

Schoenwald, S. K., Letourneau, E. J., & Halliday-Boykins, C. (2005). Predicting therapist adherence to a transported family-based treatment for youth. *Journal of Clinical Child and Adolescent Psychology*, 34(4), 658-670.

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Therapeutic adherence, or the delivery of a treatment as it was intended, is an important construct when transporting empirically supported practices from the laboratory to real world settings. The authors of this article studied factors that predicted therapeutic adherence to Multisystemic therapy (MST) among a group of therapists, caregivers, and youth. Results revealed that therapeutic adherence increased when the caregiver and therapist were the same race/ethnicity or gender. Therapeutic adherence also increased if caregivers were African American or if they had low levels of education.

There were 405 therapists and 1,711 families involved in this study. The typical therapist was female (73.8%), Caucasian (75.3%), and with a master's degree (60%) in psychology or counseling (37.3%), social work (31.9%), or other fields of study (30.8%; e.g., sociology, criminology, the humanities) and had practiced MST for three months or less (51.5%). All families started services after the therapists were recruited into the study, and families were assigned to therapists as openings became available. Most caregivers also were female (88.1%) and Caucasian (64.4%). The mean age for caregivers was 43 years ($SD = 8.40$). A quarter (25.1%) of caregivers did not complete high school; 38.5% completed high school; and 36.4% had completed some college. Youth were mostly boys (65.1%) and Caucasian (58.1%), with a mean age of 16.2 years ($SD = 2.40$). Over half of the youth had been arrested at least once (57%), and 44.2% had been in jail. Youth were most often referred for services due to a criminal or status offense (66.3%), followed by substance abuse problems (32%).

Therapists and caregivers identified their ethnicity from a list of 21 mutually exclusive items (indicating single group or mixed heritage) and were matched with caregiver ethnicity in 66% of the cases. Over half of therapists and caregivers (66.3%) also were matched for gender. The authors maintained a focus on caregiver ethnicity and gender (rather than those of the youth) because MST therapists work "intensively and extensively" (p. 661) with caregivers. At pretreatment, the Child Behavior Checklist (CBCL) was used to identify behavioral problems in the youth and the Vanderbilt Functioning Index (VFI) measured youth psychosocial functioning. Therapists, caregivers and youth completed the Therapist Adherence Measure (TAM), which includes items that correspond with the nine principles of MST1. For example, "the therapist tried to understand how the family's problems fit together," or "the family knew exactly which problems were being worked on" (p. 662). Therapists received ongoing support, including a five-day orientation to MST theory and practice, quarterly booster sessions, supervision, and weekly phone consultation with an MST expert. The average length of treatment was 19 weeks.

Caregivers gave low ratings of adherence to therapists who considered the flexible hours (ie., a "24/7" schedule) to be problematic, but gave high ratings of adherence to therapists who shared the same race/ethnicity or gender. Therapist ratings of adherence revealed higher scores when caregivers were African American (instead of Caucasian). Further, compared to caregivers who had achieved a postsecondary education, caregivers who had not completed high school were deemed by therapists to have high adherence. Higher scores on the

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DATA TRENDS

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VFI, indicating fewer psychosocial problems, were the only predictors of adherence for youth. Thus, externalizing and internalizing problems, the number and nature of referral problems, the source of referral, number of previous out of home placements, number of arrests and amount of time spent in jail prior to treatment had no effect on therapeutic adherence.

In summary, caregivers rated lower levels of therapeutic adherence to therapists who had difficulty with a home-based service delivery model that requires the therapist to be available to the client around the clock. This finding “presents challenges” (p. 666) to the therapist and additional supervision and monitoring may be in order. According to the authors, the finding that professional training or experience did not predict adherence to the nine principles of MST is “encouraging given that the nation’s mental health workforce, particularly in the public sector, consists primarily of such individuals” (p. 666). For example in this study, a third of bachelors and masters level therapists had backgrounds in sociology, criminology, history, religion, and “other humanities” (p. 664). Racial/ethnic similarity and gender similarity predicted higher levels of adherence. Because a high percentage of therapists and caregivers were Caucasian and female, the authors conducted additional analyses to ensure that this finding applied to all racial/ethnic groups and to both genders (they also conducted additional analyses to account for the effects of nesting and for missing data). The authors also comment on the finding that low levels of education predict greater adherence; in this study, low education correlated with low income, and it may be the case that “disadvantaged parents have lower expectations of child treatment relative to their more advantaged counterparts” (p. 667). Thus, caregivers with low education may find that MST meets or exceeds their expectations for treatment. Finally, low levels of youth psychosocial functioning also predicted low levels of therapist adherence, although this finding was “puzzling, particularly because youth behavior problems did not predict adherence” (p. 667).

1 For a list of these principles and an explanation, see the MST Services Home Page, at <http://www.mstservices.com/text/treatment.html#nine>