which promoted an interest in real and perceived 'barriers' to services. On clinical training, the idea of therapy as a 'Western' construct and the barriers to treatment experienced by those from non-Western cultures was discussed, but frequently these discussions were from a Western-trained therapist perspective, which casts doubt on

any insights or resolutions. The researcher commenced the research process with a curiosity about the differences in how therapy is constructed and experienced by different non-Western cultures. A reflective diary was used as a way to facilitate the researcher's reflexivity and keep their thoughts, feelings and opinions visible (Ortlipp, 2008). It gave her space to think about her prior assumptions and reflect on her position in relation to the research (see Appendix A).

2.4. Ethical Issues

Due to the potentially sensitive nature of the study, a number of key ethical implications for participants were considered: voluntary participation, confidentiality, anonymity, informed consent and risk disclosure. These are outlined in more detail in the participant information sheets (Appendix B, C, & D).

Voluntary and informed participation. Some of the participants were under the age of sixteen, thereby requiring consent from parents/caregivers, and adaptation of information sheets and consent forms. To ensure voluntary participation, the young person's decision, as to whether to participate, overruled the parent/caregiver. The researcher also discussed any queries with participants prior to obtaining written consent from each participant.

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. Any information shared in the interviews, with the exception of disclosure of risk, was not identifiable to the therapist or service.

Risk and disclosure. A clear risk protocol, in line with service procedures was discussed before interviews were carried out. Site supervisors were in a position to screen 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.

In addition to generic ethical issues, the researcher also considered the unique ethical issues for minority ethnic young people in research (Fisher et al., 2002). These included; applying a cultural perspective to the evaluation of research risks and benefits, constructing confidentiality and disclosure policies sensitive to cultural values, and engaging in community and participant consultation.

2.4.1. Ethical approval

As participants were recruited through NHS sites, the study gained ethical approval from an NHS Research Ethics Committee (REC) in May 2015 (see Appendix E), and the Royal Holloway, University of London (RHUL) Departmental Ethics Committee (DEC) in August 2015 (see Appendix F), and Research and Development (R&D) departments at two NHS recruitment sites in July and September 2015 (see Appendix G). The final site did not require additional ethical or R&D approval.

Before the study commenced, an amendment to the procedure was made. As participants were being recruited up to two-years post-intervention, it was thought the upper age limit should be changed to twenty years. A substantial amendment to change the procedure was approved by the REC (see Appendix H) and RHUL DEC (see Appendix I). The R&D office was informed.

2.4.3 Safeguarding and risk disclosure

Consistent with NHS guidance, procedures were put in place to ensure child protection. Reflecting on the experience of MST may have been emotionally challenging for participants, therefore an opportunity to debrief was incorporated into the design of the project. Consistent with NHS guidance, procedures were agreed with each MST service for participants who became very distressed, including; contacting site supervisor, providing local emergency contacts, encouraging the participant to seek support, and contacting the trust's safeguarding team and following local Child Protection guidelines.

2.5. Participants

A total of seven participants took part in the study. Table 1 provides demographic information for the sample, collected using a questionnaire (Appendix J). It provides relevant MST-related information, for example number of convictions since MST.

2.5.1. Inclusion criteria

- 1) Young people aged 11 to 20 years
- 2) Minority ethnic background, where caregiver has been born outside the UK.
- 3) English speaking
- 4) Young person and their family have been discharged having completed/dropped-out from MST treatment, up to two years previously.
- 5) The young person has participated in some of the MST sessions (MST does not require the young person to be involved in therapy, as it can be provided to parents alone).

2.5.2. Exclusion criteria

- 1) Identified risk to young person or researcher
- 2) Young people in custody, due to difficulty obtaining informed consent and constraints on time allocated for the research.
- 3) Young people in out-of-home placements, due to difficulty in obtaining informed consent from birth parents and foster parents, and constraints on time allocated for the research

Table 1: Demographic summary of sample

	Demographic Information	Number of participants (n=7)
Gender	Male	3
	Female	4
Age	14 years	1
	15 years	2
	16 years	1
	17 years	1
	18 years	2
Parent(s) country of origin*	Samoa/Holland (a)	1
	Sudan/Kenya (a)	1
	Georgia (b)	1
	Nigeria (b)	1
	Morocco (b)	1
	Democratic Rep. of Congo (c)	1
	Iraq (c)	1
Parents religion	Practicing Muslim	2
	Practicing Christian	3
	Jehovah's Witness	1
	Pentecostal	1
Number of years parents been living in the UK	11-15 years	1
	16-20 years	2
	>20 years	4
Parents speak English	Yes	7
	No	0
Languages spoken at home	English	1
	Arabic and English	3
	Yoruba and English	1
	Georgian and English	1
	Lingala, French and English	1
Young person's ethnicity (self-reported)	Black British	2
	Moroccan	1
	Kenyan & Sudanese	1
	Samoan	1
	Georgian	1
	British	1
Young person's religion	Atheist	2
	Don't know	2
	Christian	2
	Muslim	1
Time since completing MST	< 3 months	3
	<6 months	1
	< 12 months	1
	<24 months	2

Enrolled in education at time of interview	Full-time	6
	Part-time	1
Attendance in education at time of interview	>80%	6
	>50%	1
Living at home at time of interview	Yes	6
	No (care home)	1
Number of convictions since MST	0	5
	1-5	2
Therapist gender	Male	4
	Female	3
Therapist ethnicity	White British	6
	British Caribbean	1

* *a. parents from different countries, b. parents from same country, c. single parent family*

2.5.3. Sampling and theoretical saturation

Due to the specificity of the sample required, purposive sampling was used initially to identify participants who met criteria. Site supervisors accessed the electronic MST database in each service, to identify potential participants. To engage in theoretical sampling, the researcher must have developed a tentative theoretical category from the data, and then seek additional data from participants to illuminate and define categories that have emerged from earlier stages of analysis.

Charmaz (2014) suggests that theoretical saturation should be the aim of GT, but that often the term is invoked uncritically. Weiner (2007) suggests that saturation is a judgement, and Mason (2010) contends that sample size and saturation need to consider the research objectives, the skill of the researcher and the quality of the data. Dey (1999) suggests claims of saturation are not legitimate, and that ‘theoretical sufficiency’, which describes when researchers have categories which explain the data sufficiently, better fits how researchers conduct GT. The idea of sufficiency was therefore adopted in the current analysis.

2.6 Recruitment

Potential participants from inner and outer London MST sites were contacted by site supervisors to explain the study, and obtain verbal consent for the researcher to contact them. Details of those who consented to contact were securely passed to the researcher, who made telephone contact within two working days to discuss the research.

Participant information sheets (see Appendix B, C & D) were sent to participants following the conversation with the researcher, who arranged to 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. Prior to the interview, written consent was obtained in person (see Appendix K, L & M). All participants were offered a £10 gift voucher as a token of appreciation for their time. See Figure 2 for an overview of the recruitment and interview process.

2.6.1 Data collection

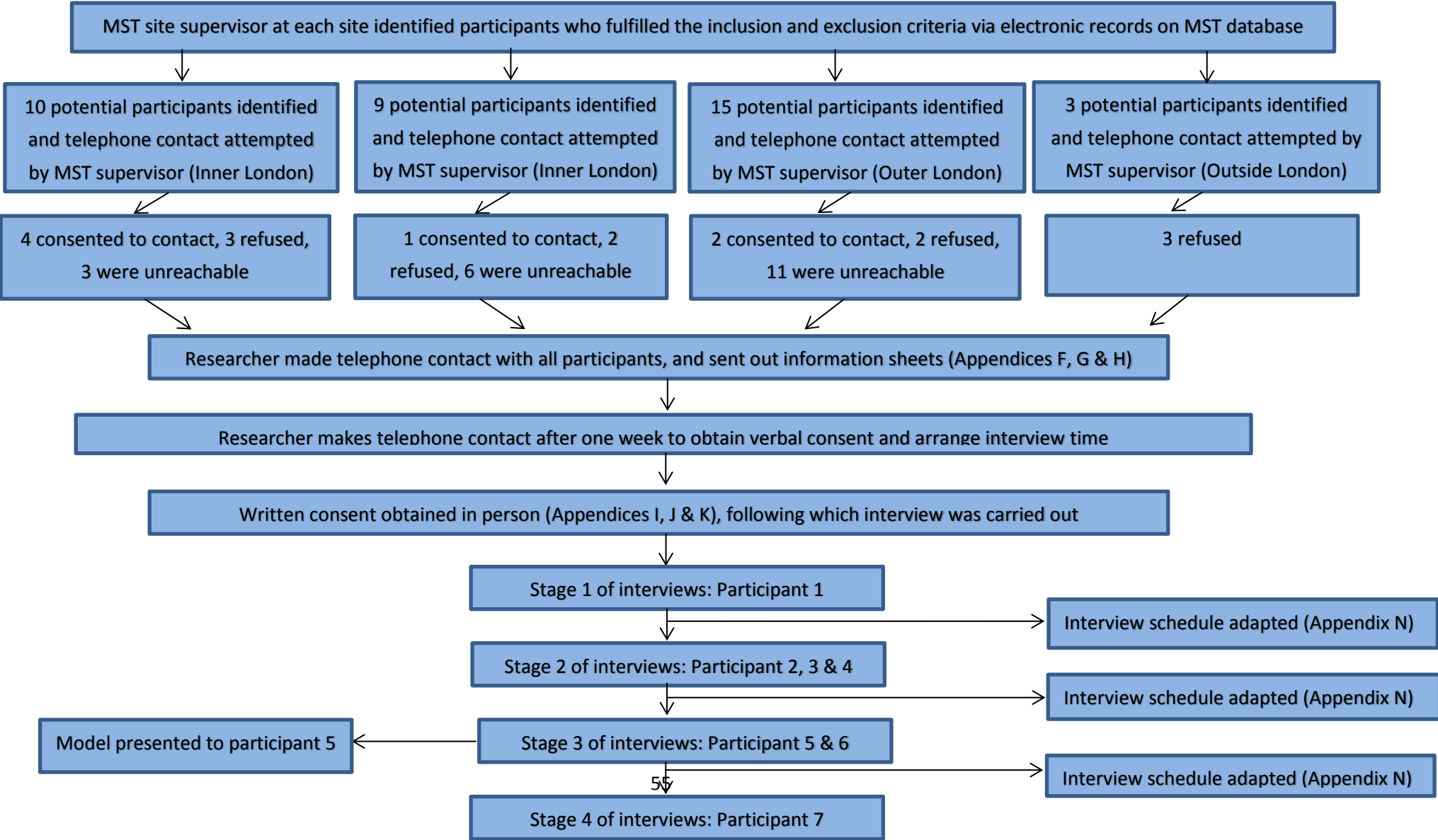
Interviews were chosen as the source of data for this study to allow for a rich understanding of young people's experiences of MST. Utilising an open-ended interview schedule and direct questions facilitated the emergence of new concepts, as well as addressing specific gaps as the research progressed (Charmaz, 2014). 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, 2014). Thus, Charmaz 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

A draft interview schedule was developed, and further refined in collaboration with the academic and site supervisors, prior to conducting the interviews. GT recommends that questions should be open-ended and non-judgemental, to allow the participants' story to emerge (Charmaz, 2014), and the schedule was based on previous qualitative MST studies (Tighe et al., 2012; Bibi et al., 2014). The interview schedule aimed to guide the interviews, starting with structured questions about participants, ethnicity, country of birth, followed by questions charting their journey through MST, including open-ended questions to allow participants' experiences of MST to emerge. General prompts encourage were included to encourage participants to elaborate on their responses and explore ideas they brought.

Figure 2: Recruitment and Interview Process



2.6.3 Piloting the interview schedule

A pilot interview was carried out with a minority ethnic young person who completed the MST intervention in the last 12 months. The young person received £10 for his time, and his data was also included in the final analysis. The purpose of the pilot interview was to identify questions that were not appropriate or helpful, and to assess understanding and sensitivity of questions. As minority ethnic service users can be hard to reach (Begum, 2006; Bernal & Castro, 1994), it was helpful to consider with the young person how the interviews could be engaging. For example, the young person highlighted that thinking about his cultural background was not something he usually did, which made the interview engaging. Overall the feedback was positive, and he did not find any of the questions inappropriate but made suggestions around areas of repetition and which questions could be made clearer. Overall, this process was helpful in ensuring that questions were relevant, sensitive and easy to understand.

2.6.4 Interviews

The interviews were conducted in the participants' homes, in line with the MST model. It was thought that this may also make it easier to participate, and that inconveniences for the participant (e.g. travel costs, availability of a quiet location) were minimised.

Interviews varied in duration from 40-90 minutes, which reflected varying conversational styles. All interviews were recorded on a digital voice recorder, with prior

consent. 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 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, 2014).

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.

2.6.5 Adapting the interview schedule

The interview schedule was adapted for successive stages of interviews based on the information provide by participants (see Appendix N) in order to gain additional data to illuminate and define tentative categories that emerged from earlier stages of analysis. This was in accordance with the principles of theoretical sampling (Charmaz, 2014). This

adaptation 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. Analysis of data

2.7.1. Transcribing

The audio-recorded interviews were written verbatim so that the process of coding could take place (ten Have, 1999). The researcher transcribed all the interviews, as a way of becoming immersed in the data, and to develop an in-depth understanding of it (Charmaz, 2014). Guidelines for doing so were followed (McLellan, MacQueen & Neiding, 2003). A denaturalised transcription style was used (Oliver, Serovich & Mason, 2005), which represents speech in a verbatim fashion, including utterances such as ‘erm’ and ‘erh’ (Davidson, 2009), and aims to be accurate in representing meanings. This was thought to suit GT, in which language is seen as a way of exploring constructions, meanings and perceptions of experience rather than reflecting absolute reality.

2.7.2. Coding

Charmaz (2014) explains that the process of coding is when the researcher begins to ask analytic questions of the data and relates to the differing levels of conceptual

abstraction the researcher is developing (Birks & Mills, 2011). Charmaz proposes that coding consists of at least two phases of initial coding and focused coding. The research can then move to theoretical coding if the emerging analysis indicates that this is necessary.

2.7.3. Initial coding

Initial line-by-line coding was carried out on each of the transcribed interviews. This involves naming each line of the data (Glaser, 1978), by defining and summarising what the researcher considers to be happening in the text. Charmaz (2014) states that by coding data as an action, rather than a theoretical label, codes stick more closely to the data and are 'grounded' in it. This helps the researcher to refrain from imposing preconceived ideas on the data. 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, 2014).

2.7.4. Focused coding

Focused coding involves using the most significant, or frequent codes from the initial coding phase to sort, synthesise and explain larger parts of the data (Charmaz, 2003). These codes are more conceptual than those in initial coding, as the data is being

analytically categorised. In this phase, the researcher identifies explanatory, conceptual patterns in the data (Birks & Mill, 2011).

2.7.5. Constant comparative analysis

The researcher used 'constant comparison methods' (Glaser & Strauss, 1967) to develop analytic distinctions at all coding levels. This involves comparing incident with incident to produce initial codes, the incidents in subsequent coded data are compared with these codes, then codes are compared with codes, codes are grouped in to categories, with which future codes are compared to and then categories are compared to categories (Birks & Mills, 2011). This is not a linear process and ideas implicit in the data of some participants may become apparent after being stated explicitly in the data of other participants (Charmaz, 2014).

2.7.6. Memo writing

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 O). Memos were written throughout the coding process as a way of exploring analytical ideas and insights about the data and codes. They were important for documenting the

constant comparison methods within and between data, codes and categories. The memos helped generate further questions and gaps in the analysis to be pursued (Charmaz, 2014). The memos, by tracing movement from initial coding to theoretical codes, are also a record of the theory development and encouraging reflexivity.

2.7.7. Theoretical coding and diagramming

Theoretical coding involves conceptualising how the tentative categories developed in focused coding relate to each other, and therefore integrate in to a theory (Charmaz, 2014). Through the 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. As such, a number of theoretical codes were generated to explain the emergent theory, and a diagram used to conceptually map out the theory, explain the properties of the categories and the relationships between them. Once the final stage of coding was complete, the emergent theory was combined with the existing MST process of change theory, and Bibi et al.'s (2014) model.

2.8. Research quality in qualitative studies

Published guidelines on conducting qualitative research were incorporated in to the design of the study and followed closely to increase the quality of the research. The

guidelines suggested by Elliott, Fischer, and Rennie (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 one's perspective

As outlined earlier, owning one's perspective is essential due to the interactive nature between the researcher and the data, and the researcher's perspective was explicit from the outset. The researcher kept a reflective diary (see Appendix A) and used supervision to reflect on how her perspective might influence the findings (Mays & Pope, 2000).

2.8.2. Situating the sample

Elliott et al. (1999) recommend situating the sample by describing participants so that the reader can consider the studies' generalisability and applicability (see Table 1).

2.8.3. Grounding in Examples

Quotations from the data have been used throughout the results section when discussing the categories that make up the GT to allow the reader to assess the fit

between the data and the author's interpretation of it, while also considering the researcher's reflections on their role in the research (Elliott et al., 1999). A section of the transcript is provided in Appendix P, to illustrate the interview process and examples of the initial codes that the researcher constructed for the raw data. Examples of memos are also provided in Appendix O, to provide readers with further insight in to the analytical processes (Elliott et al., 1999).

2.8.4. Providing credibility checks

Charmaz (2014) notes the quality and credibility of the study starts with the data. Therefore, after the first interview was carried out and transcribed, the researcher reflected with the academic and site supervisors on whether the interview schedule was collecting rich data that was sufficient enough to explore the phenomenon of interest. Codes that were developed from the data in the first transcript were checked with the academic supervisor who is familiar with a GT approach and has extensive clinical and research experience in the area of MST, and additionally with other trainee clinical psychologists using GT. The academic supervisor also commented on whether the themes were exemplified by the quotes as the analysis progressed and verified the resulting categories, their properties and the emerging theory to provide a credibility check (Elliott et al., 1999). This also helped ensure that codes or themes were not overlooked.

Participation validation was achieved by consulting a participant on the emergent theory to obtain their thoughts and views, and whether the theory resonated with their experiences. Strauss and 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 and resonating with the reader

The researcher aimed to provide a coherent understanding of the phenomenon by providing an integrated summary of their analysis by mapping out the grounded theory using a diagram, while providing a narrative account of the model (Elliott et al., 1999).

The researcher consulted a participant on the research findings to ensure it represented the subject area and resonated with them (Elliott et al., 1999), this was also verified with the academic and site supervisors. The author also presents recommendations based on the findings of the report that may be relevant to readers of this study.

2.8.7 Accomplishing general versus specific tasks

Elliott 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 and Corbin (1990) describe two levels of theory, grand and substantive theory. 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.

Chapter 3: Results

This chapter provides an account of the grounded theory analysis of the data. Young people expressed seven theoretical codes contributing to engagement and change in MST, which are outlined in Table 2 and Table 3. These theoretical codes consist of seventeen focused codes, each of which contains a number of specific properties that were produced during the initial coding stage. An analysis of the theoretical codes, the focused codes they subsume and their properties is provided below. Quotes from participants have been used to illustrate the various codes and to show how they are grounded in the data.

Any identifiable information has been removed from the quotes to maintain participant confidentiality. 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 service users' confidentiality. 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, and shows the proposed relationships between the seven theoretical codes and the focused codes that they subsume.

Table 2: Processes facilitating engagement minority ethnic young people

Theoretical codes	Focused Codes	Properties of the codes
Making the decision to engage with MST	Perceiving MST as only viable option	<ul style="list-style-type: none"> • Past service experience leading to feelings of hopelessness/uncertainty • Seeing MST involvement as other services being unable to manage • Perceiving negative future without engagement
	MST therapist aligning with young person	<ul style="list-style-type: none"> • Perceiving therapist as different to previous professionals • Immediately valuing specific traits in the therapist
	Understanding what MST does	<ul style="list-style-type: none"> • Involving young person, taking time to explain MST • Differentiating MST from social services
Understanding family culture	Understanding and respecting culture	<ul style="list-style-type: none"> • Perception that their parents feel like their culture is respected • Therapist having some knowledge about family's culture and religion
	Accepting outside help	<ul style="list-style-type: none"> • Therapist being curious about family cultural beliefs of outside help • Recognising beliefs about outside help may be at odds with MST • Perception of outside help as more acceptable to young person

Considering cultural differences

Role of cultural difference on young person's difficulties

- Young person feeling confused by differences – leading to conflict and inconsistencies
- Young person feeling judged by parents for deviating from family culture
- Therapist discussing differences between familial expectations based on culture, and UK cultural expectations

Therapist being culturally sensitive

- Therapist considering cultural difference between parent and young person
- Being curious about the young person's cultural identity

Addressing cultural differences between therapist and family/young person

- Therapist being open about own culture/religion
 - Discussing potential impact of cultural differences on engagement
 - Young person perceiving therapist culture as not important/detrimental for engagement
 - Young people seeing a therapist who is a minority ethnic as facilitating engagement
-

3.1. Engagement with MST

In keeping with previous research and the issues raised by participants, process of engagement was constructed as a distinct process to change. As MST is an intervention which focuses on parents/caregivers, engagement with the young person can be considered as an on-going process. There was variation in how participants experienced MST initially, with some wanting to be actively involved, others who took part with caution/reluctance, and some participants whose participation fluctuated. Three categories emerged in participants' accounts of engagement, which capture the mechanisms that underpin this process.

3.1.1. Making the decision to engage with MST

This category refers to participants' initial dealings with the MST service, considering relationships with referrers through to participants' reasoning for engaging with sessions. A sense of feeling uncertain yet hopeful seemed to facilitate engagement, in addition to experiencing the MST approach as different to previous services involvement and initial perceptions of the therapist.

Perceiving MST as the only viable option

Feeling uncertain about engaging with MST was expressed by all participants. Whereas some went on to describe feeling hopeful as therapy progressed, others describe becoming aware that MST was not working with their family. The majority of young people communicated perceiving MST as a 'last resort' or as the only viable option, which for some young people motivated their decision to engage with MST.

Some young people described negative experiences with previous services, which influenced their initial perception of MST.

Zoya: "MST worked with social workers, don't they? ...yeah...even some social workers were so horrible like, I've seen social workers who will do something on purpose...to actually make your life hell".

Whereas some participants described a positive relationship with their social worker as facilitating their engagement with MST.

Tatiana: "I thought it was going to work...obviously cause some people persuading me innit? My social worker...like they were thinking that I should do it.....yeah that it might help."

Most of the young people perceived other services as having run out of ideas for managing them within their family, and MST as being the last resort.

Aisha: "Things got so bad...Social services didn't know what to do...I think social services thought that their methods weren't working. And so they try bring MST..."

Themes of uncertainty and hopelessness are prevalent throughout all the young people's descriptions of MST being introduced.

Jay: "My social worker told me that...if [MST] doesn't work then I don't know what will, cause we've tried basically everything..."

Safaa: "I knew that [MST] was going to come in...everyone's there to try and make things better...but it's not going to work..."

These quotes highlight the preconceived ideas and previous experiences which can contribute to a negative view of MST as a 'last resort', and some of the subsequent uncertainty around engagement. In contrast to this, Jay described seeing MST as a last resort, which combined with contemplation of potential future life scenarios, motivated his decision to engage with MST:

Jay: "I didn't want to go to prison...the police...had me arrested a few times...it got to a point where it was so many...they just said, 'you know what, we're taking him in to custody'. And social services had one last fight with them to keep me...like out...[for MST]...A lot of my friends aren't as lucky. So a few of my friends are dead...And a lot of my friends are in prison. I didn't want to end up like them...just...some name spray painted on to a wall, with RIP written on it. That's not me."

MST therapist aligning with young person

Some young people described the MST therapist as being different to their experience of previous professionals, which facilitated their engagement.

Jay: "A lot of workers I've had over the years...they think that because of what they've heard about me...they're just gonna...go around the actual question. They think that it's going to get me angry, but [MST therapist] was always...just like, 'we're gonna talk about this today'...yeah and I liked that."

Conversely, some young people based on past experiences felt immediately mistrusting of the MST therapist which impacted on engagement.

Safaa: "Yeah I felt worried...because...when I told social services...that my dad hit me...then they got police involved...and that's why I don't like talking anymore...I just sat in...and be like 'yeah, yeah, yeah'...so then they [MST therapist] can go home, and not be thinking 'oh why is she not joining in, she has something to hide'...so I... just joined in for the sake of it."

Hussein: "I don't like people coming here...they're nosy, and just noting everything down about our lives, they don't need to know..."

Young people described certain characteristics about their MST therapists which facilitated engagement.

Aisha: "We were talking about food, we were off topic...he was just, like fun...he was nice...Cause I think he was so like outspoken...we were all just like open about talking."

Jay: "I react the same way I do every time I first meet someone...I try and figure out...what kind of person they are...like if they beat around the bush, or if they go straight for it...and [MST therapist] was pretty much straightforward..."

Understanding what MST does

Feeling confused about what MST was occurred in participants' stories of engagement, emphasising the importance of the MST therapist clearly explaining how MST works, what it would involve, and what the benefits and challenges might be.

Aisha: "One day I just came...in my living room and then saw MST...and they were just like... 'hi'. And we just signed some form...I didn't really know what I was signing...I thought...'it's not like they're asking me to sign my life away...so I'll just sign it'...'cause I felt rude."

The quote above highlights how young people feeling they have a choice about MST becoming involved, can be linked to initial engagement and later change. Conversely to Aisha, Jay talked about feeling involved in the decision to take part in MST, which was linked to a motivation for change.

Jay: "I did have a choice, and I said yeah. Cause even though I was naughty, I did want to change."

Linked to confusion about the role of MST, many of the young people also described finding it difficult to understand the differences between social services and MST.

Toben: "I don't think I had a choice, I just think they came...I think they work like social workers...I don't actually think I...know the difference"

3.1.2. Understanding family culture at engagement

Family culture featured to differing degrees for participants in the study. The majority of the young people interviewed identified cultural and religious differences between them and their parents as being linked to their difficulties, and as posing difficulties with engagement and change in MST, whereas for some culture and religion was more in the background.

Understanding and respecting culture

The MST therapist understanding the family's culture and sensitively addressing differences in a balanced way, was highlighted as being important by some young people for their parent's engagement. Aisha described how her mother became closed to different perspectives, when she felt that aspects of her culture-specific parenting were being judged.

Aisha: "If someone from a different culture...that's judging on her culture is saying...'you're doing something wrong'...she's like just saying 'no, I'm not doing anything, I know what I'm doing, I'm not doing anything'..."

Safaa: "dad was just like 'oh he's English, so obviously he's going to be like 'oh the English way is right,' and obviously he's not going to understand what our culture is'...so yeah it did impact it."

MST therapists being curious and knowledgeable about the family's culture was thought to be helpful.

Safaa: "MST's a good idea...if they changed the way...like include other things, like culture...I think it would help if it were someone from the same culture...or before they came they would know about the culture, and research the culture..."

Accepting outside help

Different views on the acceptability of outside help between parents and young people, were highlighted throughout the interviews. Aisha described that MST, and the idea of people from outside the family coming to help with family conflict and behaviour problems, was at odds with her parent's cultural beliefs.

Aisha: "MST stands for, so many things...and my culture like, doesn't stand for those things...the reason there is MST, is because people have problems...in my culture, you're not really supposed to say you have problems, or like reach out to someone if you have a problem...like with your daughter...You're supposed to fix that problem, you're not supposed to go to somebody else...Whereas, MST is like, Government-based...they're supposed to reach out and get involved. Whereas, in our culture if something happens in your family...no one can really get involved...you're not supposed to get involved in other people's family business, but like here...you're allowed to get in other peoples' family business..."

Aisha's quote strongly emphasises one barrier to engaging minority ethnic groups in MST, which is around cultural ideas about the role of family, and what a family should

do if one of the members is experiencing problems. Some participants described their parents turning to outside help when things got very difficult, as a last resort, whereas some young people described that they were the ones who sought help.

Zoya: "I ran away for two weeks...I got home and...all I got was, shouting and like shit...and I tried to go out...my dad got really angry, so he got the cable from there, and he tried to strangle me...that's when the police came and they arrested my dad, and they arrested me as well...cause my mum said, 'I don't want her in the house...'"

Aisha: "Oh, I contacted social services...well, I contacted the police and the police contacted them...I brought them here so we could like fix things. But mum thinks it's like...I just want to get them in trouble or something."

The above quote highlights the importance of the MST therapist being curious and exploring the young person and their parent(s) beliefs about outside help, as these may differ, leading to misunderstandings or conflict.

A lot of the young people described family secrecy around MST involvement. Three young people from African backgrounds described how extended family were not told about MST, and how outside help is viewed.

Toben: "It's not really accepted...it's an embarrassment. Like basically saying...you can't look after your own kids."

Tatiana: "I think they [wider family] would think...bad of the family, cause in their eyes having a social worker or therapist, it's like...bad to your family, cause

there[Congo]...it's like reputation...as well, innit? Family name...you got to keep your family name as pride like..."

Safaa: "My mum's side obviously they wouldn't care as much... 'yeah they're here to help'...but dad's side would be like, 'why are you here?' like...'it's our culture like ...we don't need your influence'..."

Safaa's quote above highlights some of the underlying worries parents might have about a therapist's motivations in treatment, as well as differences in individual family members' ideas and beliefs. Some participants described alternative cultural and religious ideas from their parents' country of origin around young people with behaviour problems, and the proposed solutions, including being sent back to their parents' country of origin and prayer.

Toben: "what they would have suggested would be...prayer, yeah praying."

Aisha: "I think they would do what their cultures do...send them back to try and fix them...my mum was about to do that...I think there was times that bad she was thinking of sending me to Sudan...and I was like 'you try and do that.'"

Zoya: "she [grandmother] said 'send her here...she obviously doesn't like living...over there, with you'"

Jay, whose father was in his country of origin while MST was involved, described his father adjusting his cultural ideas around the acceptability of treatments like MST after seeing the benefits; facilitating further engagement and building trust.

Jay: "So if you're like blatantly...physically disabled, then you're disabled. But mentally they don't really count that...so you're just naughty [in Samoa] ...so my

dad was still thinking that at the beginning...so um, his way of dealing with it...wasn't...seek for help. It was more like, they deal with it. So um, at first, I don't think he liked the whole idea of me getting help, when I was first getting in to therapy...Cause, um, he wanted to do it himself. But I think he realised that it started to help me more..."

3.1.3. Considering cultural difference

The subject of cultural differences arose in every interview to various degrees. Young people described differences between the strength of their parent's cultural and religious ideas, beliefs and values and their own. As part of engagement, young people alluded to the therapist being culturally sensitive and recognising the variations in culture within the family as being important.

Therapist being culturally sensitive

Young people spoke about how their parents' cultural and religious values differed to their own cultural identity.

Aisha: "staying a virgin...praying...no boys, cover up your body...to them it's like, bad stuff, like hanging out with boys...I don't find it bad, it can be innocent...I have morals, but...their morals are...very strong morals to follow."

Understanding young peoples' unique cultural identity is discussed in more detail in processes of change. Nevertheless, sensitively opening up conversations about culture, appeared to allow the MST therapist to explore the differences between the young person's views, based on growing up in the UK, and the parent's views, based on growing up in their culture of origin.

Aisha: "[MST therapist] would...talk about how I would think about it, like, compared to what my parents think about it...and they'd try to explain to them that like, I was brought up here and I don't know any different to what I know from here. So it will try and like sort it out."

This appeared to facilitate more open familial communication and perspective-taking, which overlaps with processes of change in MST. This highlights the inter-linked nature of engagement and change.

Role of cultural difference on young person's difficulties

Participants described the experience of growing up in one culture, whilst their parents come from a different culture.

Aisha: "I feel like, you have to be like, two different people...cause outside you have to follow the culture...and then at home you have to follow a different culture...the person I am outside is more the person I am...the only reason I do this inside, is cause...it's just stress if you don't."

Some young people described feeling confused by differences in their parent's culture and the UK culture in which they were living, and that this at times contributed to the onset of their difficulties.

Aisha: "In their country it's ok to hit your child...'cause I was brought up here...I think it's something bad to do...even though, I get where they're coming from...they want to hit a child, to get through to them...I think the children here are brought up...yeah obviously mentally as well, but physically hurting someone is bad. It's not...used to teach someone."

Tatiana: "people say 'god created the world', and then...other people saying 'no it wasn't god'...you're, kind of in between...you don't know what to follow, science or what everyone's saying...so it's kind of annoying...when I brought it up to mum, she gone and got angry."

Safaa: "My dad's really religious, from his culture. But my mum kind of understands the generation now...like my mum would not complain about what I'm wearing...or like, if I have friends that are boys...but like my dad, wouldn't like allow it...That's what kept the arguments going...if you didn't come to an agreement."

Safaa's quote highlighted differences between parent's cultural beliefs, which may contribute to additional confusion for young people trying to navigate familial and cultural expectations of behaviour. Indeed, a number of the young people described conflict with their parents over familial expectations based on culture.

Safaa: "Here...you would argue...if you didn't believe something was right...but in Morocco...it's hard to have, like your side of the story...especially if you're a child...you just have to listen to your parents...it used to get to me...like 'oh I'm so trapped'"

Aisha: "In their culture, if you think something, you probably should have like five filters...think about it, like proper deep, and then say it. But me, I'm just free with my words...got me in trouble"

Hussein: "My mum will try and make me go to church...obviously when I was young that was fine, but now I'm older, I just I don't want to...so that is arguments...yeah..."

Some participants described feeling judged by their parents, for not following familial expectations.

Aisha: ""they'll judge things...because they don't do...certain things...same as back home...like the type of friends...and the stuff I do...my activities outside..."

Zoya: "Just like religion. Everyone takes it so, like, seriously...all my friends, they have like boyfriends, and like if I tell my mum anything about my boyfriend she'll be like, 'uh don't speak to me, because you're not living the right life'...she basically thinks that I'm a slut...which is very wrong...like I do not go around sleeping with people."

Toben: "British people are not...as demanding at getting to the top...as Nigerian people, when it comes to education...It was a lot of pressure. When you're not doing well, you get quite frustrated...my mum understands me...that I'm not like

my aunt and my sisters...like they did things exactly at the right time...never got kicked out of school...or in trouble with the police...I don't think my dad likes the fact that my mum understands me...and then this creates arguments..."

The therapist considering the role of culture in relation to the problem was therefore crucial in understanding how difficulties were being conceptualised. Participants described finding it useful, when the therapist sensitively discussed cultural differences with the family.

Safaa: "so MST talked about culture, with your problems inside of that...like explain to my parents that it's different here...they'd be like 'yeah 'cause she's a girl, she would still have to go to school and get her GCSES'...but like in Morocco, it's not important for a girl in school...my parents wouldn't understand that."

Cultural differences between therapist and family/young person

The MST therapists' ethnicity and culture appeared to impact on engagement for some young people and their families. As this category, intersects engagement and change, it will be discussed in detail under processes of change. However, the reader is encouraged to understand the therapist's ethnicity and culture as permeating both engagement and change processes in MST.

3.2. Change in MST

The processes of change emerging from minority ethnic young people accounts of MST formed three distinct categories. These categories are the conceptualisation of the mechanisms thought to underpin change.

Table 3: Processes facilitating change for minority ethnic young people

Theoretical codes	Focused Codes	Properties of the codes
Having a positive relationship with the MST therapist	Building a trusting relationship	<ul style="list-style-type: none"> • Appreciating the intensity/frequency of support • Perceiving therapist as going the 'extra mile' • Therapist focusing on young person
	Advocating for the young person	<ul style="list-style-type: none"> • Giving the young person a voice • Being balanced, not taking sides
	Feeling understood	<ul style="list-style-type: none"> • Therapist focus on understanding the young person, as well as change • Valuing having one-to-one meetings and feeling listened to
Making relational family changes	Increasing family communication	<ul style="list-style-type: none"> • Spending more time together • Talking openly with parents
	Perceiving changes in each other	<ul style="list-style-type: none"> • Young person perceiving parents as changing • Young person taking responsibility for actions
Empowering the young person	Young person deciding to change	<ul style="list-style-type: none"> • Young person feeling like they are an agent of change • Young person seeing an alternative future • Distancing self from negative peers

Recognising and reflecting on cultural difference	Perspective taking	<ul style="list-style-type: none"> • Therapist opening up conversations about dual-culture influencing difficulties • Therapist putting young person's behaviour in context
Understanding young person unique cultural beliefs/values		<ul style="list-style-type: none"> • Young person developing a culture (beliefs/values) which are a blend of two cultures • Young person developing own sense of right and wrong • Therapist exploring young person's ideas about their cultural identity • Therapist taking time to explain this to parents
Therapist ethnicity and culture		<ul style="list-style-type: none"> • Therapist addressing impact of their own culture • Young person feeling like ethnicity/culture of therapist had no influence on change • Young person thinking that a therapist of similar background would promote change • Young person worrying that therapists of a similar background would be one-sided

3.2.1. Having a positive relationship with the MST therapist

Building a trusting relationship

Some young people described how a positive relationship with their therapist was crucial to engaging with and making changes in MST. The young people who described positive outcomes from MST, spoke about a trusting relationship with the MST therapist, where they felt heard and could talk openly about their problems.

Jay: "I did kind of see him as my friend, which is why it was probably easier for me to talk to him. I still saw him as like a professional...but then...if something happened or...when I attempted suicide, he came to visit me in hospital...he used to stay behind...do extra hours...if something was happening..."

Toben: "Yeah she would listen, that's why I didn't mind having it...she would listen"

Others described their relationship with the therapist as more distant or strained, which impacted on the changes that they were able to accomplish together. Zoya described that although she did not feel her relationship with the MST therapist was conducive to making change, it resulted in an increase in her personal motivation.

Safaa: "There was no relationship...it was just like...'you were here to help...just go along with it...like, thanks for coming...for trying'...there was just no relationship."

Zoya: "Sometimes the things that [therapist] used to say, used to make me so angry, it's frustrating like...I'd get really confused...so if this is like that, then why did this happen?...I got to the point where I realised I'm not stupid, I'm educated, I'm from a good family, and at the end of the day I just have to help myself to get better."

Some young people saw the intensity or frequency of the therapist's support, as helping to contribute towards change.

Jay: "I liked...the 24-hour service...that really helped...we had it three times a week, so it was pretty intense. 'Cause a lot of my other therapy, it's only once a week and...so many things can happen. 'Cause MST was three times a week, it was still fresh in my mind and you could talk about what happened yesterday...I really liked it."

Whereas some young people felt like the frequency with which they seen the MST therapist was not enough to address their family's difficulties or their own needs.

Aisha: "I think...my parents feel like...if you're coming in to the family...and like, if someone knows something through, like so many years...you can't just change it by like just coming in...for a few meetings...the therapist is not there for the real life...when we're not in a meeting...we think about so many things that we need to talk about, or need to do...but then when the therapist is here...we forget about it."

Tatiana: "I only had a couple of sessions...I think the thing is, it was normally for my mum and not really for me...I actually like hardly got to speak to them."

Advocating for the young person

Some young people described benefitting from MST therapists who focused sufficient time on getting to know them. MST therapists who developed an understanding of the young person's views on the difficulties could act as an advocate, giving the young person a voice.

Tatiana: "I actually liked it [MST]...that obviously I could speak my mind out..."

Toben: "In Nigeria...there's no form of disrespect....no arguing back...I already had a voice...but I didn't have a voice that was listened to...she...ensured that I was listened to."

Toben highlights how differences in cultural views about children expressing opinions, can be a source of conflict in dual-cultured families. The MST therapist acting as a neutral third party, considering different perspectives, and modelling how to resolve conflict was seen as facilitating change.

Toben: "I think she used...talk about things...try to get the family and me to meet halfway...put some of your points across...and it just gave like an outside perspective on things."

Aisha: "Everyone had an idea, and then MST wanted to bring all of our ideas in one idea...in the middle...sometimes it worked...if I wanted to do it, but there were times when I just wanted to go out and I was just like, 'no I'm not following that'."

Aisha's quote highlights how the young person can exert their influence over MST and its outcomes, emphasising the importance of the MST therapist engaging them in the treatment process.

Feeling understood

The MST therapist taking time to build a relationship with the young person was identified as important.

Toben: "Cause she still understood me...understood what I was saying and that..."

Some young people described feeling like MST was more focused on making changes, than on understanding them and the problem.

Aisha: "I think my culture was understood. But...it would be good to get to know the person...not just the problem, and then trying to fix it...I think if I would understand myself a bit more...I wouldn't have done certain things...I think they should have focused on why am I doing it...rather than, you shouldn't do it. They never focused on 'why am I leaving my house every day?'...instead it was like, 'you shouldn't leave your house, you should be home at this time'."

Aisha and Zoya described feeling like they would have appreciated a focus on the past, as well as the present, which might have promoted a sense of the young person feeling understood.

Zoya: "I think they [MST therapist] should be very warm...you wanna ask them about their past, what they've been through and how they feel about it...I just feel like they could be much...more understanding"

Aisha: "What they [parents] did in the past affected me. The therapist thought...just to forget about the past...and move on...when like, that's not really...how I can take stuff."

Toben spoke about valuing individual sessions, and others alluded to valuing more one-to-one sessions as a space to explore their feelings, contributing to a greater sense of being understood.

Toben: "People didn't do anything wrong...but for like improvements...they probably could have had more one-to-one sessions than group..."

3.2.2. Making relational family changes

Changes in family relationships were reported by many of the young people. Some young people described changes in a parent motivating them to make changes. Conversely, some young people who perceived a reluctance to change in their parents, were reluctant to make changes themselves. Young people who reported positive outcomes described an increase in communication and time spent with their parents, which they associate with the perceived changes in their family.

Increasing communication within the family

Many of the young people talked about how the MST therapist facilitated more open conversation with their parents, which they linked to increased perspective-taking, trust and putting the young person's behaviour in context.

Jay: "Now, dad's...come to understand a bit more. And um, probably cause of it, I'm more close to him. 'Cause...this year, is probably the first time I've had a proper conversation with him...out of my whole life."

Tatiana: "There has been changes...I wouldn't say we get along...but we are getting along now...like, we talk now. I don't have to hide it from her anymore...I just started to trust her."

Aisha: "I'm more, able to be open...not about how I'm feeling, but like what I'm doing...like if my mum would ask me if I had a cigarette...now I'd be like 'yeah ok I did'...I think that MST brought more attention to my parents that...I'm actually only 17...I'm allowed to like get in trouble sometimes...and I know what's right...I'm like...just testing everything out..."

Some young people also highlighted that since MST, they had felt more comfortable spending time with their parents.

Tatiana: "Compared to before...I'd be upstairs in my room, like locked away...but now...I'm like going out with her more, spending time together."

Perceiving changes in each other

Many young people described noticing changes in their parent(s), and subsequently taking more responsibility for their actions. Through parents making changes, the young person seems to be freer to alter their position, which they had previously been stuck in.

Jay: "she [mum] told me to be home by this time...I never was. She was making it really early for a sixteen-year-old...well, a sixteen-year-old around here...but when she kind of, eased off a bit, I was like...alright cool she's done that...so I might as well do my part."

Zoya: "Now it's different, because he's [dad] ...changed and stuff...he said how sorry he was, and my mum always says to me "I wish I had raised you differently" ...Everything has changed...the way my attitude was and just becoming a good person...I didn't realise how much I put my parents through...but...yeah, I've learned how to respect my parents"

Naturally, the reverse was also raised in participant's accounts of MST. Young people who perceived their parents as incapable of change, quickly lost motivation to change themselves.

Safaa: "I wish someone could change my dad's views...I don't think it would work...I tried to get my point across, but then I knew there was no point wasting my time."

These young people who perceived their parents as being incapable of change, described their parents as saying what the therapist wanted to hear in sessions, in order to 'get rid' of services.

Aisha: "My mum thinks the reason they're involved is because I brought them...the original reason about, like, hitting me...like...today when we speak about it, she still doesn't think it's wrong...but when they're here, like, obviously she'll say... "yeah I think it's wrong" because she wants services to go away."

Safaa: "They...act or something...cause obviously they wouldn't be like, truthful...cause if someone's on your case, and you don't want them on your case...you're going to try in every single way to like avoid the situation..."

This lack of change on either side appears to lead to feelings of hopelessness and uncertainty, and the young person feeling unable, or unwilling, to accept responsibility for their own actions, which acts as a barrier to change in MST.

Safaa: "I wouldn't really get involved in the cultural stuff, 'cause I know my parents would get angry...and anyway, I can't change what my parents think."

3.2.3. Empowering the young person

Young people feeling involved in the change process, and viewing themselves as an agent of change emerged from participants' accounts. Some young people conveyed a sense of wanting to be the one who was in control of change occurring.

Aisha: "They [parents] thought...MST for a while were doing good...stuff was changing, but it was really more that...I got tired...I just got tired, so I was like, let me just be good for a bit..."

Jay: "I got angry at one of my teachers. So I went in to the next room and smashed up his computer, and then hit a teacher...after that I decided that I didn't want to be like that anymore, and I made a big change. And everyone's said...they like the way that I am now."

Jay's quote also alludes to the importance of the young person receiving reinforcement for any changes made. Furthermore, these quotes convey a sense that young people perceive themselves as integral to the change process, a perception which may be motivated by power differences, within and outside the family. Some young people alluded to experiences of feeling marginalised and attacked outside the home.

Aisha: "Not many people like Muslim people...they always judge them...so I think, like...I like to stand for something that everyone's fighting about...Like if someone says, uh 'I don't like Muslim people', I'll be like, 'I'm Muslim, so what'..."

In addition, the majority of young people allude to feeling marginalised to some extent within the home.

Hussein: "My mum's always agreeing with other people before me...so she always agreed with MST"

Jay: "when I was younger I never really got a say in...anything...my mum would overrule my judgement straight away."

The MST therapist redressing some of these power differentials in the family, contributed to the young person feeling more involved in change and empowered to make changes themselves.

Toben: "So I already spoke what I needed to say...it just wasn't listened to...but I think she [MST therapist] ...ensured that I was listened to...it helped to be heard."

Some young people described focusing on their future and making changes to achieve goals.

Zoya: "I literally...just kept thinking what do I want to do with my life...do I really want to kill myself? ...So now I'm just focusing on my college."

Tatiana: "I didn't want to...one day look back, and obviously I want to have a good relationship with my mum...so that's why I took part."

Jay: "Cause when I was younger I did grow up in a gang around here. And I did manage to get out of it. A lot of my friends aren't as lucky."

Many young people also talked about making the decision to distance themselves from negative peers, who they saw as leading them in to trouble, which facilitated change.

Jay: "I was like...hanging around with people from this area...they're all about drugs, all about crime...I started hanging around with people who are in work, in education and want to get on with their life...and my best friend now, he has an apprenticeship...and my old best friends...are either dead or in prison."

Zoya: "The people I used to hang around with like...fucked me over...and who was there for me? My family and no one else. So that's what really made me change..."

3.2.4. Recognising and reflecting on cultural difference

Many young people described culture as playing a significant role throughout the engagement and change process in MST. Therefore, recognising and reflecting on cultural difference emerged as a significant part of the change process.

Perspective-taking

Some participants described the MST therapist opening up conversations about dual-cultures and how this may have influenced the young person's difficulties; facilitating the young person to understand their parent's perspective.

Zoya; "Yeah religion was a big part [of MST] ...I think it was being forced...I remember, I hated my dad so much, I had such anger towards him, and my mum as well. But...then growing up and learning things...made me think, at the end of the day they're my parents and they do care about me..."

Tatiana: "Certain parts of Congo...like, how poor people actually are...that can't afford to go to school. Like...obviously my mum will tell me, you have to work hard...I think she's seen everything in a different angle to how we see it."

Exploring these differences also helped facilitate parents' perspective-taking by putting some of the young peoples' behaviour in context.

Safaa: "When they [MST therapist] started bringing in things like bedtimes, curfews and how important school is...and explaining like GCSEs and

things...cause my mum didn't know...so yeah, I think that helped...her understand like, what I'm actually doing..."

Aisha: "I wouldn't have known what my dad thought...I wouldn't have asked him on a normal day. But like in a meeting cause they're [MST therapist] the ones saying it...you're already getting your answer, but you're not asking the question...I found out that, me and my dad are not that different...like he was worse when he was my age...he had his fun...he thinks like...that's what I'm going through."

Understanding young person's unique cultural beliefs/values

Many of the young people described developing their own cultural identity, conveying a sense that this identity was a blend of what they felt was good and bad of both their parent's culture and the UK culture where they had grown up.

Zoya: "They're Christians, like Jehovah's Witnesses...so they're very strict and traditional...I believe that there's a God, and I believe a lot of the things they believe...but I just don't get carried away with it...They're quite old-fashioned too, no sex before marriage and that...so because of that, I'm more of a...this generation, like the way British people are, but I'm not like...I don't believe in having boyfriend after boyfriend...to me that's disgusting as well..."

Aisha: "I think I'm more of the British...'cause I was brought up here...but I kind of, like pick and choose what to follow in my religion sometimes...and like some traditional stuff...like...even though I got pregnant before...the fact that you have

to stay a virgin 'til you're married...like I would follow that...I find that really good. Yeah...what else...um...praying, that's good. And...the events of my religion...like...Eid, Ramadan...I actually really take that seriously..."

From many of the young people's accounts, the idea of developing their own sense of right and wrong emerged.

Zoya: "I live my life the way I want to live my life. If I think that's right, I will do it. If I don't think that's right, then I won't do it...I think my lifestyle is really clean...I don't do drugs...so I don't understand why they have a problem."

Aisha: "I have morals but...their morals are more like, high...I just like to have my own rules."

Toben: "The respect thing...it's a cultural influence from Africa...I think there's a lot of countries that...are very harsh on that one...but everything else...is good, like...when it comes to being Godly...when it comes to having...an education...but I just don't feel like...because someone's ordering me, they're right...that's the only thing I don't really...agree with."

Many of the young people described valuing the 'freedom' of UK cultural practices.

Aisha: "Like here[UK]...it's ok not to have like a dad, it's ok to not have a mum...or like mum and dad, are like, not together. Or like, a sister who's like transgender...but back home that would be like, something crazy...I think British culture is very free...because the culture itself allows everyone else to do their own culture"

Safaa: "[UK] it's just more like laid back...like they don't have rules...like...proper rules...they give you ...freedom basically."

Therapist ethnicity and culture

As discussed earlier, the therapists' ethnicity and culture was described as permeating through engagement and change for young people from minority ethnic backgrounds. One young person, who had a MST therapist from a minority ethnic background described feeling like she understood the family better than a White British therapist would have.

Toben: "'Cause she was from a similar background, she wasn't being biased...she was understanding of both my parents and me...I think a British person would have understood less."

Other young people, who described feeling like they did not achieve positive outcomes from MST, felt someone from a similar background may have been able to facilitate change.

Aisha: "I think it's better when the actual therapist is the same religion or the same type of...background...like...if someone from your culture is saying...that you're doing something wrong...you're like 'oh...wait you're from my culture, you must know about it...so I should think about what I'm doing...maybe I'll not change it, but at least I'll think about...changing'."

Safaa: "If you're not the same culture, I don't think it's going to work...they won't understand you when it comes to things like, cultural...cause obviously everything ties in with your culture...they wouldn't know how to handle it all."

Some young people did express mixed views about having a therapist of a similar background. They voiced concerns that perhaps the therapist might privilege their point of view, or that their parents might be able to manipulate a therapist from a similar culture.

Zoya: "I think they would have understood more, about it...why the situation is like that, [laughs] ...actually, this is what I think...my mum...would like try to play with their head. And she'd be like 'you know how it is'...then use more excuses."

However, some young people who experienced positive outcomes described feeling like the therapists' ethnicity or culture had no influence on change.

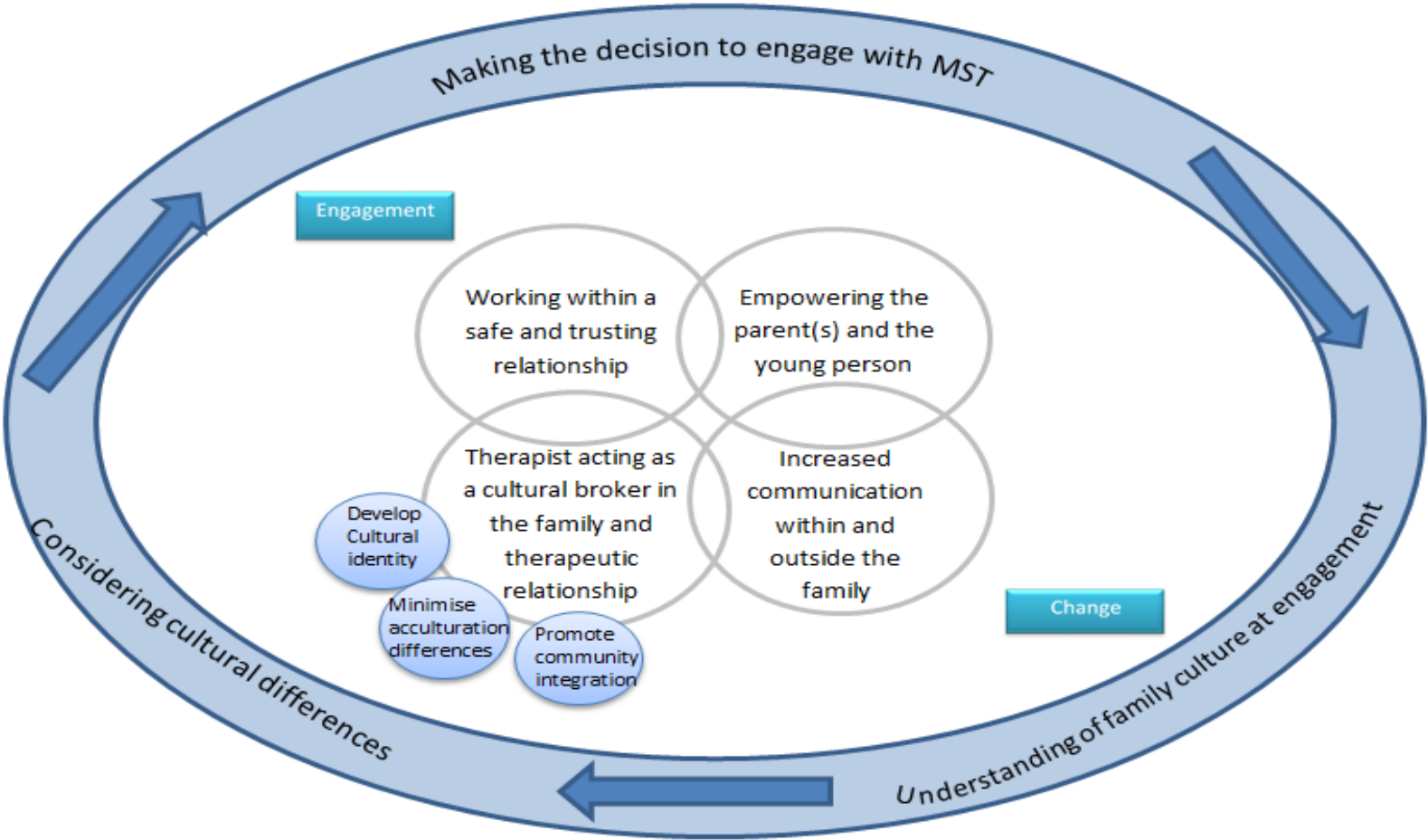
Jay: "my social worker said...that some families would prefer a black social worker...to me...it doesn't really matter. I've just always thought that whoever can help me...can help me...they might talk differently or they might have different perspectives but...in the end they all have the same...training."

3.3. Model for processes of engagement and change in MST for minority ethnic young people

Figure 3 shows a diagrammatic representation of the emergent model for the processes of engagement and change in MST for minority ethnic young people. Engagement is depicted as an ongoing process influencing change, in the outer circle, and is comprised of three inter-related theoretical categories. Based on participants' accounts, deciding to engage with MST, understanding the family's culture and having cultural differences considered contribute to successful engagement and consequently successful change. The model aims to convey that engagement and change are not separate processes, and engaging the young person and family is an ongoing process which impacts on the possibility of achieving positive outcomes.

The inner circle represents the change process, consisting of four theoretical categories depicted in the concentric circles. This conveys the interrelated relationship between these processes, which although discussed individually above, are not mutually exclusive. Having a positive relationship with the MST therapist, empowering the young person, making relational family changes and recognising and reflecting on cultural difference were identified by young people as influencing change. However, it is recognised that this change is dependent on continued engagement influenced by the factors outlined above. These categories were integrated with categories identified by Bibi et al. (2014) to create a model of change for minority ethnic young people and parents. Circles attached to the category 'Therapist acting as a cultural broker' highlight specific cultural factors identified by minority ethnic young people as influencing change in MST, which the therapist should take into consideration.

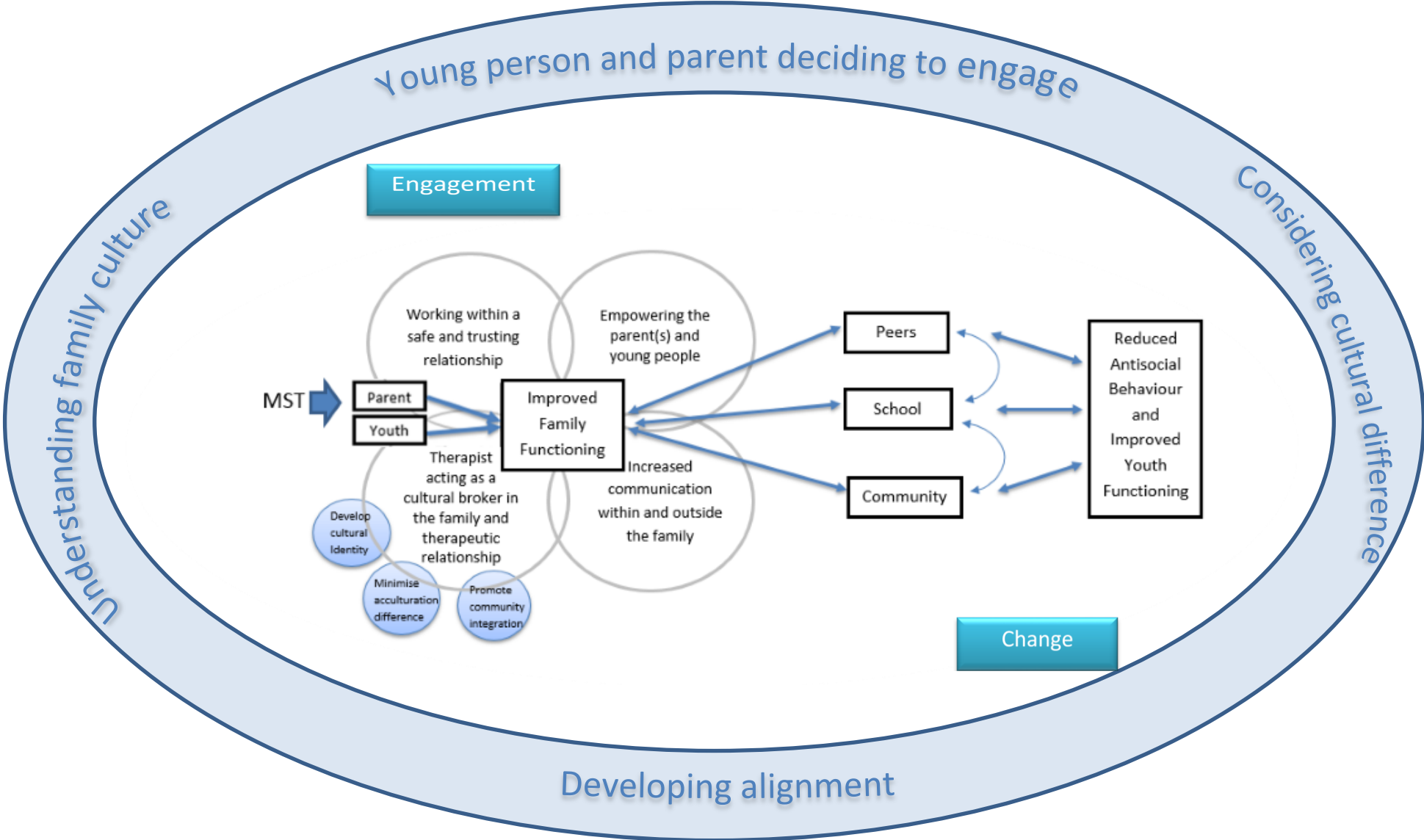
Figure 3: A model of the processes of engagement and change in MST for minority ethnic young people



3.4. Revising the MST Model of Change

One aim of the study was to consider the existing model of the process of change in MST, in conjunction with recent relevant research (Bibi et al., 2014), and evaluate whether the findings of this study could shed further light on how engagement and change is attained with minority ethnic young people. Young people's contributions highlighted unique experiences in MST, which contribute towards the proposed revised model of change and build upon recent research (Bibi et al., 2014). The model outlined in Figure 4 will be discussed further in the discussion section. It combines the model of change outlined by Henggeler et al. (2009), amended Henggeler (2015), and incorporates and expands upon the mechanisms outlined in Bibi et al.'s (2014) model of engagement and change for minority ethnic caregivers. Similarly, to Bibi et al.'s (2014) model, the original model has been adapted to incorporate processes of engagement, however engagement in the emergent model is depicted as a circular or ongoing process, which is fundamental to change and positive outcomes. Additionally, having a circular model representing the idea of engagement and change as ongoing processes, which feed into one another, fits more readily with the MST analytical process model (Henggeler & Schoenwald, 1998). As discussed above, areas specific to minority ethnic young people for the MST therapist to address have been added to 'therapist acting as a cultural broker'. The separate parent and youth boxes represent how the therapist must consider both perspectives throughout engagement and change processes. Furthermore, in line with Bibi et al. (2014), the processes of change in the emergent model outlines the mechanisms that can be understood to facilitate improved family functioning, however this has been further refined to include the young person's unique experiences of MST.

Figure 4: A revised model of the processes of engagement and change in MST



Chapter 4: Discussion

This study explored the processes of engagement and change for minority ethnic young people in MST. A grounded theory methodology was used to analyse seven participants, in order to fulfil these research aims:

- a. *Explore the factors which are experienced as facilitating or hindering engagement and change in MST from the perspective of minority ethnic young people.*
- b. *Generate a theoretical understanding of the processes of engagement and change in MST for minority ethnic young people and utilise this, in combination with previous related research (Bibi et al., 2014), to contribute towards and develop the existing MST process of change model.*
- c. *Contribute towards existing efforts to make MST an equitable treatment model for families from diverse backgrounds.*

4.1. Overview of findings

The findings of this study illuminated various psychological processes which were associated with engagement and change for the minority ethnic young people who participated in this study. The theoretical codes that related to the process of engagement included (1) making the decision to engage with MST, (2) understanding family culture at engagement and (3) considering cultural differences. The theoretical codes associated with processes of change were (4) having a positive relationship with the MST therapist, (5) making relational family changes, (6) empowering the young

person, (7) recognising and reflecting on cultural difference. These processes will be discussed below, with reference to the existing literature to consider how the findings contribute to the knowledge base.

4.2. Context for discussion

As a preface to discussing the results in detail, it is important to consider the issue of diversity within the study. In spite of the smaller sample size, the young people who took part spanned a wide and diverse range of cultural and ethnic backgrounds (See Table 1). As outlined in the introduction, when referring to ‘minority ethnic young people’ in the discussion, the reader is reminded to bear in mind the differential cultural and religious, beliefs, values and practices which are being referred to within this umbrella term (Marsella, 2011).

Based on the young people’s accounts, there were also marked differences between and within families, in terms of the process of acculturation. The majority of the parents in the current study were living in the UK for at least 10 years, nevertheless, there was great variation in acculturation-related factors, such as language proficiency, language use, nativity status, cultural-related behavioural preferences, and ethnic identity (Cabassa, 2003). Differences in acculturation was highlighted as a source of familial conflict, and a potential barrier to change in MST. Based on participants’ accounts, it appeared as though the greater the difference in acculturation between parent and young person, the stronger the narratives were around cultural and religious factors impacting on engagement and change in MST. Minimising acculturation differences has

been identified on the model as an area which requires consideration by the MST therapist when working with minority ethnic young people.

In contrast to Bibi et al.'s (2014) findings with minority ethnic caregivers, religion did feature in participants' accounts in the current study. Across the sample, families were practicing different religions, and young people described differences in adherence to, and strength of, religious convictions. In two-parent families in this study, there could also be differences between parents in the strength of religious conviction. In a similar way to acculturation, based on young peoples' accounts it appeared as though the bigger the difference in the strength of religious conviction between various family members, the more religion featured in the young person's narrative. Some young people also described their own religious beliefs as being a product of their parents, whereas others adapted their beliefs based on their own preferences and values. Schwartz et al. (2006) suggest that the changes (or lack thereof) in ideals, values, and behaviours that occur through acculturation have clear implications for how minority ethnic young people form, revise, and maintain their identity, either through imitation and identification or through exploration and construction (Serafini & Adams, 2002). Young people varied in how much they valued religion, and how important religious beliefs were to their overall identity. Acculturation, identity and integration have been highlighted in the model as areas of specific relevance to minority ethnic young people, which MST therapists should consider.

Whilst it is important to consider diversity within the sample and the unique experiences of minority ethnic young people in MST, conversely it is also important not to exaggerate

the differences between groups, including the differences between minority and majority ethnic groups (Bradby, 2003). Of note, is that many of the theoretical codes that emerged in this study overlap with processes of change identified in other studies of MST (Tighe et al., 2012; Paradisopoulos et al., 2015), highlighting some of the universal similarities that young people share across cultures. Nevertheless, a number of unique findings did emerge relating specifically to the experience of ethnic minority young people in MST. These will be discussed in greater detail because they add new dimensions to the existing models, and raise further questions in relation to how to work with minority ethnic young people and their families, however the reader is reminded that it is likely that other factors also played a part in the engagement and change process for these families.

4.3. Engagement for minority ethnic young people

Thompson, Bender, Lantry, and Flynn (2007) argue that in any family therapy the ability to engage and retain the family is key to success, yet there has been limited research comparing parents and young peoples' experiences and perceptions of family-based treatments. Engagement did emerge as an important process in young peoples' accounts of their journey through MST, in line with MST manuals stating that treatment cannot progress unless key family members are engaged and actively involved and that engagement is a precursor to successful outcome (Henggeler & Schoenwald, 1998). Bibi et al. (2014) proposed that engagement should be conceptualised as a distinct (albeit inter-related) process to change. This conceptualisation is useful for minority ethnic families, in that the engagement process may require clinicians to work with greater

sensitivity, as individuals may hold alternative beliefs to the dominant assumptions around distress and its resolution. Bibi et al. (2014) highlighted that culture can mediate expressions of distress (Webster & Robertson, 2007) and perceptions of support needs (Stewart, 2008), both of which are likely to have bearing on the engagement process. Findings from the current study further develop Bibi et al.'s (2014) concept, by depicting engagement as a distinct process, but one which is interwoven into the process of change. Once people have 'got on board' with MST, this does not mean that the engagement process, and the mechanisms which underpin it, cease to be significant. Engagement is described as an ongoing process throughout treatment, with enormous impacts on treatment outcomes. As MST is an intervention primarily focused on working with parents/caregivers, engagement as an ongoing process may have come through young people's narratives more strongly as their engagement can fluctuate, whilst the treatment progresses with parents/caregivers.

4.3.1. Making the decision to engage with MST

A number of important pre-engagement factors were expressed in participants' accounts of MST. Bhui and Bhugra (2002) argue that pathways in to mental health care are important. For minority ethnic young people these can be affected by; pre-immigration family health beliefs, the attractiveness and cultural appropriateness of services; attitudes towards services; previous experiences; and culturally defined lay referral systems (Goldberg, 1999).

The young person's previous experiences of unsuccessful interventions or a negative perception of the referrer, were described by participants in the study as hindering, or obstructing, their engagement with MST. Contrastingly, some participants described a positive relationship with the referrer, which facilitated hope and an openness to engagement, despite reservations. Wallen (1992) highlighted that when engaging minority ethnic clients, it is important to consider that cultures can differ in; what they consider to be a mental health problem, what kind of care they consider appropriate, what the perceived role of the care provider is, and what they consider to be a successful outcome. Mental health services are shaped primarily by the values and beliefs of the dominant culture, and therefore may not be perceived as desirable or helpful by minority ethnic individuals. With this in mind, if minority ethnic young people and their families also report negative past experiences of services, this can compound a family's initial suspicion and mistrust (McKay, Stoewe, McCadam & Gonzales, 1998), which need to be considered early in engagement.

Following initial impressions of MST and reservations based on past experiences, participants described meeting with the MST therapist and beginning a more active interpersonal stage of engagement. In line with other findings, the therapeutic alliance and the way the therapist worked in MST was a key component in engagement (Tighe et al, 2012; Paradisopoulos et al., 2015). Listening to the story and capturing everyone's perspective have been associated with the development of positive therapeutic alliances (Hubble, Duncan & Miller, 2000) and successful outcomes in family therapy (Friedlander, Escudero & Heatherington, 2006). Despite this, Henggeler and Schoenwald (1998) advise MST supervisors that 'an underlying assumption of MST, is that favourable child

outcomes are gained primarily by developing the capacity of caregivers to be more effective parents, and thus MST clinicians work primarily with parents to overcome barriers to their effectiveness, and devote relatively little time to working with children individually' (p.25). This is somewhat at odds with findings from this study, which indicate variation in the amount of contact-time between young people and the MST therapist, and more notably how limited contact could impact on the young person's therapeutic alliance with the therapist, contributing to suspicion and disengagement. 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, rendering them impotent.

In some young people's accounts, a positive therapeutic alliance appeared to be a catalyst for change and a springboard for trying out new ways of relating to others. Thompson et al. (2007) argue that engagement with young people is important for positive outcomes in home-based family treatments, as it estimated that 50–75% of young people referred to treatment do not initiate or complete the full course of treatment, resulting in poorer outcomes in individual, school, home, and community functioning (Kazdin, Holland & Crowley, 1997). Creating a therapeutic alliance with adolescents is particularly challenging due to youths' inherent demand for developing independence and constant striving to differentiate themselves from authority (Eltz, Shirk & Sarlin, 1995). In some ways, MST has been viewed as an antidote for this, as the intervention stresses a focus on engaging and intervening with parents/caregivers as opposed to the young people themselves (Henggeler et al., 1998). Nevertheless,

transforming adolescent resistance and reluctance into investment in treatment can be achieved through the development of a collaborative relationship with therapists that encourages youths to cultivate their own solutions (Diamond & Liddle, 1999).

Research has shown that adolescent alliances are particularly relevant to the process of change and outcome in therapy, across individual, parent and family treatments (Shirk, Karver & Brown, 2011). In keeping with findings from Paradisopoulos et al. (2015), specific therapist traits appeared to be valued by young people. Shirk et al. (2011) highlight that there are important developmental differences between youth and adult alliance, for example, cognitive development can limit younger clients' ability to evaluate connections between therapy and goals. Therefore, they suggest that a positive bond between young person and therapist may be based on relational features, such as the degree to which the therapist is stimulating, humorous, or rewarding, especially among younger clients. In line with other research (Paradisopoulos et al., 2015; Martin, Romas, Medford, Leffert & Hatcher, 2006), young people who reported positive outcomes described valuing respect, time-shared and feeling understood throughout MST, which was in contrast to their previous experiences of services. This shifted their uninterested and hopeless stance, to one of collaboration and hopefulness. Thus, their relationship to help (Reder and Fredman, 1996) may have fundamentally shifted through their experience of MST, enabling them to access services more effectively in future. As young people rarely refer themselves to family therapy and can often see limited value in treatment (Digiuseppe, Linscott, & Jilton, 1996), developing a good working alliance with the therapist becomes vital, and therapists who present themselves as an ally, can

positively impact on the building of an alliance which facilitates engagement and positive outcomes (Diamond, Liddle, Hogue & Dakof, 1999).

In line with Bibi et al.'s (2014) findings, young people in this study alluded that having limited knowledge about, or not understanding the ideas and principles behind MST, made it difficult to initially engage. Research has shown that knowledge of the healthcare system, and available treatments are important factors in determining service utilisation and engagement for minority ethnic groups (Rathod et al., 2010). As outlined above, cognitive development also needs to be taken in to account, therefore the MST therapist needs to be able to define the aims and activities with appropriate concreteness and specificity (Liddle, 1995).

A key finding of this study was that young people valued one-to-one sessions, particularly as a way of engaging with the MST therapist, and many expressed a sense that when they felt excluded from the therapy process, they disengaged. Adolescents having their own space to talk openly with the MST therapist may be particularly valued by minority ethnic young people, given the increased shame associated with their behaviour in their parents' culture, and its implications for the family (Zhou & Bankston, 1994). This is somewhat contradictory to MST literature; Henggeler and Schoenwald (1998) suggest that 'when clinical progress is slow or progress seems to have stalled, a common reason is that key family members (i.e., the child's caregivers, those adults who control family resources or have decision-making authority) are not truly "on board" with the treatment plan' (p.23). Whilst this may be the case, the influence and impact of the young persons' engagement is somewhat disregarded in MST. The findings from this

study, suggest that engagement is a reciprocal and cyclical process, in that a young person's resistance towards change can impact on a family's engagement, and vice versa. Flaskas (1997) described engagement as an 'ongoing relational process of therapy', and Shirk et al. (2011) suggest that with young people alliance formation is not simply an early treatment task, but a recurrent task, which therapists should monitor throughout treatment. Research suggests that the therapist is required to attend to multiple perspectives to develop a good alliance and a treatment plan that accommodates both youth and parent perspectives (Thompson et al., 2007). Indeed, the findings of this study suggest that engagement with adolescents, and potentially to a greater extent with minority ethnic young people, is an ongoing and relational process which overlaps with the process of change. This is in keeping with La Roche and Maxie (2003), who argue that 'the perception on the part of patient and therapist of what constitutes a cultural difference is dynamic rather than static. At different points in the therapeutic process, what is construed as a cultural difference may shift into the background, and other factors may come into the forefront' (p.181). Therefore, therapists are encouraged to engage in ongoing exploration of these changing meanings of cultural differences rather than to assume that once these differences have been understood, it is no longer necessary to continue such explorations. Furthermore, McKay et al. (1998) emphasised that identifying and addressing barriers to the use of services, must be continued during face-to-face contact with clients.

4.3.2. Understanding family culture at engagement

The MST therapist having an understanding of the family's culture featured in narratives of engagement, with some variation seemingly based upon the extent of the difference in acculturation between parents and young people. This is in keeping with previous research, which suggests that those who attached higher value to their own race, ethnicity and culture, were found to appreciate when difference was discussed in treatment, and vice versa (Chang & Berk, 2009). However, some would argue that issues and facets of culture are present overtly, or covertly, in any therapeutic encounter, and that in cross-cultural therapy they are particularly acute (Krause, 1998).

In line with other research, young people in this study described that experiencing the therapist as coming alongside the family, and aligning in a way that showed support and not criticism, was important in the early stages of MST involvement (Tighe et al., 2012; Bibi et al., 2014). In particular, young people expressed the importance of their parents feeling like their culture was understood and respected by the therapist, for engagement. This can be a particular issue in the presence of significant cultural differences between the therapist and the family. La Roche and Maxie (2003) argue that discussing cultural differences is an important skill for clinicians to develop, and if done sensitively in the initial stages of the intervention can engender a sense of being understood, contributing to the therapeutic alignment. Chang and Berk (2009) found that therapists viewed by clients as 'culturally competent' had a mix of generic skills, and specific individual knowledge about issues such as oppression, discrimination and racism. However, feeling understood can also be facilitated by the therapist

acknowledging commonalities as well as difference, which may serve to reduce the client's ambivalence and increase the therapist's credibility (Speight & Vera, 1997). This strategy may also serve to reduce initial apprehensions about treatment as by explicitly sharing commonalities, before addressing difficulties, the therapist's mirroring this experience of being similar yet different, facilitating the development of a more open sense of self, and a feeling of respect and acceptance (La Roche & Maxie, 2003).

Young people who reported feeling like their parents' culture was not fully understood by the MST therapist, described feeling like their therapist had little knowledge of the family's cultural background or that their parents' views based on cultural background were perceived by the therapist as 'wrong'. Proponents of cultural competence suggest that a practitioner must have an awareness that differences in communication, worldview, relations and definitions of health, can impact on the therapeutic encounter and outcome (e.g. Cross, Bazron, Dennis, & Isaacs, 1989; Sue, Arredondo, & McDavis, 1992), and that a practitioner must acquire knowledge of theory and practice relevant to cross-cultural therapeutic encounters, as well as knowledge of the characteristics of specific cultural groups with which they might work (e.g. Campinha-Bacote, 2002; Lo & Fung, 2003). However, with this in mind, the development of cultural competence is considered to be a lifelong process, of continuous growth in awareness, knowledge and skills (Bassegy & Melluish, 2012).

Some of the young people expressed ambivalence around engagement with MST, based on the perceived rigidity of their parents' views on the acceptability of outside help. Cauce et al. (2002) suggest that for minority ethnic groups, accessing help from formal mental health services may depend on; attitudes about mental health services such as

receptivity to care, anticipated and real negative consequences from others, self-consciousness, and stigma tolerance (Barker & Adelman, 1994; Leaf, Bruce, & Tischler, 1986). Cauce et al. (2002) argued that although the evidence is scant, there is reason to believe that culture affects these attitudes. For example, in many East Asian cultures, outside help is regarded as a source of shame or “loss of face” (Cheung & Snowden, 1990; Leaf et al., 1986; Sue, 1988; Takeuchi, Bui, & Kim, 1993). Grier and Cobbs (1968) coined the term ‘healthy cultural paranoia’ to refer to the suspicion some minority ethnic groups held towards mainstream services. Cultural mistrust is defined as the tendency to hold a generalised mistrust for people and systems that represent mainstream society (Terrell & Terrell, 1984). This mistrust may be entrenched in experiences of discrimination and racism, and wider historical, social, political and cultural influences (Keung-Ho, Rasheed & Rasheed, 2003). Nickerson, Helms and Terrell (1994), in their study of African-Americans found greater mistrust of Whites was associated with more negative general attitudes about seeking help from clinics staffed primarily by White people, and lower expectations. It was also linked with poor engagement (Biafora et al., 1993) and reduced likelihood of therapy completion (Thompson, Worthington & Atkinson, 1994). However, whether these findings generalise to non-African American populations is debateable. Nevertheless, Bhugra and De Silva (2000) suggest that the cultural context of the therapeutic interaction is of major importance, as this context brings with it societal factors and complexities, including inherent power relationships. Recognition and understanding of these are important for the work of a therapist (Bhugra & De Silva, 2000), alongside exploration of family ideas around mental health, mental health services and what ‘help’ is, bearing in mind that second-generation young people may have different ideas.

4.3.3. Considering cultural difference

A desire or appreciation of the MST therapist considering cultural difference with the young person and family, was expressed in most participants' accounts of engagement in MST. This finding is supported by research focusing on facilitating engagement with adolescents from a minority ethnic background (Jackson-Gilfort, Liddle, Tejada and Dakof, 2001). Jackson-Gilfort et al. (2001) found that talking about culturally-salient and meaningful content themes encouraged more active engagement and participation in therapy. Participants in this study described the benefits of their therapist discussing culturally-relevant topics, for example cultural differences between the parent and the young person, the confusion experienced by young people growing up in two cultures and how dual-cultured families can experience conflict. This facilitated young people feeling like their family background was understood, and more open conversations with their parents about previously 'taboo' subjects. This is in line with Thompson et al.'s (2007) findings with minority ethnic young people, that therapy sessions often elicited discussion of information the family members previously had not discussed with one another.

In line with Bibi et al.'s (2014) findings, a lack of understanding and consideration of cultural differences was highlighted by some of the young people in the study as causing disengagement from MST. This is supported by Falender and Shafranske (2008), who argue that "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). Young people also identified that this could contribute

to their parents' disengagement, and indeed 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" (p.11).

The therapist understanding and respecting cultural difference is recognised in the MST literature (Tuerk et al., 2012), and cultural sensitivity in MST was also highlighted as being important for minority ethnic caregivers (Bibi et al., 2014). What was unique in this study was the young peoples' accounts of the importance of their own ethnic identity to their sense of self, often described as a blend between their parents' culture and elements of UK culture. Yancey, Siegel and McDaniel (2002) argue that as minority ethnic adolescents negotiate the transition to adulthood, the nature and outcome of their struggles to achieve a positive identity, influence their life trajectories. It has been well documented that risk factors in adolescents tend to cluster, such that a subset of youth engages in multiple risk behaviours, including unprotected sexual intercourse, substance use, violent behaviour, and academic underachievement (Irwin, 1990; Henggeler et al., 1998). Miller (1999) argued that ethnic identity is a key construct to include when examining the grouping of risk behaviours, as ethnic identity formation facilitates the development of competencies, and can act as a protective factor. Rodriguez, Cauce and Wilson (2002) outline various stages of ethnic identity formation, with earlier stages involving low salience or social stigma to one's ethnic group, and later stages involving information-gathering and desiring intimacy with one's ethnic group (Phinney, Cantu & Kurtz, 1997). Discovering one's cultural heritage can come with conflicting feelings regarding the 'majority' cultural group (Rodriguez et al., 2002) which

has been linked to psychological distress and high anxiety/hostility (Parham & Helms, 1985). The final stage of ethnic identity formation, commitment, is associated with increased self-esteem, multi-cultural competence and an ability to better cope with racism and discrimination (Rodriguez et al., 2002). These stages can be revisited at different times, or in different contexts, therefore, encouraging young people to think of their ethnic identity as fluid may be appropriate (Rodriguez et al. 2002).

Schwartz et al. (2006) in their paper examining the role of identity in acculturation, calls for interventions to promote identity development in acculturating individuals. Given that the adolescents in this study, to a greater or lesser extent, are faced with the challenge of creating a cultural identity, that incorporates elements of both the heritage and receiving cultures, in addition to confronting the normative personal identity issues that characterise this developmental period (Arnett, 1999; Schwartz, 2005), the MST therapist needs to be culturally sensitive; enquiring about the young person's cultural identity and sensitively addressing this developmental process. 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 young peoples' accounts. Participants who described MST therapists having conversations about culture and cultural differences between parents and young people, expressed this as being a positive process. However, a number of young people continued to express a feeling of being misunderstood by the MST therapist, leading them to disengage from sessions. McGoldrick et al. (2005) argue that family therapists should help clients to understand their ethnicity and culture. Rodriguez et al. (2002) 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, thus serving as a guide for culturally-sensitive interventions. Lo and Fung (2003) suggest that additional skills are required to sustain engagement and facilitate a therapeutic alliance for positive outcomes with 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). Opening up these conversations with young people may work in the MST therapist's favour, as aspects of the young person's cultural, ethnic and religious background can act as protective factors against risky behaviours (Miller, 1999). Furthermore, by opening up conversations about the young person's culture, may alleviate parents' concerns around young people losing their native culture in favour of the host culture. This study highlights that minority ethnic young people may have a unique cultural identity from their family and from their peers, and that MST's focus on parent/caregiver engagement may be at the expense of understanding the unique perspective of minority ethnic young people, potentially resulting in disengagement which can impact on MST outcomes, which is discussed later in the chapter.

Another unique finding in this study, is that the cultural background of their therapist was perceived by some young people to have an instrumental role in the engagement and change processes. This is in contrast to Bibi et al.'s (2014) findings, as although minority ethnic caregivers expressed preferences for a minority ethnic therapist, the parents described being indifferent to the ethnicity of the therapist, providing they were professional and respectful. Family therapy literature incorporates ideas about social

power, and Rivett and Street (2009) suggest that it can be useful for therapists to explore how different families experience them as therapists if they think this would be beneficial for the family. Additionally, McGoldrick et al. (2005) argue that developing cultural competence requires coming to terms with one's own ethnic identity, and Plummer (1997) suggests that therapists need to have a keen awareness of their own cultural and racial identity, and how this may impact their relationship with client, keeping in mind that this may be different for different members of the family. For instance, multicultural researchers have noted the importance of having practitioners discuss their feelings about treating cross-cultural clients with their professional peers or supervisors (Barbarin, 1984), and exploring attitudes toward psychological help-seeking in their own communities (Chung & Lu, 1996). Such a reflection is indicative of an appreciation for the bidirectional influence of culture in a therapy interaction, to facilitate a healthy dialogue about sensitive cross-cultural topics that might arise during treatment. Asnaani and Hofmann (2012) argue that after consultation with other clinicians, the literature, and reflection on their own personal beliefs towards psychological dysfunction that a therapist can reveal some personal beliefs and experience with a family, if it is thought to facilitate willingness to engage with, and continue with treatment with the provider.

4.4. Change for minority ethnic young people

Despite the results of this study being outlined in two separate sections, the findings of the study indicated that successful engagement was not only a precursor to the process of change, but was an ongoing process throughout the MST process. The theoretical

codes which emerged in relation to the change process will be discussed below, with specific emphasis on novel findings. However, the reader is encouraged to see codes from engagement and change as inter-linked and building upon each other to facilitate change in MST for minority ethnic youth.

4.4.1. Having a positive relationship with the MST therapist

Participants in this study, in line with similar findings from other relevant research (Bibi et al., 2014; Tighe et al., 2012), found the therapeutic relationship to be instrumental in bringing about change. Given that Jackson-Gilfort et al. (2001) suggest that cultural mistrust between young person and therapist may contribute to lower expectations and disengagement from treatment, it is important that therapists facilitate a healthy dialogue about sensitive cross-cultural topics that might arise during treatment, and discuss cross-cultural issues with their professional peers and supervisors (Barbarin, 1984), if they are viewed as being detrimental to the therapeutic relationship.

Young people in this study, who experienced positive outcomes described perceiving the MST therapist as 'going the extra mile', and valuing the therapist focusing time and resources on the young person, in addition to their parents. Some participants described this as allowing them to have a voice in their family, and contributing to their sense of feeling understood. In this study, underlying themes of feeling misunderstood and not feeling heard emerged from participants' accounts. Most participants described feeling side-lined in their family, and some also described feelings of marginalisation from mainstream society as well. Where participants did not experience positive outcomes in

MST, it appeared that this pattern of feeling marginalised and not understood was replicated in the relationship with the MST therapist. These findings are somewhat at odds with MST literature, as Henggeler and Schoenwald (1998) write that 'when therapists are spending a larger than usual amount of time providing individual treatment to children, a "red flag" should go up for the supervisor. Even if progress seems satisfactory with the family and the caregivers are engaged, the therapist's individual emphasis likely will attenuate chances for long-term maintenance of change' (p.25). From this study, it engaging the young person appears to be of equal importance to engaging the caregiver, and can also impact on the outcome of MST.

4.4.2. Making relational family changes

Building upon the previous section, involving the young person in MST sessions was viewed as a way of facilitating open communication between the young person and their parent(s), and allowing the young person to notice and appreciate changes the parents were contemplating or attempting. In this study, young peoples' narratives of change, often linked with perceived changes in their parents. Participants in this study described involvement in sessions as allowing them to have conversations they would not have had before, which facilitated more positive interactions with their parent(s). Thompson et al. (2007) also found that young people mentioned their enjoyment of the time spent together as a family during family therapy sessions, adding that feeling connected and learning about commonalities and mutual interests among family members was a new experience. Thompson et al. (2007) found that parents also noted greater understanding and expressions of warmth for their adolescent child, when the therapist helped

modulate negative interactions. Thus, recognising the important role that parents play in treatment engagement in relation to their child (Kazdin et al., 1997) and the role the youth plays in the therapeutic encounter is vital for therapy to be successful. Although this complexity creates a challenge for family therapists who must build alliances with the youth and the parent, relationship-building with family members is crucial (Thompson et al., 2007).

In family therapy, members having a sense that change is possible can facilitate engagement and change (Friedlander et al., 2004), this was in keeping with the results from this study. Participants who described their parents telling the therapist what they 'wanted to hear' and perceiving no changes in their parents, described becoming despondent, disempowered and subsequently disengaging from MST. Some young people described that this was linked to their parents' ideas about the acceptability of outside help, therefore as outlined above recognition and understanding of the family's ideas about 'help', are important for the work of a therapist, in both assessment and intervention (Bhugra & De Silva, 2000).

4.4.3. Empowering the young person

Participants' accounts often featured discussions of their sense of being an agent of change, or the opposite, which impacted on how able they felt to make changes.

Children themselves frequently have little power in directly influencing the course of therapy (Dwivedi, 2002), and Walker and Donaldson (2011) in a research report looking at outcomes for vulnerable children highlighted that young people can be empowered

to take responsibility for making decisions in respect of their own needs and for working in partnership with the professionals offering them support. However, they argued that without time on their own to talk through things and make a family plan, young peoples' empowerment to make changes diminished. Furthermore, Walker and Donaldson (2011) suggest that some young people had resented their problems being discussed in front of professionals and family members, and they coped by; switching off, opting out, or by agreeing with everything that was said. These findings give further weight to the value of some one-to-one sessions with the MST therapist for young people's sense of involvement and empowerment. In this study, participants who described feeling empowered to make changes were better able to distance themselves from negative peers and envisage alternative futures for themselves, e.g. getting back in to school, getting a job and joining in pro-social activities.

4.4.4. Recognising and reflecting on cultural difference

Therapists recognising and reflecting on cultural difference within the family and between the family and the therapist was recognised as being a facilitator of change. In line with Bibi et al.'s (2014) findings young people described their parents wanting to preserve principles and practices from their culture of origin, which is consistent with other findings from research on parenting in immigrant families (Phinney & Vedder, 2006). However, young people expressed feeling like their culture was a blend of their parents' culture and the UK culture, but that this was not recognised by their parents, contributing to them feeling misunderstood. Helping family members to understand each other's culture perspective, came across as something which facilitated change in

MST. The therapist enabling the parent to see things from the young person's perspective of trying to navigate two cultures, and the young person 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 current study's findings are in keeping with this, highlighting the facilitative function of opening up cross-cultural perspectives in families with dual-cultures. Young people alluded to the impact of this in helping parents to appraise their behaviours differently, which allowed or enabled the young person to make changes in their own behaviour.

Young people having their own unique cultural and religious identity, made up of beliefs and practices which they valued from their parents' culture and certain beliefs and practices which were customary in the UK, came out in this research. The issue of ethnic identity is particularly salient for adolescents whose parents are immigrants (Rumbaut, 1994). Indeed, some participants in the current study described feeling confused by differences between their parents' culture and UK culture, alluding to confusion around what was 'right' and where they fit within these two cultures. This is in line with Thompson et al. (2007), who found that when engaging high-risk young people, gaining an understanding of self and others came out as being important. As Western societies have become increasingly individualistic, collective support for identity development among youth has waned (Côté & Levine, 2002). Schwartz et al. (2006) also highlighted that young people whose parents are familiar with the workings of the receiving society, can turn to those parents for guidance. However, young people whose familiarity with

the receiving culture exceeds that of their parents, may be left without guidance with respect to exploring avenues for personal identity development.

As outlined above, the therapist exploring how different families experience them as therapists, including addressing the therapist's own culture if they think this would be beneficial for the family, can be useful (Rivett and Street, 2009). Some participants in this study felt that the ethnic and cultural background of the therapist impacted on engagement and change. Matching clients with ethnically similar therapists has been suggested as a way of addressing these issues, on the assumption that similar backgrounds will result in the combination of knowledge, skills and patterns of communication that facilitate the provision of culturally-responsive treatment (Tharp, 1991; Sue & Sue, 2012). Research focusing on matching therapists and clients from similar backgrounds has produced inconclusive results. In their meta-analysis, Maramba and Hall (2002) found that ethnic matching resulted in significantly more attended sessions and reduced dropout rate, however the effect sizes were so small that ethnic-matching was ruled out as a clinically significant predictor of outcome. The authors argued that ethnic matching does not necessarily guarantee cultural matching, and Sue, Zane and Young (1994) argue that simply matching on ethnicity, may be less important than ensuring that the therapist reflects positive attitudes toward, and understanding of, minority experiences. It has also been suggested that ethnic match may influence engagement, but not the treatment process that leads to improved client functioning (Fujino, Okazaki, & Young, 1994). Karlsson (2005) highlights that it is, "not likely that absolutely every patient belonging to an ethnic group would benefit from ethnically matched psychotherapy. Yet, it is probable that some patients who possess specific

characteristics or who live in particular situations might benefit from ethnic matching; more specialized research might reveal such findings” (p.125).

Nevertheless, Flicker, Waldron, Turner, Brody, and Hops (2008) suggest that proponents of ethnic matching argue that, therapeutic alliance will be more easily formed due to common experience (Sue, 1988), miscommunication and misdiagnosis will be less frequent (Sue, 1988), and the therapeutic goals will be similarly conceptualised by the client and therapist. Social psychological research suggests that similarity between individuals can positively influence processes such as liking, persuasion, and credibility (Simons, Berkowitz, & Moyer, 1970), which link with positive outcomes in treatment. Ethnically matched therapists are also thought to more likely identify the impact of cultural issues on the clients’ difficulties (Sue & Sundberg, 1996). Furthermore, ethnic minority clients’ preference to work with a culturally-similar therapist is thought to relate to better treatment outcomes when clients are ethnically matched (Atkinson & Lowe, 1995). Yeh, Eastman, & Cheung (1994) found matching clients and therapists on the basis of ethnic background was associated with positive outcomes following youth and family-based treatment. Furthermore, Halliday-Boykins et al. (2005) found that in MST, young people whose caregivers were ethnically matched with the therapist demonstrated more positive outcomes and increased likelihood of discharge for meeting treatment goals. However, in both studies, non-random assignment to matched therapists leaves open the possibility that other factors accounted for the significant findings. Karlsson (2005) argues that empirical support for ethnic matching is, at best, inconclusive and lacks a foundation of rigorous research designs.

Turner and Bhugra (2011) argue that differences in ethnic and cultural backgrounds can influence the therapeutic relationship in subtle ways, which therapists need to be aware of. Zane et al. (2004) stress that when working with clients from minority ethnic groups, therapists need to be culturally-sensitive, and cultural competence has been suggested as one way of achieving this. Lo and Fung (2003) define cultural competence as an ability to 'perform and obtain positive clinical outcomes in cross-cultural encounters' (p.162), which Sue (1998) suggests involves a good knowledge and understanding of the cultural group the client is from, and an ability to know when to generalise and when to individualise - that is recognising when cultural characteristics may be relevant to the client's problems, but to see the client as an individual. Rivett and Street (2003) suggest that knowledge of a culture, might provide the general but never the specifics, and therapists need to proceed tentatively as overplaying or underplaying the role of culture risks entrenching family members deeper in their respective positions. O'Hagan (2001) argues that self-awareness is the most important component in the knowledge base of culturally-competent practice.

4.5. The Emergent Model in the Context of Existing Theory

The emergent model arose from factors young people described as contributed to being able to engage and change in MST. The model of the process of change in MST (Henggeler et al., 2009) has been adapted and revised based on previous studies examining mechanisms of change (Paradisopoulos et al., 2015; Kaur et al., 2015) and provides a rudimentary explanation how change is conceptualised in MST. Bibi et al. (2014) suggested additional factors of engagement and change for consideration when

working with minority ethnic parents. The findings from the current study propose unique, additional factors raised by minority ethnic young people to be included in the model, and suggests that engagement and change be viewed as inter-linking, reciprocal and cyclical processes, in line with other literature (Flaskas, 1997; Shirk et al., 2011). Furthermore, findings from the current study suggest that parent and youth engagement should both be considered as important which has been represented in the model as two separate boxes representing the different needs and perspectives which need to be considered.

Based upon Bibi et al.'s (2014) model, improved family functioning is elaborated with specific information about the mechanisms which underpin this, based upon the amalgamation of Bibi et al. (2014) and the current study's findings. The model presented in this study suggests that working within a safe and trusting relationship, increasing communication within and outside the family and empowering the parent(s) *and* the young person are the mechanisms that enable improved family functioning. In addition to Bibi et al.'s (2014) finding that the therapist working as a cultural broker facilitated change, this study found that the therapist needed to act as a cultural broker in the therapeutic relationship as well, which is incorporated in to this underlying mechanism. 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 parents and young people from minority ethnic backgrounds.

4.6. Critical Review

Representativeness. One of the main criticisms of qualitative research is that it lacks generalisability (Mays & Pope, 1995). As the current study was not able to recruit 10-12 participants, the generalisability of the results could be questioned. However, Charmaz (2014) argues grounded theory's aim is not to develop generalisable theories, rather to construct tentative, theoretical understandings which are situated in time, space, positions and interactions. Furthermore, as outlined in the methods this study aimed to achieve 'theoretical sufficiency', and the author believes that the categories developed explain the data sufficiently, and has verified these categories and the model with a participant. Based on Charmaz's viewpoint, what this study offers, is a contextualised exploration of the unique views of London-based young people from a variety of minority ethnic backgrounds, who had experienced an MST intervention. Thus, this study's findings should be considered within participants' contexts, which are likely to influence their perspectives. For example, this study only recruited young people whose parents' were born outside the European Union in order to capture dual-cultured families, and the issues this raised for young people attempting to engage with MST. All parents/caregivers spoke basic English and the majority had lived in the UK for a significant period of time, therefore these findings might be very different for young people who were first-generation immigrants. Therefore, the experiences represented in the current study constitute a specific group of young people and families. Nevertheless, this study did include families who had dropped-out or not achieved positive outcomes in MST, which added valuable information about the factors which hinder engagement with this specific sub-population.

Therapist perspectives. The findings of this study build upon previous research (Bibi et al., 2014), to add to the picture of process of engagement and change with ethnic minority families, however including MST therapists' perspectives would complete this picture. Burck (2005) highlights that the emphasis in systemic therapy on the therapist's contributions to what is brought forth in therapeutic sessions, should be mirrored in research. This reflects Charmaz's (2014) assertions about the ways the relationship between the researcher and the research participants affect the 'production' of the research material. Thus, with the voices of minority ethnic caregivers and young people now represented, the voice which is missing is that of the therapists, which in systemic interventions is no less fundamental to processes of engagement and change. The instrumental role of the MST therapist is echoed by Henggeler and Schoenwald (1998) in their supervisory manual when they describe practitioner-level reasons for low engagement with families.

Interviews. Numerous factors can influence the information disclosed in a research interview. Fisher et al. (2002) highlight that cultural values and traditions can influence the extent to which children and their guardians believe it is appropriate to disclose information to mental health practitioners and researchers. Although measures were taken to reassure participants about confidentiality, this may have impacted on the data received (Rapley, 2001).

4.7. Implications for Clinical Practice

Minority ethnic young peoples' accounts of MST and the factors which facilitated or hindered engagement and change has highlighted clinically relevant information which may be useful for clinicians in their clinical practice.

This study found that young people can be actively involved in MST sessions, and value both family and one-to-one sessions with the therapist. For some young people, sessions with the therapist contributed to: a different and more positive perception of services generally, a better understanding of themselves and their difficulties, and feeling empowered to make positive changes. This highlights the importance of encouraging young people to actively engage with the therapist and the therapeutic process, alongside their caregivers. This recommendation is echoed in NICE guidelines for the treatment, management and prevention of antisocial personality disorder, which suggests that professionals working with young people with ASB should balance the developing autonomy of young people with the responsibility of caregivers when developing an intervention (NICE, 2009).

The ability to work sensitively with cultural diversity emerged as a key factor in the engagement and change process. MST therapists from ethnic or cultural minorities were identified by young people as potentially being more helpful in facilitating engagement and bringing about change. As 'matching' therapists and families may not always be possible, it may be helpful for MST services to provide training for therapists on culturally-salient issues and ways of addressing these sensitively and appropriately with

a family. A further implication may be for MST services to produce guidelines for therapists when working with families who are culturally different to themselves. Some of the ideas from this study include; addressing the therapists own culture and the family's views on this, considering that the young person might have their own cultural identity which can be explored and potentially conveyed to the parents, and being open to conversations around marginalisation, racism, discrimination and other unique experiences which contribute to a family's presentation. Support will be required for therapists addressing these kinds of issues, and supervision and consultation from knowledgeable supervisors and experts is essential. Whilst cultural considerations have been highlighted as important, it is pertinent to acknowledge that individuals place themselves on the spectrum of culture, and one cannot make assumptions that because a family is from a different cultural background, that this is the most salient issue.

Participants described a fluid kind of engagement process in this study, suggesting that for young people in MST, and potentially more so for minority ethnic young people, engagement is more tentative and can vary throughout the entire MST intervention. Therefore, from this study the engagement process is not viewed as a precursory process to change, but rather an ongoing, reciprocal and cyclical process. Such findings have important implications for the therapeutic intervention of MST, where ideally the therapist will be attuned to, and attending to, positive engagement throughout the intervention. Based on the findings of this study, it may be helpful to incorporate the process of engagement in to the MST model of change, in a way which facilitates the understanding of this as reciprocal and ongoing process within MST. The conceptualisation of engagement as an ongoing process, instrumental to change

throughout MST, may be linked to cultural difference. Engaging with MST in the context of ambivalence and cultural mistrust may make the entire process of an MST intervention tentative and fragile. Therefore, when there is greater cultural difference, it may be beneficial to allow more time for engagement and be attuned to, and attend to, issues around engagement with individual family members throughout the intervention.

4.8. Implications for future research

As mentioned above this study generates ideas for future research, including extending this study to explore the views of MST therapists who have worked with minority ethnic families. Systemic theory and literature indicates that the therapist is no less fundamental to the engagement and change process than the family or the young person and so this would provide a more complete picture of this process.

This study was carried out across three London MST sites. Patterns of migration and ethnic diversity are different in other cities in the UK, and in other countries around the world. This study could be extended by exploring the experiences of minority ethnic groups with MST outside of London, as well as with first-generation immigrants and non-English speakers. Furthermore, as this sample was composed of a collection of participants from different parts of the world, further studies exploring the experiences of families from specific ethnic backgrounds would be informative.

The study highlighted that young people from minority ethnic backgrounds develop cultural and religious identities, which are a blend of their parents and the UK culture. Further research examining the implications of this for young people, how this links to antisocial and vulnerable behaviour, how marginalisation impacts on identity

development and how clinicians can best support young people with identity development might be helpful in exploring this in more depth.

A recommendation of this study was training for MST therapists on culturally-salient issues, and how to discuss these with families. A follow-on quantitative study to test out the effectiveness of this training might be useful. For example, a study examining positive outcomes and retention in MST for minority ethnic families before training, and one-year post-training across a number of MST services.

4.9. Personal Reflections

Engaging in this research process brought with it the challenge of adding the new role of researcher, on top of trainee clinical psychologist. Alongside my own social and cultural background, I acknowledged that my role as trainee clinical psychologist would influence my researcher role, and indeed during interviews I had to manage my inclination to engage in a therapeutic style, which can be somewhat interpretative. At times I felt sadness related to some young peoples' difficult experiences, but also a great deal of admiration because of their resilience. It was difficult at times to be a researcher with the agenda of exploring certain experiences in a time-limited interview, where some emotions were still raw. This was particularly salient for one participant, who given that his father was in his country of origin throughout the MST intervention, did not see his South-Pacific culture as having much impact on his experiences, and spoke mostly about his experiences of the mental health system and various diagnostic labels. Clearly these were important experiences, but given the focus and time-limited nature of the interview, I felt a pressure to guide answers back to specific questions about culture.

Given the nature of this study, I often reflected on similarities and differences between the participants and myself, and the impact these might have had on data collection and analysis. Given the difference in my own ethnic and cultural background, and those of the young people interviewed, I often wondered how participants felt about sharing their experiences with me. The second participant had spoken about feeling misunderstood by white MST practitioners and I initially wondered if ethnicity may be a barrier to participants sharing their experiences of culture, in a somewhat discriminatory and marginalised society. I was able to monitor this through the use of the reflexive journal and peer supervision. I became aware of my own reservations about discussing culturally-sensitive topics, and 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. Dwyer and Buckle (2009) suggest that being a member of the group you are studying, can promote acceptance and trust. Despite the participants recognising that I was from the UK, albeit from an area of the UK which has experienced discrimination and stigma in the recent past, I found them to be very open and enthusiastic to take part. There are also arguments against being an 'insider' (being a member of the group you are studying) with objectivity being questioned (Kanuha, 2000). I had my own assumptions at the beginning of the research and I reflected on their potential impact using my research diary. However, being an 'outsider' and not having a great knowledge of living within a dual-cultured family, meant I was very open to any possibilities when collecting and analysing my data.

4.10. Strengths of the study and conclusions

Despite some limitations, this study attempts to make a unique contribution to the MST literature regarding processes of engagement and change for minority ethnic young people. A strength of this study was that it addressed a specific gap in the existing literature by recruiting young people who had dropped-out, or completed MST, and whose parents were born outside the European Union. Whilst many studies have examined processes of change, only one has explored processes of engagement and change which focused on minority ethnic caregivers' experiences of MST.

This study illustrates the importance of young peoples' involvement in the MST process, both for familial change and for the young persons' psychological distress and experience of services. The study also draws attention to the specific mechanisms that are thought to underlie the engagement process, including understanding and addressing a family's views on outside help based in culture, and the importance of the therapist's role in considering, not only cultural difference within the family, but differences between the therapist and the family as well. The study points to the complexity of the engagement process for minority ethnic young people, including the fragility of this engagement. 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 unique factors facilitating engagement and change with MST, and also to adapt the model to include engagement, but as an ongoing and reciprocal process with change. 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 illuminates the importance of cultural sensitivity and the recognition of universal similarities in addition to difference, and the value of preserving and maintaining fidelity to the core elements of MST. It is hoped that the findings of the present study add to the MST evidence-base and enriches the clinical work of MST therapists working with minority ethnic young people and their families.

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Appendices

Appendix A: Extracts from the researcher's reflexive journal

The researcher kept a reflective journal throughout the research process to capture thoughts, process ideas and reflect on assumptions and values. Charmaz (2014) advocates the use of reflexivity, and defines it as “the researcher’s scrutiny of his or her research experience, decisions and interpretations in ways that bring him or her into the process. Reflexivity includes examining how the researcher’s interests, positions and assumptions influenced his or her inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports” (p.344).

20.11.15

I spoke with one of my field supervisors today to review my interviewing style after interviewing my first participant. One important thing she picked up on was differentiating between what ideas, values and experiences were unique to the culture within that particular family, and what ideas, values and experiences were influenced from the parent’s cultural background. I can see that I could have clarified in my first interview the subtle differences between these more. Small details like this are important when trying to understand in what ways culture can influence young people’s engagement and change within MST, and in what ways it does not influence these processes. This will also ensure against any preconceived ideas about cultural beliefs/behaviours being forced upon the data. We also spoke about some adjustments to the interview schedule, including asking questions about parental culture in a more understandable way that would promote young person’s ability to speak about it.

04.12.15

I found myself thinking a lot about the ideas and issues that Aisha raised in the interview I did with her yesterday. Aisha was very articulate about her parent’s culture and her own culture and how the differences in these contributed to her difficulties and MST getting involved, but also how this impacted on her engagement and change within MST. As I was transcribing the interview, I reflected on how misunderstood Aisha described feeling, feeling judged by her parents and at times wider society, and also misunderstood by services (including MST), and what an isolating position this must be for a young person. Reinforcing the idea of how important it can be for young people, particularly from minority ethnic backgrounds, to feel like they are understood by their

MST worker. Feeling understood was something that other young people had referred to in their interviews too. I reflected on my own feelings of being misunderstood as a teenager, and wondered about how these feelings might be amplified by being part of a minority ethnic group living in a society which at times was discriminatory and hostile.

Aisha depicted in rich detail some of the beliefs and values she believed her parents had retained from their culture of origin, in Africa, and how some of these beliefs conflicted with engagement and change within MST. She described in detail the idea of MST, as a form of outside help, being in conflict with cultural narratives around what to do when someone in your family has a problem. Which was an area I identified as wanting to follow up on in future interviews. Aisha also spoke about some of the different ideas of minority ethnic groups for managing antisocial behaviours in young people, for example sending the young person back to country of origin as a solution, which was an idea that I had not previously thought about. I reflected on my own culture and ideas about the roles of parents, and extended family as these appeared to be quite different to some of the families I was meeting. I found it useful to reflect on the potential impact these different perspectives on the role of extended family might have on the kinds of questions I asked and how much weight I placed on the role of extended family.

Aisha spoke articulately about her own values and beliefs, which appeared to be a blend of her parent's culture and the UK culture. She described feeling like she did have morals and a sense of right and wrong, but that her parents did not see this as good enough. I wondered how much of this the MST therapist had been aware of. Based on what Aisha told me, it was clear that this was a conversation that she had not been able to have with the MST therapist. She described her therapist as 'nice', but that she didn't feel understood by them. I got the sense that this became a big obstacle in making changes in this family. This was in stark contrast to Jay, who talked about his therapist helping him make sense of his difficulties and why certain things were harder for him, based on his past. Indeed, a strong and positive working alliance stood out in Jay's interview. Taking time to get to know the young person, and helping them to make sense of themselves (their own culture, values, beliefs and identity) seems to facilitate a positive experience of MST with good outcomes.

18.01.16

I was pleased with today's interview and I feel as though updating my interview schedule for the second time has enabled to ask more relevant questions and gather rich data. Safaa's interview was particularly useful in helping to consider how the therapist' ethnicity and culture can impact on engagement and change in MST. I had not considered this prior to beginning interviews, and so I was struck by how ideas and themes emerge from the data. The idea of having a therapist from a similar background was mentioned by other young people in their interviews, however there were mixed

ideas about whether matching therapists with families based on cultural background would be good or not. Some young people seem to think that therapists from a similar background to themselves would mean that their family were understood more, but voiced concerns that therapists from a similar background to their parents might be susceptible to agreeing with the parents' point of view above the young person's. I was struck by Safaa's ideas about how the MST therapists background might influence on the processes of engagement and change and wondered about how often the therapists background was openly discussed in the early stages of MST and this discussion might facilitate engagement and change for minority ethnic families.

Reflections during coding process

Analysing my initial interviews was in some ways challenging. Whilst Charmaz's (2014) recommendations were useful, I was still unsure about whether I was coding properly. To combat some of these concerns, some of my fellow trainees and I began a group meeting to discuss tips for coding and coding anonymous excerpts of each other's interview transcripts. At first, it was difficult to strike the right balance between simply describing the data, and conceptualising it. However, through constantly reviewing my previous codes as the research progressed I became increasingly more familiar with and confident in the coding process.

Following coding my first few interviews, I remember feeling surprised by how naturally participant's ideas and experiences emerged from the data, as I followed the grounded theory analysis procedure. However, the number of initial codes and focused codes I generated left me feeling overwhelmed but through the process of collecting and analysing data, for example constantly comparing codes between and within interviews, I was able to consolidate emerging focused codes. Following this, there was a sense of confusion around which focused codes 'should be' raised to theoretical categories. My research supervisor was invaluable in helping me to take a step back from the data, and focusing on what experiences the participants were highlighting through the data as being important to them and some of the unique experiences relating to culture.

During the construction of theoretical categories and the emergent model, I struggled with how to present the analysis in a way which showed the interconnectedness of the categories of engagement and change. There was a lot of overlap between some of the categories, and many of them contributed to engagement and facilitated change. Circular shapes seemed appropriate to represent the interconnectedness and cyclical, reciprocal nature of engagement and change processes.

Appendix B: Participant Information Sheet (16 years and over)

Participant Information Sheet (16 years and over), Version 2 19.05.15

Title: Processes of Engagement and Change in Multisystemic Therapy for Young People from Minority Ethnic Backgrounds

Invitation and brief Summary

My name is Aisling Bunting and I am a Trainee Clinical Psychologist at Royal Holloway, University of London. I am doing a study for my doctoral research project and I am interested in following up young people from Minority Ethnic backgrounds that had Multisystemic Therapy (MST) and finding out about their experience of this.

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. Please ask 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.

What's involved?

Explanation: purpose of and background to the research and invitation

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

I will be interviewing 10-12 young people who have had experience of MST. From this, I hope to develop an understanding of your experience of what processes helped and hindered engagement and change within MST. I hope this may help other therapists and MST teams working with families to understand the issues which might impact on minority ethnic young people, whose family are taking part in MST.

Why have I been chosen?

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

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, one-to-one, about your experiences of MST, how appropriate you felt the treatment was in addressing 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 your 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.

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 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 are the possible disadvantages and risks 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 benefits of taking part?

There may be no direct benefits of taking part in this study, however, this research project will allow you to have time and space to reflect on your experiences. Potentially, this study should help researchers and practitioners in the future to understand issues that may impact on other young people from Minority Ethnic backgrounds who are receiving MST.

If I do take part what happens to my information?

All the information you give will stay confidential. This means we will only tell those who have a need or right to know. The audio-taped recording of our discussion will be stored securely and will only be listened to by the researchers involved in this study. Any specific thoughts or views you have about the MST project will not be disclosed to your individual MST therapist.

However, if in the course of our discussions, we learn that someone is seriously planning to harm another or themselves, or commit criminal damage then we would need to inform the relevant site supervisor (either Dr Amaryllis Holland at the ----- MST site, or Dr Jai Shree Adhyaru at the ----- MST site). However, this will be discussed with you first to explain the reasons and the process.

Reporting the findings of the study

A report will be written about the findings of this study. In that report, the results will be presented in such a way that no one can identify you, your family or know that you participated. In other words, we can guarantee that information about you will be anonymous, because we will talk about groups not individuals.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the London – City Road & Hampstead Research Ethics Committee.

Expenses

You will be offered a £10 gift voucher as a thank you for taking time to talk to me. Any travel expenses to the amount of £5 will be covered.

Further information and contact details

If you would like to take part in this study, I will be in touch within the next week, to answer any further questions you may have, and to arrange a time for us to meet. My contact details are outlined below. If you have any worries about any part of this study, you should ask to speak to the researcher. Alternatively, you can contact the Academic Research Supervisor, Dr Simone Fox, or the site supervisors Amaryllis Holland and Jai Shree Adhyaru.

Appendix C: Participant Information Sheet (under 16 years)

Participant Information Sheet (under 16 years), Version 1 05.03.15

Processes of Engagement and Change in Multisystemic Therapy for Young people from Minority Ethnic Backgrounds

My name is Aisling Bunting and I am studying to be a psychologist. As part of my training, I am doing a project for my course.

I would really like to hear about your experience of Multisystemic Therapy and what you think helped or didn't help you and your family.



Our talk would be private and will be at your home. I will not tell your teachers or your family what you say.



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



You can ask for the interview to stop at any time. It will take no longer than one hour and will be recorded.



You can say yes or no. It is up to you whether you take part.



If you do decide to take part you may become a bit upset by some of the things that we talk about. If this happens you can take a break or stop the interview.



If you do want to take part, please ask someone to help you read the form. If you would like to talk to me, I would be very grateful if you could sign the attached form.



I will telephone you soon, to ask if you have any questions about the project. Then we can arrange a time to meet and talk about your experience of MST.



Thank you for taking the time to read this letter and for your help.



Yours sincerely

Aisling Bunting

Appendix D: Parent/Guardian Information Sheet

Parent/Guardian Information Sheet, Version 2 19.05.15

Title: Processes of Engagement and Change in Multisystemic Therapy for Young People from Minority Ethnic Backgrounds

Invitation and Brief Summary

My name is Aisling Bunting and I am a Trainee Clinical Psychologist at Royal Holloway, University of London. I am doing a study for my doctoral research project and I am interested in following up young people from Minority Ethnic backgrounds that had Multisystemic Therapy (MST) and finding out about their experience of this.

Your child is being invited to take part in a research study. Before you decide whether you want to give consent for them 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. Please ask if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish your child to take part.

Explanation: purpose of and background to the research and invitation

I am interested in finding out about your child's experience of MST, how well suited your child found MST to their specific cultural and/or religious beliefs, and what MST-related factors, and other factors, your child felt impacted on engagement and change within MST.

I will be interviewing 10-12 young people who have had experience of MST. From this, I hope to develop an understanding of your child's experience of what processes helped and hindered engagement and change within MST. I hope this may help other therapists and MST teams working with families to understand the issues which might impact on minority ethnic young people whose family are taking part in MST.

Why has my child been chosen?

Your child has been invited to take part in the study because your family took part in Multisystemic therapy and your child is from a Minority Ethnic background.

What will happen to my child if they take part?

If you and your child both agree that your child would like for to participate, your son or daughter 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 your child talking to the researcher, one-to-one, about their experiences of MST, how appropriate they felt the treatment was in addressing your family's specific cultural and or religious needs, and what they felt the advantages and disadvantages of this treatment were. They will also be asked to complete a short questionnaire asking about their ethnicity, religious beliefs, age and gender. If you and your child consent, you may be contacted at a later date to ask if your child wishes to comment on the research findings. You and your child are able to decline this offer without giving a reason.

Does my child have to take part?

No. It is entirely up to you and your child to decide whether or not to take part. If you, or your child, 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 or your child to change your minds. If you decide to give consent, but your child does not, then we will not continue with the research project, as we wish for both you and your child to feel comfortable taking part. If you do decide to give consent for your child 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. Your child will also be given their own copy of an age-appropriate information sheet to keep and will sign a separate form recording their consent as well. If you and your child do decide to take part, you are both still free to withdraw at any time without giving a reason. Your son/daughter's care will not be affected if you or your child do not wish to participate, or if either of you decide to withdraw from the study at any point.

What are the possible disadvantages and risks of taking part?

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

What are the possible benefits of taking part?

There may be no direct benefits of taking part in this study, however, this research project will allow your child to have time and space to reflect on their experiences. Potentially, this study should help researchers and practitioners in the future to understand issues that may impact on other young people from Minority Ethnic backgrounds who are receiving MST.

If I agree for my child and I to take part what happens to our information?

All the information your child gives will stay confidential. This means we will only tell those who have a need or right to know. The audio-taped recording of our discussion will be stored securely and will only be listened to by the researchers involved in this study. Any specific thoughts or views you have about the MST project will not be disclosed to your individual MST therapist.

However, if in the course of our discussions, we learn that someone is seriously planning to harm another or themselves, or commit criminal damage then we would need to inform the relevant site supervisor (either Dr Amaryllis Holland at the ----- MST site, or Dr Jai Shree Adhyaru at the ----- MST site). However, this will be discussed with you and your child first to explain the reasons and the process.

Reporting the findings of the study

A report will be written about the findings of this study. In that report the results will be presented in such a way that no one can identify your child, your family or know that you participated. In other words, we can guarantee that information about you will be anonymous, because we will talk about groups not individuals.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the London – City Road & Hampstead Research Ethics Committee.

Expenses

Your child will be offered a £10 gift voucher, as a thank you for taking time to talk to me. Any travel expenses to the amount of £5 will be covered.

Further information and contact details

If you would like to take part in this study, I will be in touch within the next week, to answer any further questions you may have, and to arrange a time for us to meet. My contact details are outlined below. If you have any worries about any part of this study, you should ask to speak to the researcher. Alternatively, you can contact the Academic Research Supervisor, Dr Simone Fox, or the site supervisors Amaryllis Holland and Jai Shree Adhyaru.

Appendix E: Letter of ethical approval from NHS Research Ethics Committee (REC)



Level 3, Block B
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BS1 2NT

Email: nrescommittee.london-cityroadandhampstead@nhs.net

Tel: 0117 342 1339

29 May 2015

Ms Aisling Bunting
Department of Clinical Psychology
Royal Holloway, University of London
John Bowyer Building,
Egham Hill, Egham
Surrey
TW20 0EX

Dear Ms Bunting

Study title: Mechanisms of engagement and change for minority ethnic young people in multisystemic therapy.
REC reference: 15/LO/0594
IRAS project ID: 173932

Thank you for your letter of 19 May 2015, 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 Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Maeve Groot Blumink, nrescommittee.london-cityroadandhampstead@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

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.

Conditions of the favourable opinion

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 8 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

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).

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).

Approved documents

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

Document	Version	Date
Covering letter on headed paper [Covering Letter. Responses to Research Ethics Committee Provisional Approval. 19th May 2015]	1	19 May 2015
Evidence of Sponsor Insurance or Indemnity (non NHS Sponsors only) [Evidence of Sponsor Insurance or Indemnity]	1	01 August 2014
Interview schedules or topic guides for participants [Interview Schedule]	1	10 March 2015
Interview schedules or topic guides for participants [Interview Schedule]	2	19 May 2015
Interview schedules or topic guides for participants [Interview Schedule, Version 2, 19th May 2015. Tracked Changes]	2	19 May 2015
IRAS Checklist XML [Checklist_26032015]		26 March 2015
IRAS Checklist XML [Checklist_20052015]		20 May 2015
Non-validated questionnaire [Demographic Information Sheet. Version 1]	1	10 March 2015
Other [Summary of Discussion, with amendments. 19th May 2015]	1	19 May 2015
Participant consent form [Consent Form Parent Guardian. Version 1]	1	05 March 2015
Participant consent form [Consent Form Participants 16 years+. Version 1]	1	05 March 2015
Participant consent form [Consent Form Participants under 16 years. Version 1]	1	05 March 2015
Participant consent form [Consent Form Parent Guardian. Version 1]	2	19 May 2015
Participant consent form [Consent Form Parent Guardian. Version 2. 19th May 2015. Tracked Changes]	2	19 May 2015
Participant consent form [Consent Form Participants 16 years+. Version 1]	2	19 May 2015
Participant consent form [Consent Form Participants 16 years+. Version 2, 19th May 2015. Tracked Changes]	2	19 May 2015
Participant information sheet (PIS) [Information Sheet Parent Guardian. Version 1]	1	05 March 2015
Participant information sheet (PIS) [Information Sheet Participants 16 years and over. Version 1]	1	05 March 2015
Participant information sheet (PIS) [Information Sheet Participants under 16 years. Version 1]	1	05 March 2015
Participant information sheet (PIS) [Information Sheet Parent Guardian. Version 1]	2	19 May 2015
Participant information sheet (PIS) [Information Sheet Parent Guardian. Version 2. Tracked Changes]	2	19 May 2015

Participant information sheet (PIS) [Information Sheet Participants 16 years and over. Version 1]	2	19 May 2015
Participant information sheet (PIS) [Information Sheet Participants 16 years and over. Version 2, Tracked Changes]	2	19 May 2015
REC Application Form [REC_Form_18032015]		18 March 2015
Referee's report or other scientific critique report [Research Sub-Committee and Course Executive Approval]	1	27 January 2015
Research protocol or project proposal [Study Protocol]	1	10 March 2015
Summary CV for Chief Investigator (CI) [CV Chief Investigator]	1	
Summary CV for supervisor (student research) [CV Academic Supervisor]	1	

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:

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at

<http://www.hra.nhs.uk/hra-training/>

15/LO/0594

Please quote this number on all correspondence

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

Yours sincerely




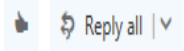
pp
Dr David Slovick
Chair

Email: nrescommittee.london-cityroadandhampstead@nhs.net

Enclosures: "After ethical review – guidance for researchers" [\[SL-AR2\]](#)

Copy to: Mr Gary Brown, University of London

Appendix F: Email of ethical approval from Royal Holloway University of London (RHUL) Departmental Ethics Committee (DEC)

 psychology.it.support@rhul.ac.uk  20/08/2015

To: pava048@rhul.ac.uk; Fox, Simone; Cc: PSY-EthicsAdmin@rhul.ac.uk; Zagefka, Hanna; Lock, Annette; uqjt005@rhul.ac.uk; ↕

Thesis

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

Applicant Name: **Aisling Bunting**

Application title: **Change Mechanisms for Minority Ethnic Youth in Multisystemic Therapy**

Comments: Approved.

Appendix G: Letters of approval from Research and Development (R&D)

Mental Health NHS Trust

Ms Aisling Bunting
Department of Clinical Psychology
Royal Holloway, University of London
John Bowyer Building
Egham Hill
Egham
Surrey TW20 0EX

01 July 2015

Dear Ms Bunting,

Research Title: Mechanisms of engagement and change for minority ethnic young people in multisystemic therapy.
Principal Investigator: Ms Aisling Bunting
Project reference: PF629
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 01/07/2015

- 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 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.

Yours sincerely,



Dr Robert Lawrence
Research & Development Director
On behalf of the Research & Development Committee.

Terms and conditions of Approval, version 1.1 01/07/2015

25 September 2015

Miss Aisling Bunting
 Department of Clinical Psychology
 Royal Holloway, University of London
 John Bowyer Building
 Egham Hill, Egham
 Surrey
 TW20 0EX

Dear Aisling Bunting,

This NHS Permission is based on the REC favourable opinion given on **29 May 2015**.

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust identified below:

Study Title: Mechanisms of engagement and change for minority ethnic young people in multi-systemic therapy.		
R&D reference: 173932		
REC reference: 15/LO0594		
Name of the trust	Name of current PIVLC	Date of permission issue(d)
		25 September 2015
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

Specific Conditions of Permission (if applicable)
If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

 Poojesh Joshi
 Research Operations Manager

Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact

May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website: <http://www.crn.nihr.ac.uk/can-help/funders-academics/nihr-crn-portfolio/recruitment-data/>
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment. If your study is Portfolio Adopted, amendments must be submitted for R&D review via the NIHR CRN (CSP), please refer to the Amendments Guidance for Researchers: <http://www.crn.nihr.ac.uk/can-help/funders-academics/gaining-nhs-permissions/amendments/>
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.


23rd March 2016

Re: Processes of engagement and change in MST for minority ethnic young people

Recruitment from the _____ for this study was approved by _____ (Programme Manager and MST supervisor) following discussion with the research supervisor Simone Fox, and a meeting with Aisling Bunting (Researcher).

As Departmental Ethics Committee (DEC) at Royal Holloway University had approved this study, and ethical approval was obtained from NHS Research Ethics Committee (REC), the _____ did not require any further ethical approval.

With best wishes for the success of this study.



Stacey Miller
Project Coordinator

Appendix H: Letter of approval of ethics amendment from NHS REC



London - City Road & Hampstead Research Ethics Committee

Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Tel: (0117) 3421339

08 November 2015

Ms Aisling Bunting
Department of Clinical Psychology
Royal Holloway, University of London
John Bowyer Building,
Egham Hill, Egham
Surrey TW20 0EX

Dear Ms Bunting

Study title: Mechanisms of engagement and change for minority ethnic young people in multisystemic therapy.
REC reference: 15/LO/0594
Amendment number: Substantial amendment dated 27 October 2015
Amendment date: 27 October 2015
IRAS project ID: 173932

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering letter on headed paper [Covering Letter Substantial Amendment]		27 October 2015
Notice of Substantial Amendment (non-CTIMP)		27 October 2015
Research protocol or project proposal [Study Protocol]	1	10 March 2015
Research protocol or project proposal [Study Protocol]	2	27 October 2015

A Research Ethics Committee established by the Health Research Authority

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

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.

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/>

15/LO/0594: Please quote this number on all correspondence
--

Yours sincerely



PP Dr David Slovic - Chair

E-mail: nrescommittee.london-cityroadandhampstead@nhs.net

London - City Road & Hampstead Research Ethics Committee

Attendance at Sub-Committee of the REC meeting in correspondence

Committee Members:

Name	Profession	Present	Notes
Dr Koula Asimakopoulou	Reader In Health Psychology	Yes	
Mr David Burbidge	Communications/Marketing Development Officer (Retired)	Yes	
Professor Diana Kombrot	Professor of Mathematical Psychology	Yes	

Also in attendance:

Name	Position (or reason for attending)
Mr Wai Yeung	REC Assistant

Appendix I: Email approval of ethics amendment from RHUL DEC

2015/091R4 Ethics Form Approved



psychology.it.support@rhul.ac.uk

To: pava048@rhul.ac.uk; Fox, Simone; Cc: PSY-EthicsAdmin@rhul.ac.uk; Zagefka, Hanna; Lock, Annette; uqjr005@rhul.ac.uk; ↕



Reply all | ▾

13/01/2016

Inbox

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

Applicant Name: **Aisling Bunting**

Application title: **Change Mechanisms for Minority Ethnic Youth in Multisystemic Therapy**

Comments: **Approved.**

The chair's decision is based on comments from the first reviewer, because the second reviewer did not process the application within a reasonable time frame.

Appendix J: Participant demographic information sheet

Demographic Information Sheet



Participant number:

Date of Completion:

GENDER: MALE FEMALE

DATE OF BIRTH: _____

ENROLLED IN EDUCATION: Full-time Part-time

ATTENDANCE: < 50% < 80% Not Attending

EMPLOYMENT: Full-time Part-time Unemployed:

LIVING AT HOME: Yes No Sometimes

PERSONS LIVING WITH: _____

(mum/dad/stepmum/stepdad/grandmother/grandfather/aunt/uncle/relative/friend)

NUMBER OF SIBLINGS LIVING AT HOME:

NUMBER OF CONVICTIONS SINCE MST: 0 1 – 5 5+

PARENT(S) COUNTRY OF ORIGIN:

PARENT(S) ETHNICITY:

PARENT(S) RELIGION: (Practicing?)

NUMBER OF YEARS IN UK: 0-5 6-10 11-15 16-20 >20

YOUNG PERSON ETHNICITY:

YOUNG PERSON RELIGION: (Practicing?)

PARENT(S) SPEAK ENGLISH?

LANGUAGE SPOKEN AT HOME:

TIME SINCE MST TREATMENT:

THERAPIST ETHNICITY:

THERAPIST GENDER: MALE FEMALE

Appendix K: Participant consent form (over 16 years)

Participant Consent Form 16 years and over

Title: Processes of Engagement and Change in Multisystemic Therapy for young people from Minority Ethnic Backgrounds

Researcher: Aisling Bunting

Please initial box:

1. I have read the information sheet which describes this study.
2. I have had an opportunity to ask questions and discuss this study.
3. I have received satisfactory answers to all my questions.
4. 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.
5. I agree for my information to be shared with authorised people from Royal Holloway University and understand that all my personal data is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).
6. I understand that the interview will be audio-recorded.
7. I have read and understood the limits of confidentiality regarding risk.
8. I agree to being contacted for comments on the findings of the study.
9. I agree for anonymised quotes from my interview to be used in publications.
10. I agree to take part in this study.

Name of young person

Signed

Date

Researcher

Signed

Date

Appendix L: Participant consent form (under 16 years)

**Participant Consent Form – Under 16 years
Processes of Engagement and Change in Multisystemic Therapy for
Young People from a Minority Ethnic Background**

If I talk to Aisling about her project:

- I understand that the interview will be recorded.



- I understand that the interview will be private.
- I understand that I can stop the interview at any time.



If you understand the statements above, you now need to decide whether you would like to take part in the project.

I have decided that I would like to talk to Aisling about her project.

Please put a circle round No or Yes.



No



Yes

Signed.....

Please print your name.....

The researcher also needs to sign the form

Researcher's signature.....

Researcher's name.....

Appendix M: Parent/Guardian consent form

Consent Form – Parent / Guardian

Title: Processes of Engagement and Change in Multisystemic Therapy for young people from Minority Ethnic Backgrounds

Researcher: Aisling Bunting

Please initial box:

1. I have read the information sheet which describes this study.
2. I have had an opportunity to ask questions and discuss this study.
3. I have received satisfactory answers to all my questions.
4. I understand that my child's participation is voluntary and I am free to withdraw my child at any time, without giving a reason and without my child's care or rights being affected.
5. I agree for my child's information to be shared with authorised people from Royal Holloway University and understand that all personal data relating to my child is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).
6. I understand that the interview will be audio-recorded.
7. I have read and understood the remits of confidentiality regarding risk.
8. I agree to my child being contacted for their comments on the findings of the study.
9. I agree for anonymised quotes from my child's interview to be used in publications.
10. I agree for my child to take part in this study.

Name of Child

Name of parent/guardian

Signed

Date

Researcher

Signed

Date

Appendix N: Final interview schedule

General background information: Family Structure and Culture

How would you describe your family to someone?

Do you think of yourself as _____? Is this important to you?

When did your parents first come to the UK? (What was it like for you when you first came here?)

How would you describe your cultural background?

PROMPT: What beliefs and values are important to you?

How would you describe your family's cultural background?

PROMPT: What beliefs and values are important to them? (E.g. *Traditional, religious?*)

Are there differences in these beliefs and yours?

What is it like to live in a family with two cultures? Was it part of your difficulties?

Can you tell me about the main differences between your culture and the British culture?

PROMPTS: What is the impact of this on your family and you? Are there any differences in how young people behave in the UK and how people behave where your parent's come from? Would there be different consequences? How do parents view their children there? *Different to here?* How do children view their parents there? *Different to here?*

Reasons for involvement in MST

How did you come to be involved in MST?

PROMPTS: What were your ideas about why the difficulties began?

What are your ideas about how the difficulties kept going?

What were your parents ideas about why the difficulties began? What were your parents ideas about what kept the difficulties going?

Were the therapists ideas different to you parents ideas? Your ideas? *If the therapist had similar ideas to you how would this have changed things?*

Engagement in MST

What were your initial thoughts about MST before starting? (*Did you have any concerns?*)

How willing were you to take part at the start?

PROMPTS: Did you have a choice? What made you decide to give it a chance?

What do you think made your parent(s) decide to take part in MST?

At the start did anything about MST make you think; 1) No I don't want to do this or 2) This will be hard for my family.

Cultural Aspects of Engagement

Did your therapist talk about culture (important beliefs/values/religious or traditional) at the beginning of MST? [Parents/yours and British?]

Were cultural differences between you, your parents and the therapist talked about before taking part in MST?

Yes/No: How did you feel about this? How did your parent(s) feel about this?

Would you have liked/did you like the MST therapist to thinking about your background and your family background?

PROMPTS: What would have been different if they had/hadn't?

Do you think cultural factors impacted beginning MST?

Cultural appropriateness of MST

Did MST fit with you and your family?

PROMPTS: How did it fit with your cultural values/beliefs and your religious values/beliefs? How did it fit with your parents values and beliefs?

Thinking about MST ideas, strategies (brief reminder, if necessary) how did these fit with your beliefs and values? What about fitting MST ideas with your parents beliefs?

How did you manage any cultural/religious beliefs that that did not match/fit with MST ideas for you/your parents throughout? Examples??

Do you feel like you had to adapt or change any of your beliefs to work with the MST model? How much do you think your parents had to alter their beliefs to work with the MST model? What was that like for you/them?

How would your community (friends/family from a similar cultural background) view this type of treatment?

PROMPTS: Would they have different/other ideas about the help/interventions for your difficulties? How might this differ? Do you think it is helpful to have others involved?

How did you manage sharing that you were involved in this treatment with members of your extended family and/or community, if there are any?

Culture and the MST therapist

Did the therapist take into account specific cultural and/or religious beliefs that you have?

PROMPTS: Do you think this was similar for your family/parent(s)? Do you feel that you were understood or not - why? Do you think this had an effect on change?

Did the therapist help you to manage cultural difference in the family? How?

Did the therapist talk about their own cultural beliefs and how this might impact MST?

What are your thoughts about the therapist's culture ethnicity and impact on the work you did together?

What are your thoughts about matching families with therapist from similar backgrounds?

PROMPTS: Is this something you would choose if you had a choice?

How would you describe the relationship with therapist/what words would you use?

Process of change

Can you tell me about any changes, if any, you noticed throughout MST?

PROMPTS: Since finishing MST? What would your parents say?

What do you feel brought about these changes?

PROMPTS: Anything else? What would your parent(s) say?

What part of MST do you think helped change you, your family the most?

PROMPTS: What did the therapist do that brought about change?

Was culture considered throughout treatment?

PROMPTS: What did the therapist do in relation to culture? 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?

Experience of MST

What was it like to be involved in MST?

What is your experience of MST? Do you think MST is a good idea? Would you recommend it?

What was it like talking to me today?

Appendix O: Memo examples

Memo- Considering cultural difference -01.02.16

Young people have talked in detail about how they came to engage with MST, there seems to be variation in how important it is for the therapist to address cultural difference for different young people.

"I was brought up here and, I don't know any different to what I know from here."

The theme of feeling understood was raised in all young peoples' stories of MST, and if a young person sees culture as contributing to their family difficulties, then this being discussed is important to their sense of feeling understood. Feeling understood was described as being important for whether or not participants continued to engage with MST or not.

R: "Do you feel like you were understood by the MST therapist – like you, not your family?"

I: No way...no...I didn't think they would have understood...cause I didn't really like tell him about my culture...so I don't know if he would have understood...so yeah... I don't know...even if I was understood...it wouldn't have made a difference...so I don't know..."

Feeling misunderstood appeared to lead to feelings of hopelessness and the young people disengaging from MST. Therapists being curious about the young person's cultural identity was identified as being important, as it took in to account the cultural differences in the family, helping the young person to feel understood. The initial codes of 'therapist considering cultural difference between parent and young person' and 'being curious about the young person's cultural identity' could be subsumed in to a broader focused code that relates to 'Considering Cultural Differences' as it was these processes that seemed to help a therapist understand cultural difference, which for families contributed to their willingness and commitment to engage.

Memo to guide theoretical sampling (informing changes made to interview schedule): asking about the acceptability of outside help

Aisha spoke about the differences between her parents' ideas about how acceptable outside help is and her own ideas. She described distinctions between western culture, which she perceives as being more accepting of people intervening in the family when there are problems, and her parents' culture of origin, who she describes as seeing 'fixing' problem behaviours as the role of the family.

"in my culture...you're not really supposed to say ...like reach out to someone if you have a problem...like with your family..."

She described feeling like when she sought help, she was reaching out for help when things were not working at home, whereas her parents' perceived this as something she did to 'get them in trouble', based on their cultural beliefs about outside help. She also described the views of some of her extended family around having services involved and the shame associated with this. She also described some of the alternative ideas suggested by her extended family for how to manage her behaviour, including being sent back to her parents' country of origin. Further questions around the acceptability of outside help will be included in to the interview schedule.

Memo to guide theoretical sampling (informing changes made to interview schedule): asking about differences in young people's behaviour in the UK and the parents' country of origin

There was a distinct variation in participants' accounts of the perceived differences between the UK culture and their parents' culture. One young person, described perceiving there to be relatively little difference between her parents' culture and the UK, but then went on to discuss many of these differences, such as opposing ideas about having friends of the opposite sex, and strength of religious conviction. Some young people, appeared to struggle with the conceptualisation of the word 'culture' and struggled to answer when asked about the cultural differences between them and their parents. They seemed to require specific and concrete questions to elicit differences in culture between the UK and their parents' country of origin. Questions which elicit some of the differences in expectations of young people's behaviour, differences in consequences for young people's behaviour and differences in solutions for problem behaviours will be included, in order to facilitate young peoples' thinking around the differences in UK culture and parents' culture of origin. This was thought to make questions more understandable, thereby encouraging more reflection on whether dual-culture had an impact on engagement and change within MST.

Understanding and respecting culture (raising a focused code to a theoretical category) to understanding family culture at engagement.

From young peoples' narratives the therapist understanding the family's culture, and the differences in culture for different family members emerged as being important in both engaging with, and bringing about change in, MST. In particular, if the therapist was from the majority culture (White British) it appeared to be important for the therapist to acknowledge these differences, validate any concerns the family had around these differences in cultural background and be curious and open to the family's cultural practices and ideas, ensuring that the parents and young people didn't feel like they're culture was being judged. Young people also described the importance of the therapist being knowledgeable about different cultures, the issues faced by minority ethnic groups (e.g. discrimination and racism) and the difficulties arising from living in a dual-cultured household. Young people described that the therapist being curious and asking

questions about the family's culture, and differences between family members whilst holding a neutral position could facilitate perspective taking on both the young person and parents side.

Differences in views on the acceptability of outside services, coming in to the family stood out as being an important factor in how easily young people and their family engaged with MST. These different views could be based in cultural beliefs around the role of the family and how family members deal with problems. The MST therapist understanding these differences in ideas about the acceptability of outside help, and how these might be different for different members of the family appeared to be a factor influencing engagement. One young person described that to get her family on board with MST might take longer because of these differences in beliefs. There was a sense that therapists needed to know when to individualise and when to generalise, such that, the MST therapist needed to spend time getting to know the family's culture - understanding what beliefs and values were unique to the family and different individuals and what beliefs and values came from culture. This aided the therapist in taking a culturally sensitive approach to exploring beliefs and values in a respectful and appropriate way, facilitating increased perspective-taking and subsequently less 'stuck' family interactions.

Appendix P: Transcript and coding sample

Transcript	Initial Coding	Focused Coding
<p>Did the MST therapist talk about culture? Like beliefs, values or religion? At the start? Yeah...</p> <p>What did they talk about? Like...like, we would talk about...how I would think about it and, like, compared to what they think about it...and they'd try to explain to them, that like I was brought up here and, I don't know any different to what I know from here. So it will try and like sort it out kind of...</p> <p>Yeah...and how was that? It didn't really work...</p> <p>Why do you think that is? Cause I think...that my parents feel like...not in a rude way but like if you're coming in to, like, the family...not the family...but the house...and like, if someone knows something, through like so many years...you can't just change it by like just coming in...for a few meetings. Cause you're not there for like the real life...not like when the real life starts... but when they routine starts...the person is like...the therapist is obviously like, not here to see like certain things...and in a meeting...and I think like when we're not in a meeting...we think about so many things that we need to talk about, or so many things that we need to do...but then when the therapist is here</p>	<p>MST therapist talking about culture in sessions</p> <p>Talking about YP views Talking about parents views Comparing both views Putting YP behaviour in context Seeing where you're brought up as influencing your views Therapist explaining why there may be differences in young person's view (UK context) Trying to sort out differences of opinion between YP and parents</p> <p>Feeling like compromising on different cultural views did not work</p> <p>YP feeling like she might offend researcher</p> <p>Perceiving parents as viewing the therapist 'coming in' to family to change long-held views</p> <p>Perceiving parents finding changing views difficult</p> <p>Therapist not being around for 'real life'</p> <p>Viewing therapist as missing valuable information</p> <p>Not seeing 'certain things'</p> <p>Thinking that outside meetings many things happen which require support</p> <p>Forgetting the important things that have happened when</p>	<p>Therapist comparing differences in cultural beliefs/views</p> <p>Therapist putting YP views/behaviour in UK context</p> <p>YP feeling therapist addressing culture didn't</p> <p>Parents perception of therapist Influencing change</p> <p>YP perception of parents ability to change</p> <p>Therapist getting a different perception of family in meetings</p> <p>Perceiving meetings as not frequent enough</p>

<p>we're like...oh yeah...we forget about it.</p> <p>Do you think that MST fit with your cultural values and beliefs?</p> <p>No...</p> <p>Why do you think that is?</p> <p>Cause...I think like in my culture...like MST stands for so many things and my culture like doesn't stand for those things? Cause like...MST, the reason there is MST is because people have problems...like with culture...in my culture...you're not really supposed to say ...like reach out to someone if you have a problem...like with your family...or like with your daughter...or something...like you try...you try to ...you're the one who's supposed to fix that problem...like it's on you it's your family. You're supposed to fix that problem, you're not supposed to go to somebody else and make them fix that problem for you.</p> <p>How could MST have worked better for your family?</p> <p>I think...if the therapists...had the same ethnicity as the family...if like...someone from my mum...her culture...is telling her something that she's doing from her culture...she'll more think about it than if someone from a different culture, that's judging on her culture is saying...you're doing something wrong...she's like just saying 'no, I'm not doing anything, I know what I'm</p>	<p>therapist is there</p> <p>Thinking MST did not fit with family cultural beliefs</p> <p>MST being at odds with family culture stands for</p> <p>Having MST for family problems Reaching out for help – necessary for MST</p> <p>Thinking it's not acceptable to ask for help in family's culture</p> <p>Trying to fix family problems Being expected to 'fix' family problems within the family</p> <p>Feeling responsible for solution Requiring family to fix themselves</p> <p>Valuing self-sufficiency in the family's culture</p> <p>Thinking parent would listen more to a MST therapist from similar background</p> <p>Parent reflecting more when therapist is from similar background</p> <p>Perceiving therapist from a different culture is 'judging' mother</p> <p>Thinking parent gets defensive of culture when with therapist from a different culture</p> <p>Perceiving parent might feel</p>	<p>MST not fitting with cultural beliefs</p> <p>Acceptability of outside help in different cultures</p> <p>Parents feeling responsible for making change</p> <p>Therapist culture influencing change</p> <p>Parents feeling culture is being judged</p> <p>Parent getting defensive with therapist from different culture</p>
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<p>doing, I'm not doing anything'...but if someone from your culture is saying...that you're doing something wrong...you're like 'oh...wait you're from my culture, you must know about it...so' I should think about what I'm doing...maybe I'll not change it but at least I'll think about...changing...</p>	<p>more understood by therapist of similar culture Seeing parent as having space to reflect on actions/views with therapist of similar background</p> <p>Impacting on change potentially</p>	<p>Thinking parent would reflect more on beliefs/behaviours with therapist from similar background</p>
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