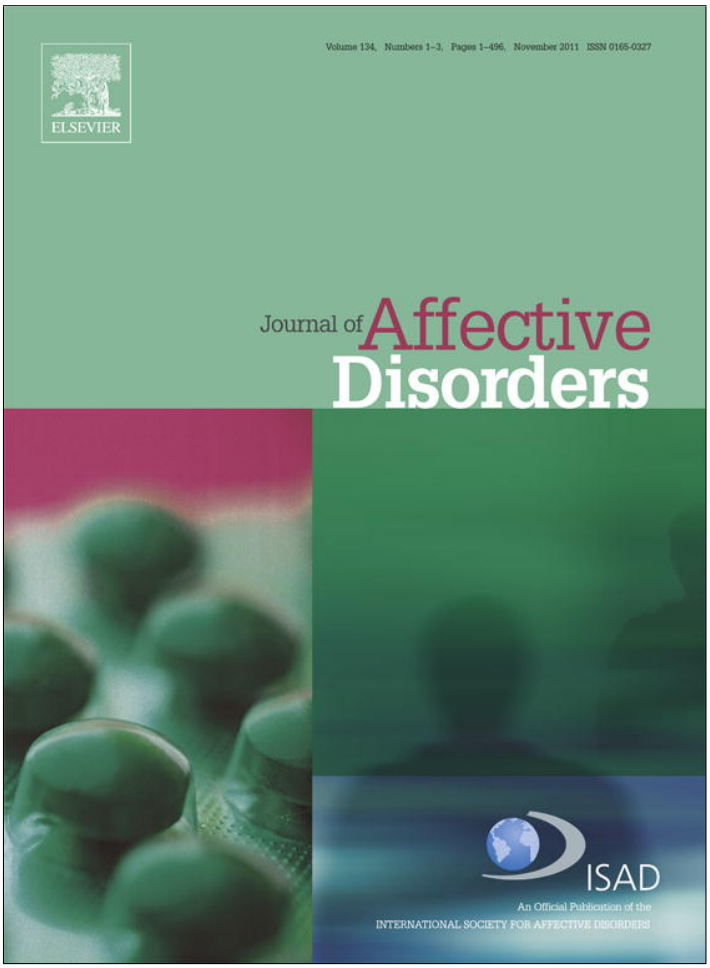

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Research report

Therapeutic processes in multi-family groups for major depression: Results of an interpretative phenomenological study

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ABSTRACT

Background: Recent research indicates that different couple and family interventions are effective in the treatment of depressed patients. However, how these psychosocial interventions work, has been less well investigated. In order to better understand the underlying treatment processes, helpful treatment experiences of depressive patients and their partners were examined in a multi-family therapy group.

Method: 24 patients hospitalized for depression and 20 partners participated in this study. Therapeutic factors were assessed using an open-ended questionnaire. Responses were analyzed using interpretative phenomenological approach (IPA).

Results: Eight recurring therapeutic factors were reported by both the patients and their partners: (1) Presence of others, (2) cohesion and understanding, (3) self-disclosure, (4) openness, (5) discussion, (6) insights, (7) observational experiences and (8) guidance from the therapist.

Limitations: Results were not fed back to the participants following analysis and only therapeutic factors that operate on a conscious level could be identified.

Conclusions: Several important therapeutic factors were identified in multi-family therapy groups for depression. These factors help to gain understanding into the processes, which should be emphasized in treatment and ought to be explored in future outcome and process research.

1. Introduction

Antidepressant medication and individual psychotherapies such as cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT) or a combination of both are generally accepted to be the treatment of choice for major depression (Henken et al., 2007; NICE, 2009). However, recent research indicates that depressed individuals and their families may also benefit from couple and/or family interventions. Different forms of couple interventions have been reported to be as effective as individual therapies in alleviating depressive symptoms, particularly for maritally distressed and depressed patients and even more effective in ameliorating relationship distress (Barbato and D'Avanzo, 2008; Gupta et al., 2003). Further, there is some evidence that single family and multi-family interventions during inpatient treatment or soon after discharge may improve long-term treatment response and remission rates of depressed patients (Lemmens et al., 2009a; Miller et al., 2005). Additionally reported benefits, particularly from psycho-educational family group interventions include increased treatment satisfaction and knowledge about mood

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disorders (Anderson et al., 1986; Keitner et al., 2002; Keller and Schuler, 2002), decreased stigmatization and social isolation (Asen and Scholz, 2010; Harter et al., 2002), a better collaboration with the mental health professionals (Keitner et al., 2002), improved family communication skills (Miklowitz, 2004), the stimulation of new perspectives (McFarlane, 2002, 2003), and learning new coping strategies in dealing with distress (Lemmens et al., 2003a,b). That couple and family interventions may produce benefit in families living with depression is not surprising since an episode of major depression is associated with significant difficulties in many areas of the family life (e.g. poor communication and problem solving, decreased social support, increased caregivers distress and marital problems) (Allan and Dixon, 2009; Coyne and Benazon, 2001; Friedmann et al., 1997; Gladstone et al., 2007; Harris et al., 2006; Heru and Ryan, 2004; Hickey et al., 2005; Miller et al., 1992; Tranvag and Kristoffersen, 2008). In spite of this family members are seldom involved in the treatment of their depressed partner or parent (Lakeman, 2007; Rober, 2008; Slack and Webber, 2008; Tranvag and Kristoffersen, 2008).

Despite the growing evidence of the efficacy of these couple and family interventions for depression, little is known about how these treatments work. Studies investigating the underlying beneficial treatment processes are scarce (Kazdin, 2007). Some reports suggest that the reduction of the partners' criticism (Bodenmann et al., 2008) or the improvement of the marital distress (Beach and O'Leary, 1992; O'Leary and Cano, 2001) in the couple interventions is likely to reduce the depressive symptoms whereas providing information to the family members, mutual support and feedback, learning by observation and identification, experiencing of communality and gaining new insights, are regarded as important therapeutic factors in multi-family groups (Asen, 2002; Asen and Scholz, 2010; Keitner et al., 2002; Lemmens et al., 2003a).

This present study is part of a randomized controlled study comparing single family and multi-family therapies with standard treatment for hospitalized patients with major depression and simultaneously investigating outcome and process variables. Although combining quantitative and qualitative approaches to research is sometimes portrayed as antithetical, others emphasize the value of combining qualitative techniques with quantitative research (Pope and Mays, 1995) particularly to improve our understanding of how treatment works and what therapeutic processes should be emphasized or avoided in treatment (Kazdin, 2008).

The details of the outcome and process study are reported elsewhere (Lemmens et al., 2009a,b) and only briefly summarized here. Compared to standard treatment multi-family therapy (MFT), to a lesser extent single family therapy had significantly higher rates of treatment responders and patients were using less antidepressant medication at fifteen month's follow-up (Lemmens et al., 2009a). The patients benefited most from the multi-family group when they experienced different kinds of behavioral interventions or activation (e.g. trying out new behavior, learning by observation, guidance from therapist, modeling) or when their partners were able to make use of the different relational aspects of the group (e.g. feeling accepted and supported by the group, confidence in helping others) (Lemmens et al., 2009b).

The aim of this qualitative study was to identify subjective treatment experiences of the participants using a qualitative phenomenological approach. This approach allowed us to identify a broader range of therapeutic processes in family groups compared to Lemmens' study (2009b), which investigated the treatment process with a structured questionnaire. Hereby, the perspectives of the patients as well of their partners are taken into account.

2. Method

2.1. Sample selection

Patients were recruited from the Anxiety and Depression Unit of the University Hospital Leuven to participate in an RCT investigating the effectiveness of single family therapy and multi-family therapy for depression. The unit provides treatment on an inpatient or a day clinic basis. Treatment is mainly offered in a group format. It lasts about 3 months and includes a number of different components such as non-verbal therapy, cognitive behavioral therapy, systemic therapy, pharmacological treatment and activation.

The inclusion criteria for the patients to participate in the RCT study were: (1) having a diagnosis of major depression as defined by DSM-IV (American Psychiatric Association, 1994) (using the Mini International Neuropsychiatric Interview, Dutch version 5.0.0., section A to O (Sheehan et al., 1998; Overbeek et al., 1999)), (2) being involved in the treatment program of the unit, and (3) cohabiting with a partner for a least one year. Except for the period of cohabiting, no other inclusion or exclusion criteria for the partner were used. A multi-family group cycle started after four to seven patients and their families gave written informed consent to take part in the study and were randomized to the multi-family arm of the study.

2.2. Participants

Of the eighty-three patients and their partners participating in the RCT, thirty-five were randomized to the multi-family condition and all agreed to participate in this process research study. Of the 35 patients, nine had a first depressive episode and 26 suffered from recurrent depression having on average suffered from 2.7 depressive episodes. The Beck Depression Inventory scores of the patients (Beck et al., 1961; Bouman et al., 1985) were 26.6 before the start of the group. The mean age of the patients was 44 years, and 45 years for the partners. Twenty-eight of the patients were female. Twenty-nine patients were married and six were cohabiting having lived with their current partner for 18.7 years. Ten patients had no children, fifteen had one or two children, and ten had 3 or 4 children. Except for two couples, no qualitative data could be obtained from the treatment drop-outs (six couples). Of the treatment completers, seven patients and eleven partners gave blank or no responses. Thus, 24 patients and 20 partners of the depressed patients participated in this study.

2.3. Organization of the multi-family groups

The treatment used in the study was a brief systemic multi-family therapy model (Lemmens et al., 2001) with some specific modifications made for this group of patients. Its format has been described in detail elsewhere (Lemmens et al., 2007a). The group was primarily a multi-couples group to which the

patients' children were invited for up to two sessions (sessions 2 and 5). The program followed a predetermined treatment protocol. The content varied with each session and focused on the impact of the depression and the treatment on the family unit (especially on the couple in session 1 and on the children in session 2), on couple issues (session 3), on restoring family functioning (especially on the couple in session 4 and on the children in session 5), on relapse prevention (session 6) and on stabilizing treatment gains (follow-up session).

A male family therapist/psychiatrist together with a female therapist led the sessions. An observation team in the room consisted of three or four mental health professionals from the unit and/or trainees in family therapy. Therapists and observers didn't change during a group cycle. The male therapist was involved in all seven groups. A group cycle consisted of six biweekly sessions and a follow-up session after three months. Each session lasted about 90 min with a break after 60 min.

2.4. Measures

Patients and partners were asked to fill out a group evaluation questionnaire (Lemmens et al., 2005) after six group sessions. The group evaluation questionnaire contained two open-ended questions about the participants' experiences of the multi-family group: (a) "Which events or experiences do you consider to have been important, helpful or good learning experiences for yourself during the past six sessions of the family group?" (b) "Which events or experiences do you consider to have been important, helpful or good learning experiences for your family during the past six sessions of the family group?" These questions were asked to each member of the group separately in order to obtain a detailed view of what each group participant perceived as helpful. In addition, it allowed us to explore if patients and partners experienced the same mechanisms as helpful. The use of these open questions gave all participants the opportunity to describe their experience in their own words, exhaustively and without restrictions (Penner and McClement, 2008; Phelps et al., 2009).

2.5. Data collection

In total, 24 patients and 20 partners gave meaningful written comments. No data were collected from the 36 participating children of the patients. Seventy-eight meaningful comments were given for the first question and 122 for the second question. The number of meaningful comments per participant varied from one to six.

2.6. Analysis

The data were analyzed using Interpretative Phenomenological Analysis (IPA) (Smith, 1995; Smith and Osborn, 2003). IPA is a qualitative research method that combines phenomenology with hermeneutics. It is phenomenological because the focus is on a detailed examination of the personal lived experiences of the participants. More specifically, IPA is concerned with trying to understand how participants themselves make sense of their experiences. The central focus is on the meanings that these experiences have for the participants and not to produce objective data of the event itself. In this way, IPA involves a double hermeneutical process: first, the participants are attributing meaning to their experiences; second, the researchers are trying to understand this process of meaning construction of the participants. Therefore and in order to enhance the trustworthiness of the research process, it is necessary that the researchers try to set aside their own beliefs, thoughts and preconceived notions about the phenomenon under investigation, a process called "bracketing" (Byrne et al., 2004; Smith, 2008). Although the form of data collection in this study is not in line with Smith's primary idea of IPA data collection, namely in-depth interviews, it is possible to do IPA on written data from open-ended questionnaires (Reardon and Grogan, 2011). Written data are indeed thinner than interview data. Nevertheless we chose IPA because of its clarity and ideographic approach.

The analysis was performed by three different researchers (first, second, and last authors), which allows through the process of investigator triangulation to enhance the validity of the study (Guion, 2002). The first author is a female clinical psychologist and Ph D student. Her pre-understanding was that depressive patients and their partners need social support but because of the depression avoid talking with others about the problems. In this way, multi-family groups may be helpful but at the same time restraining because talking with strangers may hinder in-depth analysis of own problems. The second author is a male clinical psychologist, family therapist, and assistant professor. As a family therapist he worked exclusively with single-family sessions. In fact he was skeptical about multi-family groups because of the difficulty to explore specific family dynamics within groups, although he acknowledged the richness of group processes. The last author (third researcher) is a psychiatrist, family therapist, and clinical professor. He thought that groups can render support for patients and their partners, and can prevent isolation and stigmatization. At the same time group members can gain better understanding of depression through a process of mutual learning.

In fact four texts had to be analyzed: patients describing their own experiences, partners describing their own experiences, patients describing helpful processes for their family, and partners describing helpful processes for their family. First the two texts of the patients were analyzed, next the two texts of the partners. Each text was analyzed separately. To begin with, each researcher read the text a number of times writing down first reflections, associations, and preliminary interpretations. Next, keywords that captured the essential quality of the participants' statements regarding helping processes were noted in the margin. At the same time, the themes were listed on a separate sheet. Then, the themes were discussed with the two other researchers. Similarities and differences were analyzed profoundly. In this phase, it was of vital importance to stay close to the data and nuances in meaning were discussed until consensus was reached. Next, attempts were made to cluster the themes under master themes. Each time a master theme emerged, the data were checked to see whether the master theme could capture what the participants actually wrote. With regard to the level of analysis, we opted for classification. Classification means trying to range meaning units or themes that emerge out of the data. Then, the next text was analysed in the same way. Some material referred to existing themes and master themes; for other data new themes and master themes emerged. In this way the categorization was refined and a more integrated set of master themes could be developed. This process of analysis was performed on the four

texts successively, which actually means that a text was re-analysed each time a new text was analysed.

3. Results

No major differences were found between the meaning of the responses of the patients and their partners on either of the two research questions. Patients and partners apparently reported similar experiences as helpful for themselves as well as for their family in multi-family therapy (MFT), although the patients mentioned more often than their partners that these therapeutic factors also occurred within the couple and not only within the group. Because of the close resemblance of the responses, the total dataset was merged in order to increase the detection of a broad range of therapeutic factors in MFT. The qualitative analysis resulted in eight recurring therapeutic factors: (1) presence of others, (2) cohesion and understanding, (3) openness, (4) self-disclosure, (5) discussion, (6) insights, (7) observational experiences and (8) guidance from the therapist. The different factors including some differentiation will be discussed consecutively in detail using descriptive statements each time illustrated by one selected verbatim quotation of the patients and the partners. Reported differences between patients and partners will be highlighted.

3.1. Presence of others

The presence of other group members was perceived as helpful by the patients and their partners. Instead of being a precondition for the occurrence of other helpful therapeutic experiences, the inclusion of the own and other families in treatment itself was reported as helpful. Slight differences were found between the responses of patients and their partners. The patients particularly benefited from the presence of their own family (e.g. partner and children), although the presence of the other families was also reported as helpful. They appreciated that their family members were involved in treatment and were willing to participate.

> "Participation in treatment was not easy for my family, but …. they have been able to do it." (Female patient, 40 years)

> "….the presence of the other partners…" (Female patient, 50 years)

The partners of the patients reported mainly the presence of other partners and the group in general as helpful.

> "Meeting other partners." (Male partner, 52 years)

Remarkably, both patients as well as their partners frequently reported the beneficial effects of the presence of the(ir) children in two group sessions. They found it helpful that their children, who are generally seldom involved in the treatment of their depressed parent, could interact with other children, talk to other group members and discuss their concerns with the therapist.

> "I found it important that my children were involved in the sessions." (Female patient, 40 years)

> "The presence of the children." (Male partner, 58 years)

3.2. Cohesion and understanding

Both patients and partners found it helpful to experience a sense of team feeling and belonging to the group. They benefited from the affective bond, which developed between the group members during the group sessions.

> "A form of cohesion." (Male patient, 54 years)

> "The team feeling." (Male partner, 40 years)

They also reported that it was helpful to feel understood in the group.

> "… people who understand you." (Male partner, 39 years)

> "To feel understood is very comforting." (Female patient, 37 years)

In contrast to the partners, the patients mentioned both therapeutic factors to further occur within the couple. They found it helpful to experience cohesion, support and understanding from their partner.

> "The support and understanding of my partner." (Female patient, 53 years)

3.3. Openness

Openness emerged in both patients and partners' answers as helpful. Again, the patients emphasized more the helpful effect of an open attitude within the own family compared to their partners.

> "That my partner has opened himself." (Female patient, 45 years)

> "Openness from patients and partners…." (Female partner, 49 years)

3.4. Self-disclosure

Self-disclosure was mentioned as a helpful experience by both patients and their partners. Apparently, this therapeutic factor was reported to be helpful in two different ways. First, patients and their partner found it helpful if they themselves could disclose something in the group. Further, they experienced the self-disclosure of their own family members, in particular of their children, or of other group members as helpful.

> "That I could express that a relationship should be equal and balanced." (Female patient, 54 years)

> "I found most important that thoughts could be expressed in the group…" (Male partner, 50 years)

" That my children could express their opinions and feelings…" (Female patient, 54 years)

3.5. Discussion

Discussing different topics was mentioned by both patients and partners as helpful. Both stressed that they benefited from discussions with their family members as well as with other group members and the therapists. Especially the fact that they could talk to fellow sufferers was identified as beneficial. They also reported that it was helpful that their family members were able to discuss different issues. Frequently reported topics of the discussion were: children, illness and treatment, and relationship issues.

"Discussions with the children and partners of our and other families." (Female patient, 49 years)

"To discuss problems 'more easily' with persons with similar problems." (Male partner, 49 years)

"Discussing relationships of the children." (Male partner, 47 years)

3.6. Insights

Gaining new insights was frequently mentioned as helpful by both the patients and their partners. They both reported that the group sessions lead to new insights about one-self, the depression and its treatment, and the relationships.

"That the recovery process will take a long time for everybody." (Female patient, 44 years)

"We're stuck in our relationship and urgently need some couple therapy." (Female patient, 51 years)

"Talking with others helps." (Male partner, 43 years)

"That our children like to be home alone with a baby sitter." (Male partner, 43 years)

Further, patients benefited that their children gained a better understanding of the depression.

"The fact that my children gained insight that this could happen to other people." (Female patient, 45 years old)

3.7. Observational experiences

Different observational experiences were mentioned to be important in the multi-family groups: learning by observation, experiencing universality, and discovering similarities and differences. Patients and partners apparently benefited directly from the behavior, interactions, and coping of the other group members within the group. Patients in particular mentioned listening to the stories of other group members as helpful whereas their partners were more focused on solutions. They appreciated when they could learn new coping mechanism in dealing with the depression and relationship issues.

"Listening to the experiences of others." (Female patient, 44 years)

"I've curiously listened to the responses of the others, how other families are experiencing depression and are dealing with it." (Female partner, 39 years)

Discovering the universality of problems was reported as helpful by both patients and partners.

"I've found it important that I was not the only one suffering with depression." (Female patient, 31 years)

"The things that you feel, you're not the only one who's thinking that way. This is comforting to me." (Male partner, 40 years old)

Patients and their partners reported frequently that they benefited from experiencing not only similarities but also differences with others and particularly seeing progress in others.

"That there are also others with the similar problems is comforting." (Female patient, 44 years)

"To hear similar problems in the other couples." (Male partner, 39 years)

"That other partners are sometimes less understanding than my partner." (Female patient, 39 years)

"Seeing progress in other group members." (male partner, 47 years)

Both patients and partner underlined the importance of these observational processes for their children. They appreciated that their children could learn from other children and that they could notice that they're not the only children living with a depressive parent.

"During the group session my daughter saw that there were other mothers with problems and this was important for her." (Female patient, 31 years)

"The children noticed that there were other children who were concerned about their parents." (Male partner, 43 years)

3.8. Guidance from therapist

All previously mentioned therapeutic factors mainly focus on processes operating between the different group members. However the importance of the role of the therapist was also commented on. The partners in particular pointed to the beneficial effects of the therapist. Partners often do not fully understand what is wrong with their ill partner and feel

guilty for not being able to act in an appropriate way. Receiving information about the depression and its course from the therapist was regarded as helpful. They further mentioned that the presence of a therapist was helpful for the children. It gave them the opportunity to consult an expert.

> "That it was made (by the therapist) clear that the recovery is not going to be a straight line (that there may be relapses)." (Male partner, 48 years)

> "The examples of the therapist concerning how to deal with the children." (Male partner, 42 years)

> "The children …be able to discuss it with mental health workers…" (Male partner, 52 years)

4. Discussion

The present study investigated the subjective treatment experiences of patients and their partners participating in multi-family therapy for depression. Major themes relating to important, helpful or good learning experiences were the presence of others, cohesion and understanding, openness, self-disclosure, discussion, insights, observational experiences and guidance from the therapist. Similar to previous research (Lemmens et al., 2009a,b), the depressed patients and their partners made little differentiation between helpful events at the individual and the family level, as if a beneficial event for one-self automatically produces a helpful effect for the family (and vice versa). This may point to the overall effect of the therapy at different levels, or that therapy is experienced by them as a whole. It also may have been the result of the close interplay between individual and family processes or it may partly reflect the use of the open-ended questionnaires. It may also reflect the relatively small differences in perception of therapeutic factors between the patients and their partners reported in this and other studies (Kivlighan and Goldfine, 1991; Lemmens et al., 2009b).

Although this study has used a different methodology ('Interpretative Phenomenological Analysis') compared to other studies, our findings are consistent with most clinical and research reports of therapeutic factors in multi-family groups for depressed and other psychiatric patient population. In line with Lemmens et al. (2003a,b, 2009b) and Asen (2002), the participants in our study also benefited from a open, supportive, understanding and cohesive group with room for self-disclosure and discussion. These qualities are often affected in families living with depression (Friedmann et al., 1997; Gladstone et al., 2007; Harris et al., 2006; Hickey et al., 2005; Miller et al., 1992). McFarlane (2002) has already pointed to the importance of the social support within multi-family groups. In these groups the participants, who are often socially isolated by the disorder (Gladstone et al., 2007; Harris et al., 2006), are provided an artificial social support system satisfying the technical requirements for a natural social network. Further, the supportive and cohesive atmosphere and especially the presence of fellow sufferers in the group may have stimulated openness and self-disclosure and have promoted a safe room for discussing different family and depression-related topics, which might be difficult to attain within the single family unit (Asen, 2002). Moreover, as reported by Lemmens et al. (2003a,b) and Asen and Scholz (2010), discussing these issues in the multi-family context has the effect of normalizing communication patterns and contents between the family members. These findings could highlight the added value of involving families with depression in a multi-family group, but further research is necessary to investigate this.

As found by Keitner et al. (2002) and Asen and Scholz (2010), the presence of other families also helped the depressed patients and the family members in our groups to gain new insights and to learn by different observational experiences. The large number of differences and similarities between the group members on various levels (individual, couple, family) is likely to have stimulated different cognitive processes, which helped patients and families who are often only focused directly on the depression and involved in negative related interactions to broaden their views, to generate different insights into one-self, the family and the depression (Harter et al., 2002; Hickey et al., 2005; McFarlane, 2002). In line with Lemmens et al. (2009b), the patients and their family members apparently benefited from learning from other's experiences in coping with their problems. This could again point to the value of a multi-family group format where particularly good opportunities for identification, modeling and exchanging of experiencing are present (McFarlane, 2003). In line with Asen (2002) and Asen and Scholz (2010), the patients and their families also benefited from experiencing of similarities. It may have helped them to realize that they are not alone in suffering from a depression and that their actions, feelings and struggles are normal. As a result, they may feel less isolated and stigmatized (Harter et al., 2002). In contrast to Lemmens et al. (2009b), experiencing differences was also reported to be helpful in this study. It may have helped the depressed patients and their partners to appreciate and reinforce their own or their partner's, often forgotten, resources or qualities and to realize that they're not doing that badly, especially when the situation of the other families is perceived as worse. Seeing one's own progress and the progress of other group members, which was reported to be helpful, may further instill hope, which is regarded to be an important aspect of most psychotherapeutic interventions (McFarlane, 2003).

In contrast to Lemmens et al. (2003a,b), but in line with Lemmens et al. (2009b) our findings point directly to these therapeutic factors operating not only on an individual or a group level, but also within the couple or the family. Especially the patients mentioned the helpful aspects of experiencing cohesion, support, understanding, openness and self-revelation within the couple and underpin the multi-level treatment effect of the multi-family therapy format. But the reported differences between the patients and the partners are also raising several questions, which require further investigation. Are these differences likely to be the result of the partners being somewhat overwhelmed by the group format, and therefore perhaps paying less direct attention to their own relationship, unlike the patients who were already participating in different group therapies during the treatment program? Or may they just reflect the greater focus of the partners on how other families were dealing with the depression rather than the own situation? Or may they be the result of the partners, in contrast to the patients, not

reporting any marital distress before the start of this trial (Lemmens et al., 2007b)? Or do these differences point to an understanding that in the patients lived experience, being together with their own family is the most important and relating to others outside their own family is regarded as more difficult? Indeed, as found in previous studies (Byrne et al., 2004; Coyne et al., 2002; Heene et al., 2007; Lemmens et al., 2007b; Whisman, 2001), depressed patients often struggle with important communication and relational problems. These findings may indirectly indicate that depressed patients may rather prefer or benefit more from single family than multi-family group sessions. Unfortunately, treatment preferences were not investigated in this study. But, current evidence contradicts better outcomes with single family therapy. McFarlane et al. (1995), Bellack et al. (2000), Geist, et al. (2000) and Lemmens et al. (2009a) found that in most RCT comparing single family and multi-family therapy, multi-family therapy is reported to be at least, and sometimes more effective than single family therapy. It may underpin the multi-level treatment effect of the multi-family therapy format, which may be an excellent and safe environment for dealing with relational issues without directly addressing them in a specific couple/family context.

Most striking finding of this study is that both patients and partners perceived the presence of the children as very positive. As found in previous studies (Brennan et al., 2002; Herr et al., 2007; Lovejoy et al., 2000) children may experience many difficulties in the relationship with the depressed parent. Although they are at risk themselves for developing several problems (e.g. difficult behavior, learning problems, playing less with friends, depression) (Haligan et al., 2007; Lieb et al., 2002; Skärsäter, 2006; Van Wijngaarden et al., 2004; Van Wijngaarden et al., 2009), they are seldom involved in the treatment of their depressed parent (Rober, 2008; Slack and Webber, 2008).

While our findings about the children's experiences are limited by the fact they were not directly questioned in this study, we can cautiously conclude that they benefited from self-disclosure, discussing a variety of topics, gaining new insights and experiencing different observational processes. Our findings are in line with Stith et al. (1996) indicating that children want to be involved in therapy with their parents.

Although a major emphasis in multi-family therapy is on the processes that take place between the different group members and families, and the therapists purposefully avoid taking too much of a central role in these groups, their contribution to the treatment process remains important. Their short and collaborative information giving, which in our groups tend to occur in a rather informal way through exchanges with the group members' experiences and are not structured in to a formal psycho-education, benefited the group members. As found by Lakeman (2007) and Tranvag and Kristoffersen (2008) family members often experience hostility and rejection and have the feeling that mental health workers do not pay sufficient attention to their own needs. Where there is regular contact between the mental health workers and family members, such as during in-patient treatment, it is often quite difficult and tense. Previous research by Cleary et al. (2006) found that participating in multi-family therapy may contribute to the opportunity to participate in treatment leading to a better collaboration with and support from the mental health workers. In line with Crits-Christoph et al. (2006), this study concludes that further research will be necessary to investigate the role that other therapist variables, such as the therapeutic alliance, play in multi-family groups for depression.

5. Limitations

Some potential limitations of the study need to be addressed. The method of data collection, namely open-ended questionnaires, prompts qualitative responses but allows little modification of format on the part of the participants or the researcher to find out about unanticipated directions (Madill and Gough, 2008). Though similar themes were found using a structured questionnaire (Lemmens et al., 2009b), we have to be aware that written records of experiences reveal less information than in-depth interview and only therapeutic factors that operate on a conscious level can be identified. The aim of the present study was to catch the helpful therapeutic factors in multi-family therapy and future research should explore the essence of these themes more extensively. Further, one of the researchers was the group therapist, which could be another potential limitation, but researcher triangulation adds to the trustworthiness of the study. Results were not fed back to the participants following the data analysis (member checking), which could have provided further credibility (Guba and Lincoln, 1981). The data were also analyzed after ending the therapy groups. Finally, the finding that the participants reported helpful factors, does not necessarily mean that these factors automatically result in positive outcomes. No process–outcome analysis was undertaken in this study. As mentioned earlier any conclusions about the children are limited by the fact that the children's own perspectives were not directly examined.

6. Conclusions

In this study we have identified several themes relevant to multi-family therapy for depression. Previous outcome studies have demonstrated that multi-family groups are effective but little is known about which therapeutic processes lead to these positive effects. This process research adds to our understanding of how MFT therapy is perceived as helpful by depressive patients and their partners. Our results indicate that the presence of other group members provides a cohesive and supporting atmosphere where patients and partners can come to new insights relating to their illness, relational aspects and themselves. In addition, psychosocial interventions should emphasize the value of openness, self-disclosure and discussion. These processes allow group members to learn from observations and to recognize similarities and differences in the stories of all participants. Finally, the therapist is perceived as helpful in a way that therapeutic guidance and providing information about the depression are two essential helpful aspects for patients and partners. Future outcome and process research should further explore these helpful therapeutic factors and should include the children's perspectives.

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