

Family based and systemic treatment approaches to working with antisocial behavior in young people

«Youth and emerging adults: the intersection of risk and vulnerability»

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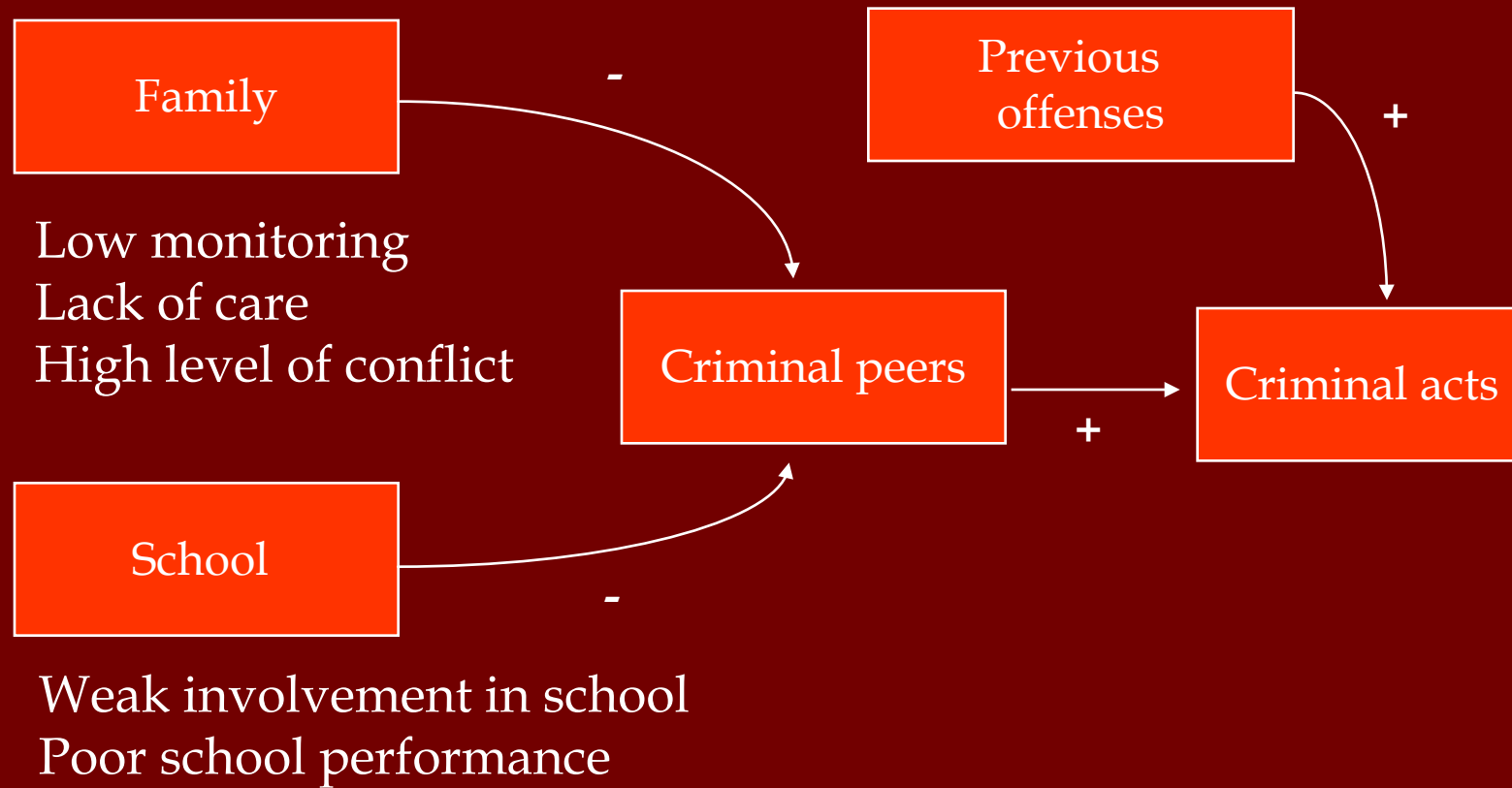
- Bronfenbrenner's social-ecological model (1979) focus on the reciprocal interplay between five systems in which the youth is embedded:
 - the microsystems (immediate environment like family and school),
 - the mesosystem (connections between microsystems),
 - the exosystem (indirect influences like child-friendly living environments) and
 - the macrosystem (cultural values and beliefs),
- According to social ecological theory, children's behavior reflects complex, reciprocal interactions in the family and in the social network,
- Social systems are active, organized and self-regulating through internal and external control,
- Social systems have identity and boundaries and consist of actors, their characteristics and relationships within and between systems.

Multisystemic Therapy as example

- Multisystemic therapy (MST) is an intensive family- and community-based treatment addressing the multiple determinants of serious antisocial behavior in youth, claiming that behavior is largely determined by the functioning of the multiple systems in which the youth is embedded (family, school, peers and neighbourhood),
- MST is a treatment program developed by Scott Henggeler and his colleagues (1998 & 2009) based on Bronfenbrenner's (1979) social ecological model and on 'empirical causal model studies' of antisocial behavior,
- In MST, the ecology of interconnected systems is viewed as the client, and the goal of the therapy is to empower the parents with the skills and resources needed to restructure the ecology of the youth,
- Antisocial behavior is maintained by problematic transactions within and between social systems such as families, schools and peer groups.

Empirical causal model for criminality and substance abuse

Condensed longitudinal model

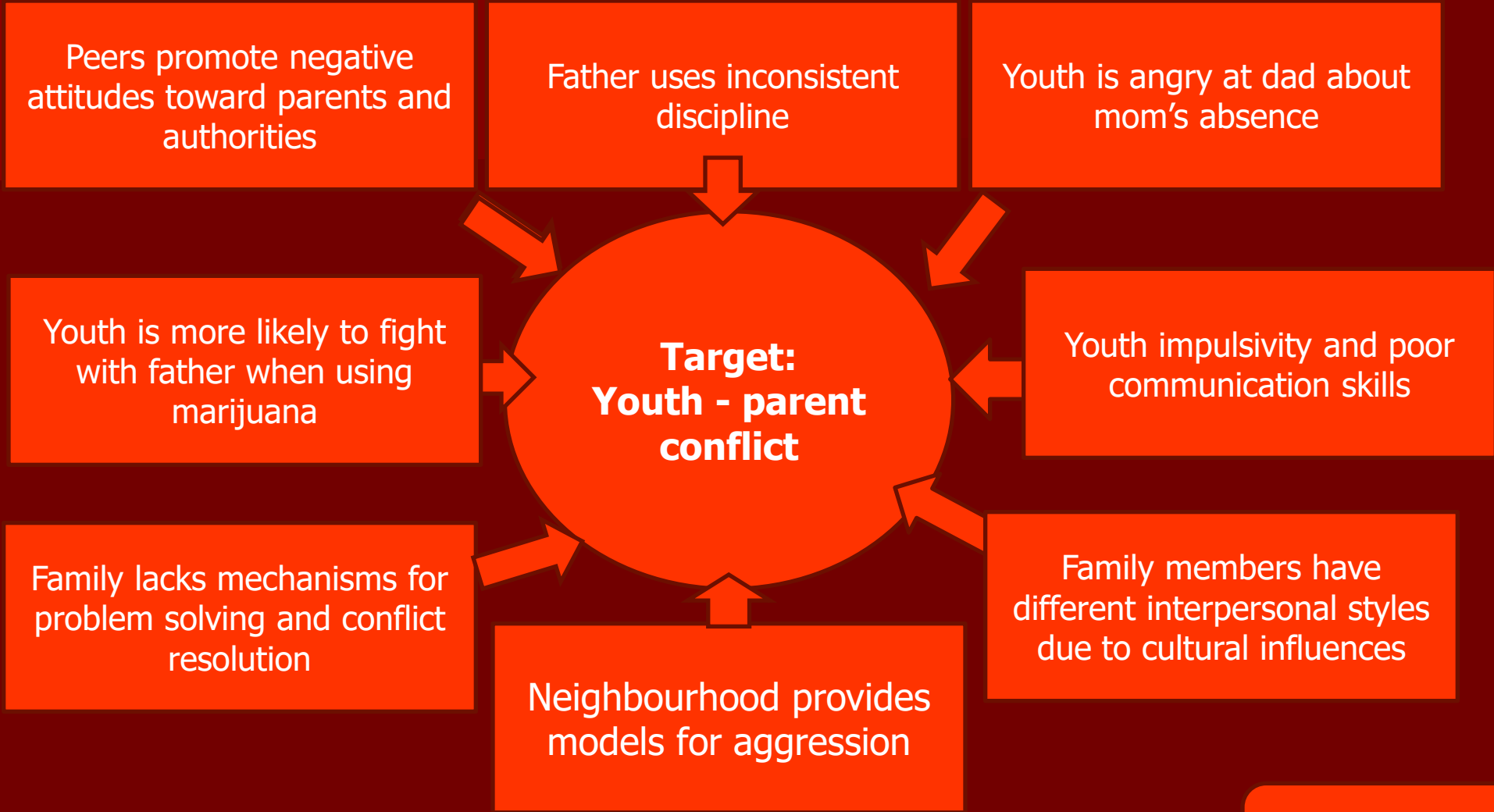


*Elliott, Huizinga & Ageton
(1985)*

The MST analytical process

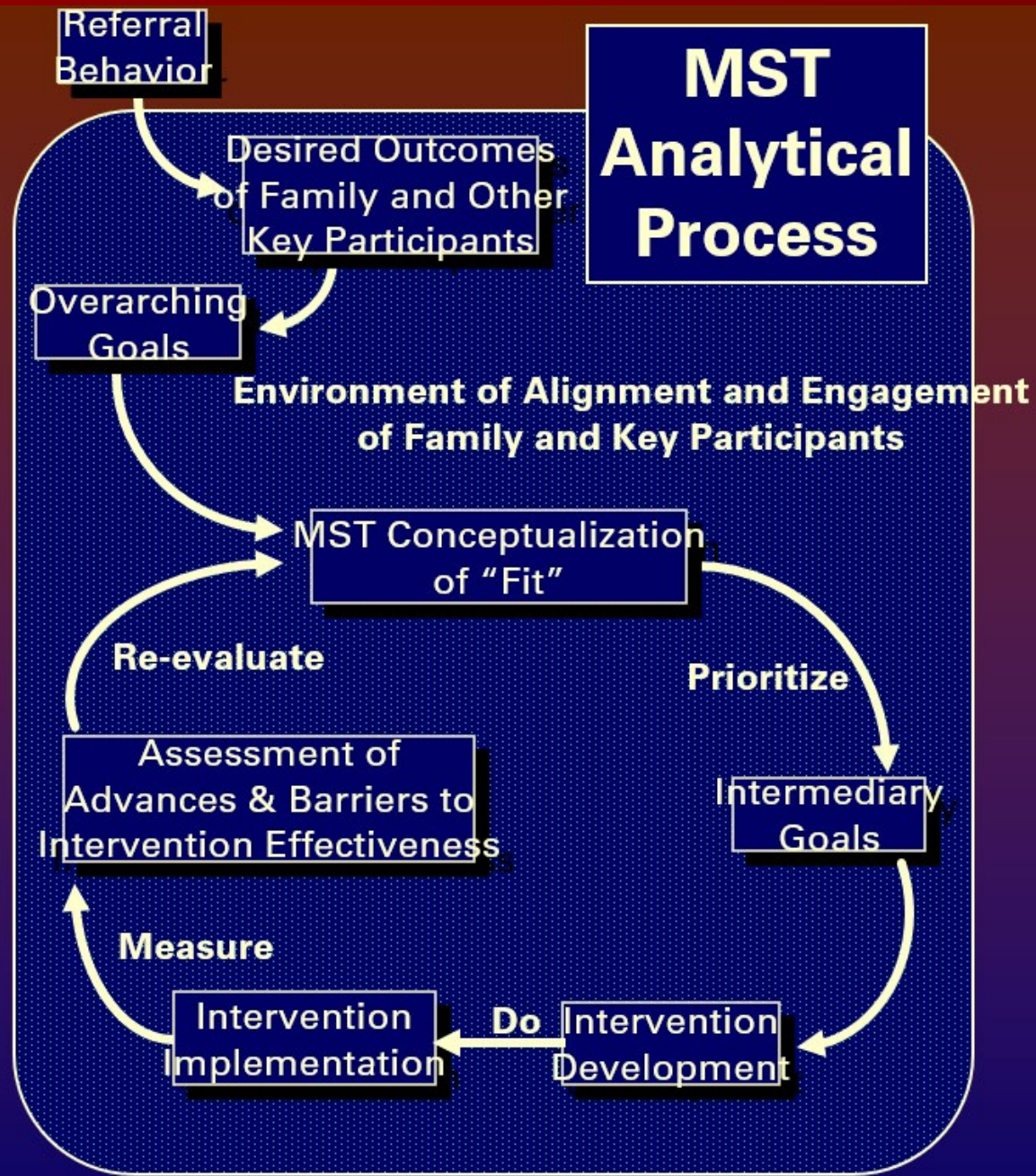
(the 'do-loop' or the 'fit circle')

- **The goal of the assessment** is to understand the mutual fit between the identified problems and the broader context,
- **The referral behavior.** The reasons for the youth's referral to MST is described by as many key stakeholders in the youth's ecology as possible (frequency, intensity and duration of problem behavior)
- **Desired outcomes** are based on information from all involved persons about the youth problems in order to identify which influential factors may directly or indirectly contribute to maintaining them,
- **Background information** is collected about systemic *strengths and needs* (weaknesses) of the youth, the family and the peer network, as well as the school and the local community,
- **Overarching goals** for treatment at the individual, family, peer and social network levels are formulated by the therapist based on ecological strengths and stakeholders' perspectives on why problem behaviors are occurring.



Evidenced by ...

MST Analytical Process



MST conceptualization of fit

An **explanatory (fit) model** integrates the informants' verified views on the influencing factors: those that cannot be verified are discarded,

Intermediary goals are prioritized by the family and stake-holders in order to reach the overarching goals.

Specific intervention strategies are developed stating 'who' is responsible for the implementation and 'when' the intervention (or other activities) should be carried out,

Any barriers to implementation (clinical or practical) are identified and removed, and the therapist assesses the outcomes of the intervention,

Re-evaluation of the intervention outcomes by the therapists, and if not successful, the information is fed back into the loop.

The theoretical principles of MST

- 1. *Finding the fit.* The primary purpose of assessment is to understand the “fit” between the identified problems and their broader systemic context (cf the ‘fit circle’),
- 2. *Positive and strength focused.* Therapeutic contacts emphasize positive communication and stress family strengths,
- 3. *Increasing responsibility.* Parent responsibility includes care, guidance, support and advice, and youth responsibility includes complying with rules and norms in their environments,
- 4. *Interventions are present-focused, action-oriented and well-defined.* Objective and measurable emphasizing the “here and now”, and avoiding technical terms,
- 5. *Targeting sequences.* Interventions should target sequences of behavior within and between multiple systems that maintain identified problems (e.g. home and school).

The theoretical principles of MST

- 6. *Developmentally appropriate.* Interventions should be developmentally appropriate and fit the developmental needs of the youth,
- 7. *Continuous effort.* Interventions should be designed to require daily or weekly effort by family members,
- 8. *Evaluation and accountability.* Interventions' efficacy is evaluated and giving up on parents is not an options; the therapists assume accountability for identifying and overcoming barriers to successful outcomes,
- 9. *Generalization.* Interventions should promote treatment generalization and long-term maintenance of therapeutic change by empowering care givers to address family members' needs.

Therapist adherence measure (TAM-revised)

- In MST, 9 theoretical principles describe the structure and content of the treatment,
- To monitor the treatment integrity of MST, the therapists fill out a short, standardized form after each home visit with information about the topics of the meeting, who was present and to what extent progress was made towards treatment goals,
- Therapist Alliance Measure (TAM). The families are contacted regularly, usually once a month, by an independent member of staff who asks them to evaluate the latest home visits by answering 28 questions related to the 9 theoretical principles of MST,
- The “Tam-revised” scale measures therapeutic alliance, client engagement and client satisfaction on a regular basis, and has proved to predict positive treatment outcomes.

Family interventions

- The family is the key to long-term results, and the most effective way to help youth is through their families,
- Parents are accepted as equal partners, but they are not relieved of their responsibility,
- *Parent empowerment*, the therapist does not take on tasks that the parents can do themselves,
- *Monitoring*. Parents are recommended to closely monitor who the youth hang out with, and what they do in their free time,
- *Control strategies* are needed in order to teach the adolescent how to tolerate frustration, manage emotions and conform to socially acceptable norms, even if the treatment focuses on strengths,
- *Unnecessary confrontations* should be avoided and therapist should offer *emotional support* when parents are frustrated,
- The therapist should prepare parents for 'battle' and help them mobilize their family and social networks in periods of struggle.

Treating family relations

- Changing parent-child relations
 - Building parental «buy-in»; motivating parents to change
 - Changing discipline strategies – rules, rewards and punishments
- Changing family-relations during treatment sessions (family therapy)
 - Changing family structure to improve individual boundaries and/or subsystem boundaries
- Addressing factors that contribute to problems in parent-child and family relations,
 - Cognitions about child rearing (knowledge and beliefs)
 - Social support and psychiatric disorders,
 - Caregiver substance abuse
- Marital distress and changing marital relations
 - Setting the stage for marital interventions
 - Dealing with negative affect and promoting compromise
- Enhancing effective functioning during and after family transitions,
 - Families affected by divorce and remarried families,
 - Single parent families

School interventions

- Great efforts are made to have the youth attend school (or job) on a regular basis,
- According to the principle of least restrictive placement, the youth should attend a regular class in a regular school where he or she can interact with pro-social peers,
- The MST therapist may establish an initial contact, but it is the caregivers who are responsible for communicating and collaborating with the school,
- The school staff, their support system and parents plan, implement and evaluate school-based interventions (e.g. Daily report card, parent groups),
- Parents should monitor, encourage and support the young person's school achievement and homework, and are advised to show engagement in schooling by frequent and constructive communication with the teachers.

Peer interventions

- Research consistently shows that most youth commit criminal offenses in the context of peer activities, and contacts with deviant friends are powerful predictors of antisocial behavior,
- Information is collected about
 - The young persons influence, popularity and role among peers
 - The number of friends in the adolescent's network,
 - What characterizes the peer contacts,
 - How peers function intellectually and socially, and
 - The proportion of prosocial as compared to antisocial friends
- Parents are advised to closely monitor the youth's whereabouts, getting to know their peers, invite them home and stay in touch with the friends' caregivers,
- Parents are encouraged to help the youth see the disadvantages of affiliating with deviant peers, but are strongly advised not to talk down the friends,
- Preparations are made to break contact with antisocial peers or gangs at an agreed time.

Individual interventions with youth

- Aggressive behavior sometimes persists despite the implementation of family interventions and other strategies to address school- and peer related difficulties,
- Although the main emphasis of MST is on systemic interventions, individual measures such as Cognitive Behavior Therapy (CBT) and pharmacological treatment are sometimes used,
- *CBT strategies* can help change the youth's dysfunctional thinking patterns and deficiencies in problem solving and CBT strategies include the modelling of new behavior, role-playing exercises, developing behavioral contingencies provided by caregivers, teaching self-instruction and problem-solving training.
- *Social skills* deficits in interpersonal relations include: a) weak relationships and dating skills, b) lack of communication skills, c) lack of sharing and cooperation skills and d) lack of problem-solving and conflict resolution skills,
- Individual social skills training is often recommended in the treatment of antisocial adolescents, using instructional strategies which can be smoothly integrated in MST interventions.

Multisystemic Treatment of Antisocial Adolescents in Norway: Replication of Clinical Outcomes Outside of the US

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Most of the MST studies, including the Norwegian RCT, were conducted as effectiveness studies in regular practice rather than efficacy studies.

Multisystemic Treatment of Serious Behaviour Problems in Youth: Sustainability of Effectiveness Two Years after Intake

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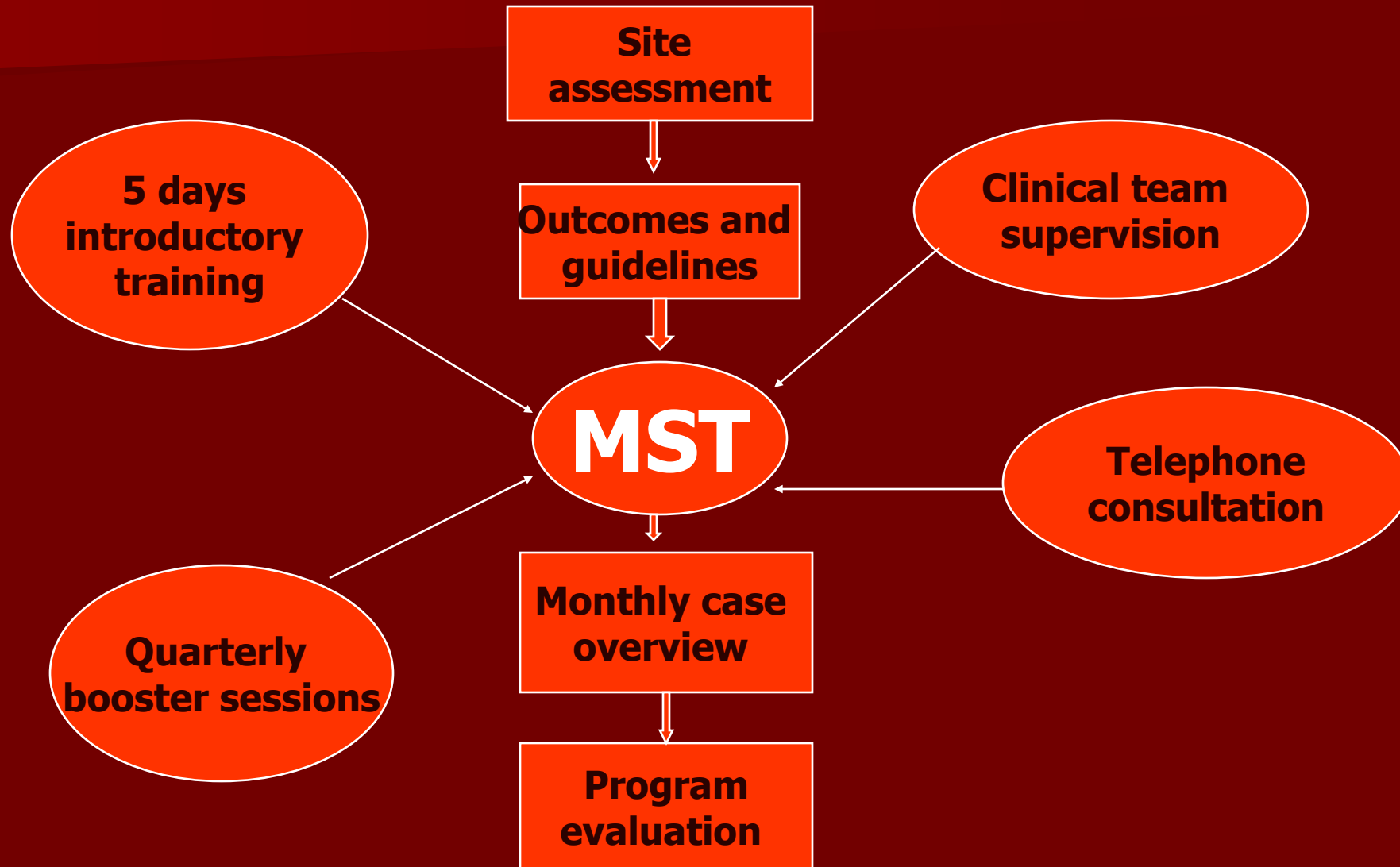
The Norwegian randomized controlled trial of effectiveness

- Positive outcomes of MST were documented in a randomized controlled trial with 100 participants, and in a follow-up study with 75 participants,
- In the pre-post study, MST significantly decreased internalizing symptoms and increased social competence in youths compared to regular Child Welfare Services,
- A marginally decrease in externalizing behavior was also reported at post treatment,
- The mean Cohen's d was -0.23,
- At follow-up two years later, 72% of the MST adolescents and 52% of those receiving regular services were living at home or under supervision by their caregivers,
- Although MST was more effective in the prevention of placements out of home, ordinary Child Welfare measures also demonstrated positive results,
- At follow up, the MST participants also scored significantly lower on measures of behavior problems and delinquency as reported by the youths themselves, their parents and their teachers.

The large scale implementation of MST in Norway

- MST was implemented across all regions of Norway from 2000, with goals for implementation activities at the national and regional level, and 24 MST teams were in operation in 2024,
- By 2021, more than 11.000 youth under the age of 18 had been referred for treatment with a completion rate of approximately 78%,
- Punitive measures against youth committing criminal acts are rare in Norway, because the age of criminal responsibility is 15 years, and also youth aged 15 to 17 years are mostly taken care of by the Child Welfare Services (Norway has no juvenile justice system),
- The first statement to be confronted when MST was implemented in Norway was: "*Works in the USA, but not 'here'*",
- In Norway there was less concern about program fidelity and effectiveness and more on the broader treatment infrastructure ensuring training and implementation quality control, strengthening family empowerment and influence, and positive impacts on service systems.

MST organizational model



Changes in the YLS/CMI risk inventory scores as predictors of MST behavioral treatment goals.

Changes in the YLS/CMI risk inventory scores as predictors of MST behavioral treatment goals

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- Participants were **2123** Norwegian youths (62% boys) with a mean age of **14.7 years**,
- The participants were exclusively referred from the municipal child welfare authorities, in the periode of 2013 to the end of 2019, and had completed treatment assessments at three time-points (pre-post and 6 months follow-up),
- The mean number of treatment days was 142 (boys: 145; girls: 139),
- In the present study, the predictive strength of the *Youth Level of Services* (YLS) risk inventory was examined at post treatment and at 6 months follow-up.

The MST behavioral treatment goals

- The MST behavioral treatment goals reported at intake, post-treatment and at 6 months follow-up:
 - - **Lives at home** (or not placed out-of-home by child welfare authorities) (Yes/No)
 - **Attends school/work** (Yes/No)
 - **No reports of violence or threats** (Yes/No)
 - **Law abiding behavior** (Yes/No)
 - **Drug free** (Yes/No)
- The MST behavioral status of the adolescents were assessed at intake by the MST team supervisor, and at post-treatment and after 6 months by therapists, parents and other informants,
- Research question: Would the status on the YLS/CMI inventory predict long term outcomes better than clinical data (e.g. CBCL)?

YLS/CMI criminogenic risk assessment

(Hoge and Andrews, 2011)

■ **1. Prior and current offenses/dispositions**

(focus on criminal history)

- Three or more adjudications (verdicts)
- Two or more failures to comply
- Prior probation
- Prior detention
- Three or more current adjudications

■ **2. Family circumstances and parenting**

(evaluates home environment)

- Inadequate supervision
- Difficulty in controlling behavior
- Inappropriate discipline
- Inconsistent parenting
- Poor relations father and child
- Poor relations mother and child

■ **3. Education/employment**

(assess school or work stability)

- Disruptive classroom behavior
- Disruptive behavior on school property
- Low achievement
- Problems with peers
- Truancy
- Unemployed/not seeking employment

■ **4. Peer relations**

(evaluation of delinquent peers)

- Some delinquent acquaintances
- Some delinquent friends
- No/few positive acquaintances
- No/few positive friends

Assessment of criminogenic risk factors (YLS/CMI)

■ 5. Substance abuse

(assess drugs and alcohol issues)

- Occasional drug use
- Chronic drug use
- Chronic alcohol use
- Substance abuse interferes with life
- Substance use linked to offenses

■ 6. Leisure/Recreation

(productive use of free time)

- Limited organized activities
- Could make better use of time
- No personal interest

■ 7. Personality and behavior

(impulsivity, temperament and behavior)

- Inflated self-image
- Physically aggressive - tantrums
- Short attention span
- Poor frustration tolerance
- Inadequate guilt feelings
- Verbally aggressive – rude

■ 8. Attitudes/Orientation

(beliefs towards authorities or offending)

- Antisocial, procriminal attitudes
- Not seeking help
- Actively rejecting help
- Defies authority
- Callous, little concern for others

Changes in the YLS/CMI risk inventory scores as predictors of MST behavioral treatment goals

- All sub-scales showed a significant decrease during treatment and a significant decrease was found for the dynamic, but also the total scale which included static risk factors,
- NB: Causal relationships could not be demonstrated in this one-group, pre-post design,
- The largest change scores were observed for the subscales “Family/parenting”, “Personality/behavior” and “Education/employment”,
- The least changes were predicted by previous “Offenses/dispositions” and “Substance abuse” problems,
- At six months follow up there was a relapse in negative outcomes for some youths, but the level of problem behavior was substantially lower than at intake.

Future directions

- At the clinical level, antisocial peers are a significant moderator of MST effectiveness,
- There is an urgent need for more effective strategies for disengaging youth from deviant peers and encouraging friendships with prosocial peers,
- Increased research is also needed on family-based treatment of drug-abuse (MST/CM),
- Therapist work is complicated by ecological contexts containing colleagues, administrators and politicians, organizational mandates and constraints, and fiscal challenges,
- Increased research is needed on the organizational and services system factors that are critical for the sustainability of high-quality evidence-based programs, including strategies for recruitment, training and retaining therapists and supervisors,
- In routine practice, simple behavioral indicators of clinical outcomes are needed, and also contextually relevant risk predictors of reoffending after treatment.