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# Functions and Challenges of the Group Supervision System for Family Therapists Delivering the Meriden Model of Behavioral Family Therapy in Japan

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Kazumi Yoshino [1]

1. Mental Health, Japan Family Work Project, Tochigi, JPN

**Corresponding author:** Kazumi Yoshino, yosshi_paul@yahoo.co.jp

## Abstract

### Introduction

The Meriden Model of behavioral family therapy (BFT) is a home-based, psychoeducational approach for individual families introduced in Japan. After completing BFT training, family therapists receive group supervision to support their clinical practice. However, no standardized supervision method has been established in Japan, and the functions and challenges of the current supervision system remain unclear. This study aimed to describe the content of group supervision and explore its functions, perceived benefits, and challenges for family therapists practicing BFT in Japan.

### Methods

A qualitative descriptive study was conducted using multiple data sources. Supervision records and group interviews with family therapists who had completed BFT training were analyzed using inductive qualitative content analysis. Twenty-six supervision records from 17 supervisees were analyzed, and 11 family therapists participated in group interviews. The data were coded according to similarities in content and meaning, progressively categorized, and integrated across the two data sources.

### Results

Analysis of the supervision records identified 91 codes related to support requested by supervisees and 149 codes related to support provided by supervisors. Supervisees sought consultation regarding BFT methods and content, shared their feelings about practice, and discussed the development of systems for implementing BFT. Supervisors provided education on BFT methods, emotional support, opportunities for peer learning and support, and assistance with developing practice systems. Group interview analysis identified 59 codes, indicating that supervision functioned as a place for learning BFT practice, peer learning and support, and gaining reassurance and renewed energy. Challenges included limitations of online communication, the limited duration of supervision, and the absence of an established approach to assessing practice competence.

### Conclusion

Group supervision supported family therapists through educational, supportive, peer-learning, and administrative functions. Future development should include improving online supervision skills, extending support beyond the initial six sessions, and establishing methods for evaluating BFT practice competence.

**Categories:** Family/General Practice, Psychiatry, Quality Improvement
**Keywords:** behavioral family therapy, group supervision, japan, mental healthcare, psychiatry, qualitative research

## Introduction

The number of people with mental disorders in Japan has increased in recent years. According to the Patient Survey, approximately 5.8 million people in Japan received outpatient treatment for mental disorders in 2020, and promoting mental health and medical care has been identified as a priority for the Japanese government [1]. A nationwide survey conducted in FY2024 among family members of people with mental disorders found that 62.8% of respondents lived with the affected individual [2]. A study analyzing narratives written by family members of people with schizophrenia in Japan described how the onset of the illness can profoundly affect their lives [3]. However, family members may experience considerable caregiving burden, and appropriate information and support are important in addressing these challenges [4].

A 2009 report by the Japanese Ministry of Health, Labour and Welfare, entitled “Toward Further Reform of Mental Health Care and Welfare” [5], called for the promotion of home medical care and home-visit nursing to strengthen community-based support. In particular, the report stated that home-visit nursing should strengthen support from the perspectives of both service users and their families. This highlights the need for home-based support tailored to the needs of individual families [6].

Family support in Japan has included approaches such as family psychoeducation and other educational support for families [6]. However, a nationwide survey conducted in FY2024 found that, among respondents to a multiple-response question about support needs, 40.3% identified the need for home-based support and treatment services for service users and their families, while 56.9% identified the need for individualized support systems tailored to service users' wishes [2]. These findings highlight the importance of developing accessible, individualized support that responds to the circumstances and needs of each family. In Japan, efforts have also been made to develop and promote support for individual families [7,8].

Behavioral family therapy (BFT) is an evidence-based, skills-based psychoeducational intervention for people with mental health conditions and their families. Originally developed by Professor Ian Falloon and

colleagues in the early 1980s, BFT aims to increase understanding of mental health conditions and their treatment, reduce stress within families, and improve family communication and problem-solving skills. The intervention also involves helping families recognize early warning signs of relapse and develop plans to maintain recovery [9].

Family interventions have been incorporated into evidence-based treatment recommendations for people with psychosis and schizophrenia, including the Patient Outcomes Research Team (PORT) guidelines in the United States [10] and the National Institute for Health and Care Excellence (NICE) guidelines in the United Kingdom [11]. Meta-analyses have identified psychoeducational and coping-oriented interventions involving families as effective adjuncts to pharmacotherapy, with such interventions associated with reductions in relapse and hospitalization rates [12].

The Meriden Family Programme, developed by Birmingham and Solihull Mental Health NHS Foundation Trust in the United Kingdom, was established to promote the implementation of BFT in mental health services [13]. Importantly, the Meriden Family Programme is not a therapeutic intervention itself; rather, it provides training and ongoing support for healthcare professionals and trainers to facilitate the delivery of BFT in clinical practice [13]. In addition to professional training, the program emphasizes the importance of organizational support and collaboration among managers, commissioners, trainers, family therapists, service users, and carers to establish and sustain family work within healthcare services [13].

In Japan, the Meriden Model of BFT is implemented as an individualized, home-based psychoeducational approach for families, incorporating several components [9,14], including engagement, assessment, formulation, identification of early warning signs, communication skills training, problem-solving, and goal attainment [9,14]. This model was introduced in Japan in 2015, and training for behavioral family therapists in Japan began in 2018 [7,8].

In Japan, post-training group supervision is provided to family therapists who have completed the BFT basic training program. According to the Japan Family Work Project's training information, six online supervision sessions are provided at approximately two-month intervals following completion of the training [15]. Although this supervision system has been established, no standardized written protocol specifying the supervision approach has yet been developed. Practical approaches to supervision are shared among trainers through trainers' meetings. However, the extent to which the current supervision system supports family therapists in their BFT practice remains unclear. No previous studies have examined the functions and challenges of group supervision for therapists delivering BFT in Japan. Therefore, this study explored the functions, benefits, and challenges of group supervision for family therapists delivering BFT in Japan.

Preliminary findings from this study were presented as a conference abstract at the 27th Annual Conference of the Japanese Society for Psychiatric Rehabilitation, held in Osaka, Japan, on November 23, 2019.

## Materials And Methods

### Design

This study employed a qualitative descriptive design using multiple data sources [16]. A qualitative descriptive approach was selected because little is known about the functions and challenges of group supervision for BFT practitioners in Japan. Data were collected from group supervision records and group interviews with 11 family therapists who had completed BFT training. The content, functions, perceived benefits, and challenges of the supervision system were explored inductively.

### Content and structure of group supervision

Group supervision was provided six times to family therapists delivering BFT after completing a BFT training program. Family therapists became eligible for group supervision after commencing BFT practice. Therefore, the system allows family therapists to join group supervision at any time after they have started practicing BFT. Upon completion of the six supervision sessions, participants may request a Practitioner Certificate issued by the Japan Family Work Project, an organization established to promote the dissemination of BFT in Japan.

The group supervision sessions were conducted online via Zoom once every two months, with each session lasting one hour. Supervision groups were formed at the completion of the training program, with a maximum of five supervisees in each group. The supervisors served as trainers in the face-to-face BFT training program attended by the supervisees. Thus, the supervisors and supervisees had established professional relationships prior to the commencement of group supervision.

The supervision covered a broad range of issues related to the practice of BFT. Because participants shared cases from their clinical practice within the group, confidentiality and anonymity were agreed upon to prevent the identification of service users or their families. A co-supervisor documented the content of each supervision session using a standardized supervision record form. The form consisted of two sections: a checklist section in which the topics addressed during supervision were selected, and a free-text section in which the supervisor summarized the content of the supervision. Identifying information about service users or their families was not included in the free-text section.

### Participant selection and eligibility criteria

A criterion-based purposive sampling approach was used to identify eligible participants for this study. The target population comprised family therapists who had completed the BFT training program at either of two sites (City A and City B). Eligibility for participation in the study required completion of the training program and provision of informed consent.

Of the 20 family therapists who completed the BFT training program, 19 provided informed consent to participate in the study. One therapist who did not provide consent was excluded from the study.

For the analysis of supervision records, eligibility required that family therapists had commenced BFT practice and participated in group supervision. Therefore, therapists who had not commenced BFT practice

and consequently had not participated in group supervision were excluded from this analysis. Two of the 19 therapists who consented to participate did not meet these eligibility criteria. The supervision records of the remaining 17 family therapists were included in the analysis.

For the group interview analysis, eligibility required participation in a group interview and provision of informed consent for the interview. Of the 17 family therapists whose supervision records were analyzed, 11 participated in the group interviews conducted in City A and City B. All 11 provided informed consent and were included in the interview analysis. Of the six therapists who did not participate in the group interviews, one was unable to attend for health-related reasons, two were unable to participate due to scheduling conflicts, and the other three were unable to attend due to financial constraints related to travel costs, as they lived far from the interview venues. Their supervision records remained included in the supervision record analysis.

## Data collection and analysis

Data were collected from two sources: (1) group supervision records and (2) transcripts of semi-structured group interviews with family therapists who had completed BFT training. Data collection was conducted from November 2018 to March 2020. The supervision records covered the period from November 2018 to February 2020, while group interviews were conducted in both City A and City B in March 2020. Qualitative data from both sources were analyzed using inductive qualitative content analysis.

For the supervision records, the data consisted of descriptions extracted from the free-text sections. These descriptions concerned the support provided by supervisors and the support sought by supervisees in relation to the topics selected in the checklist sections. The extracted data were repeatedly read and coded based on similarities in content. The codes were then progressively abstracted and grouped into subcategories and categories [17]. The identified categories were organized chronologically according to the supervision sessions.

The group interviews were conducted in City A and City B by a researcher who was not involved in the supervision process. Each interview lasted one hour and was conducted using a semi-structured interview guide (Appendix A). The guide explored participants' experiences of group supervision, including aspects they found helpful or unsatisfactory and their suggestions for improvement. It also addressed their concerns and anxieties about practicing as family therapists, the support they had received or needed, and their expectations for future practice.

For participants who had commenced BFT practice but were not currently practicing it, the guide additionally explored the reasons for this, the support they had received, any support they felt had been lacking, and the support they would have liked to receive.

The interviews were audio-recorded and transcribed verbatim. Participants' facial expressions and the interviewer's impressions were also recorded in field notes. The transcripts were read repeatedly, and segments with coherent meanings were identified and coded. The codes were subsequently compared based on their semantic similarities and progressively abstracted to generate subcategories and categories [17].

All coding and categorization were conducted by the sole author, with guidance from a researcher experienced in qualitative research. The data were not independently coded by a second researcher.

## Descriptive analysis

No inferential statistical analyses were performed in this study. The number of codes identified in each category was counted for each group supervision session. These counts were descriptively summarized and presented in a stacked bar chart to illustrate changes in the categories of support requested by supervisees across the six supervision sessions. The analysis focused on describing the distribution and temporal changes in the codes rather than testing statistical hypotheses. Excel (Microsoft Corp., Redmond, WA) was used to tabulate the data and create the graphs.

Qualitative coding and categorization were performed manually, without the use of computer-assisted qualitative data analysis software. Excel was used only to tabulate code counts and create descriptive graphs.

## Rigor

To enhance the credibility of the analysis, the sole author repeatedly reviewed the coding and categorization processes. A researcher with expertise in qualitative research provided methodological guidance throughout the analysis. The author and this researcher discussed the developing codes, subcategories, and categories to examine the consistency and appropriateness of the interpretations. The second researcher did not independently code the data. In addition, methodological triangulation was employed by analyzing two different data sources: group supervision records and group interview transcripts. Comparing the findings from these sources helped provide a more comprehensive understanding of the functions and challenges of the group supervision system.

## Ethical considerations

This study was conducted with the approval of the Ethics Review Committee of Goryokai Hospital on January 19, 2018 (approval no.: 2018-2). Informed consent for participation in the study was obtained by the researcher, who was also involved in the BFT training program. Before obtaining consent, the researcher explained the purpose of the study both verbally and in writing, emphasizing that the study aimed to obtain participants' candid views and experiences to help improve the group supervision system. Participants were informed that participation was voluntary and that declining to participate would not adversely affect their participation in group supervision or their eligibility for certification. They were encouraged to express their opinions freely, including any concerns or criticisms regarding the supervision system.

In addition, each participant who took part in the group interviews provided consent to participate in the interviews. Participants were given both verbal and written explanations of the background and purpose of

the study, the research methods, the protection of personal information, the voluntary nature of participation, their right to withdraw from the study at any time, and how the research findings would be used and reported.

The group interviews were conducted in private rooms to ensure participants' privacy. Participants also agreed to maintain the confidentiality of personal information and other information shared by fellow participants during the group interviews.

## Results

### Characteristics of the participants

Of the 20 family therapists who completed the BFT training program, 19 consented to participate in the study. Among the 17 supervisees, 5 were men, and 12 were women. The 11 group interview participants comprised seven nurses, two psychiatric social workers, and two occupational therapists. The characteristics of the study participants are presented in Table *1*.

| Characteristics | Category | Participants in supervision record analysis (n = 17), n (%) | Group interview participants (n = 11), n (%) |
|---|---|---|---|
| Sex | Female | 12 (70.6%) | 7 (63.6%) |
| | Male | 5 (29.4%) | 4 (36.4%) |
| Age group (years) | 30-39 | 12 (70.6%) | 8 (72.7%) |
| | 40-49 | 3 (17.6%) | 2 (18.2%) |
| | 50-59 | 2 (11.8%) | 1 (9.1%) |
| Occupation | Nurse | 11 (64.7%) | 7 (63.6%) |
| | Psychiatric social worker | 4 (23.5%) | 2 (18.2%) |
| | Occupational therapist | 2 (11.8%) | 2 (18.2%) |

**TABLE 1: Characteristics of the study participants**

Note: This table was generated from the data collected in the present study and was not adapted from any previously published source.

### Findings of the supervision records

A total of 26 records documenting group supervision sessions conducted between November 2018 and February 2020 were included in the analysis. These records documented the supervision provided to the 17 family therapists who participated in the study. Analysis of the records yielded 91 codes related to support requested by supervisees and 149 codes related to support provided by supervisors.

The support requested by supervisees was categorized into 3 categories and 13 subcategories: (1) consultation regarding BFT methods and content, (2) sharing of family therapists' feelings, and (3) consultation regarding the development of systems for BFT practice.

The support provided by supervisors was categorized into 4 categories and 18 subcategories: (1) explanation of the structure and methods of BFT, (2) emotional support for family therapists, (3) provision of opportunities for peer support, and (4) support for developing systems for BFT practice. The key findings are described in the text, while detailed numerical results are presented in Tables *2*, *3*.

| Category | Subcategory (number of codes) | Excerpts from supervision records |
|---|---|---|
| Consultation regarding BFT methods and content | Consultation about how to conduct sessions and the model's methods (30) | "The observed problem-solving session was conducted around the topic of the service user connecting with their parents via smartphone with the speakerphone on. We discussed the issue but did not reach a conclusion. The question is whether observed problem-solving should be conducted only once or whether it can be repeated a second time" (Supervisee 41, Supervision 2). |
| | Consultation about the principles and structure of BFT (14) | "The ongoing case has progressed to the problem-solving stage. As this is a challenging case, regular home-visit nursing services will continue. When should we decide to conclude the family work intervention?" (Supervisee 108, Supervision 5). |
| | Practical consultation regarding individual cases (7) | "The mother devotes herself to her child, and I wonder whether this may be why she has difficulty identifying goals for herself" (Supervisee 25, Supervision 1). |

| | | |
|---|---|---|
| | Exchange of practical opinions among family therapists (4) | "During the engagement stage, the family (Fa) asked a question about a handout, and I explained the technique to them. I wonder how other trainers would explain this technique" (Supervisee 64, Supervision 3). |
| Sharing of family therapists' feelings | Expressing difficulties in BFT practice (20) | "Observed problem-solving was conducted without the family present. The family could not think of a topic to discuss, and although I tried to make some suggestions... The household is separated, communication is not going well, and conversation is kept to a minimum. I am wondering what the next step should be" (Supervisee 65, Supervision 3). |
| | Sharing updates on the progress of the sessions (7) | "The reported problem-solving has been completed, and next time we will move on to observed problem-solving. The father has become kinder and more positive towards the family, which feels very encouraging. I am thinking of holding a family meeting next time" (Supervisee 31, Supervision 2). |
| | Concerns about skills as a family therapist (2) | "The engagement stage is about to begin. As this is an Assertive Community Treatment team, many service users have severe mental health conditions. After considerable effort, a suitable case has finally been selected, and the therapist is preparing to begin BFT. However, the therapist feels anxious about implementing BFT for the first time, and the intervention has been repeatedly postponed due to the demands of daily work" (Supervisee 28, Supervision 1). |
| | Expressing confidence initiating BFT (1) | "Although this is a case in which building a therapeutic relationship is difficult, the service user knows the family therapists and has said that they would be willing to work with me. So, I think the intervention can begin smoothly" (Supervisee 26, Supervision 1). |
| | Sharing positive changes in families (1) | "The mother made a positive comment, saying that she had never seen the service user make such an effort before. This suggests that she has noticed changes in the service user" (Supervisee 40, Supervision 2). |
| | Sharing feelings after gaining a deeper understanding of BFT (1) | "Both family therapists were able to work together to deliver BFT. Home-visit nursing and BFT were provided, with BFT conducted once every three weeks. The case had progressed to the reported problem-solving stage. On July 1, the service user brought a notebook and showed it to the therapist, suggesting a high level of motivation. During a review with A (family therapist), it was noted that it would have been helpful to ask the service user about the notebook. Having both family therapists present also led to many new insights" (Supervisee 96, Supervision 5). |
| Consultation regarding the development of systems for BFT practice | Sharing methods for implementing BFT within the organization (2) | "The team discussed with the company staff how to integrate Assertive Community Treatment and BFT into their practice. They decided to introduce BFT to a case other than the therapist's own case" (Supervisee 30, Supervision 1). |
| | Questions about collaboration between BFT and other services (1) | "The usually quiet service user talks at length about their favorite manga. Would it be better to incorporate home-visit nursing sessions in addition to BFT? Is it appropriate to include home-visit nursing as part of the intervention?" (Supervisee 61, Supervision 3). |
| | Sharing how BFT could be introduced (1) | "I will be starting BFT support at Hospital C. One of the people who received BFT training in City D in March works at Hospital C, and we will be practicing together. Would it be appropriate for the two of us to provide BFT together? I am wondering how we should approach this" (Supervisee 92, Supervision 4). |

**TABLE 2: Categories and subcategories of support requested by supervisees**

Note: This table was generated from data collected in the present study and was not adapted from any previously published source.

| Category | Subcategory (number of codes) | Excerpts from supervision records |
|---|---|---|
| Explanation of the structure and methods of BFT | Advising on how to proceed with cases (36) | "With a new case, I think it is important to spend sufficient time on engagement. Building a therapeutic relationship is also important. If individual assessments are incorporated over several sessions, the family's needs can be elicited at the same time. Therefore, it may be appropriate to proceed with the engagement process while gradually introducing the assessment" (Supervisor 85, Supervision 5). |
| | Advising on BFT methodology (27) | "Regarding formulation, rather than moving immediately to the next step, it may be better to use the Communication and Problem-Solving Checklist (CPC) on page 52 of the text, take sufficient time to discuss the issues with the family, and then consider how to proceed" (Supervisor 24, Supervision 3). |
| | Explaining the principles of BFT (11) | "BFT is not simply about listening to the service user's interests and preferences. It may also be important to clarify the structure of the intervention and establish clear boundaries" (Supervisor 19, Supervision 3). |
| | Advising on | |

| | | |
|---|---|---|
| | the stance expected of a family therapist (7) | "Believe in the strengths of the service user and their family, and engage with them in ways that help them recognize their own strengths and abilities" (Supervisor 67, Supervision 4). |
| | Explaining the limitations of BFT (1) | "It might be better to distinguish between the issue of divorce and the issues addressed through BFT, at least initially" (Supervisor 64, Supervision 4). |
| Emotional support for family therapists | Praising good practice (12) | "It is wonderful to see such significant progress after the situation we had before. Please keep up the good work" (Supervisor 76, Supervision 5). |
| | Supporting family therapists' current practice (11) | "From what I have heard, things seem to be progressing well. Let's keep up the good work and continue moving forward" (Supervisor A, Supervision 1). |
| | Encouraging continued practice (8) | "Although this is a challenging case, support is needed. Do not give up. Take every opportunity to meet with the service user and continue building the relationship, as each encounter may lead to further opportunities for engagement" (Supervisor 30, Supervision 3). |
| | Acknowledging family therapists' efforts (2) | "It is impressive how far this case has progressed, considering how difficult it was to make progress at the beginning. You have worked very hard. You have also made detailed adjustments, such as the order in which things are done. Good work" (Supervisor 94, Supervision 6). |
| | Demonstrating an empathic stance (2) | "Some cases may have to be discontinued, so it is important that the family therapist does not become too discouraged" (Supervisor 46, Supervision 4). |
| | Discussing ways to alleviate fear regarding practice cases (1) | "The therapist also feels afraid of the father. Through the assessment process, the therapist can gain a better understanding of the father and reduce their feelings of fear" (Supervisor M, Supervision 2). |
| Provision of opportunities for peer support | Sharing experiences as family therapists (11) | "If it were me, I would first proceed with an assessment focused on the service user. If the partner also wished to participate, I might conduct an assessment focused primarily on the partner at a later point. However, for an initial case, I think I would proceed with an assessment centered on the service user" (Supervisor C, Supervision 1). |
| | Eliciting ideas from other family therapists (8) | "There is an easy-to-understand handout that we use as a combined resource, so I will give it to them" (Supervisor 110, Supervision 6). |
| | Jointly exploring responses to difficult cases as family therapists (3) | "I do not think it would be effective to proceed without the father. Would it be necessary to address the father's domestic violence in parallel with BFT? Please consider whether this would be possible and how we might approach the situation. We should also consult our supervisors in the UK about how to handle such a challenging situation" (Supervisor 34, Supervision 4). |
| | Eliciting praise from other family therapists (2) | (Comment from Family Therapist B): "If I were in this situation, I think I would be taken aback and struggle to know how to respond. I would feel that I couldn't provide that kind of support myself, and I would be really impressed by someone who could" (Supervisor 3, Supervision 3). |
| | Sharing plans for developing the future BFT system (3) | "By approaching the ward where a potentially suitable case is being treated, we can introduce BFT to the ward staff and approach the case at the same time, thereby establishing pathways for future referrals. As pioneers in this field, I believe that developing these pathways is also important for ensuring the future development of BFT" (Supervisor 6, Supervision 4). |
| Support for developing systems for BFT practice | Advising on developing systems for BFT practice (2) | “I have become a board member of the family association in city E. Since we will also be working with the family association in the same community, I think we will be able to support them together” (Supervisor 105, Supervision 6). |
| | Sharing the need to develop new approaches to practice (2) | "There are no fixed rules about how BFT should be provided, so you can use a method that is easy for you to implement. At our hospital, when two therapists are involved, we designate a primary and a secondary therapist, with the primary therapist continuing to work with the case throughout. However, the assessment is completed intensively by both therapists. This has a major advantage because conducting the assessment with two therapists allows us to begin sessions involving the entire family as early as possible. Going forward, I would like you to develop various pathways and approaches to providing BFT" (Supervisor 69, Supervision 4). |

**TABLE 3: Categories and subcategories of support provided by supervisors**

Note: This table was generated from data collected in the present study and was not adapted from any previously published source.

To explore changes in supervision content over time, the categories and subcategories were arranged chronologically according to the six supervision sessions (Figures 1, 2). The values presented in the graphs represent the number of codes.

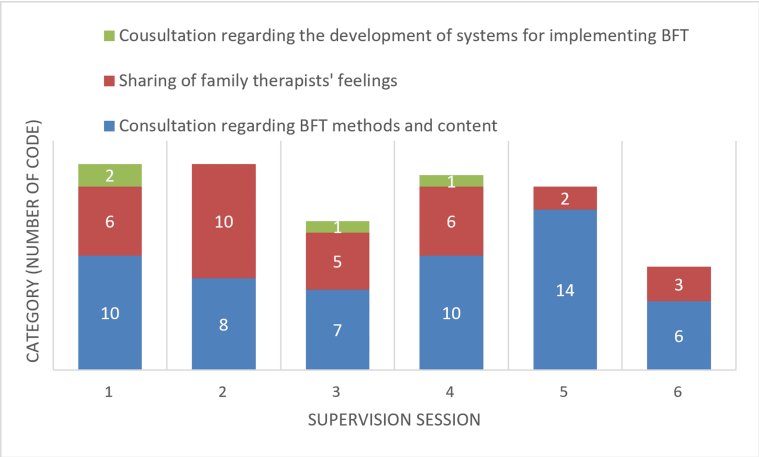



**FIGURE 1: Support requested by supervisees**

BFT: Behavioral family therapy.

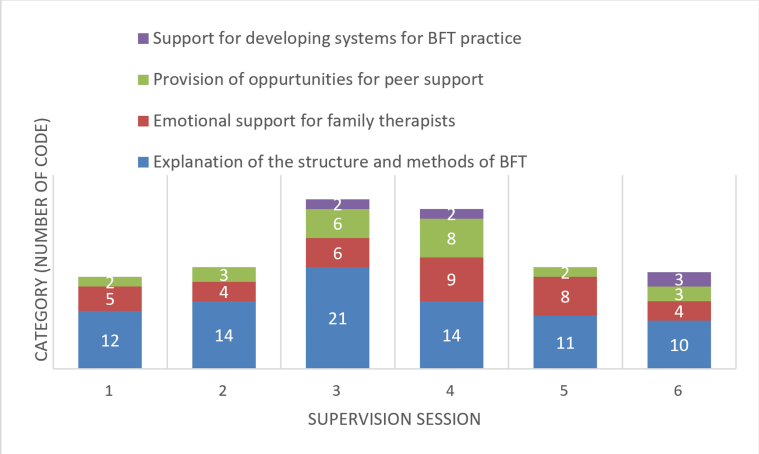



**FIGURE 2: Support provided by supervisors**

BFT: Behavioral family therapy.

## Support requested by supervisees

A summary of the support requested by supervisees is presented in Table 2. The largest category of support requested by supervisees is related to the methods and implementation of BFT. Supervisees frequently sought advice regarding session management, application of BFT principles, and case-specific challenges. The following excerpts from the supervision records illustrate these concerns:

"The mother devotes herself to her child, and I wonder whether this may be why she has difficulty identifying goals for herself" (Supervisee 25, Supervision 1).

"The observed problem-solving session was conducted around the topic of the service user connecting with their parents via smartphone with the speakerphone on. We discussed the issue but did not reach a conclusion. The question is whether observed problem-solving should be conducted only once or whether it can be repeated a second time" (Supervisee 41, Supervision 2).

Other subcategories reflected similar concerns about BFT practice and therapist development (Table 2).

## Support provided by the supervisor

A summary of the support provided by supervisors is presented in Table 3. Corresponding to the support requested by supervisees, the largest category of support provided by supervisors is related to the methods and structure of BFT (Table 3). Supervisors frequently provided guidance on the practical application of BFT to individual cases, its methods and underlying principles, and the professional attitudes expected of family therapists. The following excerpts from the supervision records illustrate these concerns:

"With a new case, I think it is important to spend sufficient time on engagement. Building a therapeutic

relationship is also important. If individual assessments are incorporated over several sessions, the family's needs can be elicited at the same time. Therefore, it may be appropriate to proceed with the engagement process while gradually introducing the assessment" (Supervisor 85, Supervision 5).

"Regarding formulation, rather than moving immediately to the next step, it may be better to use the Communication and Problem-Solving Checklist (CPC) on page 52 of the text, take sufficient time to discuss the issues with the family, and then consider how to proceed" (Supervisor 24, Supervision 3).

Other subcategories reflected similar concerns about supporting therapists in their clinical practice (Table *3*).

## Quantitative changes in the content of support

When the support requested by supervisees and the support provided by supervisors were examined chronologically, the most frequent type of support provided by supervisors throughout all supervision sessions was explanation of the structure and methods of BFT, while the most frequent support requested by supervisees was consultation regarding BFT methods and content. Chronological analysis demonstrated distinct changes in the content of supervision over time.

In contrast, consultations regarding the development of a system to support the supervisees' BFT practice began in the first supervision session and continued through the fourth session, which was the midpoint of the supervision process. Support from the supervisors for developing a system for BFT practice began in the third supervision session, also around the midpoint of the supervision process, and continued through the final supervision session.

In addition, the emotional support needs expressed as sharing of family therapists' feelings decreased as supervision progressed, whereas emotional support provided by supervisors remained relatively constant as a theme throughout all six sessions. The provision of opportunities for peer support varied in frequency across sessions but was provided throughout the entire supervision period.

Consultations in the early supervision sessions focused mainly on understanding BFT methods and applying the model to practice. In later sessions, consultations increasingly concerned case management and termination of the intervention. In other words, the focus of supervision shifted over time from understanding the BFT model and its methods to the practical application of BFT in individual cases.

## Findings of the group interviews

From participants' accounts of their experiences of supervision, 59 codes were extracted and organized into two categories and six subcategories. Key findings are described in text, while detailed numerical results are presented in Table *4*.

| Category | Subcategory (number of codes) | Representative quotation |
|---|---|---|
| Functions of supervision | A place for peer learning and support (24) | "I found that group supervision provided a really strong sense that I could learn on my own. For example, beyond what the trainer told us, I would think, 'Oh, I see. This person is doing things this way, so maybe I could try that approach myself'" (SM3,5,10). |
| | A place for learning how to practice BFT (11) | "When I actually tried to start doing it on my own, I found that I would get confused about even small things. I would mix up the order of things, and I realized that the way you proceed—and even the order in which you proceed—differs depending on the family. I found myself struggling with it quite a lot. I thought I would be able to ask my colleagues relatively easily, but because we work in different places, I surprisingly didn't have many opportunities to do so. Since we had supervision, I feel that I was able to ask a lot of questions" (OF2,3,7). |
| | A place to gain reassurance and renewed energy (10) | "It was such a supportive environment, and it really helped me. There was never any criticism like, 'Is that really appropriate structurally?' or 'I wonder whether that is the right way to do it.' Instead, they accepted what I was doing and then helped me return to the framework. I felt that this was consistently very helpful" (SF2,2,15). |
| | Benefits of Zoom format (4) | "I live in a somewhat remote area, so even if I were to come to city E, it would be quite a long way and would take a lot of time. Being able to do it right there is really convenient" (SM5,14,32). |
| Limitations of the current supervision | Limitations of the Zoom format (5) | "With Zoom, I don't really know when or how I should join in, so I just stay quiet and listen the whole time" (OF1,12,17). |
| | Limitations of the current format of supervision sessions (5) | "When I think about what comes next, the supervisors and trainers are nearby at the moment, so I am somehow managing to keep going with the feeling that I have to do it, I have to do it. But once they are no longer there, when I have to move on to the next case, I am a little worried about how much motivation I will be able to generate on my own. So, I think that if there were someone who could continue to support me, or encourage me from behind, through a second or third case as well, I might be able to get started a little sooner—not necessarily smoothly, but at least a little sooner. And perhaps that would allow me to provide BFT support to more people" (SF5,17,33). |

**TABLE 4: Findings of the group interview**

Note: This table was generated from data collected in the present study and was not adapted from any previously published source.

*Functions of Supervision*

A summary of the functions of supervision identified through the group interviews is presented in Table 4. The most frequently coded subcategory was "A place for peer learning and support" (24 codes), followed by "A place for learning how to practice BFT" (11 codes) and "A place to gain reassurance and renewed energy" (10 codes). These findings suggest that participants particularly valued the opportunities for peer learning and support offered through group supervision. The following quotation illustrates this subcategory:

"I found that group supervision provided a really strong sense that I could learn on my own. For example, beyond what the trainer told us, I would think, 'Oh, I see. This person is doing things this way, so maybe I could try that approach myself'" (SM3, 5, 10).

The remaining subcategories reflected the various roles that group supervision played in supporting supervisees (Table 4).

*Limitations of the Current Supervision*

A summary of the limitations of the current supervision is presented in Table 4. The limitations identified by the participants concerned not the content of supervision itself but rather the format in which supervision was conducted. As illustrated by the following examples, challenges arising specifically from the online format of supervision represent a distinctive finding of this study:

"With Zoom, I don't really know when or how I should join in, so I just stay quiet and listen the whole time" (OF1,12,17).

Another subcategory also reflected the difficulties experienced by supervisees with the current group supervision system (Table 4).

## Discussion

The support provided in group supervision for family therapists was clarified from the perspectives of both supervisors and supervisees. The following discussion considers how the current supervision system functions to support family therapists in their BFT practice after completing family therapist training.

### Functions and perceived benefits of group supervision as the support system for family therapists

The analysis of the supervision records showed that supervisors' support addressed the three main areas of support needs expressed by supervisees: consultation regarding BFT methods and content, sharing of family therapists' feelings, and consultation regarding the development of systems for BFT practice. In response to these needs, supervisors provided explanations of the structure and methods of BFT, emotional support for family therapists, opportunities for peer support, and assistance with developing systems for BFT practice. These findings suggest that the supervision system addressed many of the support needs expressed by supervisees. The group interview findings complemented these results, as participants described group supervision as a place to learn how to practice BFT, engage in peer learning and support, and gain reassurance and renewed energy.

These findings are broadly consistent with previous research on clinical supervision. Milne et al. [18], in a synthesis of 24 empirical studies, proposed a basic model of clinical supervision highlighting the role of supervisory interventions in influencing supervisees' clinical practice. In the present study, supervisors provided explanations of BFT methods, advice on individual cases, and opportunities to exchange practical opinions. These activities can be understood as educational interventions that support the development of clinical skills. Aarons et al. [19] addressed the implementation of evidence-based practice in public service sectors through a conceptual model, highlighting the importance of understanding the factors influencing implementation in clinical practice. Furthermore, Kadushin and Harkness [20] identified four major functions of supervision: support, education, administration, and evaluation. The present study identified the educational, supportive, and administrative functions of supervision, although a systematic evaluative function was not evident. Milne [21] examined the empirical definition of clinical supervision, further underscoring the importance of clarifying the nature and functions of supervision.

More specifically, in response to supervisees' consultations regarding BFT methods and content, such as questions about how to conduct sessions and apply the model, supervisors explained the structure and methods of BFT and encouraged the exchange of practical ideas among family therapists. Group supervision therefore functioned as an educational setting in which family therapists could develop their understanding and practical skills for delivering BFT.

Regarding the supportive function, supervisors responded to supervisees' need to share their feelings, including difficulties encountered in BFT practice and updates on the progress of sessions. They provided emotional support by acknowledging family therapists' efforts, praising their work, and jointly exploring solutions to difficulties encountered in practice. Supportive supervision has also been examined in previous research. Aftab et al. [22] reported that an enhanced supportive supervision intervention improved selected clinical performance indicators among community health workers. Although their study involved a different professional context and assessed performance quantitatively, both studies highlight the importance of supervisory support and feedback in helping practitioners improve their practice. In the present study, the supervision records documented instances in which supervisors and supervisees jointly explored responses to difficult cases and shared their experiences related to family therapy practice.

The findings concerning peer learning and support are also noteworthy. The group interview analysis identified peer learning and support as a subcategory of the functions of supervision, while the analysis of supervision records identified the provision of opportunities for peer support as a category of support provided by supervisors. These findings suggest that the supervisor-led group supervision provided opportunities for peer learning and mutual support among supervisees.

In this study, "peer learning within group supervision" refers to opportunities for supervisees to exchange their practice experiences, share practical ideas, discuss clinical cases, and provide mutual support during sessions facilitated by designated supervisors. This is distinct from a peer-supervision arrangement in which supervisory consultation is conducted among peers rather than led by a designated supervisor.

Previous literature has highlighted the benefits of group supervision, including opportunities for peer feedback, observational learning, and professional networking [23]. One possible explanation for these findings is that supervisors, who also had experience practicing BFT, facilitated collaborative learning by encouraging supervisees to share their experiences and learn from one another.

Another notable finding from the graphs was that the number of codes related to the sharing of family therapists' feelings by supervisees decreased as supervision progressed. In terms of content, there was little change in the sharing of positive feelings, such as updates on the progress of sessions, whereas codes reflecting negative feelings, such as difficulties in BFT practice, decreased. This pattern may suggest that opportunities to discuss and address difficulties through supervision helped family therapists manage some of the challenges they encountered in practice. However, the decrease in the number of codes does not necessarily indicate that the actual level of distress experienced by supervisees decreased.

One possible explanation is that this pattern may have been associated with opportunities to discuss and address difficulties in BFT practice, together with the educational and supportive functions of supervision. These functions included emotional support for family therapists and the provision of opportunities for peer support. Supervisors also modeled the supportive, non-judgmental stance expected of a family therapist in accordance with the principles of BFT. A positive supervisory alliance has been identified as a central factor supporting supervisees' confidence and professional growth [24]. The principles of BFT emphasize a collaborative and supportive approach tailored to the needs of individual families [9]. These aspects of supervision may have helped create an environment in which supervisees felt supported and able to discuss difficulties in their BFT practice.

Another important finding concerned the development of systems for BFT practice within organizations. Supervisees discussed concrete practical issues, such as how BFT should be provided within their organizations and how it should be coordinated with other services. In contrast, supervisors addressed broader issues, such as the need to develop new approaches to practice and establish systems for BFT implementation. This difference suggests that supervisees tended to focus on immediate practical challenges, whereas supervisors also considered the longer-term development of BFT practice within their organizations. Because BFT was a relatively new form of support being promoted for wider implementation in Japan, these discussions reflected the distinctive circumstances of this period and the role of family therapists as pioneers in developing the practice. Opportunities for BFT training and supervision in Japan

have remained limited [7,8,13,15]. In this context, group supervision played an important role not only in supporting therapists' clinical practice but also in facilitating the development of local implementation systems.

This organizational role of supervision can be considered in relation to the implementation framework proposed by Falloon et al. [25], which emphasizes the importance of organizational and contextual factors in the adoption, implementation, and sustainment of evidence-based practices. In the present study, supervision provided a forum for discussing how BFT could be incorporated into existing services and how collaboration with other services could be established. These findings suggest that group supervision may contribute to the implementation of BFT not only by supporting individual therapists but also by addressing organizational challenges associated with introducing and sustaining a new intervention.

## Practical implications

The findings of this study have several practical implications for the design and implementation of group supervision for family therapists practicing BFT. First, group supervision should provide a balanced combination of educational guidance on BFT methods, emotional support, and opportunities for peer learning and mutual support. Supervisors play an important role not only in providing professional guidance but also in facilitating active participation and interaction among supervisees. This is particularly important in online group supervision, where some participants may experience difficulty knowing when or how to contribute to discussions.

Second, supervision should address not only individual clinical cases but also organizational issues related to implementing BFT within existing services and coordinating with other professionals and services. Third, the findings highlight the need to consider continued support beyond the initial six supervision sessions and to develop appropriate approaches for assessing family therapists' practice competencies. These considerations may help strengthen the supervision system and support the sustainable implementation of BFT in clinical practice.

To my knowledge, this is a rare study to examine the functions and challenges of group supervision for therapists delivering the Meriden Model of BFT in Japan. The findings provide practical insights into how supervisor-led group supervision can support both the professional development of family therapists and the organizational implementation of family interventions in settings where BFT is newly introduced.

## Limitations and challenges of the group supervision system

The group interview analysis identified several limitations of the current supervision system. Because supervisees and supervisors lived in different regions, supervision was conducted online using Zoom. Although participants described the convenience of online supervision as a benefit of the Zoom format, they also identified limitations, including the time required and the difficulty of communication compared with face-to-face supervision.

Sherbersky et al. [26] indicated that supervisors' proficiency in technology in online environments is important for effective communication in supervision. It has also been pointed out that nonverbal communication can be easily overlooked, particularly in group supervision [27]. In the current supervision system, supervisors do not receive specific technical training for online supervision, and the quality of online supervision depends substantially on the individual supervisor's IT skills.

Previous studies have identified three types of "presence" that are necessary to facilitate effective interaction between supervisors and supervisees in telesupervision: "social presence," referring to the perception that both parties are real persons communicating with each other; "psychological presence," in which online technology is regarded merely as a medium and the focus remains on the relationship between the supervisee and supervisor; and "emotional presence," referring to the supervisor's ability to convey a willingness to support the supervisee in difficult situations [28,29].

In the current supervision system, supervisors are trainers who provide a five-day, face-to-face training program for family therapists and subsequently provide supervision to the participants of that training. Therefore, as supervisors and supervisees have had opportunities to meet directly in person before beginning supervision, social presence may have been established. Furthermore, connections and trusting relationships developed through the training program may have helped establish psychological presence during supervision.

As indicated by the findings of the present study, supervisees experienced various difficulties while implementing BFT and required emotional support. In practice, supervisors provided support such as acknowledging family therapists' efforts in implementing BFT and jointly exploring responses to difficult cases. These findings suggest that emotional presence was also supported within the current supervision system.

However, although supervisors provided emotional support to help family therapists cope with the difficulties they encountered in their practice, it remains unclear to what extent supervisors' willingness to help was effectively conveyed to supervisees in an online environment, where nonverbal communication can be more difficult to perceive. At present, effective communication skills in online supervision appear to depend considerably on the individual competencies of supervisors. Therefore, training supervisors in effective online communication skills may be necessary to enhance the quality of supervision. Developing such training represents an area for further improvement in the current supervision system.

As noted above, the content of support provided by supervisors demonstrated the "support," "education," and "administration" functions of supervision, but the "evaluation" function was not identified. Contemporary supervision models emphasize competency assessment and evaluation as essential elements of effective supervision [30]. At present, there are no specific evaluation criteria for assessing supervisees' practice competencies, and assessment is based largely on the supervisees' own perceptions of their practice. The supervision records included statements such as concerns about skills as a family therapist. Supervisors responded to such expressions of anxiety through praise and support, but these responses did

not constitute an approach based on systematic competency assessment.

## Strengths of the study

This study has several strengths. First, it employed a qualitative descriptive design using two complementary data sources: group supervision records and semi-structured group interviews. The combination of these sources enabled an examination of both the support requested by supervisees and the support provided by supervisors, as well as the supervisees' own experiences, perceived benefits, and challenges of group supervision.

Second, the study analyzed 26 supervision records from 17 family therapists across six group supervision sessions. This allowed the examination of changes in support needs and supervisory responses over the course of the supervision process, rather than relying on data from a single session or time point.

Third, the study included family therapists who had completed BFT training at two sites in Japan, providing insights into group supervision within actual clinical and organizational contexts. By examining the supervision system from both the perspective of the supervision records and the experiences of participating family therapists, this study provides context-specific insights into the functions and challenges of group supervision for practitioners delivering the Meriden Model of BFT in Japan, an area that has received limited research attention.

## Limitations of the study and future challenges

The preliminary findings of this study were presented at the 27th Annual Conference of the Japanese Society for Psychiatric Rehabilitation on November 23, 2019. However, data collection and analysis continued after the conference presentation. The 26 supervision records included in the final analysis were generated between November 2018 and February 2020, and the group interviews were conducted in March 2020. Therefore, the conference abstract reported preliminary findings and did not represent the completed study. The COVID-19 pandemic emerged during the later phase of the study. Although it did not affect data collection, the increased workload associated with infection prevention and control measures at the researcher's workplace limited the time available for data analysis and delayed its completion.

Regarding the continuity of the supervision system, no formal written manual has been developed. According to information provided by trainers involved in the program, the basic structure and operating principles have been maintained through the transfer of practical knowledge from experienced trainers to newer trainers. This process has helped maintain the general framework of the supervision system examined in this study. However, because the system relies on experience-based knowledge transfer rather than a standardized written manual, some variation in the way individual supervisors conduct sessions may occur. Therefore, the findings should be interpreted as reflecting the general framework and functions of the supervision system rather than every aspect of its implementation.

This study has several methodological limitations. First, it involved a relatively small sample of family therapists who had completed the BFT training program at two sites in Japan. Therefore, the transferability of the findings to other family therapists and group supervision systems operating in different clinical and organizational contexts may be limited.

Second, because this was a qualitative descriptive study, it was not designed to establish causal relationships. Although the findings suggest that group supervision provided educational and emotional support and opportunities for peer learning, this study cannot establish whether supervision directly improved therapists' clinical competencies or the quality of care provided to service users.

Third, selection bias may have affected the group interview findings. Although the supervision records of 17 family therapists were analyzed, only 11 participated in the group interviews. The experiences and opinions of those who did not participate may have differed from those of the interview participants, and their perspectives may therefore not have been fully reflected in the interview findings. In particular, three therapists were unable to participate because of travel costs associated with their distance from the interview venues. Their experiences and perspectives regarding online supervision may have differed from those of the participants who attended the interviews. Consequently, the findings may not fully reflect the views of therapists for whom online supervision may be particularly important.

Another potential limitation is that the researcher who obtained informed consent was also involved in the BFT training program. Although participants were explicitly informed that declining to participate would not affect their participation in group supervision or their eligibility for certification, the researcher's dual role may have influenced their willingness to participate or express critical opinions. This may have introduced social desirability bias. In addition, because the data were collected through group interviews, participants may have been reluctant to express negative opinions in front of other participants.

With regard to the supervision records, they were originally prepared for routine supervision purposes rather than specifically for research, which may have limited the level of detail and consistency of the information available for analysis. Another limitation relates to the nature of these records, which were supervisors' written summaries rather than verbatim transcripts of the sessions. The recorders' subjective interpretations, including their selection of topics and the emphasis placed on particular issues, may therefore have influenced the content of the records. Although the information from these records was considered alongside the group interview data, the influence of recorder subjectivity on the analysis cannot be excluded. In particular, information concerning the support requested by supervisees was mediated through the co-supervisors' observations and interpretations rather than being based on supervisees' direct accounts. Consequently, the perspectives of supervisees may not have been fully represented in the supervision records.

Furthermore, member checking was not conducted. Therefore, the interpretations and categories developed through the analysis were not returned to participants for confirmation. This may have limited opportunities to verify whether the findings accurately reflected their experiences and perspectives.

Future research should proceed in several complementary directions. First, larger-scale quantitative studies involving family therapists and supervisors from multiple training sites and institutions are needed to further examine the functions, perceived benefits, and challenges of the current group supervision system. Such studies would help determine whether the findings of the present qualitative study are consistent across different clinical and organizational settings.

Second, further research is needed to develop appropriate methods for evaluating family therapists' competencies in delivering BFT. These methods could include assessments of therapists' knowledge and practical skills, confidence in implementing BFT, and fidelity to the Meriden Model. Longitudinal studies examining changes in these indicators before and after supervision, as well as during the follow-up period, would help clarify the contribution of supervision to therapists' professional development. In addition, studies following therapists after completion of the initial six supervision sessions would be valuable in identifying their ongoing support needs, the challenges they encounter when continuing BFT practice, and the types of support required to maintain their clinical practice.

Third, based on the findings of the present study, a structured supervision manual should be developed to clarify and standardize the objectives, structure, and key components of group supervision. The manual could incorporate the educational and supportive functions of supervision, opportunities for peer learning and mutual support, and support for developing organizational systems for BFT practice. Following its development, empirical studies should be conducted to evaluate the feasibility, acceptability, and consistency of implementation of supervision based on the manual, as well as its effects on therapists' knowledge, confidence, and clinical competencies. Comparative or longitudinal studies would be particularly useful in examining whether manual-based supervision improves the quality and consistency of supervision.

Finally, future studies should also examine whether improvements in supervision and therapists' competencies translate into better support for service users and their families. Outcomes such as family members' burden, communication and problem-solving skills, satisfaction with support, and service users' clinical and social functioning could be explored. Such research would help clarify the relationships between the quality of supervision, therapists' clinical practice, and outcomes for service users and their families. Further efforts are also needed to improve supervisors' skills in online communication and facilitation to enhance the quality of group supervision.

## Conclusions

This study identified several functions and perceived benefits of group supervision for family therapists delivering BFT in Japan. Group supervision provided education on BFT methods, emotional support, opportunities for peer learning and support, and support for developing systems for BFT practice. Participants also perceived group supervision as a place to learn how to practice BFT, gain reassurance, and share experiences with peers. However, challenges were identified regarding online communication, the limited duration of supervision, and the absence of an established approach to assessing family therapists' practice competence. These findings suggest that future development of the supervision system should focus on enhancing online communication, providing continued support beyond the initial six sessions, and establishing appropriate approaches to assessing BFT practice competence.

## Appendices

### Appendix A

*Group Interview Guide*

The following questions were used to explore participants' experiences of group supervision, concerns and support needs related to BFT practice, and thoughts about their future activities.

1. How would you describe your experience of the group supervision?

- What aspects did you find helpful?

- Were there any aspects you were dissatisfied with, or any requests for improvement?

2. At this point, what concerns or anxieties do you have about practicing as a family therapist delivering BFT?

- What kind of support would be helpful to you?

- Have you been able to identify this support yourself?

3. For participants who had commenced BFT practice but were not currently practicing BFT:

- What were the reasons you were no longer practicing BFT?

- What support, if any, had you received so far?

- What kind of support would you like to receive?

4. What requests or suggestions do you have regarding the support provided to family therapists?

5. What are your thoughts about your future work as a family therapist delivering BFT?

## Additional Information

### Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

**Concept and design:** Kazumi Yoshino

**Acquisition, analysis, or interpretation of data:** Kazumi Yoshino

**Drafting of the manuscript:** Kazumi Yoshino

**Critical review of the manuscript for important intellectual content:** Kazumi Yoshino

## Disclosures

**Human subjects:** Informed consent for treatment and open access publication was obtained or waived by all participants in this study. Goryokai Hospital, Sapporo, Hokkaido, Japan, issued approval 2018-2. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** This study was supported by the Daido Life Welfare Foundation through its Regional Health and Welfare Research Grant. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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