Engaging Multiproblem Families in Treatment: Lessons Learned Throughout the Development of Multisystemic Therapy *

PHILLIPPE B. CUNNINGHAM, Ph.D.
SCOTT W. HENGGELER, Ph.D.*

Multisystemic therapy (MST) is a family-based treatment model that has achieved ***high rates of treatment completion with youths*** *who* ***present*** *serious* ***clinical prob****lems, and their families. The success of MST in engaging challenging families in treatment is due to programmatic commitments to family collaboration and partnership as well as to a* ***conceptual process*** *that* ***delineates barriers to family engagement, develops and*** *implements* strategies *to overcome these* barriers, *and evaluates the success of* these *strategies. This article provides an overview of the nonspecific/ universal engagement strategies used by MST therapists, frequently observed barriers to achieving therapist-family engagement, and specific strategies* to *overcome a sampling of these barriers.*

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In this article we describe the clinical and programmatic processes by which multisystemic therapy (MST; Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, et al., 1998) programs have achieved high engagement and treatment completion rates with youths presenting serious clinical problems and their families. MST is a well-validated (see Kazdin & Weisz, 1998; Stanton & Shadish, 1997) family-oriented treatment that is based on a social-ecological model of behavior (Bronfenbrenner, 1979). Consistent with the social-ecological model, decades of research have shown that serious clinical problems, especially youth criminal activity and drug abuse, are multidetermined— influenced by the interplay of youth cognitive variables and skills, family relations, peer interactions, school variables, family support networks, and neighborhood context. In light of the multidetermined nature of serious clinical problems, a defining feature of MST, and one that distinguishes MST from most family therapy approaches, is that clinical efforts address risk and protective factors across the youth and family's social ecology. For example, MST interventions often aim to disengage youths from deviant peers and, concomitantly, develop relations with prosocial peers by using indigenous resources. Likewise, significant clinical resources aim to promote youths' school and/or vocational competence.

Regardless of the specific goals of treatment, a fundamental assumption of MST is that the youth's family or caregiver is the key to favorable long-term outcomes, even if that caregiver presents serious clinical challenges. Treatment goals are therefore largely defined by family members or caregivers, and the vast majority of MST clinical resources are devoted to developing the capacity of the caregiver to achieve those goals (versus treating the child or adolescent individually). Within this context, engagement of the family in the clinical process is viewed as primary—an essential (but not sufficient) step toward achieving targeted outcomes. Regarding outcomes, MST has a strong track record in improving family functioning and decreasing long-term rates of antisocial behavior and out-of-home placement, as demonstrated

through numerous randomized clinical trials (see Henggeler, 1999; Henggeler, Rone, Thomas, & Timmons-Mitchell, 1998 for current overviews). Hence, the utility of the MST engagement strategies is supported by the effectiveness of interventions used within the MST model; interventions that draw from pragmatic family therapy approaches (for example, Haley, 1976; Minuchin, 1974); evidence-based intervention models such as behavior therapy (Munger, 1993); and cognitive behavior therapy (Kendall & Braswell, 1993).

As background for this clinically oriented article, the evolution and evidence of effective MST engagement strategies are pertinent. The first MST outcome study began in the late 1970s and was published in 1986 (Henggeler, Rodick, Borduin, et al., 1986). In this study, 116 families of inner-city juvenile offenders were referred for MST treatment, but were not under court order to enter or to complete treatment. Nevertheless, 91% of the families began treatment, and 82% of these completed treatment. Similarly, in a more recent study (Borduin, Mann, Cone, et al., 1995), 84% of 92 families of chronic and violent juvenile offenders randomly assigned to the MST intervention condition completed treatment. These rates of treatment completion compare favorably to those generally achieved with children and adolescents presenting antisocial behavior, and their families (Kazdin, Maurice, & Bass, 1993).

With expanded resources in the 1990s and the maturation of quality assurance protocols surrounding MST programs, the MST engagement process has become exemplary. Although this statement is rather bold and room for improvement always remains, the contention is supported by the treatment completion rates of our most recent randomized trials. As described in Henggeler, Pickerel, Brondino, and Crouch (1996), 57 of 58 (98%) substance-abusing or -dependent juvenile offenders (with significant psychiatric comorbidity) assigned to the MST condition completed a full course of treatment lasting an average of 130 days. The lone dropout received 6 weeks of services and 28 hours of direct therapeutic contact. Similarly, in a recently completed study of MST as a family- and community-based alternative to inpatient hospitalization for youths presenting mental health emergences, that is, suicidal, homicidal, psychotic (Henggeler, Rowland, Randall, et al., in press), a full course of MST, encompassing an average of more than 100 hours of direct clinical contact, was completed by 77 of 79 (97%) families referred to the MST condition. These rates of treatment completion have set a new standard in the field and demonstrate that low engagement is virtually always a solvable problem given the necessary desire and commitment of the treatment program.

The challenge, however, is translating successes achieved in randomized trials to real world settings. As Weisz and his colleagues have documented (Weisz, Donenberg, Han, & Kauneckis, 1995, clinicians in university-based clinical trials generally work under very different conditions than counterparts in real world settings. For example, therapists participating in clinical trials are generally provided the resources (for example, reasonable caseloads, training, supervisory support) needed to adhere to specific intervention protocols. Although MST dissemination sites across North America are structured to provide such resources to clinicians, we recognize that many community-based practitioners will not have access to the support needed to follow all aspects of the MST engagement protocol (described subsequently). Nevertheless, many aspects of the protocol are attitudinal and do not require additional financial costs. Before describing the MST engagement process, the role of engagement in achieving clinical outcomes (necessary but not sufficient) is noted, and key indicators of engagement and lack of engagement are identified.

OPERATIONALIZING FAMILY ENGAGEMENT

As discussed in Henggeler and Schoenwald (1998), treatment cannot progress unless key family members are engaged and actively participating in the treatment process—helping to define problems, setting goals, and implementing interventions to meet those goals. The clinician may have developed a "brilliant" set of intervention strategies, but such strategies will have little value in the absence of a strong therapeutic alliance. Practitioners must remember that parents and other family members are essential to achieving positive outcomes, and such outcomes are almost always accomplished through hard work by the family members. Family members (and clinicians!) who are not engaged in treatment are unlikely to put forth the effort needed for favorable outcomes. Hence, concomitant with a thorough assessment process, MST practitioners work toward achieving strong engagement from the time of their first contact with the family.

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

Signs of Engagement

Indicators of engagement include, for example:

- *High rates of attendance at sessions*— assuming that sessions are scheduled at convenient times for family members and barriers to service access are overcome.
- *Completion of homework assignments*— The provision of daily and weekly assignments linked with treatment goals provides an excellent opportunity to track participant engagement and efforts. Hard work, whether successful or not, almost always reflects family engagement.
- *Emotional involvement in sessions*— Engagement is indicated when family members are lively and energetic during sessions, actively debating and planning intervention strategies. Although the absence of emotional involvement does not necessarily indicate the absence of engagement (some families have very low-key styles, but are sincerely motivated), the presence of emotional energy generally reflects engagement.
- *Progress is being made toward meeting treatment goals—Almost* by definition, families that are progressing toward their goals are engaged in the treatment process.

Signs of Engagement Problems

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

- *Difficulty scheduling appointments—If* the family is only willing to schedule, for example, one appointment per week even though their child is at imminent risk of out-of-home placement, the care-givers are probably not engaged in the treatment process.
- *Missed appointments—When* appointments are frequently missed after family members have agreed, a priori, on meeting times, a lack of engagement is often

indicated.

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

The following sections describe (a) the nonspecific engagement strategies used by MST therapists, (b) common barriers to engagement, and (c) specific strategies used to overcome these barriers. The nonspecific strategies tend to have counterparts across most models of psychotherapy, whereas the specific strategies are applicable to those cases where engagement is not proceeding as planned.

NONSPECIFIC/UNIVERSAL STRATEGIES

Children and their families referred for MST services usually come from clinical populations historically considered recalcitrant to treatment or labeled resistant (for example, criminal offenders, drug abusers). Often, the families and professionals referring the families (probation officers, social workers, teachers, guidance counselors) have experienced multiple failures in their attempts to ameliorate the serious problems presented by the youth. Against this backdrop, MST therapists are asked to engage and develop therapeutic and collaborative alliances with family members who are often at their 'wits' end." Because the number and complexity of factors that can hinder the engagement process are considerable, several nonspecific, universal strategies for facilitating engagement are central to the MST engagement process. Importantly, the value of each these strategies has been empirically supported.

Empathy

The sine qua non of client engagement, cutting across schools of psychotherapy, is therapist empathy (Fiore, 1988; Linehan, 1993; Schaap, Bennun, Schindler, & Hoog-duin, 1993). According to Rogers (1959):

> …empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the 'as if" condition. Thus, it means to sense the hurt or the pleasure of another as he senses it, and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased etc. [p. 210].

Therapist empathy increases clients' trust and feelings of being understood (Johnson & Matross, 1977), is often rated by clients as one of the 'most helpful" treatment-related experiences (Morris & Sucker-man, 1974; Rorty, Yager, & Rosotto, 1993),

and is a significant predictor of a strong therapeutic alliance (Schaap et al., 1993). Consistent with other schools of thought, MST assumes that therapist empathy is critical for engaging clients. Indeed, be-cause families referred for MST services are often demoralized and feel ostracized, interactions with a caring, empathic adult who 'understands" their plight can set the stage for the collaboration necessary for obtaining clinical outcomes.
Expecting a therapist to have a truly empathetic understanding of every client is unrealistic. Several procedures, however, can be used to increase a therapist's empathy. For example, the therapist can be asked to put himself or herself in the caregiver's shoes, or to appreciate that, in spite of many obstacles facing the client, he or she has worthy hopes and dreams for the children. At the outcome level, the therapist can visualize how family members might reach their goals. Thus, by taking a social perspective, the therapist can cognitively and emotionally attempt to experience the world of the client. In light of the numerous hardships experienced by multiproblem families, ample material is usually available to elicit therapist empathy.

Gift Giving

Therapist behaviors and strategies that provide the client with direct and immediate benefits during the initial sessions have been labeled 'gift giving" (Sue & Zane, 1987). These immediate benefits can include normalization of problems and feelings; anxiety or guilt reduction; increased hope, faith, and behavioral skills; and experiencing a trusting and understanding relationship. Thus, for example, a caregiver who blames himself for his adolescent's serious antisocial behavior may be given the gift of guilt reduction by the therapist. By increasing the caregiver's understanding of the complexity and multidetermined nature of antisocial behavior, as well as the difficulty that any parent would experience attempting to manage such adolescent behavior, the problem can be normalized to some extent and self-blame can be reduced. Feeling better, more hopeful, and having increased skills after clinical sessions reinforces the engagement process.

Credibility

As suggested by Sue and Zane (1987), outcomes are better for clients who believe in the competency of their therapist and the viability of the interventions being recommended. Therapist credibility can be ascribed or achieved. Ascribed credibility is th3 status or role assigned by others, whereas achieved credibility pertains to a therapist's behavior (skills) during sessions. Ascribed credibility, which is mediated by perceived expertise and attractiveness, is primarily important during the initial stages of treatment when the therapeutic relationship is forming (Heppner & Claiborn, 1989). Therapists can achieve credibility by focusing on three interrelated areas, their conceptualization of the problem, solutions to the problem, and the goals of treatment (Sue & Zane, 1987). How a therapist conceptualizes family problems is critical in enhancing his or her credibility. When the conceptualization is a credible formulation consistent with the worldview of the client, the therapeutic alliance is promoted. Thus, therapists must be prepared to offer credible analyses of the presenting problems, using language and metaphors in the vernacular of the client and consistent with the client's worldview. At the problem-solution level, the therapist must present an intervention that is manageable for the client, fits his or her expectations, and is logically connected to the conceptualization of the problem. One of the defining factors in client "resistance" occurs when a therapist asks or attempts to force a client to change in ways that the client feels are unmanageable, will not work, or exceed his or her capability (Schaap et al., 1993). Thus, therapists can foster credibility by being competent, knowledgeable, and reliable professionals; tailoring or adapting

expectations to clients' individual strengths; and creating an atmosphere of negotiation, respect, and choice.

Scientific Mindedness

Scientific mindedness (Sue, 1998) refers to a conceptual process by which therapists develop and test hypotheses regarding the determinants of client behaviors. An important benefit of scientific mindedness for the engagement process is to check the negative stereotyping that is often applied by clinicians to antisocial youth and their caregivers (for example, the parent is lazy; unmotivated, uncaring) and can interfere with the engagement process. A caregiver who is extremely angry and upset that she has had to take off work for the third straight day because of her son's misbehavior in school, may be characterized (hypothesized) as having a hostile relationship with her son. An alternative hypothesis, however, could be that the caregiver's anger is more closely associated with threats from a supervisor who is unhappy with her frequent absences from work. By developing and testing hypotheses, therapists can avoid personal prejudices and "ethnocentric biases" (Sue, 1998). As described next, developing and testing hypotheses regarding barriers to therapist-family engagement is a central task of MST therapists and supervisors.

IDENTIFYING BARRIERS

As noted previously, the initial goal of MST is to engage family members in the intervention process, with engagement being an essential step toward obtaining positive clinical outcomes. This view is consistent with findings across the psychotherapy process literature (see Patterson & Chamberlain, 1988; Pinsof, 1989) showing that therapists who have not engaged clients in treatment are unlikely to achieve clinically significant improvements. As discussed in the previous section, MST therapists use a variety of nonspecific engagement strategies to facilitate the development of the therapeutic alliance. Often, however, these strategies alone are not sufficient to engage families with youths who present serious clinical problems. When engagement is not progressing as planned, MST therapists and treatment teams conduct a iterative process aimed at identifying the barriers to successful engagement, and developing strategies to overcome those barriers. Specifically, (a) factors that might be associated positively or negatively with engagement are assessed; (b) hypotheses regarding the roles of these factors are developed; and (c) strategies to target the relevant factors are developed and implemented. In essence, the clinician develops hypotheses regarding the causes of poor engagement, assuming a social-ecological model of behavior, and then tests those hypotheses by implementing engagement strategies that are based logically on the hypotheses. The success or lack of success of these strategies either confirms or refutes the hypotheses. Consistent with the standard MST conceptual model for understanding the basis for clinical problems (Henggeler, Schoenwald, et al., 1998), when hypotheses are refuted, the resulting new information is used to develop alternative hypotheses, which are then tested, and so forth. The process does not end until the barriers to effective engagement are identified and the caregivers are engaged.

The remainder of this section describes common barriers to engagement that have beck" experienced within MST programs. Although these barriers are heterogeneous, they tend to fall within three general domains: caregiver-related factors, therapist-related factors, and client-therapist relationship factors. Each domain is discussed separately, but factors across these domains are often interrelated conceptually and clinically. In the final• section of this article, sample strategies for addressing these factors are presented.

Caregiver Factors

Personal Attributes or Characteristics

Several proximal caregiver influences on the engagement process include substance abuse, mental health problems ~for example, untreated bipolar disorder), intellectual limitations, level of comfort with receiving services (embarrassment), extent of suffering, and poor self-efficacy expectations (doubts that personal behavior can produce favorable outcomes). In the broader psychotherapy literature, these proximal factors have been conceptualized as "fundamental characteristics of client demoralization" (Schaap et al., 1993). Essentially, failing skills and competencies, low empowerment, and a history of interpersonal ineffectiveness have often demoralized caregivers to the point that they feel incapable of effecting desired change or may be incapable of achieving outcomes in their present state (for example, cocaine abusing). On the one hand, such caregiver characteristics can generate a host of negative affective responses during the initial stages of therapy, for both the caregiver and practitioner, and present significant challenges for the evolving therapeutic relationship. On the other hand, grasping the underlying bases of demoralization allows the clinician to develop strategies to address those specific contributors.

Family and Social Influences

More distal influences on the engagement process include family factors such as low parental bonding with the child (why engage if the child isn't loved?) and marital conflicts regarding treatment; extrafamilial influences such as employment status, social isolation (low social supports), a history of coercive or adversarial interactions with mental health or social service providers (children had previously been removed from the home by social we *Ware),* and secondary gain associated with the status quo (the financial benefits of having a child with a disability). Environmental factors influencing engagement may also result from referral processes such as how much choice parents have about receiving services (for example, is it a condition of probation for the child or the threat of child removal), how treatment was presented to the family, and outcome expectations generated by the referral source (for example, this probably will not work, but let's try it anyway).

Therapist Factors

From the perspective of therapist credibility discussed previously (Schaap et al., 1993), therapists can behave in ways to maximize or minimize their social influence. Because therapists are socially recognized as expert "helpers," clients often expect that clinicians have the knowledge, skills, and resources necessary to solve the family's current difficulties. Unfortunately, clinicians can behave in ways that undermine their credibility and capacity to engage families in the treatment process.

Personal Characteristics

Engagement can be influenced by therapist experience, expertise, and cognitive and interpersonal flexibility. The adage "if you only have a hammer, everything becomes a nail" is an appropriate metaphor for describing therapist with of a limited range of clinical competencies across a wide range of clients. For example, inexperienced therapists may respond to a client's legitimate requests for help or suggestions with the Socratic method (repeated questioning leading to client insight), which may evoke client frustration and undermine the therapist's credibility as an expert. Therapists, therefore, who exhibit behavior inconsistent with their ascribed status as expert helpers will undermine conditions for social influence and client engagement (Schaap et

al., 1993). Similarly, for example, therapists who commiserate with clients around similar interpersonal difficulties (for example, spousal infidelity) may be perceived by clients as incapable of helping them. In fact, too much therapist self-disclosure (Curtis; 1982) has been found to have a detrimental effect on the client's perception of therapist empathy, and competence.

How therapists conceptualize clients' problems can also hinder the engagement process. An insidious attributional bias that can develop among therapists working with challenging families is "victim blaming." Research examining attributions of responsibility and blame (see Howard, 1984) has shown that the optimal setting conditions for victim blaming include a victim who is female, severe consequences for the victim, and an observer who cares about what happens to the victim and has no control over those consequences. These setting conditions are usually met by MST therapists who (a) often work with single-parent, female-headed families, (b) target serious antisocial behavior, and (c) usually come from the ranks of professionals who have an intense desire to help people, particularly children. Blaming clients for their problems, even if the problems are largely self-imposed, does not facilitate engagement.

Several other therapist characteristics can contribute to negative therapist affect, which, in turn, impedes the development of collaborative therapeutic efforts. As described more extensively by Henggeler and Schoenwald (1998), these characteristics include stress and burnout (it's difficult to engage with families when the therapist wishes he or she had a different job); being child-centered versus family-centered (many child mental health practitioners entered the field because they liked interacting with children, but did not particularly care for interacting with adults, especially parents who were substance abusing or physically abusive); discomfort discussing or addressing certain issues or being repulsed by the behavior of a family member (many clinicians will have great difficulty engaging with a father who sexually abused his daughter); personal problems (personal, marital, family, mental health, or drug problems can interfere with clinical effectiveness); and fear for personal safety (the clinician might fail to engage a key caregiver—a spouse-abusing husband—out of fear). Additional therapist barriers to engagement pertain to difficulty understanding, appreciating, or accounting for clients' cultural backgrounds or value systems, and how these can impact family interactions, goal-directed behavior, and adherence to treatment plans. For example, a middle-class therapist of any race may have difficulty understanding why a single mother of five children, facing financial hardship, will continue a relationship with the father who fails to support his children financially, or why she refuses to seek legal recourse that could alleviate financial pressures.

Environmental Factors

The engagement process also can be undermined by contextual influences surrounding the clinician. These include the culture of the treatment team and influences of the provider organization and other stakeholders. For example, treatment teams that conceptualize lack of engagement as evidence of client resistance or motivational deficits are likely to reinforce such sentiments among therapists and jeopardize the development of collaborative therapeutic relationships (since the therapist feels little empathy for the caregiver or blames the caregiver for his or her circumstances. Provider organizational factors such as commitment to implement MST fully and the willingness to modify policies and dedicate resources to achieve outcomes (that is, a commitment to therapist training and supervision, policies supporting flex-time and camp-time, purchasing cellular phones and pagers for therapists) can augment the therapist's capacity to engage a family. For example, the

size of the therapist's caseload or the burden of other priorities and organizational responsibilities can affect how much time and effort a therapist can commit to engaging a challenging family Likewise, stakeholder factors can support or impede the engagement process: for example, a fee-for-service funding structure acts as a disincentive for attempting to - engage caregivers who are actively avoiding therapeutic contacts (for example, not being home for scheduled appointments).

Therapist-Caregiver Interactions

An often overlooked possibility when clients are not engaged in therapy is the mutual influence of the therapist and client. For example, Patterson and Chamberlain (1988) demonstrated that when therapists responded to caregiver "resistance" with confrontation or teaching, parental resistance increased. On the other hand, when therapists responded to resistance with nondirective behavior such as "support," parental resistance decreased. Similarly, because of previous negative experiences with mental health professionals (leading to a negative attributional bias toward therapy and therapists), clients may initially react to the therapist with anger or hostility, to which the therapist may respond with defensiveness and counter controls. From the perspective of mutual social influence, client resistance can be seen as functional and the therapist response as a natural reaction to client behavior. Unfortunately, such interactions **do** not set the stage for collaboration or engagement. Clearly, therapists and clients shape each other's behavior through the reciprocal and bidirectional nature of their interactions. Similarly, therapists and clients also may have opposing views regarding the conceptualization of the problem, the goals of treatment, or the optimal strategies for meeting treatment goals. Such differences can ultimately lead to client and therapist frustration and client drop-out. Ignoring these mutual influences can have untoward effects on the therapeutic relationship and the engagement process.
In summary, engagement is influenced by numerous factors pertaining to caregivers, the clinician, the interaction between the therapist and caregivers, and the social contexts of each. Because the MST therapist and treatment team are ultimately responsible for family engagement, effective strategies for identifying and overcoming the key barriers to engagement are essential to the success of MST programs. The remainder of this article provides examples of strategies used in MST programs to overcome specific barriers to engagement.

OVERCOMING BARRIERS

This section focuses on specific strategies addressing the aforementioned barriers to engagement. Because of space limitations, only a subsample of specific strategies are presented. The use of these strategies, however, is assumed to occur within a context that is generally conducive to engagement. That is, the specific strategies are used within a clinical context in which the following has already occurred:

- The rationale, possible benefits, and structure of treatment have been articulated.
- Family strengths have been identified and acknowledged.
- The therapist has taken a collaborative approach with the family and views family members as full partners in the treatment process.
- Treatment goals have been set primarily by the family
- Services are provided at times convenient to the family.

If these basic components of the MST clinical process have not occurred, the consideration of specific strategies should be delayed until the necessary context has been established.

Targeting Caregiver Factors

Mistrust

A common experience of MST therapists is that caregivers initially mistrust the therapist due, in part, to the caregiver's history of negative experiences with other mental health or social service providers. We have found that time and therapist honesty, reliability, and advocacy are the best strategies to overcome caregiver lack of trust. Several steps are recommended:

- The caregiver's lack of trust should be validated when clinically appropriate. That is, the lack of trust is considered reasonable given the caregiver's history.
- The therapist should indicate that he or she wants to earn the family's trust. Thus, the therapist should communmicate to the family that he or she would only expect family trust to develop following the demonstration of "trustworthy" behaviors.
- The therapist explicitly agrees to be honest and straightforward with the caregiver, and, in ***turn,*** expects the caregiver to give forthright feedback regarding his or her confidence in the clinician's honesty.
- The therapist communicates and acts with complete integrity throughout treatment. If the therapist engages in behaviors that forsake family trust (for example, coercive behavior to gain the family's compliance with a court order or agency edict, or loses neutrality in meetings with other agencies, or distorts messages from the family), the therapist should acknowledge the behavior, apologize, and develop a plan to rebuild the lost trust.

Hence, an explicit overarching goal of the treatment process is for the clinician to earn the family's trust. And, consistent with all overarching goals developed within the MST framework, the outcome of this goal is monitored continuously and specific plans are made to address any additional barriers to achieving the goal.

Hopelessness

Caregiver hopelessness is another common barrier experienced by MST therapists working with caregivers of children and adolescents with serious antisocial behavior. Caregiver hopelessness often arises from personal failures in ameliorating the youth's emotional and behavioral difficulties as well as failure experiences with mental health professionals. To address this barrier, therapists should focus on themes that highlight individual and family strengths and expand the client's view of attainable outcomes. Several interrelated processes can be pursued concomitantly:

- *Re framing* can be used to alter a client's negative conceptualization of a problem to a view that is more conducive to favorable change (Webster-Stratton & Herbert, 1994). For example, the thought "My son's problems are all my fault" can be changed to "Thinking like this only makes me feel bad. Maybe I'm partly to blame for his problems, but I'm also his best chance for a solution." Thus, the caregiver can shift his or her focus from self-defeating perceptions to empowering beliefs.
- ***Positive*** *reinforcement* can be used liberally whenever "evidence" of client effort and improvement appears. That is, the therapist should seek and acknowledge "small wins" (Weick, 1984). For example, during the initial sessions the therapist can reinforce clients' attendance at sessions and giving their best effort. Moreover, clients who successfully complete small tasks are likely to attempt more complex tasks later in treatment (Schaap et al., 1993).
- Therapists should maintain a *pro blemsolving stance.* The consistent focus of treatment is on the attainment of treatment goals through the development and implementation of well-conceived intervention strategies and the identification of any barriers to the success of those strategies. Hence, the overriding thrust of

treatment is action and solution-focused—an emphasis that is not conducive to feelings of hopelessness.
- Therapists should maintain a *strength* ***focus*** by emphasizing what is good about the family and what family members do well. The strength focus contrasts with the traditional deficit focus of mental health services, and it both engenders hope and facilitates engagement.

Caregiver Clinical Problems

Low engagement can be the result of serious clinical problems presented by the caregiver (for example, depression, schizophrenia, cocaine, dependence), which, if not treated effectively, will decrease the probability of client engagement. In such cases, addressing serious caregiver psychopathology is the immediate priority of treatment because caregivers are not likely to resolve child problems until their own difficulties are attenuated. The logical implication is that therapists, and their corresponding teams and programs, must have access to state-of-the-art services for adults with severe mental illness or substance abuse. As discussed in the MST treatment manual (Henggeler, Schoenwald, et al., 1998), such access is gained either through the competencies of the family-based practitioner or close collaboration with ecologically-minded providers of evidence-based adult services. In addition, while caregiver problems are being addressed, the family-based therapist should identify indigenous social supports to serve as protective factors for the child (for example, a caring extended-family member) and provide the caregiver help in managing the family's daily affairs.

Low Social Support

More often than not, MST therapists collaborate with families who are hard working, spend an inordinate amount of time trying to make ends meet, and have children with special and challenging needs. Environmental demands on such families can be so overwhelming that little time or energy is available for engaging in the treatment process. As noted by Farrow (1996), 'Conditions will not improve for many families unless they receive the help they need closer to home, in a form attuned to the conditions in which they live" (p. 15). Helping caregivers develop and use indigenous social support resources, therefore, can address practical barriers to engagement and endear the therapist to the caregiver.

Consistent with a social-ecological perspective, therapists can begin identifying indigenous supports by examining the caregiver's social network, including extended family, friends, neighbors, coworkers, and community contacts (church members, participants in neighborhood organizations). Indigenous supports have the potential to provide instrumental aid (money, time, in-kind assistance, child care), emotional support (empathy, concern, caring, trust), appraisal feedback (affirmation, social comparison), and information (job opportunities). Ultimately, such supports are critical for the long-term maintenance of therapeutic change in the MST model (see Henggeler, Schoenwald, et al., 1998), but they can also be used to facilitate the engagement process. For example, a neighbor can care for the mother's three young children as she meets with the therapist to discuss her problem adolescent. In the development of sustainable indigenous supports, however, reciprocity must be established between the caregiver and persons providing support. Thus, in the given example, the mother would also provide a useful service for the neighbor to maintain the support system.

Targeting Therapist Factors

Family Attitudes Toward Therapists

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

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

Cultural Non-Connect

Irrespective of race, a common therapist barrier to engaging a family is a lack of understanding and appreciation for cultural or values-based differences. For example, a middle-class therapist may have difficulty with the apparent low regard for education evidenced by a father who periodically keeps his eldest daughter home from school to help with care for her younger siblings. If the therapist has difficulties empathizing with the caregiver, lack of cultural understanding is a common reason. Several processes can be used to prevent a cultural non-connect or to ameliorate one that arises:

- The best prevention strategy is for programs to hire therapists who have broad cultural experiences and value cultural diversity. Particularly valuable are professionals who were raised in the targeted communities or have prior experience working in those communities. Similarly, flexibility is a highly valued quality in therapists, whereas rigidity should be avoided.
- When a clinician's personal prejudices are affecting clinical judgments or the engagement process, colleagues might help the clinician to gain a better appreciation of the life circumstances of persons with serious psychosocial problems. For example, occasional opportunities for emotional intimacy may be worth the downside or less favorable aspects of an alcoholic boyfriend for a lonely mother with little adult support in her life.
- A fundamental characteristic of successful MST programs is respect—respect for families, for colleagues, for professionals from other agencies, and so forth. Clinicians can adamantly disagree with caregivers about the benefits/ costs of certain actions. Discussions, however, must be conducted within a context of mutual respect, otherwise, the clinician will not be capable of affecting positive change even if he or she prevails in the discussion. Few cultural divides are irreconcilable when individuals are treated with unconditional respect.
- When the therapist and/or treatment team does not have the requisite expertise for cultural understanding, team members are responsible for identifying this gap of information and for determining appropriate resources within the community to fill the gap.

Therapist Is Repulsed

Certain types of behavior (sexual abuse, physical abuse, domestic violence) are naturally repulsive to therapists and other caring persons. Although these behaviors normally evoke negative emotions and possible desire for retribution, therapists who display such reactions will usually have difficulty engaging key family members and the perpetrator in treatment. Therapists who cannot align and collaborate with perpetrators will have only modest success working in MST programs because many of the families include individuals who have engaged in illegal, distasteful, and harmful behavior. Given that collaboration with all family members is the most reliable and productive way to decrease the probability of future victimization of children, therapists must be helped to find ways to collaborate. Collaboration does not equal condoning, and the therapist is not expected to "like" each family member. Rather, as with all MST interventions, the therapist must be able to identify the strengths of the systems and help the family to change their social ecology in ways that make future abuse less likely: (opening communication channels, developing indigenous support systems, and helping the family set rules and limits effectively for both child and adult behavior).

One strategy for motivating a therapist to engage and collaborate with someone viewed negatively is to focus on the larger goals—that is, reducing the chances of any reoccurrence of the abuse by promoting the development of child and caregiver competence. Expressing anger toward the perpetrator might feel good to the therapist, but such expressions will block opportunities for collaboration and, consequently, be of little value to the children and other family members. Another strategy for helping therapists to control their negative affect has been coined the "cup of coffee" intervention. Here, the therapist puts clinical assessments and interventions on hold and spends considerable time in informal settings with the family member (for example, the perpetrator) who is evoking the negative affect. The therapist's goal during this time is to gain an understanding of the caregiver's view of the world and to examine how the behavior that is distasteful to the therapist fits into this worldview. Usually, as the therapist appreciates the caregiver's own social ecology, negative affect decreases and the development of a therapeutic alliance is promoted.

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

CONCLUSION

Resisting the pull of pathology is not easy when working with multiproblem families (Waters & Lawrence, 1993). Therapists need constant feedback and support to maintain a collaborative and empathic stance. Consistent with the strength focus of MST programs, when a therapist has difficulty meeting expectations regarding family engagement, the onus shifts to the treatment team to help the therapist. We assume that therapists are hard-working professionals who want the client to improve and are doing their best to engage the client. Lack of engagement, however, indicates a need for help and support. Consequently, instead of allowing the therapist to flounder indefinitely, using ineffective engagement strategies (often leading to therapist anger, frustration, resentment) or blaming the family or therapist for failure, the treatment team formally (during group supervision) and informally (during social interactions with colleagues) provides engagement consultation to the therapist. In addition, in order to support the engagement process, MST programs mandate the use of nonpejorative, nonjudgmental, and nonblaming language (both written and verbal) when discussing or describing clients (see Henggeler, Schoenwald, et al., 1998). Through word and deed, MST treatment teams must create a validating work environment by searching for and using "nonpejorative or phenomenological empathic interpretations" (Linehan, 1993; p. 118) of client and therapist behavior and circumstances.

Such a frame is consistent with Waters and Lawrence's (1993) notion of reconnecting people with their own yearnings or underlying strivings, or, in the vernacular of MST treatment principles, being goal-directed and strength-focused.

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COMMENTARY
CHALLENGES TO FAMILY ENGAGEMENT: WHAT CAN MULTISYSTEMIC THERAPY
TEACH FAMILY ThERAPISTS?

Susan 8. Stern, Ph.D.t

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FAMILY-BASED intervention is key in the development of a comprehensive treatment plan for antisocial and delinquent youth. Yet, therapists often find that these families are difficult to engage and retain in treatment. In turn, parents report that intervention is stressful and that they feel blamed by practitioners (Arnbert, 1997; Stern & Smith, 1999). Among families that begin outpatient treatment for child conduct problems, 40—60% drop out prematurely and against therapist advice (Kazdin, 1990; Prinz & Miller, 1996). This disturbing statistic represents failure for children and families who need but do not receive services, and for communities that experience the consequences of child mental health problems and antisocial and delinquent activity. It is indicative of difficulties faced by the agencies and service delivery systems that operate with limited resources and are impacted by the costs associated with low engagement and attrition, such as frequent cancellations and “no shows.”

“Engaging Multiproblem Families in Treatment” (Cunningham & Henggeler, 1999) underscores the need for parents and other caregivers to he committed and actively involved in treatment. Its authors report on “lessons learned” from working with seriously distressed youth and their families. Some readers may be quick to dismiss these lessons as nothing new to family therapists. Indeed, family therapists have

been especially attentive to developing and writing about strategies that decrease blame and engage all family members. But dismissal would miss crucial points about what is distinctive in this approach. Multisystemic therapy's (MST) high rates of treatment engagement and retention, paired with positive treatment outcomes in a succession of studies, suggests that the approach is on target. MST results are particularly impressive given that the approach focuses on youth with serious clinical problems and multistressed families, those least likely to complete or benefit from treatment (Dumas & Wahler, 1983; Kazdin, 1990; Webster-Stratton, 1985). Rather than comment on specific strategies that Cunningham and Henggeler describe, or on the similarities MST shares with other family therapy approaches, I will accent its more distinctive features, as I understand them.

1. **Multiple systemic influences**: Although multisystemic therapy is family centered, it is a social-ecological model that extends beyond the family system (Henggeler, Schoenwald, Borduin, et aL, 1998). Numerous research studies across disciplines have shown that youth behavior is multiply determined by the reciprocal interaction of individual child characteristics and characteristics of key social systems in which youth are embedded (Henggeler, 1991; Smith & Stern, 1997). MST therapists systematically assess and address strengths and needs in these multiple domains (family, peers, school, neighborhood/community). This is one of the unique characteristics of MST that likely significantly contributes to its efficacy, and it may also contribute to family engagement. Because characteristics at each system level (for example, association with deviant peers) can be linked to problematic youth behavior, a multisystemic assessment frame is probably more congruent with the family's reality and experience of the problem. Even when focusing on family strengths (as MST emphasizes), family interventions still run the risk that— while sending caregivers the message they are responsible for helping youth change— therapists may also send a subtle message that parents (grandparents, etc.) are to blame for the child's difficulties. Broadening assessment and intervention beyond *within-family* processes conveys an understanding of the difficulties of raising children in today's society, and can decrease emphasis on what to parents may feel like their failed attempts or inability to control their child. Casting a wider net also draws the therapist's attention to a greater range of strengths and supports that can be used to facilitate treatment and maintain families' involvement in the face of barriers to engagement. -

A social-ecological model also recognizes caregivers' context and the stresses that disrupt adult well being and parenting and negatively impact children (Stern & Smith, 1995; Stern, Smith, & Jung, 1999). Like other family system approaches, MST therapists assess needs and supports in caregivers' lives. However, when parental context and stress (for example, poverty, parent substance abuse, depression) interfere with engagement or parenting, MST places a greater emphasis on retaining children in the home and using indigenous supports in the family's ecology to strengthen the parenting subsystem. Expanding our view of family therapy and enlisting indigenous supports from the multiple systems in which caregivers are embedded (for example, church, neighborhood, work) can increase the contextual and cultural responsiveness of intervention and can enhance parental engagement.

MST is an intensive family preservation model that stresses provision of services in a youth's home and community. Treatment is delivered according to nine principles that emphasize empowering caregivers with skills and support so that they can carry out change strategies across key systems linked to problematic child behavior. Providing treatment in the natural ecology increases treatment access and social validity, and undoubtedly contributes to treatment engagement and retention. Nevertheless, home-based treatment does not guarantee family engagement, particularly when engagement is considered in its broader context as family emotional investment and active involvement in intervention planning and follow-through.

2. Systematic process for overcoming barriers to engagement: Cunningham and Henggeler refer to the iterative process used in MST to systematically identify barriers to engagement at each system level, and to develop strategies to overcome these barriers. This is a parallel process to that used throughout MST to identi1~r obstacles to implementation, test hypotheses about their role, and generate solutions. Although such a process is not unique to MST, its structured, systematic use is distinctive. I suspect that this process helps a therapist to persist in her or his attempts to engage challenging families. Therapist frustration can lead to negative attributions that reinforce blaming and may prompt confrontation that, in turn, strengthens resistance (Patterson & Forgatch, 1985). In contrast, MST's iterative process provides therapists *with* support and structure to reframe the situation for themselves, and to generate specific solutions that fit an individual family's circumstances.

Cunningham and Henggeler point to caregiver factors, therapist factors, and therapist-caregiver interactions in systematically conceptualizing and testing alternative explanations for engagement difficulties. The influence of youth behavior and its consequences on the family is another, perhaps underemphasized barrier to engagement (Stern & Smith, 1999). For instance, families of youth with serious clinical problems are likely to have a history of negative interactions with social service agencies, including unsuccessful previous intervention attempts. Undoubtedly, caregivers have repeatedly experienced disappointment and frustration that must be recognized in current engagement efforts. Situational demands and constraints (lack of transportation, childcare, daily hassles) may also impede engagement (Prinz & Miller, 1996), and one wishes that the authors had more fully addressed this area even though some of these barriers are mitigated in MST through home-based treatment.

Based on an ecological perspective, McKay and colleagues have developed and tested a model of initial treatment engagement that focuses on child, family, environmental context, and agency setting barriers for inner-city families, and that considers therapeutic- and agency-level strategies to overcome these barriers (McKay, Bennett, Stone, & Gonzales, 1995; McKay, Nudelinan, McCacani, & Gonzales, 1996). This model also explicitly recognizes the effects of systemic racism and oppression on many families, and how these experiences can create obstacles to treatment engagement that must be addressed for contextually responsive treatment.

3. Accountability: A hallmark of MST is its emphasis on accountability—accountability for engagement, accountability for treatment outcomes. When obstacles are encountered, it is the responsibility of the therapist and treatment team systematically to identify and overcome engagement barriers, using creativity and persistence. MST's programmatic commitment to accountability (both for engagement and treatment outcomes) is rare in family therapy and reminiscent of behavior therapy's stance of therapist accountability for outcomes—if treatment is not working, the therapist has not yet identified the maintaining contingencies. In MST, it is assumed that engagement *will* happen. In describing the iterative engagement process, the authors write "the process does not end until the barriers to effective engagement are identified and the caregivers are engaged" (p. 271). Studies of MST dissemination show that individual family outcomes are associated with adherence to the nine underlying treatment principles (Henggeler, Melton, Brondino, et al., 1997), reinforcing that accountability has important implications for MST's effectiveness.

In practice, holding therapists accountable for the treatment process and outcomes requires attitudinal as well as structural changes, which include creating an atmosphere where the therapist can be nondefensive and having colleagues available for problem solving. As Cunningham and Henggeler note, many family thera-

pists do not have the supports that are available to MST therapists, but supervisors can foster such an atmosphere by explicitly recognizing that the work can be quite challenging, and the need to problem solve being "stuck" is to be expected (with the emphasis on solving).

4. MST accentuates evidence-based practice: One of MST's most successful treatment engagement strategies may be that treatment works! While MST is individualized and highly flexible, a notable, distinguishing characteristic is its reliance on empirically based interventions, drawing primarily from behavioral and cognitive-behavioral approaches and 'pragmatic," focused structural and strategic family therapies. As Cunningham and Henggeler point out, engagement refers not only to staying in treatment but also to investing in it. Once in treatment, the ongoing retention and active involvement of caregivers may depend on treatment relevance and progress. In assessing barriers to treatment participation, Kazdin, Holland and Crowley (1997) found that both parent and therapist evaluation of treatment relevance were significant factors in discriminating treatment completers from dropouts. MST's focus on the known determinants of dysfunctional youth behavior and understanding the ecological fit increases social validity so that caregivers are likely to experience treatment as relevant. MST's dependence on empirically based techniques increases the likelihood that treatment will be experienced as effective. Engaging and retaining families in responsive and effective treatment is a challenge met by MST with considerable success. As family therapists, the approach deserves our close attention in light of its striking success with court-involved youth (Borduin, Mann, Cone, et at., 1995; Henggeler, Melton, & Smith, 1992), and promising findings for youth and families coping with substance at use and/or serious emotional disorders (Randall & Henggeler, in press). Although there may be considerable overlap in MST and other family therapy models in conceptualizing and addressing family engagement, its comprehensive strategy distinguishes it from other approaches. It has successfully operationalized an ecological model. It uses systematic hypothesis testing and a problem-solving approach to overcome barriers to treatment engagement and implementation; it relies on empirically validated interventions, and has a programmatic commitment to accountability

Despite the critical importance of family engagement in the treatment of youth, there has been little empirical work. Most research has focused on identifying characteristics that predict treatment attrition. Encouragingly, we are beginning to see more research designed to understand families' experiences of barriers to treatment engagement (Kazdin et al., 1997) and to develop and test interventions to enhance treatment engagement (McKay et al., 1996; Miller & Prinz, 1990; Santisteban, Szapocznik, Perez-Vidal, et al, 1996; Szapocznik, Perez-Vidal, Brickman, et al., 1988). The field of family therapy has addressed the issue of engagement of individual families clinically but insu1~cient attention has been devoted to engagement in a larger context as a service delivery problem. Hopefully, we will see increasing research on how to engage and retain families in treatment, so that the lessons learned can benefit the many youth and families who currently do not access or remain in treatment.