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Exploring Service Users' Experiences of the Meriden Model of Behavioral Family Therapy in Japan: A Qualitative Study

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Abstract

Background

The Meriden Model of Behavioral Family Therapy (BFT) is a home-based family psychoeducation intervention designed to improve communication, collaborative problem-solving, and recovery within families affected by mental illness. Although BFT has been introduced in Japan, little is known about how service users experience the intervention and perceive its contribution to recovery. This study explored the lived experiences of service users who received BFT in Japan.

Materials and methods

A qualitative study was conducted with 14 service users who had completed BFT at two healthcare institutions in Japan. Five focus group interviews were carried out and audio-recorded. Verbatim transcripts were analyzed using narrative analysis to explore how participants constructed meanings from their experiences over time. Codes were generated inductively and organized into progressively higher levels of abstraction. Categories were subsequently arranged along a temporal axis to develop a storyline of participants' experiences before, during, and after BFT.

Results

Fifty-three third-level codes (Code 3) were identified. Before BFT, participants described struggling with symptoms, medication-related difficulties, self-stigma, social isolation, and challenges in family communication. In the period following BFT, participants reported maintaining stability through self-management, strengthening family relationships, and using collaborative problem-solving strategies. At the time of the interviews, participants described improved family communication, greater self-understanding, enhanced self-acceptance, and increased confidence in pursuing personally meaningful goals. Many participants perceived that communication skills, family rules, and problem-solving approaches learned during BFT had become integrated into everyday life. Although some participants experienced emotional challenges while reflecting on personal and family issues during the intervention, they generally viewed the involvement of family therapists as supportive and helpful.

Conclusions

Participants perceived recovery as extending beyond symptom management to include improved family relationships, enhanced self-understanding, and the pursuit of meaningful life goals. The findings suggest that BFT may support recovery-oriented family relationships and collaborative coping in Japanese community mental health settings. Further research with larger, more diverse populations is needed to clarify the contribution of BFT to recovery and family well-being.

Categories: Therapeutics, Family/General Practice, Psychiatry
Keywords: behavioral family therapy, community mental health, family psychoeducation, family relationships, mental illness, qualitative research, recovery

Introduction

For more than two decades, efforts to promote community-based mental health care and reduce reliance on long-term psychiatric hospitalization have gradually expanded in Japan [1]. However, regional disparities in community resources and a lack of direct support for families have placed substantial burdens on family caregivers [2]. In particular, approximately 60% of people with mental illness in Japan live with their families [3]. This situation has been influenced by social structural issues associated with the Japanese family system, in which family members were legally required to assume guardianship responsibilities [4], as well as by persistent stigma rooted in family etiological theories [5,6]. These factors have placed a substantial burden on families.

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In Western countries, where deinstitutionalization began more than 20 years earlier than in Japan, early research identified an association between family living environments and the course of schizophrenia, including relapse following hospital discharge [7]. In family research, expressed emotion (EE) refers to the emotional attitudes and behaviors displayed by relatives toward a family member with mental illness, particularly criticism, hostility, and emotional overinvolvement [7]. Families characterized by high levels of EE have consistently been associated with increased relapse rates among individuals with schizophrenia [7]. The EE literature suggested that family interactions may influence the course of severe mental illness and highlighted the importance of supporting families, not only service users. Consequently, a range of family-based interventions, including family psychoeducation and Behavioral Family Therapy (BFT), were developed to reduce family stress, improve communication, enhance problem-solving, and promote collaborative coping within families [8-10].

Family psychoeducation was subsequently introduced in Japan, where families also began to be regarded as collaborators in treatment. However, this perspective continued to emphasize families primarily as partners in treatment, and family members often continued to make substantial personal sacrifices in their caregiving roles [11]. Furthermore, family psychoeducation did not become widely disseminated within the Japanese context at that time because of the realities of psychiatric care, including staff shortages and difficulties in securing sufficient time for interventions [12].

It was not until the 2000s that greater emphasis was placed on families as recipients of support in their own right. The Kohnodai model, adapted from McFarlane's approach [13] for Japanese psychiatric settings, is currently the most widely used family psychoeducation model within Japanese psychiatric services [14]. Similar to McFarlane's model, it is a hospital-based multifamily psychoeducation program involving multiple families and service users [13,14].

Against this background, the author has been working to disseminate the Meriden Model of BFT, a home-based family psychoeducation intervention, in Japan [15]. The Meriden Model of BFT is a psychoeducational model developed in 1998 by the Meriden Family Program (Family Research and Training Center) at the Birmingham and Solihull Mental Health NHS Foundation Trust in the United Kingdom [16]. Family therapy encompasses a range of interventions that seek to improve communication, relationships, and problem-solving among family members [8,9]. BFT is a structured family intervention that combines psychoeducation, communication skills training, and problem-solving techniques to support individuals with mental illness and their families [9,17]. Unlike many traditional family therapy approaches that primarily focus on family dynamics and interpersonal relationships, BFT emphasizes acquiring practical communication and problem-solving skills that can be applied in everyday family life.

Furthermore, unlike hospital-based multifamily psychoeducation programs, the Meriden Model is delivered to individual families in their home environment and emphasizes collaborative goal setting, communication skills training, and structured problem-solving tailored to each family's circumstances [16]. Previous studies of behavioral family interventions and family psychoeducation have demonstrated benefits in reducing relapse rates, improving medication adherence and social functioning, and reducing family stress among service users with schizophrenia and bipolar affective disorder [17-19]. More recently, the model has also been applied to families experiencing a range of mental health problems, including schizophrenia, bipolar disorder, schizoaffective disorder, and other severe and enduring mental health conditions [20].

BFT may support personal recovery by facilitating understanding, communication, and collaboration within families [16]. However, the effectiveness of BFT in Japan has not yet been sufficiently established, and its applicability in the Japanese cultural context requires further examination. Therefore, this study aimed to explore the experiences of service users who received BFT in Japan, focusing on perceived changes in family relationships, self-understanding, and recovery over time, as well as participants' perceptions of the role of BFT in these processes.

Materials And Methods

Overview of the Meriden Model of BFT

BFT aims to enable service users and their families to solve everyday problems independently, without ongoing involvement from family therapists, while encouraging each family member to identify and achieve their own goals and hopes [16]. To achieve this aim, sessions lasting approximately one hour are provided to service users and their families through home visits, usually once a week to once every two weeks [16]. The number of sessions varies depending on the number of participating family members and their skill levels but typically ranges from 10 to 15 sessions [16].

All BFT sessions were delivered by therapists who had completed the BFT training program and were either receiving post-training supervision or had completed the six-session supervision program. To promote adherence to the Meriden Model, therapists used a Japanese translation of the official Meriden Family Program practice manual. They implemented the intervention according to the procedures described in the manual. The same manual, training requirements, and supervision procedures were used at both participating institutions, and no site-specific modifications were made. Although therapists followed the

procedures described in the official practice manual, no formal fidelity assessment was conducted.

The intervention adopts a behavioral approach focusing on observable actions rather than internal mental states [9]. Although sessions generally follow the sequence outlined in Table *1*, their structure can be flexibly adapted according to the circumstances and needs of each family [16]. Furthermore, sessions are conducted with established ground rules to ensure that they provide an effective learning environment for the family [16].

Phase	Component	Content
1. Engagement	1. Discussing the benefits of BFT	Meeting with the family to discuss the potential benefits of the approach.
	2. Agreeing to participate	Confirming the family's willingness to try the approach.
2. Assessment and goal setting	3. Individual assessment	Assessing individual family members.
	4. Family assessment	Assessing family communication and problem-solving.
	5. Formulation and goal setting	Collaboratively identifying family resources, problems, and goals.
3. Establishing family meetings	6. Planning family meetings	Discussing how to proceed with the family and establishing family meetings without the therapist.
4. Intervention	7. Psychoeducation	Sharing information about the disorder and its impact.
	8. Communication skills training	Training in active listening, expressing positive feelings, making positive requests, and expressing difficult feelings.
	9. Problem-solving training	Developing family problem-solving skills.
5. Consolidation and ending	10. Booster sessions	Providing booster sessions to reinforce skills and support continued application.
	11. Disengagement	Gradually ending the therapist's involvement with the family, as appropriate.

TABLE 1: Outline of the Meriden Model of BFT

BFT: Behavioral Family Therapy

BFT is also founded on specific principles and values [16]. Service users are regarded as experts by experience in relation to their illness and symptoms, family members as experts by experience in observing and caring for the service user, and family therapists as experts in providing support [16]. Together, they can establish a collaborative working relationship by mutually respecting one another's experiences and knowledge [16].

According to confirmation received from the Meriden Family Program, the Meriden Model of BFT is in the public domain, and permission is not required to describe or discuss the model in academic publications. The associated training manual is copyrighted; however, this study did not reproduce any copyrighted training manual content.

Design

This study employed a qualitative design using focus group interviews and narrative analysis to explore how service users constructed meaning from their experiences of receiving BFT over time [21]. Data were collected from focus group interviews involving 14 service users who had received BFT. Their freely expressed thoughts and feelings about receiving BFT were explored inductively.

Participant selection and eligibility criteria

Participants were service users who had received BFT from two healthcare institutions in City A and City B. Participants were recruited using purposive sampling. Individuals who had completed BFT were considered eligible because they were expected to provide rich information regarding their experiences of the intervention. Eligibility for participation in the study required completion of BFT and provision of informed consent. Individuals who had not completed BFT, did not provide informed consent, or could not be

contacted were excluded from participation.

Of the 23 service users who had completed BFT, 22 were informed of the purpose and methods of the study; one had transferred to another healthcare institution and could not be contacted. Of these 22 service users, 14 provided informed consent to participate in the study. Participants had been diagnosed with mental disorders by attending psychiatrists at the participating institutions as part of routine clinical practice.

Data collection and analysis

Focus group interviews were conducted in September 2024 and February 2025 across two cities, Cities A and B. Five focus group interviews were conducted (Group 1: n = 2, Group 2: n = 2, Group 3: n = 3, Group 4: n = 2, and Group 5: n = 5). These groups comprised one group whose participants had completed the intervention less than one year earlier, two groups whose participants had completed BFT at least one year but less than three years earlier, and two groups whose participants had completed BFT three or more years earlier.

Semi-structured focus group interviews lasting approximately 60 minutes were conducted using an interview guide developed by the author based on the study aims. The interview guide is provided in Appendix A. Participants were asked about their thoughts and feelings regarding their experiences of receiving BFT and their current lives.

Each focus group interview was conducted by two trained BFT practitioners: a main interviewer and an assistant interviewer. To help participants feel comfortable and reduce anxiety during the interviews, interviewers were assigned based on their previous therapeutic relationships with the participants. Whenever possible, therapists who had previously provided BFT to the participants were assigned to conduct the interviews. When this was not feasible, these therapists were invited to attend the interviews as supporters alongside the participants. With the participants' consent, the interviews were audio-recorded and transcribed verbatim.

Narrative analysis was employed to understand how participants constructed meanings from their experiences over time while preserving the context and sequence of their narratives [21]. The verbatim transcripts were read repeatedly to gain an overall understanding of the participants' accounts. Segments referring to experiences of BFT were extracted and coded inductively, with attention to the meanings participants expressed and the context in which they appeared. The codes were then organized into progressively higher levels of abstraction (Codes 1-3 and themes) based on similarities in content and meaning.

Subsequently, the extracted codes and themes were organized along a temporal axis to develop a storyline describing participants' experiences before, during, and after BFT. Throughout this process, the relationships among codes and themes and their consistency with the original narratives were considered. No qualitative data analysis software was used.

Rigor

To enhance the trustworthiness of the analysis, the author repeatedly discussed code classification and the wording used to express levels of abstraction with a researcher experienced in qualitative research. Through these discussions, coding decisions, category development, and theme interpretation were reconsidered and refined. An audit trail documenting the analytical process, including coding decisions and the development of categories and themes, was maintained throughout the study.

Because this was a single-author study, the author conducted all coding, categorization, and data analysis. Independent coding by multiple researchers was not performed. Member checking was not conducted. Although data saturation was not formally assessed, few substantially new themes emerged during the later stages of analysis.

Ethical considerations

This study was conducted with the approval of the Ethics Review Committee of Goryokai Hospital (approval number: 2024-1). After obtaining institutional permission from the participating healthcare organizations, informed consent was obtained from each participant. Participants were provided with written and verbal explanations of the study's background and purpose, research methods, protection of personal information, voluntary participation, the right to withdraw at any time, and the handling of research findings.

The interviews were conducted in private rooms to protect the privacy of the groups, and participants also agreed to protect personal information shared within their groups.

Results

Participant characteristics

The study included 14 participants: eight male and six female. The mean age was 39.6 years. All participants except one lived with their families. Participant characteristics are presented in Table 2.

Participant	Age	Sex	Diagnosis	Living arrangement during BFT	Approximate age at illness onset	Duration of BFT (calendar period)	Timing of BFT completion	Family members participating in BFT	Focus group (1-5)
1	18	Female	Autism spectrum disorder/ Schizophrenia	Living with family	Approximately 15 years old	22 months	July 2024	Service user and one parent	1
2	27	Male	Schizophrenia	Living with family	Approximately 22 years old	31 months in total	May 2024	Service user and parents; subsequently, younger brother also participated	1
3	45	Female	Bipolar affective disorder	Living with family	Approximately 23 years old	7 months	May 2023	Service user and husband	2
4	40	Male	Schizophrenia	Living with family	Approximately 15 years old	18 months (including a 7-month hospitalization)	May 2022	Service user and parents	2
5	47	Female	Schizoaffective disorder	Living with family	Approximately 16 years old	33 months (including a 3-month hospitalization)	November 2020	Service user and parents	3
6	37	Female	Schizophrenia	Living with family	Approximately 15 years old	31 months	September 2019	Service user and parents	3
7	33	Male	Schizophrenia	Living with family	Approximately 16 years old	28 months	December 2021	Service user, parents and younger sister	3
8	55	Male	Schizophrenia	Living with family	Approximately 25 years old	5 months	September 2023	Service user and wife	4
9	42	Female	Schizoaffective disorder	Living with family	Approximately 22 years old	5 months	September 2023	Service user and husband	4
10	43	Male	Schizophrenia	Living with family	Approximately 24 years old	9 months	July 2022	Service user and parents	5
11	47	Male	Schizophrenia	Living with family	Approximately 30 years old	11 months	March 2019	Service user and one parent	5
12	45	Female	Schizophrenia	Living alone	Approximately 20 years old	12 months	September 2020	Service user and parents	5
13	43	Male	Schizophrenia	Living with family	Approximately 27 years old	14 months	May 2020	Service user and one parent	5
14	33	Male	Schizophrenia	Living with family	Approximately 25 years old	7 months	April 2020	Service user and parents	5

TABLE 2: Characteristics of the study participants

This table was generated from data collected in the present study and was not adapted from any previously published source. The calendar duration of BFT includes periods of hospitalization where indicated. Participants were assigned to five focus groups based on the time elapsed since completing BFT.

BFT: Behavioral Family Therapy

Results of the analysis

Because participants' narratives evolved as the group discussions progressed, coding was conducted while preserving participants' words and meanings as much as possible. Initial codes were grouped into higher-order categories through three stages of abstraction. Figure 1 presents the temporal organization of the 53 third-level codes (Code 3) derived from participants' narratives.

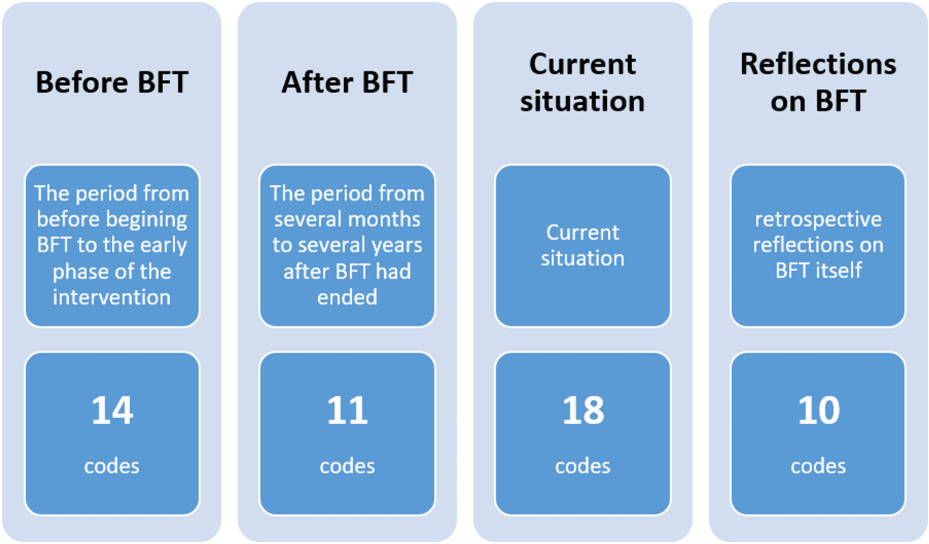


FIGURE 1: Temporal organization of participants' narratives describing experiences before BFT, after BFT, current situations, and reflections on BFT

BFT: Behavioral Family Therapy

A total of 53 third-level codes (Code 3) were extracted. When these codes were organized along a temporal axis, 14 third-level codes (Code 3) described experiences from before the initiation of BFT to the early phase of the intervention, yielding four themes. Eleven third-level codes (Code 3) described experiences from several months to several years after the completion of BFT, yielding three themes. Eighteen third-level codes (Code 3) described participants' current situations at the time of the interviews, yielding four themes. Additionally, 10 third-level codes (Code 3) reflected retrospective perceptions and experiences of BFT itself and could not be arranged along the temporal axis; these yielded three themes. Table *3* presents an overview of themes and thematic descriptions representing service users' experiences of the Meriden Model of BFT. Detailed examples of the coding process are presented in the Appendices.

Phase	Theme	Description
During the period from before initiation of BFT to the early intervention phase	Struggling to manage symptoms and disability-related challenges	This theme reflects participants' difficulties in managing the symptoms of mental illness and the challenges associated with disability. Participants described experiencing declines in physical and psychological well-being, burdens associated with treatment, and struggles to cope with the impact of illness on daily functioning and life goals.
	Experiencing unresolved emotions and self-stigma	This theme reflects participants' experiences of unresolved emotional distress and negative self-perceptions associated with mental illness. Participants described inner conflict, self-blame, guilt, and dissatisfaction with being defined primarily by their diagnosis.
	Experiencing social isolation and exclusion	This theme captures participants' experiences of social disconnection and marginalization resulting from mental illness. Participants described feeling isolated from others, excluded from social relationships, and disconnected from society.
	Difficulty achieving mutual understanding within the family	This theme reflects participants' struggles to achieve mutual understanding and effective communication within their families. Participants described difficulties expressing their experiences, feeling burdened by family involvement, and perceiving emotional distance or differences between themselves and family members.
Several months to	Maintaining stability through self-management	This theme reflects participants' efforts to maintain stability and prevent relapse following BFT. Through self-monitoring, lifestyle adjustments, and awareness of their own condition, participants described developing strategies to manage everyday challenges while sustaining recovery.
	Strengthening family	This theme captures how participants developed more supportive and collaborative relationships with family members. Improved communication, shared problem-solving, and

several years following completion of BFT	relationships and collaborative coping	mutually agreed family rules facilitated coping with illness and contributed to greater family cohesion.
	Sustaining recovery through the long-term application of BFT skills	This theme reflects the enduring influence of skills acquired through BFT. Participants described applying strategies learned during the intervention to manage difficulties, achieve realistic goals, and support their ongoing recovery over time.
Current situations	Strengthening family relationships and collaborative living	This theme captures participants' experiences of living in more supportive and cooperative family environments now. Participants described greater mutual understanding, increased emotional closeness, and the ability to adapt daily life through collaborative family efforts.
	Developing self-understanding and self-acceptance	This theme reflects the development of greater self-awareness and acceptance of one's illness experiences. Participants described becoming more able to understand their thoughts and feelings, view themselves objectively, and let go of self-blame and anger related to their condition.
	Experiencing personal growth and recovery	This theme captures participants' perceptions of personal growth beyond symptom management. Participants described gaining confidence, achieving meaningful goals, improving interpersonal skills, and recognizing positive aspects of their lives as indicators of recovery.
	Integrating BFT learning into everyday life	This theme reflects incorporating knowledge and skills learned through BFT into participants' daily lives. Even when participants no longer consciously recalled specific intervention content, they perceived its influence in their everyday coping and decision-making.
	Seeking change and understanding through BFT	This theme captures participants' motivations for engaging in BFT. Participants described a strong desire for recovery, hopes for improved family understanding, and the important role of family encouragement in initiating participation in the intervention.
Retrospective reflections on BFT	Experiencing challenges and support during BFT	This theme reflects participants' experiences throughout the intervention process, including both supportive and challenging aspects. Participants valued professional guidance and opportunities for reflection while also describing emotional difficulties associated with confronting illness-related experiences and family issues.
	Finding lasting meaning in the BFT experience	This theme captures the enduring significance participants attributed to BFT after completing it. Although some no longer remembered the specific content of the intervention, they described gaining insights into themselves, their relationships, and their life experiences that continued to hold meaning over time.

TABLE 3: Themes and thematic descriptions representing service users' experiences of the Meriden Model of BFT

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

BFT: Behavioral Family Therapy

Narratives concerning the period before and at the beginning of BFT

Codes describing the period before BFT indicated that participants struggled to manage symptoms and disability-related challenges. This theme encompassed deteriorating health, distress caused by medication side effects, a desire for non-pharmacological recovery, perceptions that medication altered one's sense of identity; feeling helpless when unable to solve problems or achieve goals; and feeling exhausted from setting overly ambitious goals. In particular, participants experienced side effects of medication and felt that medication had changed who they were. Although they strongly desired forms of recovery other than medication, they were unable to find such alternatives and felt lost. For example, participants described distress caused by medication side effects as follows:

> I also have side effects. Quite a lot, actually. So, even when I'm told to take medication, I feel that, rather than doing that, I would like to find some other way to heal myself. I have various feelings about it. (P5)

> I think this is probably a common side effect of psychiatric medication, but it makes you want to eat-really, all the time. So, if the calories I consume by eating aren't offset by physical activity, of course I gain weight. That's why I thought I should go outside and get some exercise. But, well, this actually became one of the reasons why I found it difficult to go outside. I was always thinking about how people around me saw me. (P6)

The analysis also indicated that participants experienced unresolved emotions and self-stigma. This theme was reflected in the codes experiencing unresolved emotions and inner conflict, dissatisfaction with being reduced to a diagnostic label, and illness-related self-blame and guilt. Participants described enduring self-stigma that could not be easily overcome, as illustrated by the following quotations:

> There is no reason for us to feel ashamed of our illness to that extent. Still, I always carried the belief that becoming ill was somehow a bad thing. (P6)

The analysis also revealed a theme of social isolation and exclusion, with codes including experiencing social exclusion and experiencing social isolation. The following quotation illustrates a participant's experience of social exclusion:

> At the park in front of the school, a bus came by, and I was yelled at by the bus driver. It was really awful. Then, when I bumped into a student, the student looked at me and glared at me while brushing my arm away. I felt like I would have been better off if the student had hit me. Also, a few days before I cut my arm at school, I tried to jump from a height. The amount of time I spent at school gradually became shorter and shorter. (P1)

Participants also described difficulty achieving mutual understanding within the family. These experiences were reflected in the codes difficulty achieving mutual understanding within the family, difficulty communicating openly within the family, feeling burdened by excessive family involvement, and perceiving oneself as different from one's family. One participant shared that she had started BFT because she wanted to be able to talk with her family about her illness:

> We hardly ever talked about my illness as a family, so I decided to participate because I thought it would be good to have an opportunity to talk about it. We didn't talk about my illness or anything like that before. (P12)

Detailed examples of the coding process for this phase are presented in the Appendices.

Narratives concerning the period from several months to several years after BFT ended

During the first several months following completion of BFT, codes such as continuing to live a life that was not markedly different from before, living cautiously and trying not to overexert oneself, and becoming aware of personal changes and being able to cope with them were identified, highlighting the maintenance of stability through self-management. For example, one participant talked about her careful approach to daily life as follows:

> Above all, I try not to push myself too hard. I try to stop doing things that I can't manage and focus on doing what I can. If I push myself too hard, I gradually become more and more fatigued, and when I get tired, I'm more likely to become manic. So, I try to live my life without pushing myself too hard. (P3)

Additionally, strengthening family relationships and collaborative coping were identified through codes such as using family support to improve one's health, making family relationships more harmonious, recognizing the importance of rules within the family, and solving problems through discussions with family members. For example, one participant described his positive view of changes in his family as follows:

> I think my father has changed the most. Before that, I suppose it was basically because he was a man, but we didn't really talk. Even when there was a problem, he seemed to have the attitude of dealing with it on his own. But after we started Family Work (BFT), we began talking more. We also started

> having dinner together. We used to avoid interfering with each other, but during dinner and at other such times, we started talking a little more with each other. I think my father probably changed the most. (P14)

Following completion of BFT, participants described sustaining recovery through the continued application of skills learned during the intervention. This theme encompassed codes related to recalling and applying BFT components to cope with difficulties, achieving short-term, concrete goals, not consciously recalling the support received, and feeling that recovery was progressing. The following quotation illustrates a positive change in a participant's life:

> I learned how to express my feelings to other people. Through the sessions, I was able to build a foundation for communication, and I think I gradually became able to tell others what kind of help I needed at the time. As an extension of that, I had really disliked making phone calls and couldn't do it. I had an extremely strong aversion to making phone calls, but I eventually became able to do it. I started feeling that I could call government offices and even people I knew. Being able to make phone calls was a really significant change for me. (P6)

Detailed examples of the coding process for this phase are presented in the Appendices.

Narratives concerning the current situation

Many codes concerning participants' current situations reflected strengthening family relationships and collaborative living. These included codes continuing to follow rules within the family, wanting to achieve goals by following the example of family members, developing more positive feelings toward one's family, perceiving positive changes in the atmosphere within the family, feeling that family members had become more interested in oneself, making adjustments to daily life as an entire family, experiencing the emergence of communication within the family, and becoming able to consider ways of reducing the burden on family members. One participant described a positive change in her family relationships as follows:

> My father and mother have started paying more attention to whether I seem to be doing okay, I guess. They've started noticing when I'm still at the "yellow light" stage, so to speak. They'll point things out, like, "Haven't you been talking less lately?" or "Aren't you smiling as much?" And then I think, "Oh, that could be a little dangerous, so I need to be careful. I need to make sure it doesn't become a red light." Before, they didn't really point things like that out to me. They might have talked about it between themselves, but they've started coming to me and asking, "Are you feeling a little unwell lately?" So, I feel like things have changed a little. (P12)

Another participant described a change in her feelings toward her mother, explaining that comments from her mother that had previously felt hurtful no longer affected her in the same way, as follows:

> Her little comments don't feel hurtful to me anymore, and we laugh together quite often. I feel like I'm in a very happy place now. (P1)

The following codes reflected participants' developing self-understanding and self-acceptance: being able to view oneself objectively, developing a deeper understanding of oneself, organizing one's thoughts, and no longer feeling anger toward oneself for having become ill. For example, one participant talked about his self-awareness as follows:

> And I think I've become much more introspective, too. Um, how should I put it... I don't worry about things as much, and sometimes I think, "Maybe I'm a little too energetic," or, when I look back, "Maybe I was actually just acting normally." I've also been taking my medication properly and going to the hospital regularly. I think I've become much more aware of myself and my condition. (P7)

At the same time, the theme of experiencing personal growth and recovery was identified. This was reflected in codes such as feeling that communication skills for interacting effectively with others had been acquired, experiencing the joy of accomplishing desired goals, feeling that even modest happiness is sufficient, and appreciating having gone two years without rehospitalization. One participant described gaining confidence in her ability to interact with others:

> I had some communication practice, and there was a session where we practiced asking other people for things. I was really bad at asking people for favors, but because we practiced using specific situations, I became able to ask other people for things. (P12)

Furthermore, while some participants continued to consciously apply BFT skills, as reflected in the code applying what was learned in everyday life as needed, others reported not being consciously aware of the influence of BFT. In other words, this theme can be characterized as "integrating BFT learning into everyday life."

Detailed examples of the coding process for this phase are presented in the Appendices.

Codes representing retrospective reflections on BFT itself

The preceding three subsections described narratives concerning the period before and at the beginning of the intervention, the period after receiving BFT, and the participants' current situations. Additionally, codes related to retrospective reflections on experiences during BFT delivery were identified, such as engaging in the intervention with a desperate desire to get better.

These included participants' motivations and expectations before the intervention, such as engaging in the intervention with a desperate desire to get better, beginning BFT because of family support and agreement, and wanting family members to understand one's condition. Together, these codes illustrated participants' seeking change and understanding through BFT.

Furthermore, after experiencing BFT, participants reported finding the involvement of a third party (family therapist) helpful, feeling that one's lack of knowledge about one's illness was exposed, finding it emotionally difficult to revisit one's own and one's family's past through BFT, finding some aspects of the intervention easy to understand and others difficult to understand, and feeling confused after hearing the explanation of BFT. Together, these codes gave rise to the theme of experiencing challenges and support during BFT, which reflected participants' feelings of uncertainty, anxiety, and concern throughout the BFT process, as well as the support provided by therapists.

In contrast, codes such as forgetting the content of the support and having an opportunity to gain some understanding of one's own life reflected the enduring significance of BFT when considered within the broader course of participants' lives, despite being expressed in relatively abstract terms. Together, these codes contributed to the theme of finding lasting meaning in the BFT experience.

Detailed examples of the coding process for this phase are presented in the Appendices.

Storyline of BFT for service users over time

The following storyline describes participants’ experiences of receiving BFT over time, focusing on the relationships and contexts surrounding the codes, including changes in mental and physical conditions, family-related experiences, and participants’ social relationships.

Before receiving BFT, participants experienced poor physical condition due to medication side effects and hoped to recover through means other than medication. They had also become frustrated and felt at a loss after their attempts to solve problems and achieve their goals through means other than medication had failed. In their relationships with society, they felt uncomfortable, guilty, and excluded because they were perceived only as a person with an illness, which contributed to their social isolation. Their relationships with family members were also difficult; they felt isolated within the family, and their family relationships felt burdensome.

Under these circumstances, participants encountered BFT and decided to receive support because they wanted to change their circumstances and were encouraged by their family members. For several months after completing BFT, they continued their usual routines while exercising caution and avoiding overexertion, and gradually became able to implement specific goals established through BFT. In their relationships with family members, they became able to discuss matters and engage in activities together while following mutually agreed family rules. They also became aware of changes in themselves and were able to respond to them, allowing them to feel that their recovery was progressing. Perhaps as a consequence of these changes, they did not consciously recall the specific support they had received through BFT.

At the time of the interviews, participants reported having incorporated what they learned through BFT into their everyday lives, including the use of family rules. They described acquiring communication skills and feeling more capable of acting independently. In relation to their families, they reported being better able to express their feelings, accept positive feedback from family members, and consider the burdens placed on their families. They also reported improvements in family communication, greater self-reflection, and an

increased appreciation of small moments of happiness.

Looking back on their experience of BFT, participants engaged in BFT with a strong desire to improve and a wish for their family members to understand them. Their family members' agreement to participate encouraged them to undertake BFT. However, during the process, they experienced distress from exposing their inner selves and revisiting their past experiences with their family. They were sometimes confused about BFT, forgot some of its content, or found certain aspects difficult to understand. At such times, the involvement of a family therapist as a third party was helpful. Nevertheless, participants felt that BFT had provided them with a valuable opportunity to gain new insights into their own lives.

Discussion

This study explored how participants perceived changes in their lives from before receiving BFT to the present. Participants described changes in family relationships, self-understanding, everyday problem-solving, and the pursuit of personally meaningful goals. Their narratives suggested that recovery involved not only symptom management but also stronger family relationships and a more positive understanding of themselves.

Recovery has been described as a process through which individuals accept and overcome the challenges associated with mental illness while building meaningful lives despite ongoing difficulties [22]. Before receiving BFT, participants described experiences of despair, self-stigma, social isolation, and difficulties communicating with family members. These findings are consistent with previous studies indicating that people with mental illness frequently experience both public stigma and self-stigma during the recovery process [23].

Participants retrospectively described entering BFT with a strong desire for change and a hope that family members would better understand their experiences. Several months to several years after BFT, they reported becoming more able to manage daily life, recognize changes in their condition, and make use of family support. At the time of the interviews, many participants described improved family relationships, greater self-understanding, and increased confidence in pursuing personally meaningful goals.

These perceived changes may be related to key components of BFT. Participants frequently referred to improved communication with family members, family meetings and rules, and collaborative problem-solving.

Previous studies of family psychoeducation and behavioral family interventions have reported beneficial outcomes for individuals with mental illness and their families [17]. For example, Hogarty et al. examined the effects of family psychoeducation, social skills training, and maintenance pharmacotherapy on relapse and EE among individuals with schizophrenia [18]. In their study, the first-year relapse rate was 19% in the family treatment group, 20% in the social skills training group, 0% in the combined treatment group, and 41% in the control group. These findings suggest that family interventions, particularly when incorporated into comprehensive treatment approaches, may help reduce relapse risk.

Similarly, Dixon et al. evaluated a peer-led family education program. They reported improvements in family members' knowledge about mental illness, empowerment, acceptance of their relative's illness, and problem-solving skills. Family members in the intervention group also reported reduced distress, although no significant difference was observed in subjective illness burden between the intervention and control groups [19]. These findings highlight the potential value of family interventions in strengthening family members' understanding and coping abilities.

The present findings are consistent with these studies, as participants described improved family communication, greater mutual understanding, and the use of collaborative problem-solving skills in everyday life. However, these previous studies primarily examined clinical outcomes or the experiences and coping abilities of family members, whereas the present study focused on service users' own experiences of BFT.

Previous publications on the Meriden Model of BFT have also highlighted the importance of collaborative approaches to family support and the need to adapt interventions to the circumstances of individual families. Fadden and Heelis described the development and implementation of the Meriden Family Program over 10 years, emphasizing the importance of collaboration among service users, carers, therapists, trainers, managers, and commissioners in promoting family work within mental health services [16]. Similarly, Jhadray et al. discussed applying the BFT model in complex family situations, highlighting the need to understand and respond to the diverse needs of individual families [20]. These reports are consistent with the present findings, in which participants described improved communication, collaborative problem-solving, and greater mutual understanding within their families. Similar to previous BFT reports, participants valued collaborative approaches tailored to the circumstances of individual families.

However, these previous publications primarily focused on implementing family work and its application in

clinical practice, whereas the present study explored service users' own accounts of their experiences. This study further highlights how service users perceived improvements in communication, collaborative problem-solving, and mutual understanding as contributing to self-understanding, self-acceptance, and recovery-oriented goal pursuit. These findings provide a service-user perspective on the potential contribution of the Meriden Model of BFT to personal recovery.

Participants also described becoming more aware of their mental and physical condition and developing a deeper understanding of themselves. Marková and Berrios conceptualized insight not only as an understanding of one's illness but also as an understanding of how the illness affects one's interactions with the world [24]. Psychoeducational approaches have been associated with greater insight and self-awareness among people with mental illness [25,26]. Participants' narratives suggested that opportunities for discussion and reflection within BFT may have contributed to self-understanding and self-acceptance.

At the same time, participants reported that some aspects of BFT were emotionally challenging. Reflecting on personal experiences and family relationships was sometimes described as difficult. Nevertheless, many participants reported that involving a family therapist as a neutral third party was helpful. These findings suggest that supportive and collaborative therapeutic relationships may facilitate participation in family interventions.

Interestingly, some participants reported that they could no longer clearly recall specific techniques or components of BFT, yet continued to use the skills and approaches they had learned during the intervention. This may suggest that aspects of BFT gradually became integrated into participants' everyday coping strategies. This pattern was also reflected in the temporal organization of participants' narratives shown in Figure *1*.

Taken together, the narratives in Figure *1* suggest a temporal process in which difficulties experienced before BFT were followed by opportunities for communication, reflection, and collaborative problem-solving during the intervention. Over time, these experiences appeared to contribute to improved family relationships, greater self-understanding, and increased confidence in pursuing personally meaningful goals. Rather than representing discrete outcomes, participants described these experiences as interconnected and evolving aspects of recovery. Improvements in family functioning may support recovery by strengthening mutual understanding and enabling service users and family members to respond collaboratively to challenges associated with mental illness.

The present findings may be particularly relevant within the Japanese context, where many people with mental illness continue to live with family members and where families often assume substantial caregiving responsibilities. Participants described improvements in family communication, collaborative problem-solving, and mutually agreed family rules, suggesting that BFT may help families move beyond relationships centered primarily on caregiving toward more collaborative and recovery-oriented interactions.

Furthermore, unlike the hospital-based multifamily psychoeducation programs traditionally implemented in Japan, the Meriden Model is delivered to individual families in their home environment. Participants' narratives suggest that this individualized approach may facilitate discussion of family-specific concerns and support the integration of communication and problem-solving skills into everyday family life. Therefore, the Meriden Model may complement existing multifamily psychoeducation programs in Japan by addressing the unique circumstances and communication patterns of individual families.

Strengths

One strength of this study is that, to the author's knowledge, it is among the first qualitative studies to explore service users' experiences of the Meriden Model of BFT in Japan. Unlike many previous studies that have focused on relapse rates, family burden, or family members' perspectives, the present study examined the experiences of service users themselves. It explored how they understood the contribution of BFT to their recovery. Additionally, participants included individuals whose BFT experiences ranged from less than one year to more than three years before the interviews, allowing consideration of both short-term and longer-term perceptions of the intervention. The use of narrative analysis also facilitated exploration of recovery as a temporal and evolving process.

Implications for practice

The findings of this study have several implications for mental health practice. Participants described communication, collaborative problem-solving, and support from family members as important elements of their recovery journeys. These findings suggest that family interventions such as BFT may contribute to recovery-oriented mental health care by strengthening communication and collaboration within families. Additionally, the home-based and individualized nature of the Meriden Model may enable family-specific concerns to be addressed in everyday living environments. Within the Japanese mental health care context, where many service users continue to live with family members, BFT may provide a useful complement to existing multifamily psychoeducation programs by supporting recovery-oriented relationships between service users and family members.

Limitations and future research

This study has several limitations. First, the study included only 14 participants who had received BFT at two medical institutions, which may limit the transferability of the findings. Most participants had schizophrenia-spectrum disorders and lived with family members; therefore, the findings may not apply to individuals with other psychiatric diagnoses, different living arrangements, or other cultural contexts. Additionally, participants were limited to individuals who had completed BFT and agreed to participate in the study. Consequently, individuals who discontinued BFT or had less favorable experiences may have been underrepresented. Participants who perceived BFT more positively may have been more willing to participate, potentially contributing to the predominance of favorable narratives in the analysis.

Second, focus group interviews may have influenced participants' narratives through interactions with other group members, and some participants may have withheld sensitive information. Moreover, because participants reflected on experiences that occurred several years earlier, recall bias cannot be ruled out. Participants may also have reconstructed their experiences of BFT in light of their current circumstances and recovery status.

Third, the changes participants described cannot be attributed solely to BFT. Ongoing psychiatric treatment, medication, community support, employment experiences, and natural recovery processes may also have influenced their perceived changes over time.

Furthermore, although efforts were made to help participants feel comfortable during the focus group interviews by assigning therapists who had previously provided BFT as interviewers whenever possible or having them attend as supporters when this was not feasible, their involvement may have influenced participants' responses. In particular, participants may have felt reluctant to express negative opinions or experiences regarding BFT, potentially resulting in social desirability bias.

Finally, the author's involvement in disseminating and training the Meriden Model of BFT in Japan may have influenced data interpretation. Although efforts were made to enhance reflexivity through ongoing supervision and discussion with a qualitative research expert, the possibility of researcher allegiance toward BFT cannot be completely excluded.

Future research should examine the experiences and potential effects of BFT across different diagnoses, age groups, living arrangements, and settings. Including individuals who discontinue BFT would provide a broader understanding of their experiences and the factors influencing continued participation. Exploring the perspectives of family members and family therapists would also provide a more comprehensive understanding of the contribution of BFT to recovery. Furthermore, longitudinal studies examining changes over time and comparative studies investigating differences between BFT and other family intervention approaches may further clarify the contribution of the Meriden Model to recovery and its role within mental health services.

Conclusions

This study explored the experiences of 14 participants who received BFT in Japan. Participants described changes over time in family communication, self-understanding, everyday problem-solving, and their ability to pursue personally meaningful goals. Participants' narratives suggested that recovery encompassed not only symptom management but also improvements in family relationships, enhanced self-understanding, and the pursuit of personally meaningful goals. However, given the qualitative design and the absence of a comparison group, these findings should not be interpreted as evidence of the causal effectiveness of BFT. Further research is needed to examine the experiences of service users and family members across different settings and to clarify the potential contribution of BFT to recovery. The findings suggest that BFT may provide a framework for supporting recovery-oriented family relationships in Japanese community mental health settings.

Appendices

Semi-structured interview guide

The author developed the following interview guide to explore service users' experiences of receiving the Meriden Model of Behavioral Family Therapy (BFT), perceived changes over time, family relationships, recovery experiences, and the perceived influence of BFT on everyday life. Questions were used flexibly, and additional probing questions were employed when clarification or elaboration was required.

Semi-structured interview questions used in the focus group interviews

The interviews were conducted using a semi-structured interview guide. Participants were encouraged to speak freely about their experiences of receiving the Meriden Model of BFT, their family relationships, recovery process, and current lives. Follow-up questions were used as needed to explore topics in greater depth.

1. Motivation for Participation

What made you decide to participate in the Meriden Model of BFT?

2. Experiences During BFT

What kinds of activities or sessions did you experience during BFT?

What aspects of the program were particularly memorable or had a strong impact on you?

3. Circumstances Before and During the Early Stages of BFT

What was your life like when you started BFT?

How would you describe your family relationships at that time?

What were your mental health symptoms and difficulties like at that time?

4. Life After Completing BFT

How have you lived your life since completing BFT up to the present?

Follow-up prompts included:

Why do you think that happened?

How did that change occur?

What helped those changes happen?

What difficulties did you experience?

5. Perceived Influence of BFT

Looking back now, do you feel that any experiences from BFT have been useful in your life?

If so, what aspects have been useful?

Why do you think they have been helpful?

6. Remembering BFT After Completion

After BFT ended, did you ever think about or recall your experiences of BFT?

Did BFT ever become a topic of conversation within your family?

If participants answered yes, follow-up questions included:

What reminded you of BFT?

In what situations did you remember it?

What kinds of conversations did you have about it?

7. Family Communication

Do you and your family talk about things that make you happy or things that concern you?

What kinds of topics have you discussed recently?

How was communication within the family when your illness first developed?

8. Coping With Difficulties

Have there been any recent difficulties or problems that you had to deal with?

How did you cope with them?

9. Goals and Hopes

Do family members talk with one another about their goals, hopes, or things they would like to do?

What kinds of goals do you have?

Are you currently able to pursue or achieve those goals?

Are these goals shared and discussed within your family?

Theme	Category (Code 3)	Subcategory (Code 2)	Initial (Code 1)	Representative quotation
Struggling to manage symptoms and disability-related challenges	Struggling with deteriorating health	Poor physical condition resulting in an inability to act or communicate	Poor physical health left the participant unable to speak or take action	“I spent all day lying in bed at home, and my mother was busy. Looking back, I felt that I should have helped with the housework, but I was not feeling well physically.” (HPC11)
	Distress caused by medication side effects and a desire for non-pharmacological recovery	Preference for recovery through means other than medication due to severe side effects	Desired recovery through non-pharmacological approaches because of medication side effects	“I also experienced side effects, quite severe ones. Even when I was told to keep taking the medication, I often wished that there were other ways to heal or find relief.” (SPC109)
	Feeling that medication altered one's sense of identity	Feeling that medication altered one's sense of identity	Felt that medication had altered personal identity	“I think this is a common side effect of psychiatric medication, but it made me want to eat all the time. If you cannot burn off the extra calories through physical activity, you naturally gain weight. That became one of the reasons I stopped going outside because I worried about how other people saw me.” (SPC113)
	Feeling helpless when unable to solve problems or achieve goals	Feeling lost without a way to solve problems	Lacked strategies for problem-solving and felt adrift	“Problem-solving and goal achievement were exactly what I had been seeking. However, I did not know how to solve problems or achieve goals, and whenever I wanted to address an issue, I did not know what steps to take and felt completely lost.” (SPA74)
	Feeling exhausted from setting overly ambitious goals	Becoming burned out from setting excessively high goals	Became exhausted after striving toward unrealistic goals	“In the past, I used to set very high goals and work extremely hard toward them, but I often ended up burned out because of it.” (SPC213)
Experiencing unresolved emotions and self-stigma	Experiencing unresolved emotions and inner conflict	Emergence of motivation and emotional activation following BFT	Experienced renewed motivation and emotional awakening while taking BFT	“I developed a strong desire to cook for myself. I simply wanted to make something on my own. At the same time, I was struggling with another part of myself that did not really want to do it.” (SPB93)
	Dissatisfaction with being reduced to a diagnostic label	Resistance to being viewed solely as a psychiatric patient	Resented being viewed solely through the lens of mental illness	“If I felt cold, I could just put on a blanket, and if I felt hot, I could take it off. I do not understand why every action has to be interpreted through the lens of illness. There should be less discrimination, especially when people with and without mental illness do the same things.” (SPC134)
	Illness-related self-blame and guilt	Feeling guilty about oneself because of one's illness	Felt guilty and blamed oneself for becoming ill	“There is no reason for us to feel ashamed of our illness to that extent. Still, I always carried the belief that becoming ill was somehow a bad thing.” (SPC125)

Experiencing social isolation and exclusion	Experiencing social exclusion	Social rejection by others leading to a suicide attempt	Experienced social rejection culminating in a suicide attempt	“The bus driver yelled at me. It was awful. Then, when I accidentally bumped into a student, the student glared at me and brushed my arm away.” (SPA154)
	Experiencing social isolation	Withdrawal from society due to medication side effects and distrust of others	Lived in isolation, shaped by medication side effects and distrust of society	“During that period, my world consisted only of the hospital, my family, and myself. I continued struggling with the side effects and resenting society.” (SPC29)
Difficulty achieving mutual understanding within the family	Difficulty achieving mutual understanding within the family	Perceived lack of understanding and hostility within the family during difficult periods	Felt misunderstood by family and perceived hostility during periods of distress	“I felt that I gradually became more distant from my family. Even so, perhaps my father tried to understand me. At the worst times, however, I sometimes felt that both my mother and father were my enemies.” (SPA178)
	Difficulty communicating openly within the family	Avoidance of discussions about illness within the family	Illness-related topics were avoided within the family	“We rarely talked about my illness within the family. I hoped we might have opportunities to discuss it, but conversations about the illness never really happened.” (HPC25)
	Feeling burdened by excessive family involvement	Feeling overwhelmed by excessive family involvement	Felt burdened by excessive family involvement and concern	“My family was constantly concerned about me, and I actually found that overwhelming because all of their attention was focused on me.” (SPC47)
	Perceiving oneself as different from one's family	Feeling that family members could not understand one's experiences	Believed family members could not understand one's situation or experiences	“My parents paid close attention to me, yet they often said that they still could not really understand who I was.” (SPC103)

TABLE 4: Coding process during the period from before initiation of BFT to the early intervention phase

All themes and categories (Code 3) identified in the analysis are presented. Subcategories (Code 2), initial codes (Code 1), and representative quotations are illustrative examples selected to demonstrate the coding process.

BFT: Behavioral Family Therapy

Theme	Category (Code 3)	Subcategory (Code 2)	Initial (Code 1)	Representative quotation
Maintaining stability through self-management	Continuing to live a life that was not markedly different from before	Continuing a home-centered lifestyle similar to before	Has continued living mostly at home with weekly day-care attendance, similar to life before BFT	“My life is not really different from how it is now. I attend day care once a week and spend most of my time at home.” (SPB63)
	Living cautiously and trying not to overexert oneself	Living cautiously and avoiding overexertion	Tries to prevent symptom exacerbation by focusing on manageable activities and avoiding excessive effort	“The most important thing is not to push myself too hard. I try to stop doing things I cannot manage and focus on what I can do because overexertion leads to fatigue and can trigger manic symptoms.” (SPB155)
	Becoming aware of personal changes and being able to cope with them	Recognizing early warning signs and responding appropriately	Became aware of personal warning signs and learned to monitor them	“I learned what my own ‘yellow signals’ were and realized that I should pay attention whenever those symptoms appeared.” (HPC35)

	Using family support to improve one's health	Improving health through participation in sports activities with family support	Improved physical health and reduced weight by attending a sports club together with family	"I started going to a sports club with my mother. Before BFT, I weighed 80 kilograms, but I lost 10 kilograms, and my blood test results returned to normal." (HPC107)
Strengthening family relationships and collaborative coping	Family relationships becoming more harmonious	Family relationships becoming more harmonious	Family relationships improved, and participation in activities outside the home became possible	"Relationships within my family became much more harmonious, and I was able to engage in activities outside the home." (SPC47)
	Recognizing the importance of rules within the family	Recognizing the importance of rules within the family	Realized that establishing family rules is important	"I learned that it is important for family members to establish rules together." (SPC97)
	Solving problems through discussions with family members	Developing a habit of discussing difficulties as a family	Developed a routine of discussing financial and daily-life problems with family members	"Whenever we faced financial difficulties, we started having family budget meetings and discussing together how to manage our daily expenses." (HPB386)
Sustaining recovery through the long-term application of BFT skills	Being able to recall components of BFT and use them to cope	Recalling BFT strategies when facing challenges	Applied concepts learned in BFT to cope with situations after the program ended	"The topics from BFT and things that M had told me would come back to mind, and I could think of what I should do in a particular situation." (SPC211)
	Becoming able to achieve short-term and concrete goals	Achieving meaningful personal goals	Successfully achieved a personally important goal and gained new experiences	"Graduating from high school was one of the goals I had set for myself, and after achieving it, I was able to take my first trip outside city-H with my mother." (SPC61)
	Not consciously recalling the support received	Not consciously recalling the BFT after completion	Did not actively think about the program because of the demands of daily life	"I never really thought about BFT after it ended. I was simply occupied with everyday life." (SPC231)
	Feeling that recovery was progressing	Experiencing greater functioning and fulfillment in daily life	Became better able to communicate needs and seek support from others	"The communication sessions helped me build a foundation, and as a result, I became able to tell others what kind of help I needed." (SPC219)

TABLE 5: Coding process several months to several years following completion of BFT

All themes and categories (Code 3) identified in the analysis are presented. Subcategories (Code 2), initial codes (Code 1), and representative quotations are illustrative examples selected to demonstrate the coding process.

BFT: Behavioral Family Therapy

Theme	Category (Code 3)	Subcategory (Code 2)	Initial (Code 1)	Representative quotation
	Continuing to follow rules within the family	Maintaining family rules established through BFT	Continues to use family rules learned through BFT in everyday life	"We still use the family rules. For example, we have the right to say, 'Please stop, I don't want to talk about that,' and we can ask each other for help when needed. We also try not to bring up the past or make assumptions about one another. These have become our basic family rules." (SPC265)
	Wanting to achieve goals by following the	Learning realistic goal-setting from	Began setting more achievable and personally relevant goals	"I set some goals, but before I knew it, I had not achieved a single one. (laughs) My husband helped develop the family goals, and he achieved all of his goals. Looking back, I think I should have set goals that were closer and more realistic. They were probably too

	example of family members	family members	after observing family members' success	ambitious. The next time I set goals, I want them to be more achievable and relevant to my everyday life." (SPB193)
	Developing more positive feelings toward one's family	Feeling happier about family relationships	Feels happy about increased warmth and laughter with family members	"My mother's small comments no longer hurt me, and we laugh together quite often now. I feel that I am in a very happy place." (SPA287)
Strengthening family relationships and collaborative living	Perceiving positive changes in the atmosphere within the family	Increased positive interactions within the family	Perceived a more relaxed and supportive family atmosphere with more casual conversations	"Having M (family therapist) involved in BFT made a tremendous difference. Things progressed much more smoothly, and the atmosphere within our family changed. What stands out most is that we laugh and chat together much more often now." (SPC239)
	Feeling that family members had become more interested in oneself	Recognizing increased family involvement	Noticed greater support and engagement from family members	"Even now, my father still gives me rides every day. He was not the kind of person who used to do that. But he said, 'If you are going to work hard, I'll take you,' and he has continued to support me ever since." (HPC88)
	Making adjustments to daily life as an entire family	Managing daily life collaboratively as a family	Family members worked together to reduce stress and maintain stability	"Through our family meetings, I feel that I became less rigid in my thinking, and we were able to create a more fulfilling life at home." (SPA258)
	Experiencing the emergence of communication within the family	Increased openness in family communication	Became able to discuss issues that had previously been difficult to talk about	"I've become able to say things that I couldn't express before. This might sound like I'm bragging, but I've become able to speak up for myself, and people have been helping me with that. I'm expressing my own thoughts and feelings, although I'm not sure whether I'm doing it the right way. Still, I think I talk more than I used to." (HPC51)
	Becoming able to consider ways of reducing the burden on family members	Contributing to family well-being	Reduced the burden on family members through increased participation in household tasks	"At first, all I did was clean the cat's litter box. Later, I started bringing in the laundry and helping with housework. Being able to reduce my mother's burden, even a little, was one of the biggest changes for me." (HPC60)
Developing self-understanding and self-acceptance	Being able to view oneself objectively	Increased objective self-awareness	Developed the ability to view oneself more objectively through understanding personal characteristics	"By learning about the characteristics of my developmental disorder, I feel that I have become better able to view myself objectively." (SPA414)
	Developing a deeper understanding of oneself	Enhanced understanding of one's mental and physical condition	Gained deeper insight into personal condition and daily functioning	"I have become much more reflective. I worry less about things, and I can notice when I might be becoming overly energetic. I take my medication properly and continue attending hospital appointments. I think my awareness of myself and my condition has become much clearer." (SPC210)
	Becoming able to organize one's thoughts	Improved cognitive organization	Became able to organize thoughts and pursue goals through incremental steps	"I think I have become better able to organize my thoughts. Rather than focusing on large goals, I have learned to work steadily toward smaller ones, and that is how I have made it this far." (HPC69)
	No longer		Became less	"During BFT, I realized there was a deep sense of anger

	feeling anger toward oneself for having become ill	Letting go of self-blame	self-critical and no longer angry at oneself for developing mental illness	underneath everything. In the end, I was angry with myself. I blamed myself for developing bipolar disorder and believed it happened because I was weak. That anger would well up inside me. Now, instead, I focus on preventing myself from falling into that way of thinking." (HPB99)
Experiencing personal growth and recovery	Feeling that communication skills for interacting effectively with others had been acquired	Increased confidence in social interactions	Gained confidence in communicating with others through skills learned in BFT	"The communication training in the BFT programme helped me gain confidence in talking with other people. I also feel that speaking regularly with M (family therapist) helped me become more comfortable around others." (SPA260)
	Experiencing the joy of accomplishing desired goals	Experiencing achievement through small goals	Experienced a sense of accomplishment through gradual goal attainment	"Recently, I have started to experience a sense of achievement from steadily accomplishing small goals. I think that approach is better because it helps me avoid burning out." (SPC213)
	Feeling that even modest happiness is sufficient	Appreciating ordinary happiness	Came to value small, everyday sources of happiness	"I enjoy having a drink, so for me, being able to have a drink after work is enough. Those small things are what happiness means to me now." (HPB409)
	Appreciating having gone two years without rehospitalization	Recognizing sustained stability	Appreciated maintaining recovery without hospitalization despite challenges	"It has been two years since I was last hospitalized. There were times when I thought I might not make it. (laughs) There were periods when depression became so overwhelming that I felt I could do nothing and worried that I was in danger, but somehow I managed to get through them." (SPB163)
Integrating BFT learning into everyday life	Applying what was learned in everyday life as needed	Deliberate use of BFT skills	Intentionally applied BFT coping strategies in challenging situations	"When I start feeling overwhelmed, I remember the 'stop-thinking' technique we discussed in the anger management sessions. I also recall learning that anger is a secondary emotion, and I try to think about what my original feeling was underneath the anger." (SPA77)
	Not being consciously aware of the influence of BFT	Implicit use of BFT learning	Felt that BFT learning had become naturally integrated into everyday life	"We learned to analyze situations and understand one another better. Looking back, I think that process gradually deepened my understanding without me even realizing it. Rather than consciously thinking, 'This is because of BFT,' I feel that what I learned has naturally become part of my everyday life." (HPB264)

TABLE 6: Coding process of participants' current situations

All themes and categories (Code 3) identified in the analysis are presented. Subcategories (Code 2), initial codes (Code 1), and representative quotations are illustrative examples selected to demonstrate the coding process.

Theme	Category (Code 3)	Subcategory (Code 2)	Initial (Code 1)	Representative quotation
Seeking change and understanding through BFT	Engaging in the intervention with a desperate desire to get better	Strong motivation for recovery	Participated in BFT with an urgent desire to recover from illness	"I did not always understand the technical terms that were used. Some parts were difficult, but I was desperate. I felt that if I did not learn this, my illness would never improve. That is how determined I was." (SPC83)
	Beginning BFT because of family support and agreement	Family support as motivation for participation	Began BFT because family members agreed and supported participation	"My family was somewhat embarrassed about it, but they agreed to participate. That support was one of the reasons I decided to try BFT." (SPA56)
			Hoped family	

	Wanting family members to understand one's condition	Desire for family understanding	members would better understand personal experiences and condition	“My condition was not particularly bad at the time, but I wanted my family to understand me better and to know more about what I was experiencing.” (HPC31)
Experiencing challenges and support during BFT	Finding the involvement of a third party (family therapist) helpful	Facilitating family discussions through professional involvement	Benefited from a neutral third party who helped prevent emotional escalation within the family	“When it was only family members, discussions could easily become emotional and heated. Having a third person involved helped to calm things down, and that was very helpful.” (SPC237)
	Feeling that one's lack of knowledge about one's illness was exposed	Confronting limited illness-related knowledge	Realized personal lack of knowledge about mental illness through participation	“The topics were quite difficult and detailed. Sometimes I felt that my lack of knowledge was being exposed. Participating made me realize how much I still did not understand.” (SPC81)
	Finding it emotionally difficult to revisit one's own and one's family's past through BFT	Emotional burden of revisiting past experiences	Found it emotionally difficult to reflect on personal and family history	“We talked about many things from my past, as well as my wife’s past. Remembering those experiences was emotionally difficult at times.” (HPP55)
	Finding some aspects of the intervention easy to understand and others difficult to understand	Mixed experiences of intervention materials	Found visual tools helpful and memorable despite the complexity of some content	“The handmade cards showing current symptoms and symptoms I wanted to improve were particularly memorable. The illustrations made the information easy to understand and left a strong visual impression on me.” (HPC33)
	Feeling confused after hearing the explanation of BFT	Initial uncertainty about the intervention	Felt confused when first introduced to the BFT program	“When I was first asked whether I wanted to take part, I honestly felt confused because I did not really understand what the BFT was or how home-based support worked.” (SPC47)
Finding lasting meaning in the BFT experience	Forgetting the content of the support	Fading memory of intervention content	Could no longer clearly recall the specific contents of BFT	“Now that I live in a group home, I have mostly forgotten what it was like when I was participating in the BFT.” (SPB61)
	Having an opportunity to gain some understanding of one's own life	Gaining insight through life review	Developed greater self-understanding through reflecting on personal life experiences	“During the individual assessment, they asked about my life from elementary school through college and even my work at a nursery school. Looking back on my past helped me understand the differences between when I was unwell and when I was doing better, and it helped me organize my thoughts and feelings.” (SPC71)

TABLE 7: Coding process for retrospective reflections on BFT

All themes and categories (Code 3) identified in the analysis are presented. Subcategories (Code 2), initial codes (Code 1), and representative quotations are illustrative examples selected to demonstrate the coding process.

BFT: Behavioral Family Therapy

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. Ethics Review Committee of Goryokai Hospital issued approval 2024-1. **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 a grant from the NAKANISHI MUTSUKO NURSING PRACTICE RESEARCH FUND. **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:** The author serves as a board member of the Japan Family Work Project, an organization that promotes and implements the Meriden Model of Behavioral Family Therapy (BFT) in Japan. This relationship is disclosed for transparency.

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