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Walden University

College of Social and Behavioral Sciences

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Emmanuel Akpan

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Walden University

2018

Abstract

Intensive Outpatient Treatment Program Dissertation Abstract

by

Emmanuel Akpan

Dissertation submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services: Family Studies & Intervention Strategies

Walden University

February 2018

Abstract

Psychosocial support from family is important in outpatient treatment programs for individuals with depressive disorder. The purpose of this phenomenological study was to explore the lived experiences and perceptions of parents of patients with depressive disorder regarding intensive outpatient treatment. The research question was what are the experiences and perceptions of parents of patients with depression regarding their role as caretakers in intensive outpatient treatment? The conceptual framework was a biopsychosocial framework and family systems theory. Content analysis was used to analyze data provided from interviews with parent participants (*n* = 8). Many participants reported high levels of involvement with various forms of support. They maintained positive relations with professionals, were involved in patient socialization, and facilitated adherence to patients' treatment plans. The results of this study indicated that family caregivers experienced ambivalent emotions toward their roles and patients. Findings also indicated experiences of exhaustion, strong emotions about the burden of having to support the patient, and concern for their own and the rest of the family's well-being. Future researchers should study these aspects further. Researchers, clinical practitioners, and policy makers must increase efforts to support those who help family members suffering from depression to intensify the search for effective ways to reduce the toll on those caregivers. Because of these findings, researchers could expand literature to illuminate the decisions and practices of psychotherapists, leading to improvements in intensive treatment programs for both patients and their caretakers. This study impacts social change by providing insights to aid policy makers in ensuring that outpatients receive the best treatment program available and that their primary caretakers are psychologically prepared and healthy.

Intensive Outpatient Treatment Program for Patients with Depressive Disorder: A Parental Perspective

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The Doctoral Dissertation submitted in Fulfillment
of the Requirements for the Degree of
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Chapter 1: Introduction

Introduction

Psychosocial support from family is important in outpatient treatment programs for individuals with depressive disorder (De Silva, Cooper, Li, Lund, & Patel, 2013; Houston, Cooper, & Ford, 2014). The success of outpatient treatment programs for individuals with depressive disorder can depend on the nature of support received from their family (van Grieken et al., 2014). Psychosocial interventions can facilitate treatment success by allowing patients to have access to emotional, financial, moral, or physical support (Wong et al., 2014).

Caregiver burden can be experienced by family members who take care of individuals with depressive disorder (De Silva et al., 2013; Mohammed, Priya, & George, 2015). Being the primary caretaker of an individual with depression can induce stress and result in poor psychological health (Kumar & Gupta, 2014). The focus of this study was to increase an understanding of the experiences and perceptions of the parents who were the primary caretakers of patients with depressive disorder and involved in intensive outpatient treatment programs.

In this chapter, I will introduce the main of the topic of my study. The organization of the chapter will be based on the following: (a) background, (b) problem statement, (c) purpose of the study, (d) research questions, (e) theoretical framework, (f) nature of the study, (g) definitions, (h) assumptions, (i) scope and delimitations, (j) limitations, and (k) significance. I will conclude the chapter with a summary of the main points of the study.

Background

Treatment for depressive disorder can have different approaches based on the goals of psychiatrists or psychologists (Kupfer, Frank, & Phillips, 2012; van Straten, Hill, Richards, & Cuijpers, 2015). Psychiatrists or psychologists often use a combination of pharmacological and psychological intervention to treat patients with depressive disorder (Jakobsen, Hansen, Simonsen, & Gluud, 2012). Burnand, Andreoli, Kolatte, Venturini, and Rosset (2014) found integrating pharmacological and psychological treatment was not only an effective approach, but also led to less treatment failure and better work adjustment, minimizing the cost of the treatment.

In addition to pharmacological and psychological interventions, psychosocial support can also be critical for treating depressive disorders (De Silva et al., 2013; Houston et al., 2014). Psychosocial intervention through psychoeducation is a component of an intensive outpatient treatment programs for individuals with depression (Flint, Cuijpers, Horder, Koole, & Munafò, 2015; van Grieken et al., 2014). De Silva et al. (2013) found psychosocial interventions could improve the social functioning of individuals with depression.

Psychosocial support from family members is important in outpatient treatment programs for individuals with depressive disorder (De Silva et al., 2013; Houston et al., 2014). According to Taylor, Chae, Lincoln, and Chatters (2015), family can present either a risk factor or a protective factor for major depressive disorder. The factor depends on the nature of the connection among family members. Psychoeducation and family involvement both play important roles in the success of treatment programs intended for patients with depression (Katsuki et al., 2014). Insufficient involvement of the family is one of the factors that can impede recovery of patients with depression (van Grieken et al., 2014).

Being the primary caregiver of a depressive patient can be stressful (Kumar & Gupta, 2014; McCann, Songprakun, & Stephenson, 2015). Kumar and Gupta (2014) provided insights into the influence of taking care of outpatients with depressive disorder on a caregiver’s own psychological health. The results of the study indicated that caregiver burden was a phenomenon that needs attention. McCann et al. (2015) noted that guided self-help could be beneficial in alleviating the burden that caregivers experienced taking care of outpatients with depressive disorder.

Problem Statement

Treating major depressive disorders often involves combining pharmacological and psychological interventions (Cuijpers, 2015; van Straten et al., 2015). In addition to pharmacological treatments, intensive outpatient treatment programs utilize various psychological interventions such as psychoeducation, family-centered interventions, individual counselling, and group therapy as parts of a single comprehensive program (van Straten et al., 2015). To minimize social isolation and enhance access to care and support, psychosocial interventions are an important component of an intensive and comprehensive outpatient treatment program for patients with depressive disorder (De Silva et al., 2013; Houston et al., 2014).

One of the goals of intensive outpatient treatment for patients with depression is to enhance their support system and improve the functioning of their family (Humphries-

Wadsworth, 2012). Family support is often an important component of an intensive outpatient treatment program for patients with psychological disorders, such as depression (Anastasia, Humphries-Wadsworth, Pepper, & Pearson, 2015). Family support is defined as the emotional, financial, moral, and physical support provided to any member of a family who has a disorder or disability (Xiaolian et al., 2002). When a professional involves the family in the treatment plan, managing patients with mental illness can be facilitated by emotional support, access to resources, and enhanced problem-solving skills (Dixon, McFarlane et al., 2014; Dixon, Stewart et al., 2014).

Despite the importance of family in intensive outpatient programs for patients with a depressive disorder (Anastasia et al., 2015; Humphries-Wadsworth, 2012), I could not find any study that focused on the perspective of parents as part of the treatment plan. In the literature, I did not find information regarding ways in which parents of patients with depression experienced perceive being part of an intensive treatment plan. Focusing on the perceptions of parents of patients with depression, regarding outpatient treatment, is significant because family support is important in the management and success of treatment programs (Dixon, McFarlane et al., 2014; Dixon, Stewart et al., 2014). Exploring the perceptions and experiences of parents might provide insights that could facilitate a more thorough understanding regarding involving a patient’s family in effective intensive treatment plans for patients with depression.

Purpose of the Study

The purpose of the qualitative phenomenological study was to explore the experiences and perceptions of the parents of patients with depressive disorder regarding intensive outpatient treatment. The phenomenon of the study was the parental perspective on the intensive outpatient treatment program for patients with depressive disorder. The research approach that I used was qualitative in nature and hermeneutic phenomenological in design. The results of the study could lead to positive social change in terms of improved interventions for patients with depression by providing an enhanced understanding of the role of parents as part of an intensive treatment plan. The results would also be useful to educators, social service workers, and treatment providers to enhance the current treatment plan used for patients with depression.

Research Question

I did not find information regarding ways in which parents of patients with depression experience and perceive being part of an intensive treatment plan. The research question for the study was the following: What are the experiences and perceptions of parents of patients with depression regarding their role as caretakers in intensive outpatient treatment?

Conceptual Framework

The conceptual framework included the biopsychosocial framework and the family systems theory (Bowen, 1966). Engel (1977) developed the biopsychosocial framework to highlight the importance of integrating biological, psychological, and social interventions in a single treatment program. The biopsychosocial framework can be conceptualized as a model to view a disorder or illness, including the appropriate provision of patient care or treatment. Regarding patient care, the rationale for integrating multiple intervention perspectives in a single program is to provide the most comprehensive treatment possible without being constrained by a single approach (Engle, 1977).

Professionals have used the biopsychosocial framework for treating psychological disorders, including depression (Peters, Taylor, Lyketsos, & Chisolm, 2012). In addition to pharmacological and psychological treatment, family support is often needed to enhance the effectiveness of the program (De Silva et al., 2013; Houston et al., 2014). With the involvement of family members in the treatment of individuals with depression through psychoeducation, patients have access to social support that can enhance sustained recovery (Katsuki et al., 2014).

Bowen (1966) developed the family systems theory. The main premise of family systems theory is that the family represents the emotional unit of an individual. Based on the framework of family systems theory, individuals do not function in isolation. Instead, individuals are understood to be a part of an interconnected and interdependent family unit. I used the family systems theory as a foundation to increase the understanding of why parents have an important role in a comprehensive outpatient treatment plan for patients with depression. Within the family systems theory, parents are expected to play a role in the treatment of a child who is being treated for depression (Bowen, 1966).

Nature of the Study

The nature of the study was a qualitative research method using a hermeneutical phenomenological research design. A qualitative research approach is used in studies that require depth to have a comprehensive understanding of a phenomenon that is under researched (Marshall & Rossman, 2014). Qualitative research methods involve using tools, such as interviews, which can produce diverse and comprehensive data needed to describe the processes involved in a complex phenomenon (Silverman, 2013). The selection of a qualitative research approach was consistent with the purpose of exploring the experiences and perceptions of the parents of patients with depressive disorder regarding intensive outpatient treatment using methods that would produce rich and detailed data based on interviewing the participants.

Phenomenological research is a qualitative research design that focuses on exploring a phenomenon using the lived experience and the subjective perceptions of individuals who are directly involved in the issue being explored (Moustakas, 1994). Phenomenological research relies on the oral or written expressions of participants to describe their own experiences of a phenomenon (Moustakas, 1994). Phenomenological research was appropriate because the experiences and perceptions of the parents of patients with depressive disorder could be best explored in a research design that would allow for intensive and deep exploration through semi-structured interviews.

The specific type of phenomenological research design that I used was hermeneutical. Hermeneutical phenomenological research is based on the methodology developed by Heidegger (1975), who believed that human existence was interpretive. Based on Heidegger’s framework, hermeneutical phenomenology shows human beings as concerned about their own fate in a context that is unfamiliar and alien. Hermeneutical phenomenology was appropriate for this study because exploring the experiences of parents of patients with depression aligned with the assertion of Heidegger that human experiences could be understood through the process of interpretation.

Definitions

In this section, I define the following key terms that are central to the proposed study:

Depressive disorder: This term is defined as a psychological diagnosis characterized by various affective and cognitive symptoms such as feelings of sadness, inadequacy, suicide ideation, and loss of interest (American Psychiatric Association [APA], 1993).

Family support: This term is defined as the emotional, financial, moral, and physical support provided to any member of a family who has a disorder or disability (Xiaolian et al., 2002).

Intensive outpatient treatment program: This term is defined as the use of pharmacological, psychological, and psychosocial intervention to treat patients with depressive disorder in an outpatient arrangement (Cuijpers, 2015; van Straten et al., 2015).

Primary caregiver: This term is defined as the male or female biological or non-biological parent of the patient who is being treated for intensive outpatient program for depressive disorder. A primary caretaker is a person who is directly involved in taking care of a patient (Delgado-Guay et al., 2013).

Assumptions

The first assumption was that all participants were the true primary caregivers of depressive adult patients who underwent intensive outpatient treatment. Being a primary caregiver entails direct involvement and support in the care of a patient who is undergoing outpatient treatment (Delgado-Guay et al., 2013). Providing support to patients can manifest in terms of emotional, financial, moral, or physical assistance (Xiaolian et al., 2002). During recruitment, I confirmed that the definition of a primary caregiver applied to all participants.

The second assumption was that the responses of the primary caregivers were accurate, honest, and in-depth. I explained to the participants that all their responses would only be used in the study, and pseudonyms were used to ensure anonymity. To encourage candor, I also attempted to make the participants feel comfortable by attempting to build rapport. I did not interrupt the participants and offer my own comments during the interview to prevent personal biases from interfering with their responses.

The third assumption was that the use of semi-structured interviews to capture the lived experience of the participants would be adequate and sufficient. Semi-structured interviews are effective in collecting in-depth data from participants because of the open-ended nature of the questions that are asked (Galletta, 2013). I also used follow-up questions when necessary to gain further insights about the initial responses of the participants.

Scope and Delimitations

One delimitation of the study was that the study only involved parents who were considered the primary caregivers of adult depressive patients who underwent intensive outpatient treatment. The rationale for this delimitation was to maintain homogeneity in the sample, which was critical in the development of the lived experience of the participants as a single group. Even though social support could come from spouse or friends, I only focused on parents who were considered primary caregivers to enhance the homogeneity of the sample.

Another delimitation of the study was that recruitment only occurred at a community center in the eastern part of the United States. The rationale for the selection of the setting was both based on convenience and the higher probability of reaching the target sample size of eight participants. Coordinating with psychiatrists and therapists who worked in the organization led to having access to potential volunteers who fit the eligibility criteria.

Limitations

The first limitation of the study was that the use of only eight participants might not lead to data saturation. A sample of 10 participants is usually considered a sufficient number to reach data saturation, but saturation can occur earlier or later (Francis et al., 2010). If data saturation was not achieved with the target sample size, I then recruited more participants until the data analysis was considered saturated.

Another limitation of the study was that the results could not be generalized to all primary caregivers of adult depressive patients who underwent intensive outpatient treatment. The concept of psychosocial support was broad and might not apply to all caregivers of patients. Even though the lack of generalizability is considered a limitation, qualitative studies are not intended to be generalized because the results are often based on the unique and subjective experiences of a small group of individuals (Marshall & Rossman, 2014).

Significance

The success of intensive outpatient treatment programs can be enhanced through family support (Anastasia et al. 2015; Dixon, McFarlane et al., 2014; Dixon, Stewart et al., 2014). This research addressed the limited understanding of family support on psychosocial interventions by focusing on the experiences and perceptions of parents of patients with depression regarding intensive outpatient treatment. Focusing on the experiences and perceptions of family members, such as the biological parents of patients, is important because they are usually the main caregivers of outpatients who have depressive disorder (Kumar & Gupta, 2014). This research was significant because it could provide an enhanced understanding of the role of parents as part of an intensive treatment plan for patients with depression.

Because of the findings of the study, researchers may continue to expand the literature that could illuminate the decisions and practices of psychotherapists that can lead to improvements in intensive treatment programs for both patients and their caretakers. Insights, gained from this study, could aid policy makers in ensuring that outpatients receive the best treatment program available and that their primary caretakers are psychologically prepared and healthy. The results of the study may highlight the importance of considering the role of parents as the primary caretakers of outpatients with depression in an intensive treatment program.

Summary

Psychosocial support is an important component of a successful outpatient treatment program (De Silva et al., 2013; Houston et al., 2014). Despite the importance of family in intensive outpatient programs for patients with depressive disorder (Anastasia et al., 2015; Humphries-Wadsworth, 2012), there seems a lack of research that focuses on the perspective of parents as part of the treatment plan. To address this research problem, the purpose of this qualitative phenomenological study was to explore the experiences and perceptions of the biological parents of patients with depressive disorder regarding intensive outpatient treatment.

The theoretical framework was based on the biopsychosocial framework and the family systems theory (Bowen, 1966). The nature of the study was qualitative research method using a hermeneutical phenomenological research design. This research was significant because it could provide an enhanced understanding of the role of parents as part of an intensive treatment plan for patients with depression.

The next section will contain the literature review. The topics discussed in the upcoming chapter are: (a) depression and mental health disorders, (b) intensive outpatient settings for patients with depression, (c) psychological treatment approaches for major depressive disorder, (d) value of psychological interventions, (e) value of combination therapies, (f) value of family support, and (g) caregiver burden. The chapter will conclude with a discussion of the identified literature gap.

Chapter 2: Literature Review

Introduction

Patients diagnosed with depression, who receive treatments through intensive outpatient treatment programs, often go through various psychological interventions, such as psychoeducation, family-centered interventions, individual counseling, and group therapy, as part of a single comprehensive program aside from receiving pharmacological treatments (van Straten et la., 2015). These psychological interventions show family support is an important component of intensive outpatient treatment programs for patients with mental health disorders (Cuijpers, 2015; van Straten et al., 2015).

After thoroughly reviewing the literature, I found a dearth of studies that indicated ways in which psychological interventions, especially family support components of those treatments, effectively helped both patients coping with depression and their families. (De Silva et al., 2013; Houston et al., 2014; Luciano et al., 2012). While these researchers have suggested that interventions might act as important components of an intensive and comprehensive outpatient treatment program for patients with depressive disorder, it was not known how parents of patients with depression experience and perceive being part of an intensive treatment plan or what their main roles are in the overall treatment plan.

The purpose of the proposed qualitative phenomenological study was to explore the experiences and perceptions of parents of patients with depressive disorder regarding intensive outpatient treatment. The results of the study could lead to improved interventions for patients with depression because of an enhanced understanding of the experiences of parents in an intensive treatment plan. Exploring the perceptions and experiences of parents might also provide insights to lead to a better understanding of the involvement and influence of family members in an effective intensive treatment plan for patients with depression. The results would also be useful to educators, social service workers, and treatment providers to enhance current treatment plans used for patients with depression. The findings of this study might also serve to improve intensive outpatient treatment programs for patients with depression, especially because such programs could enhance the patients' support system and improve the functioning of their family (Humphries-Wadsworth, 2012). By focusing on the perceptions of parents of patients with depression, the management and success of outpatient treatment programs may be improved (Dixon, McFarlane et al., 2014; Dixon, Stewart et al., 2014).

Literature Search Strategies

I used major search databases such as *EBSCOHost*, *JSTOR*, *ScienceDirect*, *PsychArticles*, and Google Scholar to search the literature. The search terms used to locate the literature included *bipolar disorder, caregiver burden, depression, family-centered interventions, family psychoeducation, family support, group therapy, major depressive disorder, intensive and comprehensive outpatient treatment programs,* and *outpatient treatments.* Many of the studies included in the review were published from 2012 to 2015; older sources were only used for the theoretical framework.

The next section is a review of the related literature, which includes an overview of depression and psychological disorders, the different types of these disorders, the different approaches to understanding depression, and its causes and effects. Next, I will discuss literature on the value of psychological interventions, including a discussion on psychoeducation, family-centered interventions, individual counseling, and group therapy as a part of a single comprehensive program (van Straten et al., 2015). This section will then include a discussion of the value of family support (De Silva et al., 2013; Houston et al., 2014; van Grieken et al., 2014). Another section will be devoted to the problem of caregiver burden. These sections will highlight a gap that the current study is designed to address. A gap in the current literature is that it is not known how parents of patients with depression experience and perceive being part of an intensive treatment plan. The discussion of the gap and literature summary will be the last sections of this literature review.

Review of Related Literature

Depression and Mental Health Disorders

Professionals have categorized mood disorders into two major types: depressive disorders and bipolar disorders (Kessler, Chiu, Demler, & Walters, 2005; McCracken & Morley, 2014). The former are characterized by one or more prolonged periods of serious depression, while at least one period of extreme euphoria and one or more periods of severe depression characterize the latter. Bipolar Disorder is also referred to as manic depression (Baldessarini, Pérez, Salvatore, Trede, & Maggini, 2015).

Regardless of the type, researchers have found that depression alters the way an individual perceives the world and can make it difficult for those affected to strive for the type of life they desire (Dowrick & Martin, 2015; Hankin et al., 2015; Jenkins & Goldner, 2012). Experts often refer to depression as the “common cold of mood disorders" (Jenkins & Goldner, 2012, p. 1). Although there are treatments available for depression, the condition often goes untreated (Dowrick & Martin, 2015; Hankin et al., 2015; Jenkins & Goldner, 2012). Kessler et al. (2005) found less than half of the persons with mood disorders received treatment, and this unmet need for intervention might cause major problems, as even mild to moderate mood disorders could be debilitating.

Many patients do not seek treatment for clinical depression, as most individuals have problems recognizing the symptoms. Symptoms, such as sadness and withdrawal, may be well known, but others, such as anxiety, panic, irritability, and sleeplessness, are often overlooked (Righi & Pierguidi, 2015). The public and patients do not know how clinical depression works and the kind of treatment required. Similar to other diseases, if the treatment for depression is administered earlier, the illness is easier to treat and less likely to recur (Kessler et al., 2005; Righi & Pierguidi, 2015). It is important though to seek appropriate intervention for mood disorders, as general practitioners do not specialize in this field; given the highly specialized diagnostic procedure and treatment regime, patients are often incorrectly diagnosed and medicated (Dowrick & Frances, 2013). Stigmatizing of people with depression as lacking moral backbone came from a lack of medical insight and information; despite greater tolerance and information distribution, such beliefs are remarkably resistant to change (Pescosolido, Medina, Martin, & Long, 2013).

Depression Associated with Different Circumstances

Adolescents versus the elderly. Adolescents between the ages of 13 and 18 years of age are vulnerable during this age period for the onset of depression. This age group represents a large portion of depression diagnoses, and most of lifetime cases in grown-ups come from disorders that had their onset in adolescence (Hankin et al., 2015). During adolescence, the occurrence of depression rises significantly, and this makes the study of depression in this age group important, especially in females, as the incidence is higher (Calvete, Orue, & Hankin, 2012). On the other end of the age scale, depression may develop in the elderly; according to Aziz and Steffens (2013), 3% to 4.5% of the geriatric population may present with depression symptoms much like major depressive disorder. Depression that develops late in life is associated with cerebrovascular compromise (Aziz & Steffens, 2013; Schatzberg, 2002) and can be an early sign of dementia. Psychosocial factors that may lead to depression include, among others, the loss of a spouse leading to bereavement and a lack of a confidante, loneliness, neuroticism, and disability (Aziz & Steffens, 2013).

Severe illness. Another life situation where depression may develop is severe illness, such as cancer. However, a study comparing cancer survivors with normal healthy persons showed that the cancer survivors did not show prevalence for either depression or anxiety (Mitchell, Ferguson, Gill, Paul, & Symonds, 2013). In HIV patients, depression and anxiety are comorbid and pose a further treatment burden on health care professionals and families. Persons living with HIV have a prevalent tendency of developing depression, which experts estimate as 12.5% cases of major depression disorder, and a further 13.2% presenting with other depression, totaling around 25.6% living with depression (Do et al., 2014).

Perinatal depression. In contrast, during a period of happiness when a new baby was born, mothers may develop depression. An under-diagnosed psychological condition is perinatal depression, which is widespread and severely affects the welfare of women, and their families. Due to insufficient identification methods, women with post-delivery depression may not seek or receive intervention. Timely intervention is vital and screening to identify those at risk should be implemented (Milgrom & Gemmill, 2014). Although these and other groups may seem to present with a higher prevalence of depression, this is not necessarily the case, as depression is not related to age of life situation (Righi & Pierguidi, 2015).

Depressive Disorder

Major depression (MD) is a widespread, impairing, recurring, and frequently long-lasting condition (McClintock, Husain, Greer, & Cullum, 2010), as well as a rather persistent health problem of modern society. Despite years of research, fundamental questions remain. For example, scientists have not found a reliable association between genetics and depression (Daly et al., 2013; Wray et al., 2012). The search for effective treatment ideas for depression continues (Tansey et al., 2012), and antidepressants versus placebos do not show any positive results for a significant number patients (Pigott, Leventhal, Alter, & Boren, 2010). Recently a “questionable” trustworthiness for a depression diagnosis was recorded in the DSM-5 field trials (Regier et al., 2013).

According to Dowrick and Frances (2013), the main causes for depression include chemical imbalances, stress, drugs, reactions to medication, and mental disorders. Psychologists used to attribute mental disorders to early-childhood experiences; however, the perception has changed, and psychologists now believe that it is not the parents who are responsible, but the brain of the individual. The concept that mental illness was caused by a disparity of chemicals in the brain erupted in the 1950s, when psychiatric drugs were advertised to assuage the symptoms of mental illnesses (Dowrick & Frances, 2013; France, Lysaker, & Robinson, 2007; Lacasse & Leo, 2015). Deacon (2013) examined the effects of an explanation of chemical imbalance on a patients' experience of guilt about the condition and found the explanation reduced self-stigma but might also serve to increase a sense of hopelessness due to poor expectations of prognosis and doubting non-biological treatments, such as psychotherapy.

The World Health Organization defined health and well-being in 1948 and has not changed the definition since (as cited in de Vries et al., 2016). The definition reads, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (de Vries et al., 2016, p. 167). In 1987, new standards promulgated on Quality of Life (QoL) and Residents' Rights in America (Kane, 2003). According to these standards, an individual's dignity must be maintained providing individuals with choices and opportunities to participate in planning for own care. How to spend their time was included under QoL. Different foci are placed on the interpretation of QoL depending on the field of study or care, as no single domain makes up the entirety of QoL (Kane, 2003). For instance, studies were carried out regarding QoL for cancer patients, patients with major depression, and others.

Daly et al. (2010) studied 2307 patients with major depressive disorder (MDD) and found that the there was an inverse relationship between the severity of the depression and QoL. Furthermore, socio-demographically disadvantaged participants with more severe depression were found at the greatest risk for poor QoL. In a more recent study, Ishak et al. (2013) evaluated the interaction between depressive symptom severity, functioning, and QOL in 319 urban outpatients suffering from major depressive disorder. The researchers sought to understand the quality of life of those with major depressive disorder. Ishak et al. also found that depression significantly and negatively affected patients’ QoL. The results showed that negative effects on QoL could increase in a monotonic fashion in accordance with depressive symptom severity, but depression symptom severity could only account for 48.1% of the changes in the quality of life among the outpatient population. Although Ishak et al. focused on an outpatient setting, the study differed from this current study in that it did not focus exclusively on adolescents and did not include the perceptions of parents in intervention process. Ishak et al. did not mention whether the outpatient setting included parents (or significant others), which this current study focused on studying.

A Swedish project revealed similar findings where the researchers used postal surveys to investigate health-related quality of life (HQoL) and found that the presence of depression had a detrimental effect on the QoL of persons with depression. In cases where anxiety was comorbid with major depression, the HQoL was significantly more negatively affected (Johansson, Carlbring, Heedman, Paxling, & Andersson, 2013). Seeing that depression is highly prevalent and that it negatively affects the QoL of patients and taking the prohibitive cost of treatment into consideration, van Zoonen et al. (2014) suggested that efforts to prevent depression or to postpone the onset thereof should be increased. This study did not focus on intervention and did not include family members in the management of the disorder. However, findings did have implications for this present study.

Luppino (2015) assessed the connection among depression and obesity, or metabolic disturbances empirically. The researcher evaluated whether treatment setting (inpatient versus outpatient) could mediate this relationship. The researcher concluded that depression was a significant predictor of obesity. Results showed that outpatients tended to be less depressed, and therefore less at-risk of obesity. Other studies confirmed the findings of Luppino; however, these found an inverse relationship between classic depression and weight gain.

While classic depression is associated with a loss of weight, atypical depression is associated with obesity (Levitan et al., 2012). Researchers concluded, in a study on Mexican Americans with obesity, there was a high risk of depression and metabolic syndrome in Mexican American females with low educational levels (Olvera, Williamson, Fisher-Hoch, Vatcheva, & McCormick, 2015). The comorbidity of obesity with depression and bipolar disease can be best addressed when the intervention includes the family members, especially the mother who traditionally oversees meals.

Two complementary hormones linked with various physiological functions, chiefly energy balance, leptin, and ghrelin, were showed as associated with mood disorders. However, there remained a contradiction, as some researchers found elevated levels of these hormones related to depression and anxiety conditions, while others indicated that depressed patients have depleted levels of these hormones, even before and after treatment, compared to controls. What is clear is that the neural routes, linked with the control of food intake *via* ghrelin and leptin, also affect emotional changes (Zarouna, Wozniak, & Papchristou, 2015). More information on this development is needed; however, this possible biological link with obesity in depressed individuals is important, as this has implications for intervention and the provision of information to family members in an outpatient setting.

Influence of depression on family members. Depression, being a mood disorder, also negatively influences the patients’ abilities to express affect and to participate or relate to experiences. This aspect has implications for the person’s social participation. Therefore, it is necessary to focus on the effect of the adolescent’s depression on the parental interaction. Studies have found that there is a higher incidence of parental criticism and negative feelings, most notably anger, toward the child with depression (McCleary, & Sanford, 2002). Parents display less positivity toward the depressive child and there is in increase in family dissonance (Yap & Allen, 2008).

In a recent study, the accuracy of parents in determining the adolescent’s daily experiences was found related to better psychological adjustment (decreased depression and stress levels; Human et al., 2014). Troubled family relationships are often attributed to the beginning of depression in children. The interpersonal theories of depression and family systems theory show that depression affects the family interactional patterns. Hollenstein, Allen, and Sheeber (2016) indicated a link between affective relations between family members and the development of symptoms of depression in children. The affective quantity approach shows that the amount and timeframe of affect—positive or negative—communicated in families separates depressed from nondepressed children. According to Hollenstein et al., negative parent behavior—hostility, sadness, or dysphoric affect—has been linked to depressive disorder. Because of more recent insights into the transactional nature of family interaction, there is increased interest in the integration of the parents in the patient's treatment regime (Abaied & Rudolph, 2014).

Effectiveness of outpatient treatment options. Rosner, Pfoh, Kotoučová, and Hagl (2014) examined the effectiveness of an outpatient treatment program for people suffering from prolonged grief disorder through a randomized controlled clinical trial. The cited researchers particularly examined whether outpatients, diagnosed with prolonged grief disorder, experienced better outcomes with integrative cognitive behavioral therapy for prolonged grief and comorbid depression. The researchers found that treatment completers experienced improvements in their grief symptoms and a reduction in depression symptoms. The researchers found that outpatient treatment might be effective. Those who diligently follow treatment prescriptions and complete treatments as outpatients can experience a reduction in their grief and comorbid depressive symptoms. There were no control long-term outcomes available, as the patients on the waiting list received intervention before the long-term outcomes were determined (Rosner et al., 2014).

Difficulties associated with outpatient treatment options. There are challenges associated with current outpatient treatments for patients with depressive disorders. Jeon et al. (2014) compared variances of depressive symptoms among Korean and American outpatients suffering from major depressive disorder. Existing literature have shown that compared to the American population, East Asians usually have fewer depressive symptoms. Jeon et al. gathered data from 1,592 Korean and 3,744 American outpatients on their depressive symptoms and compared them to each other; results indicated that the previous findings that showed Asians have fewer symptoms were inaccurate. Results indicated that Korean patients experienced lower guilt and depressed moods but have higher scores for hypochondriasis and suicidal tendencies. The outpatients, regardless of whether they were Americans or Koreans, had the same functionality levels and quality of life. The researcher concluded that Asians, particularly Koreans, might be under-diagnosed. This issue is a significant problem because early diagnosis of and intervention for depression can serve as deterrents to committing suicide (Jeon et al., 2014). This study did not indicate whether the misdiagnosis of Korean patients came because of patients attending outpatient clinics. However, the findings of this study come as a timely warning for embarking on diagnosis and treatment in outpatient settings as early and correct diagnosis is essential.

Weber, Wehr, and Duchemin (2016) examined the prevalence of antipsychotic prescriptions in psychiatric inpatients compared to outpatients with anxiety disorders. Gathering retrospective data from 1,699 patients, regarding their anxiety disorder diagnosis, Weber et al. found a significant relationship between antipsychotic prescription and patient characteristics. It was found that more inpatients compared to outpatients received antipsychotic medication. Moreover, rates can vary depending on the type of disorder that the participant has. Outpatients with posttraumatic stress disorder, as well as obsessive-compulsive disorder, were given antipsychotic prescriptions much more frequently compared to those without these disorders. Results also showed that comorbidity with depression was linked to comorbidity with borderline personality disorder. Age was a further factor; older patients received more prescriptions of antipsychotics. Results of the study led to the conclusion that psychiatrists would prescribe antipsychotics to a significant percentage of patients with anxiety disorders, and that this trend was more prevalent among inpatients. These findings elicit questions regarding the treatment protocol of inpatient versus outpatient. Further research is warranted to establish the basic assumptions that medical personnel hold regarding inpatient/outpatients' severity of symptoms and the diagnostic protocol followed.

Kupfer et al. (2012) synthesized information on the different treatment perspectives on major depressive disorder. Kupfer et al. evaluated the new clinical, neurobiological, and treatment perspectives of major depressive disorders. The researchers evaluated the developments of these perspectives since 2007. Results indicated that advances in neurobiology have increased significantly. Evaluation of genetic, molecular, and neuroimaging studies have shown that psychiatrists continue to prescribe antidepressants, while new treatment compounds are being researched. This review also revealed that there were two treatment-related issues: higher level of suicide risk associated with selective serotonin reuptake inhibitors, and the risks of antidepressants for pregnant women. The findings led to the conclusion that no fully satisfactory, safe, and effective treatments for people diagnosed with major depressive disorders are available. Kupfer et al. did not indicate whether patients were being treated in an inpatient or outpatient setting. From the previous discussion, one concluded that outpatients might have received equal to less attention from medical staff, as it seemed that the staff were under the impression that outpatients were not as severely affected by the depression compared to inpatients. Nonetheless, the implications for the current study were that patients might not receive the best treatment option available, given the fact that physicians tended to prescribe antidepressants when faced with a patient with depressive disorder.

Psychological Treatments for Major Depressive Disorder

There are several psychological treatments for major depressive disorder that researchers have found as beneficial for enhancing the effectiveness of pharmacological treatments (Casacalenda, Perry, & Looper, 2014; Kupfer et al., 2012; Linde et al., 2015; van Straten et al., 2015). Burnand et al. (2014) found that integrating pharmacological and psychological treatments led to less treatment failure and better work adjustment, thus minimizing the cost of the treatment.

Van Straten et al. (2015) also researched the existing state of major depressive disorder treatments. The author reviewed 14 studies and found that screening remained widely used to determine who the patients were and what care was necessary to meet their individual needs. In addition, results from the meta-analyses indicated that stepped-care had a moderate effect on depression. Stepped-care interventions can differ in the quantity and length of treatment steps, the treatments included, and the experts who carry out the treatment. The criteria also varied among the stepped-care interventions. Van Straten et al. concluded that stepped care could be a prevailing model for treating major depressive disorder; however, psychiatrists should not remain complacent with this treatment. Instead, researchers should continue to measure the evidence of cost-effectiveness compared to high-intensity psychological therapy. Stepped-up care is minimally invasive, while still providing sufficient intervention to achieve the outcomes set. This aspect can be seen at an outpatient facility as the patients are not admitted to the hospital facility and only see the medical staff for the predetermined number of steps. This intervention alternative allows for more patients treated by a single staff member while still providing planned quality intervention. Although this is not what the current study focused on, the findings of this study might be applicable to this service model.

Benefits of Different Treatment Options in Depression

Burnand et al. (2014) examined a set of treatments for major depressive disorder. The cited researchers compared a combination clomipramine and psychodynamic psychotherapy to using clomipramine alone in treating individuals with major depressive disorder from 20 to 65 years of age. Gathering data from 74 patients with major depressive disorder assigned to 10 weeks of acute outpatient treatment, results showed that combining clomipramine with psychodynamic psychotherapy and using clomipramine alone led to marked improvements for all patients. However, the combination of clomipramine and psychodynamic psychotherapy led to better results. The combination led to fewer treatment failures, better adjustment to work at 10 weeks, and better overall functioning. As a result, hospitalization rates at discharge were lower. Individuals who received the combined treatments lost fewer workdays, improving cost savings further. The findings of the study led to the conclusion that supplementing clomipramine with psychodynamic psychotherapy may be more cost-effective than using clomipramine alone (Burnand et al., 2014). Burnand et al.'s (2014) findings paralleled the aims of the current study, as it evaluated the outcomes of outpatient treatment for cases with major depression. Although mention was not made of whether the family members were included in the psychotherapy sessions, the fact that patients received therapy in combination with the medication implied that the current study could use the results of the Burnand et al. study as comparison.

Byatt, Levin, Ziedonis, Simas, and Allison (2015) evaluated multiple study designs and results to measure the degree to which interventions in outpatient perinatal care can lead to improvements in depression care uptake. The researchers sourced materials from PubMed, CINAHL, PsycINFO, ClinicalTirials.gov, and Scorpus (EMBASE). Results showed that depression care in outpatient perinatal care settings could be managed well if the care was beyond getting screening alone. The researchers linked enactment of other interventions with increased use of mental healthcare services. Screening done with interventions can lead to faster detection of depression, assessment that is more accurate, and more-appropriate referral and treatment in outpatient care settings (Byatt et al., 2015). When not coupled with intervention, an average woman who screens positive for depression is likely to engage in only one mental health visit. However, with patient engagement strategies, the rate of mental health visits can double. The results led to the conclusion that outpatient care treatments should be more comprehensive to be most effective (Byatt et al., 2015). The researcher's results directly reflected to the current study, as both focused on outpatient care for depression and the success thereof. Byatt et al. (2015) did not mention whether direct family members were included in the sessions. Although the Byatt et al. study focused on perinatal care—being adults—and the current study had adolescents with depression as a focus area; the two studies have enough commonalities to be used in comparison.

Casacalenda et al. (2014) provided information about the success of pharmacological and psychological treatments aimed at clinical depression. The researchers aimed to determine which treatment approach could lead to full remission. The researchers assessed the percentages of full remission through a synthesis review of literature on patients with MDD in which the treatments of pharmacotherapy psychotherapy were compared the control conditions to each other (Casacalenda et al., 2014). Casacalenda et al. (2014) showed that among the treatments, antidepressant medication and psychotherapy led to positive outcomes and reduction of depressive symptoms. Within this study, antidepressant medicines refer to tricyclic antidepressants and phenelzine, and psychotherapy refers to cognitive behavior therapies and interpersonal therapies. No differences existed on the effectiveness of these treatments when compared to each other (Casacalenda et al., 2014). Among the participants who used medication as their main treatment, 46.4% could achieve full remission. Conversely, 46.3% of participants who used psychotherapy could attain full remission. Both are effective treatment approaches compared to no exposure to any treatment. Mild or moderately depressed outpatients may benefit from these as a first-line treatment (Casacalenda et al., 2014). Casacalenda et al (2014) did not mention whether the treatment was provided to inpatients or outpatients and whether the patients were adolescents only. However, the current research outcomes could be compared to the

Casacalenda et al. study, as both dealt with patients with depression and treatment options. In this case, Casacalenda et al. did not mention whether the direct family members were included in the treatment, as was the case in the current study.

Challenges with Treatments

Dolberg, Larsson Lönn, and Kvist (2014) investigated factors that could trigger a relapse among older patients exhibiting clinical depression who already achieved remission from escitalopram in an outpatient setting. The researchers obtained data from 405 patients who were at least 65 years old and who received 12-week, open-label escitalopram 10 or 20 mg/day. The results of the study showed that multiple factors could lead to relapse in an outpatient care setting. Dolberg et al. found that among elderly patients with major depressive disorder, females were more likely to relapse. In addition, early remission, low baseline depression score, major depressive episode duration, as well as escitalopram dosage could all affect relapse rate. Patients given additional 20mg escitalopram after 2 weeks of open-label treatment experienced high rates of relapse. The same occurred for patients with a baseline depression score below median. Results showed that in an outpatient care setting, certain factors can make relapse possible and interrupt patients’ remission. Although Dolberg et al. focused on treatment for patients with depression in an outpatient setting, it focused the attention on elderly patients and only medication without a therapeutic intervention option. There are some pointers to be taken from the Dolberg et al. study that might be useful for the current study to ensure that relapses do not occur. The first suggestion that comes to mind is to rally the support of the parents during the intervention ensuring that they understand and accept the importance of continued use of the medication in preventing relapses.

Dudek, Siwek, Zielińska, Jaeschke, and Rybakowski (2013) used an outpatient setting to investigate the stability of the diagnoses of clinical depression. The cited researchers also evaluated the scope of diagnostic conversions into bipolar disorder. Dudek et al. performed a retrospective chart review of 122 patients that were already primarily diagnosed with clinical depression. Results incited that earlier onset of major depressive disorder is a factor that can lead to higher risk of diagnostic conversion to bipolar disorder. Moreover, age of illness onset and time to diagnostic conversion are negatively related to each other. The researchers found those who underwent diagnostic conversions from clinical depression into bipolar disorder in an outpatient setting to be more treatment-resistant, to have a greater amount of illness incidences, and to experience more hospitalizations. Results led to the conclusion that in an outpatient setting, diagnostic evolution from major depressive disorder to bipolar disorder can occur among one third of patients; these patients may be more prone to resisting treatment. The results of the Dudek et al. study might be important for the current study and future research, as it issued a timely warning that diagnosis in an outpatient setting should be done with care so that patients’ diagnoses did not need conversion. Although conversion from major depression to bipolar disease might not be completely eradicated, the fact that conversion patients were more resistant to treatment and had more illness episodes emphasized the importance of the initial diagnosis and treatment. The results of this study warrant further investigation into psychological diagnosis made in an outpatient setting versus inpatient setting to establish whether the percentages of conversions from major depression to bipolar are the same or differ and what the implications for treatment success are.

Jakobsen et al. (2012) provided empirical support about the effectiveness in integrating pharmacological and psychological treatments for major depressive disorder. Jakobsen et al. evaluated the effects of cognitive therapy compared to interpersonal psychotherapy for patients diagnosed with clinical depression. Using a Cochrane systematic review methodology, Jakobsen et al. compared the advantages and disadvantages of cognitive therapy against interpersonal psychotherapy for treating major depressive disorder. Jakobson et al. evaluated seven trials, and showed that four out of the seven reported no significant differences between the trials. None of the trials revealed that these therapies could lead to adverse effects. Jakobsen et al. concluded that the treatments being compared—cognitive therapy and interpersonal psychotherapy—had similar effects on the depressive symptoms. Regardless of the instrument used—Beck Depression Inventory or the Hamilton Rating Scale for Depression to compare the two interventions at cessation of treatment—results showed that the two treatments were not significantly different from each other (Jakobsen et al., 2012). Although not mentioning whether the therapies were offered in an inpatient or outpatient setting, for this current study, it was significant that the findings of the Jacobsen et al. (2012) study did not reveal any variances in the effectiveness of the two therapies studied. Therefore, any of the two therapies could be utilized in the current study without having to account for the differences in outcomes. The inclusion of the parents in the therapy situation could be studied with either therapeutic approach.

Linde et al. (2015) provided information about the effectiveness of different psychological treatment approaches in treating patients with clinical depression. Linde et al. evaluated if pharmacological treatments are better than placebo in primary care settings. Pharmacological treatments refer to using antidepressants. In addition, Linde et al. evaluated the differences between substance classes on their efficiency and suitability. The authors reviewed 66 studies with 15,161 patients, which showed that compared to placebo, tricyclic, tetracyclic antidepressants, selective serotonin reuptake inhibitors, a serotonin-noradrenaline reuptake inhibitor, a low-dose serotonin antagonist and reuptake inhibitor, and hypericum extract were all superior. However, compared to each other, there were no statistically significant differences in their effectiveness. Compared with other drugs, TCAs and SSRIs are most effective in a primary care setting. However, results also showed that TCAs and SSRIs' superiority over placebo was not that high. The study under discussion had implications for the current study, as it found that in some cases, pharmacological treatment delivers results that were no different from placebo treatment. The different treatment options for drugs did not deliver statistically different results—the researcher did not have to account for the type of pharmacological treatment chosen and could focus attention on whether the parents were included in the treatment or not in this current study.

Oei and McAlinden (2014) evaluated the relationship between the quality of life and symptom change for patients who underwent group cognitive-behavior therapy

(CBT) for anxiety and depression in a psychiatric outpatient clinic. Oei and McAlinden used several survey instruments—the Beck Anxiety Inventory (BAI), Zung Self-Rating Depression Scale (Zung-SRDS), Quality of Life Inventory (QOLI), and Satisfaction with Life Scale (SWLS)—to gather data before and after treatments from 177 outpatients undergoing eight sessions of group CBT. The researchers reported that group CBT in outpatient settings could be effective. The authors observed significant changes in the quality of life and symptom changes of those who participated. The findings of the study led to the conclusion that in a psychiatric hospital outpatient setting, group CBT can be successful in improving the quality of life and life satisfaction levels of those with anxiety and mood disorders, specifically after their anxiety and depression symptoms are reduced. The results of the Oei and McAlinden study could be comparable with the current study, as it utilized an outpatient setting and psychotherapy. Oei and McAlinden did not reveal whether the family members were included in the intervention; in that sense the study, was not completely comparable.

Literature on the value of psychological interventions will be discussed next. These include discussion on psychoeducation, family-centered interventions, individual counseling, and group therapy. These are a part of a single comprehensive program on top of the pharmacological treatments (van Straten et al., 2015).

Value of Psychological Interventions

This section contains empirical support on the effectiveness in integrating pharmacological and psychological treatments for clinical depression (Burnand et al., 2014; Jakobsen et al., 2012). De Silva et al. (2013) examined the effects of psychosocial interventions on social functioning in people diagnosed with either depression or schizophrenia in low and middle-income countries. De Silva et al. hypothesized that psychosocial interventions could effectively treat mental disorders in these countries by enhancing social functioning of the individuals. Results led to the conclusion that psychosocial interventions given to individuals with depression and schizophrenia in outpatient and primary care settings could be effective. The results of the De Silva et al. study spoke directly to the current study, as it involved patients with depressive disorder in an outpatient setting and provided both pharmacological and psychological intervention. Again, the study did not mention inclusion of family or parents and did not focus on adolescents, making the applicability of the findings imperfect.

Houston et al. (2014) provided information about the importance of psychosocial support and intervention in the enhanced functioning of individuals with depressive disorder. Houston et al. followed 103 people using Internet-based depression support groups and evaluated whether their depressive symptoms improved after six months and then after 12 months. Results indicated that half of the participants preferred to use the support group heavily, wherein 37.9% only wanted online communication and not face-to-face counseling. During follow-up at either 6 or 12 months, the participants were still using the support groups. Results showed that heavy users of these Internet-based support groups experienced significant and positive effects on their health, with some experiencing a resolution of their depression compared to moderate users. Findings led to the conclusion that Internet depression support groups can be an effective supplement to face-to-face depression care, particularly for those that will use these groups heavily.

High depression severity scores and social isolation resolved through these support groups. This study was important, as it highlighted a way in which more patients could be reached at a lower cost and less restrictive environment. The study also highlighted that there were personal differences in the group of internet users and those who did not use the internet heavily but required more regular intervention could be targeted to attend an outpatient facility. Although the study dealt with patients with depression, it did not exclusively target adolescents and did not include family members in the intervention. The Houston et al. study, although important for the 21st century internet dependent young population, did not significantly interact with the current study.

Katsuki et al. (2014) provided information about the role of psychoeducation and family involvement in the success of treatment programs intended for patients with depression. Using a randomized controlled trial approach, Katsuki et al. evaluated the success of family psychoeducation for improving the psychological health of relatives of patients that exhibited major depressive indicators for a minimum of one year. Although major depressive disorder (MDD), or clinical depression, is a chronic disorder, there is still an absence of research that considered the effects of interventions for the families of patients with chronic depression (Katsuki et al., 2014). Katsuki et al. (2014) randomly placed participants (patients with MDD and their relatives) into two groups of treatments. First was the family psychoeducation, where the patients’ family underwent four 2-hour weekly multifamily psychoeducation sessions in combination with the patient’s usual treatment. The second was counseling for the family, plus the patient’s usual treatment. The cited researchers measured the relatives’ mental health and the severity of depressive symptoms after the treatments. Even though the researchers' trials yielded inconclusive results, the researchers claimed that family psychoeducation might ensure the well-being of the family of patients with MDD. Once the researchers finalized conclusive results, the finding contributed to treatment plans involving the patient's family. The Katsuki et al. study paralleled the current study, as it evaluated treatment results where two types of family involvement were compared. Although the Katsuki et al. study did not focus exclusively on adolescents with depression and the perceptions of their parents being involved in the treatment or not, it was one of the most applicable studies available to compare with the outcomes of the current study.

One of the strengths of the Katsuki et al. (2014) study was that different psychological health care personnel participated and could evaluate the family psychoeducational program from different viewpoints. Secondly, the family psychoeducation, used in this study, placed additional focus on the strong points of the family, which is an improvement on the McFarlane, Lynch, and Melton (2012) model. Furthermore, although the focus of the study was the families' mental health, the patients were also assessed. Lastly, the size of the sample was based on a previous pilot study by the same authors, which led to an accurate estimation of the number of cases required. Limitations of the study included the way the MDD diagnosis was made, as it was not typically done in a structured interview. Instead of the Hamilton Depression Rating Scale which was used in the study, clinicians used a self-report intervention for evaluation purposes. The inclusion of families who displayed low levels of stress were included in the study whereas in clinical practices it would not be the case. Due to the focus of the study—the effectiveness of family psychoeducation in improving the mental health of the family members of the patients with MDD—an attention-placebo was not used. In sum, the study conditions resembled true clinical settings; therefore, the results could be applied in clinical practices.

Morokuma et al. (2013) claimed that among the different psychological therapies used to treat mood disorders, family psychoeducation might lower symptom severity and prolong the time to relapse. Morokuma et al. evaluated the differences between the effects of adding psychoeducation on dealing with family's expression and the effects of treatment as usual to prevent relapse among patients. The researchers randomized 34 patients suffering from major depressive disorders in full or partial remission to receive either group psychoeducation plus the patient's usual treatment, or just the patient's usual treatment. Results showed that the patients in the intervention group experienced significant longer time in between relapses. Group psychoeducation included six sessions of group lecture and group problem solving. In addition, those in the intervention group experienced greater decreases in their depressive symptoms. The researchers concluded that patient psychoeducation could have positive effects on the course and outcome of major depressive disorders. The outcomes of the Morokuma et al. study have implications for the current study, as it involved the family in the intervention program. The positive results resulting from group psychoeducation for treating clinical depression had implications for the current study, where the researcher examined the parents' perceptions regarding the treatment of adolescents with MDD.

Some recent studies have evaluated the effectiveness of family psychoeducation (Dixon, McFarlane et al., 2014; Dixon, Stewart et al., 2014; Dyck et al., 2002; Hackethal et al., 2013; Hernandez, 2015; Nagy et al., 2015; Luciano, Del Vecchio, Sampogna, De Rosa, & Fiorillo, 2015; Schiffman et al., 2014; Shimodera et al., 2012; Shin et al., 2013; Timmerby, Austin, Wang, Bech, & Csillag, 2015). Shimodera et al. (2012) evaluated the cost-effectiveness of family psychoeducation in preventing the relapse of a patient who recovered from major depression. The researchers designed a randomized controlled trial involving 57 patients diagnosed with major depressive disorder and undergoing maintenance treatment, wherein patients' family members were randomized into treatment as usual or treatment as usual with family psychoeducation. Results of the study indicated that the patients that received family psychoeducation experienced a higher number of relapse-free days. This is another study that showed that family psychoeducation should be integrated into usual treatments for mental health disorders such as depression. Family psychoeducation can prevent relapse from taking place, compared to treatment as usual. Clinicians should consider this in their treatment recommendations for patients with depression. The fact that relapse could be mitigated by including family members has implications for the current study that focuses on adolescents and their parents involved in the intervention.

Most of the literature on family psychoeducation found the same thing: This intervention was not used as frequently as desired, despite the positive benefits (Coker, Williams, Hayes, Hamann, & Harvey, 2016; Kolostoumpis et al., 2015; Lyman et al., 2014; McFarlane et al., 2012; Patra & Subodh, 2012). These studies also highlighted the value of family support (Amenson & Liberman, 2001; Cohen et al., 2013; Duckworth & Halpern, 2014; Harvey & Hanlon, 2013; Kung, Tseng, Wang, Hsu, & Chen, 2012; Nagi & Davies, 2015; Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2015). A gap in the literature was identified, namely although there were several studies conducted on the usefulness of family psychoeducation and support in the treatment regime of patients with depression, studies that focused exclusively on adolescents with depression or bipolar disease and the involvement of their parents remained lacking. I addressed the literature gap in this current study.

Value of Combination Therapies: Medications and Psychological Interventions

There are three main treatments for depression: medication, psychotherapy, and electro-convulsive therapy (ECT), and these can be used separately or together (Heller et al., 2014; Khan, Faucett, Lichtenberg, Kirsch, & Brown, 2012). Antidepressants, such as serotonin and norepinephrine—known as monoamines, influence the functioning of some neurotransmitters in the brain (Atiwannapat, Arden, & Stewart, 2014; Carvalho, Macêdo, Hyphantis, & McIntyre, 2013). Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) have immediate effect on the activity of neurotransmitters. Conversely, they have the disadvantage of being intolerable due to side effects and the dietary restrictions imposed using MAOIs. Medications, such as selective serotonin reuptake inhibitors (SSRIs), have limited side effects, and hence, patients are more likely to commit to continued usage. Both types of medication are effective for the treatment of depression, but the effect of each medication on patients varies from person to person (Atiwannapat et al., 2014; Carvalho et al., 2013).

Though antidepressants begin to effect brain chemistry with the first dose, it takes several weeks for these to be clinically effective (Atiwannapat et al., 2014; Carvalho et al., 2013). Several slow-onset adaptive changes within the neurons are brought out by the antidepressant. It is also possible that the critical events behind the long-term adaptations in neuronal functions related to the effects of the antidepressant drugs could be the activation of chemical messenger pathways within neurons, as well as changes in the way that genes in the brain cells are expressed (Atiwannapat et al., 2014; Carvalho et al., 2013). Currently, researchers seek understanding of the mechanisms that mediate the continuing changes in the neuronal function produced by antidepressants and other psychotropic drugs within the cells, as well as to understand the way the illness alters these mechanisms (Atiwannapat et al., 2014; Carvalho et al., 2013). The knowledge of how and where in the brain these medicines work can lead to developing targeted and effective treatments that might bring an early clinical response to the antidepressants. Moreover, the mechanism of action can lead to the design of innovative and tolerable medicines, as it reveals the way that different drugs produce side effects (Atiwannapat et al., 2014; Carvalho et al., 2013).

Psychotherapy functions by changing the functioning of the brain (Klein et al., 2014). Certain types of psychotherapy, specifically cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT; Rosselló & Bernal, 1999) can relieve depression. The negative thoughts and behavior, usually associated with patients with depression, is relieved by CBT (Klein et al., 2014; Park, Cuijpers, van Straten, & Reynolds, 2014; Rosselló & Bernal, 1999). IPT focuses on improving personal relationships that can lead to MDD. Though CBT may prove helpful in the cases of MDD in children and adolescents, antidepressants are often initially necessary for those with severe, recurrent, or psychotic depression (Klein et al., 2014; Park et al., 2014; Rosselló & Bernal, 1999).

Studies have shown that adults with moderate to severe depression may benefit from psychotherapy, when in combination with antidepressants, alone both these treatment regimens are less effective (Driessen et al., 2015; Spijker, van Straten, Bockting, Meeuwissen, & van Balkom, 2013). Studies have shown that older adults with recurrent depression have reduced recurrence when treated with antidepressants in combination with IPT, compared to those who had only medication or therapy. However, recent studies have indicated that those with mild depression do not experience greater gains with combination therapy than with CBT or IPT alone. Ongoing studies have indicated the effectiveness of IPT in the treatment of dysthymia (Driessen et al., 2015; Spijker et al., 2013).

Another effective treatment for depression is Electroconvulsive Therapy (ECT). More than 80% of patients with severe depression improve after ECT. In ECT, the patient is given anesthesia, and then a seizure in the brain is produced by applying electrical stimulation to the brain through electrodes placed on the scalp. In this therapy, repeated treatments become necessary (Guloksuz, Rutten, Arts, van Os, & Kenis, 2014; Tohen & Abbott, 2014). However, ECT has side effects, including memory loss and cognitive problems, although these side effects are short-lived. Modern advances in ECT have reduced the side effects, although some have reported lasting problems. Though this therapy is effective in relieving of acute depression, the problem may recur after the treatment is discontinued (Guloksuz et al., 2014; Tohen & Abbott, 2014).

Value of Family and Significant Others' Support

Over 50% of patients with major depressive disorders make insufficient progress with the existing treatment options. The reasons for this phenomenon include the patients' viewpoints and understanding about major depressive disorders influence treatment outcomes (van Grieken, et al., 2014). The researchers assessed the patients' views on which factors inhibit their recovery from major depression disorders. Four reasons surfaced (i) patients were not sure about the nature of their depression disorder, (ii) patients did not understand or agree about the nature of their treatment, (iii) an unfavorable relationship with the therapist, and (iv) inadequate participation of significant others. Xiaolian et al. (2002) confirmed that a positive relationship between family support and the patient's self-care behavior existed. Mohammed et al. (2015) explored the burden on caregivers in India. They reported that mothers were most often the caregivers, the biggest caregiver burden was the influence on their wellbeing. Caregivers also indicated that the relationship with their spouses was unfavorably impacted on and that there was a lack of appreciation for their caregiver role. The caregivers complained that others did not recognize the severity of the disease and this influenced their relationship with other people.

Disrupted parenting may result from different stressors, such as the death or departure of a loved one, parent depression, anxiety, and chronic illness—in parents or children. Furthermore, decreased parental warmth, increased conflict between the parents, either over-involvement or too little involvement in the child's life, are all factors that increase the child/teen's risk of depression (Yap, Pilkington, Ryan, & Jorm, 2013). When parents live in low economic circumstances, it increases the risk of depression and disrupted parenting, which in turn put the child further at risk (Yap et al., 2013). In sum, depression in parents puts the child in higher risk for psychopathology due to the exposure to disrupted behaviors of the parents (Yap et al., 2013). Studies have shown that psychological interventions for patients with depression and other mental disorders can only be effective if there is adequate family support (De Silva et al., 2013; Houston et al., 2014; van Grieken et al., 2014). Studies show that family is a factor that can be a risk or protective element for MDD (De Silva et al., 2013; Houston et al., 2014; van Grieken et al., 2014).

Anastasia et al. (2014) evaluated the effectiveness of an outpatient treatment program for acute social ideation, the Family-Centered Brief Intensive Treatment (FC-BIT). Individuals hospitalized for acute suicidal ideation were treated as outpatients employing the family-centered short-term intensive treatment or the intensive outpatient treatment minus the family element. Those who underwent FC-BIT were asked to identify family members or other supportive people to be part of therapy. Results showed that FC-BIT patients experienced greater improvement in their depressive symptoms, hopelessness, and suicidality at the end of treatment, compared to those with treatment without the family component. Results led to the conclusion that the role of family cannot be discounted for the treatment of individuals with depressive symptoms and suicidal tendencies. Family support can be critical for making sure suicidal ideation levels remain at manageable levels. Family support can also lead to improved problem-solving or coping skills. This study paralleled the current study, as it had family support as its focus.

Taylor et al. (2015) provided support regarding the important part the family plays as both a risk of and protective element against MDD. Taylor et al. explored associations between lifetime and 12-month major depressive disorder (MDD), depressive symptoms, and involvement with family and friends. The cited researchers examined these relationships in the context of African-American and Black Caribbean adults diagnosed with clinical depression (Taylor et al., 2015). For African-Americans specifically, closeness to family members was crucial for both 12-month and lifetime major depressive disorder. The researchers found friend and familial support to be crucial for depressive symptoms for this population group. Conversely, for Caribbean Blacks, family closeness is not as crucial as for African-Americans when it comes to reduction in depressive symptoms. However, the researchers found that family support among Caribbean Blacks was directly and positively associated with reduction of psychological distress. Lastly, results revealed that negative interactions with family was linked to higher levels of major depressive disorder and depressive symptoms for both population groups in the study (Taylor et al., 2015). The results of the study under discussion could be linked with the current study, as it focused on family support in the treatment of depressive disorder.

Van Grieken et al. (2014) examined the perspectives and experiences of individuals with depression regarding the factors that impede treatment success. One of the main themes that emerged from the data was the insufficient involvement of the family in depression recovery. Van Grieken et al. interviewed 27 patients who had recovered from major depressive disorders through professional treatment, and reported that there were several problems associated with the treatments received. These include the unclear and inconclusive nature of the participants' clinical depression what the treatment contained, a negative affiliation with the professional; lack of access to psychological healthcare services; and inadequate contribution of partners. Findings of the study led to the conclusion that improvements are still needed on MDD treatments. Therapists can improve treatments when they know the perspectives of patients on their experiences of treatments and the outcomes from these treatments. Additional studies demonstrated the value of family support for patients with mental health disorders (Joling et al., 2012; Pernice-Duca et al., 2015; Sangalang & Gee, 2012; Zauszniewski, Bekhet, & Suresky, 2015). Van Grieken et al. (2014) emphasized family support was essential for treating patients with depressive disorder. This had implications for the current study that had the inclusion of parents and their perceptions thereof in the treatment of adolescents with MDD as its focus.

Despite the value of psychological interventions for patients with depression, especially if family support is present and strong at the same time, the problem of caregiver burden persists. Studies have shown that caregiver burden is a phenomenon that needs attention (Kumar & Gupta, 2014; McCann et al., 2015). The following section will highlight the gap that the current study is designed to close.

Caregiver Burden

This section will discuss the effects of caregiver burden on caregivers and patients who suffer from major depressive disorder. Kumar and Gupta (2014) provided insights into the effects of taking care of outpatients with depressive disorder on the caregivers' own psychological health. The researchers found that caregiver burden is a phenomenon, which needs attention. Kumar and Gupta claimed that depression could be disabling and debilitating. In relation to this, caregiver burden can be significant in unipolar depression. Therefore, future research should evaluate the sociodemographic factors shaping the mental health and encumbrance experienced by caregivers of patients suffering from unipolar depression. Kumar and Gupta gathered data from 80 outpatients with unipolar depression and their primary caregivers. Kumar and Gupta (2014) found, "Caregiver burden was significantly higher in female spouse, employed caregivers and spouse caregivers married within the last one year as compared to caregivers other than wife, those unemployed and those married for more than one year" (p. 1). The level of caregiver burden was the same regardless of the severity of the patient's depressive episodes. The researchers concluded that there is a need for early psychosocial intervention for vulnerable family caregivers; however, this need remains unmet (Kumar & Gupta, 2014).

Luciano et al. (2012) claimed that clinical depression frequently caused a high level of family burden. However, despite the extent of this burden on the family, there is limited research regarding family burden and the effect of family psychoeducational interventions on MDD. Existing studies have included limited methodologies, clear outcome measures, and accurate follow-ups. Despite the limitations, these studies have shown that psychoeducational family intervention can be effective for family members caring for individuals with unipolar depression (Luciano et al., 2012). The researchers recommended this literature gap to be closed by future researchers. Luciano et al. (2012) also recommended that clinicians consider including psychoeducational family intervention for treating unipolar depression. There is a need for early psychosocial intervention for vulnerable family caregivers.

McCann et al. (2015) noted that guided self-help could be beneficial in alleviating the burden that caregivers experience when taking care of outpatients with depressive disorder. McCann et al. evaluated the effectiveness of a cognitive behavior therapy guided self-help manual in improving the caregiving experience of family members taking care of individuals diagnosed with MDD through a randomized controlled trial. A total of 27 caregivers were randomized to guided self-help, and another 27 caregivers made up the control group, which only received standard information and support. Both control and guided self-help groups received a short weekly telephone call. The cited researchers evaluated the participants at three periods. Findings revealed that caregivers in the intervention group experienced more significant reduction in their negative caring experiences from baseline to post-treatment, compared to those in the control group. Those in the intervention group also experienced enhanced positive caring experiences in same time, compared to those in the control group. The researchers concluded that guided self-help could improve positivity among caregivers, while alleviating their negative experiences with caring for someone with depression.

Zendjidjian et al. (2012) evaluated the quality of life among caregivers of individuals with affective disorders, including major depressive disorders and bipolar disorder. The cited researchers also compared the quality of life levels of caregivers of individuals with schizophrenia and of caregivers in general. Zendjidjian et al. also aimed to assess the influence of socioeconomic and clinical factors on the caregivers' quality of life. The researchers gathered data on quality of life from the psychiatric departments of a French public teaching hospital. The data from 232 caregivers of individuals with affective disorders and 246 caregivers of individuals with schizophrenia showed that the quality of life among caregivers of individuals with affective disorders is negatively affected. Caregivers of patients with affect conditions experienced lower quality of life, primarily because the person has experienced an altered psychological and mental state. Results also showed that among caregivers of those with emotional conditions, women, parents, and caregivers all living in the same home lessened the depression symptoms of the children (Zendjidjian et al., 2012).

Von Kardoff, Soltaninejad, Kamali, and Eslami Shahrbabaki (2015) claimed caregivers of people with mental illnesses faced several types of burdens. However, even though studies have confirmed that caregiver burden is real, there is a lack of literature examining what the burden feels like from the perspectives of the caregivers themselves. The roles of cultural traditions and beliefs have not been studied as extensively as needed. Kardoff et al. aimed to determine the precise burdens experience by caregivers of patients diagnosed with schizophrenia and affective disorders. By interviewing 45 caregivers, the researchers found 11 themes on the nature of caregiver burden from the perspectives of the caregiver themselves. These 11 themes correspond to the main burdens experienced by the caregivers: incertitude, unawareness, emotional burden, stigma and blame, financial burden, physical burden, restriction in routine, disruption in routine, dissatisfaction with family, relatives, and acquaintances, troubles with patients' adherence to medication, and problems with health services and governmental support. Results of the study led to the conclusion that caring for individuals with mental disorders takes a toll on the caregiver, not just physically. Caregiver burden encompass emotional and financial difficulties and can lead to conflicts in family relationships. Psychosocial support for caregivers therefore is crucial.

More researchers have highlighted the problem of caregiver burden (Burke, Elamin, Galvin, Hardiman, & Pender, 2015; Cheng, Lam, & Kwok, 2013; De Silva et al., 2013; García-Alberca et al., 2012; Lin, Chen, & Li, 2013; Lum, Lo, Hooker, & Bekelman, 2014; Mohammed et al., 2015; Olawale et al., 2014; Otero et al., 2015). To understand why family support can be lacking for patients with depression; understanding the burden on caregivers is critical; this phenomenon can shed light on parents' experience with caring for their children with depression in an outpatient setup.

Mohammed et al. (2015) conducted cross-sectional research to evaluate the burden of a caregiver in a community mental health program in India. The researcher gathered data from 46 randomly selected patients with psychological disorders registered in a community mental health program and their caregivers. The researchers surveyed participants with Burden Assessment Schedule and WHO Disability Assessment Scale, they and reported that most mental health patients' primary caregivers were their mothers. In addition, the researchers found significant levels of caregiver burden among the female caregivers. The researchers also found that insufficient resources to address the mental health needs of patients serve as one reason behind high level of caregiver burden (Mohammed et al., 2015). The study was limited regarding generalization, as the sample size was small. Furthermore, it was not possible to hypothesize which factors contributed to the problem since a cross-sectional nature design was used. Similarly, it could not be determined which of the community services could mitigate the burden. Lastly, many of the participants were exposed to the Asian Tsunami in 2004 and although the effects thereof might have been processed over time, the influence thereof cannot be completely ruled out of the findings (Mohammed et al., 2015).

This section about the burden that mental illness has on caregivers, most often females—mothers in the case of children and female spouses or caregivers—highlights an important aspect of intervention of people with depressive disorder. On the one hand, several studies found family support was significant in the recovery and prevention of relapse of patients with MDD. The burden that patients with depression place on the caregiver and families may result in negative effects on the intervention as the caregiver can simply not go on any further. The current study examines the perceptions of the parents of adolescents with depression and the results thereof may be useful in designing support programs for caregivers of patients with depression.

Conclusion and Literature Gap

The gap in the literature was that it was not known how parents of patients with depression experienced and perceived being part of an intensive treatment plan. Dixon, Stewart et al. (2014) provided information about the role of family in outpatient treatment programs for patients with depression. Through a literature review synthesis, Dixon, Stewart et al. found that it remained unclear what made a family intervention successful. In addition, there is a need to improve the sophistication and accuracy of certain indicators of benefits. The role of psychoeducation programs is also vague, and using family psychoeducation in routine clinical practice is still limited.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to explore the experiences and perceptions of intensive outpatient treatment from the perspective of parents of patients diagnosed with depressive disorder. This chapter will include a detailed discussion of the methodological plan for the proposed single case study. The main sections that will be included in this chapter are the following: (a) research design and rationale, (b) role of the researcher, (c) methodology, and (d) issues of trustworthiness. I conclude the chapter with a summary of the key methodological issues, procedures, and concepts that I will use to accomplish the goals of the study.

Research Design and Rationale

The research question of the study is as follows: What are the experiences and perceptions of parents of patients with depression regarding their role as caregivers in intensive outpatient treatment programs? The central phenomenon that I examined were parents who were the primary caregivers of adult patients treated for depression in intensive outpatient treatment programs. I used a qualitative research approach to explore intensive outpatient treatment based on the experiences and perceptions of the parents of patients with clinical depression.

Qualitative research is the systematic approach of exploring a phenomenon using the subjective perceptions and experiences of individuals who have direct involvement in a specific issue or event (Corbin & Strauss, 2014). The qualitative approach to research often involves using tools that yield data that are large in quantity, deep in terms of scope, and varied in terms of type of data that can be collected (Silverman, 2013). Even though the results in qualitative studies are not often used to generalize outside the sample, the information can be utilized to inform or shape future studies about the same phenomenon (Corbin & Strauss, 2014; Patton, 2002; Silverman, 2013).

The selection of qualitative research approach was appropriate because the level of detail collected from qualitative tools, such as semi-structured interviews, was critical in gaining a deeper understanding of the research phenomenon. The narrative that I generated from the qualitative data could not be made using quantitative methods, such as statistical tools. Quantitative data are more appropriate in studies that involve the examination of the relationship of different variables within a given context (Neuman, 2005). This method did not align with the purpose of the study.

I used a phenomenological research design to address the purpose and the research questions of the study. Phenomenological research is the exploration of a phenomenon based on the perspectives of participants and their own subjective realities, experiences feelings, perceptions, and opinions (Groenewald, 2004; Moustakas, 1994). Using a phenomenological research method was applicable because exploring the lived experience of parents of depressive patients undergoing intensive outpatient treatment using semi-structured interviews could lead to data that represented the depth and scope of their experiences. Phenomenological research aligned with the purpose and research questions that I developed based on the emphasis on lived experience, focused exploration using semi-structured interviews, and subjective reality of the participants (Moustakas, 1994).

The specific type of phenomenological research design that I used was hermeneutical, which was based on the methodology, as developed by Heidegger (1975) who believed that human existence was interpretive. Based on Heidegger’s framework of phenomenology, human beings are considered as concerned about their own fate in a context that is unfamiliar and alien. Hermeneutical phenomenology was appropriate in this study because exploring the experiences of parents of patients with depression regarding their roles as caregivers in intensive outpatient treatment aligned with the assertion of Heidegger that human experience could be understood using the process of interpretation.

Role of the Researcher

In qualitative studies, the researcher plays the most important role regarding the collection and analysis of data (Walker, Read, & Priest, 2013). The researcher is responsible for the recruitment, collection, and interpretation of data, as well as the presentation of findings (Patton, 2002). My skills as the researcher were important in accomplishing these tasks satisfactorily and effectively. I attempted to review textbooks about ways in which to conduct phenomenological research, particularly how to facilitate semi-structured interviews.

To enhance the objectivity of the results, I needed to identify my personal beliefs and biases about the topic of the role of parents as the primary caregivers in intensive outpatient treatment programs for patients with depressive disorder. My personal views on the topic included (a) parents should play a significant role in the success of intensive outpatient treatment programs for individuals with depressive disorder, and (b) lack of psychosocial support could be detrimental in the sustained progress of outpatients with depressive disorder. Through the reflexive identification of these personal views, I could assist other researchers in evaluating the trustworthiness of the study.

Methodology

Participant Selection Logic

The population for the study included parents who were the primary caregivers of adults who have depressive disorder and underwent intensive outpatient treatment. A family member who was the primary caregiver was operationally defined as the parent of the patient. The logic for the selection of the population was that parents who were primary caregivers played an important role in the psychosocial support that depressive patients received during treatment, as suggested by researchers (Anastasia et al., 2015). From that population, the sample consisted of eight participants.

I used purposive sampling strategy to recruit the target sample size of eight participants. The purposive sampling technique is a non-probability sampling method that relies on specific participant characteristics to access often hard to reach populations, such as the primary caregivers of adult outpatients receiving intensive treatment for depression (Suri, 2011). In this study, a family member who was the primary caregiver was operationally defined as the parent of the patient. Purposive sampling technique was appropriate for this study because a homogenous group was needed to maintain the purpose of a phenomenological study, as suggested by Moustakas (1994).

The selection of participants was based on fulfilling certain key criteria central to the phenomenological study. The eligibility criteria for the study were the following: (a) parent who was at least 18 years old, (b) parent of an individual with depressive disorder who was at least 18 years old when diagnosed, (c) parent of a depressive patient who underwent intensive outpatient treatment, (d) parent who was considered the primary caregiver of a depressive patient, and (e) parent who was willing to participate in individual semi-structured interviews. To ensure that the criteria set were present in all the participants in the sample, I reiterated these key eligibility criteria during the scheduling of the interview and at the beginning of the face-to-face appointment.

I selected a sample size of eight parents based on the concept of data saturation. Ten participants are usually sufficient in qualitative studies to reach data saturation, the point at which data become repetitive and no additional information can be collected (Francis et al., 2010). According to Francis et al. (2010), data saturation in qualitative research can be usually achieved at 10 participants, with a higher confidence at 13 participants. If data saturation was not achieved at the target 10 participants, the sample size was expanded. However, data saturation could be achieved earlier than 10 participants. I added more participants if data saturation was not reached at 10 participants.

I identified, contacted, and recruited potential participants by coordinating with psychiatrists and therapists from community center in the eastern part of the United States. I discussed the purpose of the study and the nature of the participation of potential participants. After permission to use the non-profit organization as the site for recruitment, I posted several advertisements within the premises of the clinic, inviting potential participants join the study.

Instrumentation

As the researcher, I am considered the main instrument in this qualitative study, as suggested by researchers (Patton, 2002; Walker et al., 2013). Being the main instrument of the study entailed recruiting participants, as well as collecting and analyzing data. I read qualitative methodology and phenomenological research textbooks to ensure that I had the necessary skills and knowledge to accomplish my goals and responsibilities as the researcher.

Semi-structured interviews (see Appendix A) were the main source of data to collect information about the experiences and perceptions of the parents of patients with depressive disorder regarding intensive outpatient treatment. Semi-structured interviews involve the use of open-ended questions to extract information from participations without leading or suggestions (Galletta, 2013). Through the responses of the participants in the semi-structured interviews, I generated a detailed description of their experiences. The level of detail in phenomenological research would not be possible with the methods used in quantitative research, such as surveys.

Procedures for Recruitment, Participation, and Data Collection

For the recruitment of participants, I identified and contacted potential participants by coordinating with psychiatrists and therapists from community center in the eastern part of the United States. I discussed the purpose of this study and the nature of the participation of potential samples with appropriate representatives from the non-profit organization. After permission to use the non-profit organization as the site for recruitment, I posted several advertisements within the premises of the clinic, inviting potential participants to be part of the study.

After potential participants were identified, I scheduled the semi-structured interviews individually. At the time of the scheduled interview, I discussed and presented the informed consent forms with everybody in the sample. I used informed consent forms to ensure that participants comprehended the general nature of this research and the key procedures for participation and withdrawal. After signing their signatures, I collected the informed consent forms to archive in writing the voluntary participation of the individuals who would participate in the study.

For the actual data collection, I conducted semi-structured interviews. The location and time of the interview depended on the agreement during the discussion of the schedule for each participant. Each interview lasted for 45 minutes to 1 hour. To aid in the transcription process, I digitally recorded the interview after I secured the permission from the participants. After the interview was completed, I informed the participants that I would send a summary of the preliminary analysis through email with the goal of collecting feedback.

Data Analysis Plan

After the transcription process was complete, I used the NVivo software in the storage, organization, and processing of the data collected from the interviews. NVivo is a qualitative tool that allows researchers to perform data analysis with the aid of software features such as categorizing and clustering, linking of raw data and themes, and generating illustrative tables and figures to summarize the results (Bazeley & Jackson, 2013). I used NVivo in the coding process in the categorization of data by assigning nodes and group labels based on thematic content.

For the research question of the study, I used the modified van Kaam method of phenomenological analysis, as described by Moustakas (1994), to analyze the data. To conduct the phenomenological analysis of data, I performed several key procedures central to the generation of themes needed to describe the lived experience of the participants as a group. The goal of the analysis was to generate a composite description of the lived experience of the sample as a group.

The first step was horizontalization, which involved cataloguing all the applicable experiences extracted from the interviews (Moustakas, 1994). I inspected the transcript and assigned the corresponding invariant constituents based on the main idea expressed in each portion of text, such as a response to a specific interview question. Invariant constituents are the smallest unit of idea within a text, represented in a code or label (Moustakas, 1994).

The second step was the reduction, elimination of the data based on determining what was relevant and irrelevant to the phenomenon explored (Moustakas, 1994). The results of this step were the identification of invariant constituents that were relevant to the research question. I deleted invariant constituents that did not provide insights related to the research question.

The third step was clustering and thematizing, which was based on the invariant constituents that were developed (Moustakas, 1994). I generated labels to reflect the core themes of the phenomenological analysis. These themes reflected patterns that emerged from the different invariant constituents that I could code. The result of this step was a collection of themes that represented the lived experience of parents of patients with depressive disorder, regarding intensive outpatient treatment.

The fourth step was the validation of the invariant constituents and the themes by reviewing the raw data for the final time (Moustakas, 1994). I inspected each invariant constituent and the corresponding themes to ensure that the results could be accounted for in terms of the actual data from the transcripts. The result of this step was a list of the final invariant constituents and the corresponding themes central to the lived experience of the participants of the study.

The fifth step was the generation of individual textural description, detailing the experiences of each participant using direct quotes from that data (Moustakas, 1994). I developed the individual textural descriptions by summarizing the experience of each participant using their own words from the transcripts. The sixth step was the generation of individual structural description, which focused on providing a narrative of the different meanings of the data, as based on time, space, and relationship to self (Moustakas, 1994).

The final step was the generation of a composite description detailing the essence of the experience of the parents of patients with depressive disorder regarding intensive outpatient treatment (Moustakas, 1994). I created a composite description of the lived experience of parents of patients with depressive disorder regarding intensive outpatient treatment. This composite description also reflected the answer to the research question an in-depth narrative report.

I addressed discrepant cases by presenting the individual textural and structural description results for each participant in the presentation of findings. These individual descriptions reflected the scope of the responses that emerged from the analysis. These descriptions did not necessarily reflect the themes presented in the composite report, but including these narratives did provide a more complete picture of the entre data.

Issues of Trustworthiness

In qualitative studies, the concepts of validity and reliability are not easily applied because these are usually intended in quantitative studies wherein variables are measured (Golafshani, 2003; Morse, Barrett, Mayan, Olson, & Spiers, 2008). Instead of reliability and validity, the quality of qualitative studies is often gauged in terms of trustworthiness (Golafshani, 2003). To increase the trustworthiness of the study, I focused on enhancing the credibility, transferability, dependability, and confirmability of the study.

Credibility is defined as the extent to which the results can be regarded as accurate (Golafshani, 2003). I increased the credibility of the study by conducting member checking with the participants. Member checking is a strategy of asking the feedback of the participants to gain insights about the accuracy of data (Morse et al., 2008). Prior to the finalization of the lived experience of the entire sample as a group, I sent each participant with the individual textual description narrative. I instructed the participants to review the document and provide a short feedback on the extent to which the individual textual description narratives reflected their true experiences.

Transferability is defined as the extent to which the results can also be true or applicable to the larger population outside the sample (Golafshani, 2003). To address the transferability of the study, I generated a thick description of the methodological procedure, decision, and assumptions made during the study (Shenton, 2004). Through the availability of these thick descriptions, the responsibility of transferability was given to other researchers.

Dependability is the extent to which the same results can be obtained twice in different studies (Morse et al., 2003). I enhanced the dependability of this study by accounting my decisions in every aspect of the study through audit trail (Shenton, 2004). I enhanced the dependability with audit trails by documenting the procedure, including the changes and modifications that I made from the original plan.

Confirmability is defined as the extent to which the results can be considered free from bias. Confirmability occurs so that other researchers can validate the same findings using the same procedures (Golafshani, 2003). I enhanced the confirmability of the study by explicitly detailing my personal biases and beliefs about the topic of the study, as suggested by Shenton (2004).

Ethical Procedures

I addressed the need to secure agreement to gain access to the participants within the selected organization by personally coordinating with the appropriate leader or administrator of the community center in the eastern part of the United States. After explaining the purpose of the study and the need to recruit participants in their organization, I asked the administrator to sign an approval letter. The approval letter granted me access to recruit participants within the organization.

I sought the approval of the Internal Review Board (IRB) of the Walden University by lodging an application form. The IRB form included information on the strategies that I used to enhance the ethical standards of my research, such as the protection of the participants, process for withdrawal, minimization of risks, and process with withdrawal. After the approval of IRB was secured, data collection commenced.

Regarding ethical concerns related to recruitment materials and processes, I discussed and presented the informed consent forms to the participants. I used informed consent forms to ensure that participants understood the general nature of the study and the key procedures for participation and withdrawal. After signing their signatures, I collected the informed consent forms to archive in writing the voluntary participation of the individuals who participated in the study.

To address withdrawal, I informed all participants about the procedure during the debriefing period during recruitment. If participants wanted to withdraw before the data collection, not attending the scheduled interview would automatically mean withdrawal. Participants could also inform me in advance about their withdrawal through email or phone call. A request through email or phone needs to be made if withdrawal was desired after the interview was conducted. I removed all files collected from participants who expressed the desire to exit the study.

I protected the data that I collected from the participants by concealing their real names. To protect the identities of the participant, their real names were not used in the processing, analysis, and presentation of data. Participants were assigned a unique code, such as “Participant 01-10,” to conceal their real names and identities in every stage of the study.

I was the only individual who could access the data collected from the participants. After the dissertation was approved and published in the university library, I planned to destroy every data from my personal archive. I would destroy the informed consent forms through shredding and permanently delete electronic files, such as NVivo coding results and transcripts, by removing these data from my computer.

Summary

The purpose of the qualitative phenomenological study was to explore the experiences and perceptions of the parents of patients with depressive disorder regarding intensive outpatient treatment. The selection of qualitative research approach was appropriate because the level of details that could be collected from qualitative tools, such as semi-structured interviews, was critical in gaining a deeper understanding of the research phenomenon. The specific type of phenomenological research design that I used was hermeneutical, which was based on the methodology and strategy developed by Heidegger (1975).

The population for the study was parents who were the primary caregivers of adults who had depressive disorder and underwent intensive outpatient treatment. From that population, the sample consisted of eight participants, who were purposively recruited. Data were collected using individual semi-structured interviews. After the transcription and the storage of data in NVivo were accomplished, I used the modified van Kaam method of phenomenological analysis, as described by Moustakas (1994), to analyze the data.

The next chapter will contain the presentation of the results based on the data analysis that I conducted. The chapter will involve describing the setting of the study, identifying the demographic characteristics of the sample, outlining the data collection and data analysis procedures, demonstrating evidence of trustworthiness, and presenting the findings. The findings will reflect the key themes of the study based on the results of the phenomenological method of analysis.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore the phenomenon of experiences and perceptions intensive outpatient treatment from the perspective of parents of patients diagnosed with depressive. Depressive disorder is defined as a psychological diagnosis, as characterized by various affective and cognitive symptoms, such as feelings of sadness, inadequacy, suicide ideation, and loss of interest (APA, 2013). Intensive outpatient treatment is defined as the use of pharmacological, psychological, and psychosocial intervention to treat patients with depressive disorder in an outpatient environment (Cuijpers, 2015; van Straten et al., 2015). One research question was used to guide this study: What are the experiences and perceptions of parents of patients with depression regarding their role as caretakers in intensive outpatient treatment?

This chapter includes a description of the physical setting in which data are collected. A description of participants' relevant demographic characteristics follows this section, and then by descriptions of the implementation of the data collection and data analysis procedures, as described in Chapter 3. In addition, this chapter includes a discussion of the evidence of the trustworthiness of this study's results, followed by a presentation of the results themselves. The chapter concludes with a summary of the findings.

Setting

All interviews were conducted and audio-recorded at a community center in the eastern part of the United States in a private room offered by the center, so that participants would feel comfortable providing full and honest responses to the interview questions.

Demographics

Participants included eight parents who were primary caregivers of adult outpatients who were diagnosed with depressive disorder. The eight parents were from eight different families. A primary caretaker is a person who is directly involved in taking care of a patient (Delgado-Guay et al., 2013). All participants met the following inclusion criteria: (a) parent who was at least 18 years old, (b) parent of an individual diagnosed depressive disorder who was at least 18 years old when diagnosed, (c) parent of a depressive patient who underwent intensive outpatient treatment, and (d) parent who was considered the primary caregiver of a depressive patient. Table 1 shows details of the participants’ caregiver status.

Table 1

Details of Participants' Caregiver Status

P	Duration of loved one's treatment (in months)	Number of months as primary caregiver	Does loved one live with caregiver?	How many professionals on healthcare team?	How often does loved one consult professionals?	How many other caregivers in family?
1	8	8	Yes	3	Monthly	2
2	8	8	Yes	2	Biweekly	0
3	6	12	No	4	3 per week	0
4	30	24	Yes	3	3 per week	0
5	180	72	No	5	2 per week	0
6	6	6	Yes	3	Weekly	3
7	9	3	No	3	3 per week	2
8	84	84	No	0	N/A	1

Note. Participant 3's loved one preferred to live in her own apartment, and Participant 3, in deference to this wish, agreed to monitor the patient's treatment while the patient maintained a separate home. Participant 6's loved one lived with her mother, while Participant 6, the father, provided care and held joint custody.

Data Collection

I conducted semi-structured interviews with eight participants at a community center in a private room offered by the company. The average duration of each interview lasted 45 minutes. I audio-recorded interviews using a digital recording device. There were no variations in data collection from the plan presented in Chapter 3, and no unusual circumstances were encountered during data collection.

Data Analysis

I transcribed recorded interviews verbatim and uploaded transcriptions into NVivo 11 software for analysis. I analyzed data using the modified van Kaam method of phenomenological analysis, as described by Moustakas (1994). Moustakas described a six-step process. The first step was horizontalization, which involved cataloguing all the applicable experiences extracted from the interviews. The second step was the reduction or elimination of the data according to the researcher’s determination of what were relevant and what were irrelevant to the phenomenon being explored. I set the following inclusion criteria: (a) parent who was at least 18-years-old, (b) parent of an individual diagnosed depressive disorder who was at least 18-years-old when diagnosed, (c) parent of a depressive patient who underwent intensive outpatient treatment, and (d) parent who was considered the primary caregiver of a depressive patient. The third step was clustering and thematizing. The fourth step was the validation of the themes by reviewing the raw data for the final time. The fifth step was the generation of individual textural descriptions, detailing the experiences of each participant using direct quotes from that data. This step was represented by the coded NVivo files from the transcription of each participant’s interview. The final step was the generation of a composite description detailing the essence of the experience of the parents of patients with depressive disorder regarding intensive outpatient treatment. The sixth step was represented by the presentation of results in this chapter and by the chapter summary.

Evidence of Trustworthiness

Credibility of the study was enhanced through member-checking with the participants. Prior to the finalization of the lived experience of the entire sample as a group, I sent each participant the individual textural description and instructed the participants to review the document to provide feedback on the extent to which it reflected their true experience. Participants recommended no changes. To address the transferability of the study, I generated a thick description of the methodological procedure, as well as of the decisions and assumptions made during the study. I enhanced the dependability of this study by accounting for decisions in every aspect of the study through audit trails, in which I documented the procedure, including any changes and modifications from the original plan. I enhanced the confirmability of the study by explicitly detailing personal biases and beliefs about the topic of the study, as suggested by researchers (Morse, 2015).

Results

This presentation of results is organized by theme. The two major categories of responses that emerged during the analysis of data related to the experiences and perceptions of parents of patients with depressive disorder were *experiences and perceptions of outpatient treatment and experiences* and *perceptions of being a primary caregiver*. Relating to outpatient treatment, different themes and subthemes emerged which will be discussed in detail in the following section. Shared experiences and perceptions consisted of responsibilities, socializing the patient, adhering to a treatment plan, and relationships with professionals. Findings associated with perceptions and experiences of the caregiver role included emerging themes, such as participants' experiences of the most significant experiences of caregiving, of the emotions that characterized the caregiving experience, of the most significant challenges associated with caregiving, of the influence of the patient's illness on the family, and of their goals as caregivers.

Theme 1: Experiences and Perceptions of Caregiver Duties in Outpatient Treatment

Participants described their experiences and perceptions of outpatient treatment in terms of the general responsibilities entailed by their role. They provided more detailed accounts of specific responsibilities. Specific responsibilities, discussed by the participants, included socializing the patient, adhering to a treatment plan, and mediating in relationships with professionals.

Subtheme 1: Responsibilities. In the data associated with this subtheme, participants described the caregiver duties, which served as the context and stimuli for their feelings about and perceptions of the role. Caregiver responsibilities, reported by participants, ranged from crisis intervention and making themselves available as emotional supports to day-to-day management of living activities. Participant 5 reported a less intense level of involvement than other participants did, stating that the role was limited to the following:

> Occasionally, I ask to make sure that she's taking her medication. Make sure she keeps up with her schedules but also make her responsible for her own schedules with the clinic… To call if we need help or she's in crisis… My role is to be supportive, to make sure they're taking their medication as prescribed, to catch

> any signs or indications that she's going in a bad direction and to be her safety net but to also make her responsible.

Participant 7 gave the patient considerable autonomy to encourage the patient to undertake self-care:

> I try to attend the scheduled family meeting and keep an eye on his prescribed medications, making sure he takes them as prescribed and he doesn't overdose, and I keep a distance sometimes just to avoid sabotaging his progress. I give him space to do and think what he wants to do, after all he's the patient, and he just has to do things for himself.

Participant 7 added that while he encouraged the patient to take responsibility for self-care, he considered himself responsible for providing a significant amount of emotional support and monitoring:

> Let's face it, he's attempted suicide twice, it's a growing concern. It's a very big concern and I help him to combat the disease. I try by minimizing his denial to the existing depression and he's still in the … pre contemplation stage of change. I try to motivate him to, again as they said, preparing him to get to another stage of change … Make sure he doesn't hang out with the wrong crowd. I usually remind him to go to treatment or I drive him there … I monitor his medication, his hygiene, and I make sure he participates with the treatment. Sometimes, I talk with the staff and seek alternative ways to help and at times just make sure that everything is okay with him.

Participant 8 also described a limited role, which involved substantial emotional support:

> My role as far as the medical side was taking her to the psychiatrist. Sometimes, filling the medication … keeping an open dialogue and letting her that she is safe to talk to me about anything that she's feeling, which she has. And not being judgmental and being in the same situation, I have empathy and the understanding of what she's going through.

For Participant 4, the caregiver role was limited to crisis management, including, “Watching for overdosing. Mood swings, aggression. Anxiety flare ups… [as well as] Positive input, creating distractions. Communicating during panic attacks...Watch for appetite. Unusual fatigue. Hours of sleeping. Isolation. Not communicating. Panic attacks.”

Participant 1 described a different limited role, in which the patient desired maximum autonomy, but, for reasons of safety and prudence, the caregiver monitored her closely. In this supervisory, but otherwise hands-off role, the primary caregiver provided some financial assistance and made sure the patient was aware that emotional support was available if needed:

> Since our daughter is still under our insurance, we help her out with co-payments and prescriptions. She pretty much goes to all of her appointments by herself … My husband and I always let our daughter know that we're here to talk and to participate in her recovery process. Currently, she is keeping us at arm's length … determined to live independently … We do have a contract in place to ensure her

> safety. She is only allowed to drive her car to her part-time job, her classes, and to treatment. She checks in by texting her location … Ultimately, she's learning from her negative consequences that she's experienced … We try to remain positive, calm, set an atmosphere of lightheartedness and encouragement. So, we hope and pray that our positive example will be as role models to her. (Participant 1)

For Participant 1, the caregiver role was also adapted to the patient’s interests and eating disorder:

> I am available to talk with her, whatever she needs as far as going to a movie, she likes to paint … Since she has an eating disorder, I try to provide availability for meal planning. I help her with shopping, with groceries. We help her with her cell phone bill, her car insurance, and repairs. She's still in school.

Other participants described caregiver roles that involved them in the management of day-to-day activities. For example, Participant 2 stated that the role consisted of

> support in rides, getting them there, reminders, direction when he's confused about what he should do...I will pick up his medication for him … At times, they will ask me to sit in on the session, and I will do that and give them additional feedback as to where he's at.

Participant 2 did not feel that the role just described was in the best interests of the patient, however: “Honestly, I find that it's better when I stay away. I pay attention to it, and I realize it, so I know I have to stay away and be quiet, and then I ask, ‘Are you taking your medication?'" Participant 3 described careful monitoring of treatments, but also a high level of engagement with the patient's informal socialization:

> My involvement has been checking the quality of the treatment both the intensive outpatient and also monitoring the medication prescribed by the physician or psychiatrist just to make sure that we were being given the right medications…[And] my involvement actually is dropping her off, picking her up, monitoring the medication consumption. I'm personally concerned about overdosing and so I just want to make sure that I keep an eye on everything that's going on...I do try as much as I can to engage her in outside activities. We try to schedule things such as camping and we're involved in church services and prayer meetings … She enjoys shopping so I try to incorporate that into her weekly activities just to be able to give her that hope and happiness in what she enjoys doing. Also, I make sure that she gets enough rest and self-care is on top of the list; making sure that she gets her hair done or nails done and just making sure that she's okay in all areas.

Participant 6 indicated the highest level of caregiver involvement represented in this study's sample, describing a role that included treatment monitoring, encouragement of socialization, monitoring of independent socialization, financial assistance, and assistance with self-care and day-to-day responsibilities. Thus, the role entailed

> support, making sure that she goes through treatment as designed and taking medication without missing it. I can experience her acting different if she forgets to take her medication … being the sole responsibility to care for her everyday

> activities including home maintenance, financial control, keeping track of her treatment appointments … Exposing an encouraging for events and activities that she used to enjoy but abandoned because of this disease. Monitor her mood changes for safety, because she has expressed suicidal ideation before she was admitted into the mental health hospital. She is my wife. Therefore, it's imperative for me to help her take a bath regularly. (Participant 6)

Subtheme 2: Socializing the patient could be fun or nerve-racking. Participants described a variety of roles, ranging from encouraging socialization as a means of counteracting isolation to discouraging contact with problematic companions. Participant 4 described the encouragement of socialization in a patient who tended to remain in the home or even in bed as, “Encouraging socializing. Actually, getting out of bed. Going outside. Going for walks. Caring. Encouragement.” For Participant 7, getting the patient to socialize even within the family caused feelings of frustration and futility:

> Unfortunately, honestly, his problems seem to absorb everyone's convenience right now. All other family activities evolve around him, he's like the king of his castle. He wouldn't come out of his room. He does whatever he wants and sometimes he ordered people around, so his friends ... I'm telling you, his friends have kept distance. They kind of distanced themself [sic], and they don't want to be involved. He's just kind of a loner. The interaction with other people, kind of crazy. Having people around him, sometimes is deterring, so that's that.

For Participant 5, who felt optimistic about the prospect of socialization, the goal was to keep the patient open to variety of activities: “I try to get her to go to as many things as possible outside of the home to try and keep her from isolating. And I encourage her to join other social groups.” For Participant 6, being there for the patient and offering emotional support was the extent of feasible socialization, such that the goal was “to continue to display and express my love toward her concerns by doing something to lift up her spirit.”

Participant 8 described an active and stimulating, but not overwhelming regimen of social activities, and described these activities as fun and engaging:

> We don't go out partying or anything. When I'm with her and we're out and about in public, it's usually me embarrassing because I'm doing something silly or stupid, but that's mostly through my attempt to make them laugh, make memories, and enjoy ourselves. Sometimes, I do it purposely, most of the time I do not purposely, but she never seems to be embarrassed or regret being with me and when I'm around her and her friends, and like her boyfriend, she's always herself; she never seems to pretend to be somebody else, and her boyfriend likes me a lot.

Participant 3 attempted to assemble support networks composed of other depressed patients and their families, such that performing the role felt effortful but obligatory:

> In the past six months, being very involved, and I try to find support network, family with depressed individual or any kind of mental illness, anxiety, and things like that. I find a support network and I put together barbecue or just getting people together so they can actually have that support and talk to each other about her difficulties.

For Participant 2, the role consisted more of imposing constraints than of overcoming the patient’s resistance to socialization, and the role was associated with significant anxiety: “I try to see when he's with friends and who he's interacting with, and then red flags will come up if I think the people he's around may not be conducive to him, and then I will say something.”

Subtheme 3: Adhering to a treatment plan was difficult but often beneficial. Participants reported a range of experiences with being part of a treatment plan. The tersest comment was offered by Participant 2, who said that involvement in the plan was, “exhausting.” Participant 1 reported minimal involvement with the treatment plan of a patient who strove for autonomy:

> Because of my daughter's age and her quest for independence, I have not been on any disclosure forms, so I would say that I'm on the sidelines waiting to be called into the game. In the meantime, I pray, I make myself available. However, I don't force, hover, demand, or discourage.

Participant 3 saw the information that became available through the treatment plan to achieve a more empathetic understanding of the patient’s experience:

> I try gaining more insight to the disease because … usually when you're affected by this disease you just have to break it down to absorbable elements so you can actually express or feel more sympathetic or empathetic to the person that you're taking care of. So, information is very important. I'm trying every day to understand the extent of this disease.

Four participants reported positive experiences with treatment plans. Participant 5 appreciated the guidance: “It makes it a little bit easier that somebody lays out a treatment plan, and it's easier for you to follow instead of guessing on what to do and how to help.” Participant 7 also appreciated the guidance and insight facilitated by the treatment plan, and considered these benefits valuable to the family as a whole:

> It's like having more understanding of what triggers the disease. For the life of me, I have no idea, to engage in genetic studies I guess, of depression … to implement the best therapeutic technique I guess, to watch his wellness. I mean, if he gets better, we all get better, so that's what I want for him.

For Participant 6, the primary benefit of the treatment plan was its facilitation of a better understanding of the illness: “I've been able to receive a lot of therapeutic information given and understanding the disease and its effect to the brain.” Participant 8 spoke in the most positive terms of the treatment plan, expressing appreciation for the chance it provided to give informed consideration to different treatment options:

> I'm enjoying my experience. Sometimes, things don't go the way I think they should because there's another opinion out there, which I take into consideration, but my treatment plan is great. I enjoy it. It's very helpful. It's very … it keeps me sane, it being my outlet.

Subtheme 4: Relationships with professionals were positive. No participants reported strongly negative experiences with professionals. Participant 8 was the only member of the sample who offered a complaint, but this complaint concerned a negative aspect of an experience that was judged overall as positive:

> Well, the one I did know, we had a good relationship, but it was just friendly. We just talked about The Walking Dead, and even though I still felt he was not a good match for my daughter in helping her, I bit my tongue, she liked him because he yessed her to death, so that's why I didn't like her. He yessed her to death. He didn't challenge or argue, you know, like you do? Like, when you say, "Hey, guess what? I'm not going to agree with you." I don't think he ever said that. That was the relationship.

Three participants expressed regret that, due to the patient’s wishes, they did not have more contact with the professionals involved in the treatment plan. Participant 1 spoke of being saddened by this exclusion:

> Since my daughter does not want to include me in her treatment plan, and she hasn't signed any disclosure forms or release forms, I would say that I don't really have any relationship. I don't even know who her therapist is, which makes me sad because I would very much like to be a part of it.

Participant 2 expressed regret about being excluded from therapeutic treatments, while deprecating the therapeutic process as an occasion for the therapist and patient to make accusations against the parents:

> At this point in time, unfortunately, when someone is an adult, there is privacy and HIPAA. Therefore, you're not really a part until the patient themselves says, "I want this person in here." Usually, it's so that they can tell you what you did to make them that way, unfortunately, not for any insight whatsoever.

Participant 4 said of the professionals involved in the patient’s care: “Hadn't spoken to them, I feel guilty.” The remaining four participants described positive relationships with professionals. Participant 5 said the relationships were the following: “Good. I think they're receptive to listening to family members. Some of them are more receptive to listening than others.” Participant 7 described a productive partnership: “There's mutual respect and we get along with the health care people. They're okay.” Participant 6 had been surprised by the amount and variety of professional help that was available:

> Getting to know some of the professionals was an eye-opening experience and to understand the extent of their services. Some have done beyond the call of duty. They have worked hard to respond to some of my demanding questions concerning the recovery time.

Participant 3 gave the most positive account of relating to professionals:

> My relationship with the healthcare professionals who are actually managing this case is very positive. We have mutual respect and trust for one another. They are always available to answer any questions or concern. So, I'm very, very impressed with the professionals.

Theme 2: Experiences and Perceptions of Being a Primary Caregiver

In describing the most significant experiences associated with caregiving, participants remembered potentially tragic incidents in which they could intervene, the help they had received from providers, and their own experiences of frustration and pain. The emotions associated with caregiving included depression, hopelessness, anxiety, powerlessness, and frustration, but also happiness and joy. The most significant challenges that the caregivers encountered included stubbornness and other difficult behaviors on the part of the patient, the drain the illness and its treatment exerted on time and other resources, and feelings of powerlessness and exhaustion. The influence on family of the patient's illness included financial and emotional strain, feelings of isolation, conflict, resentment, and perceptions that family members, other than the patient, were being neglected by the caregiver. When asked to describe their caregiving goals, participants spoke of gaining a better education about the illness for themselves and others and of advocating more effectively on the patient's behalf.

Subtheme 1: Significant experiences included empathizing and making a difference. Three participants reported that their most significant experiences as primary caregivers had been negative. Participant 4 remembered the occasion: "When she cut herself, and I found a noose in a closet, [and when she] asked for a gun to hurt [herself]." Participant 6 also identified a specific incident as the most significant experience: "When my wife tried to commit suicide by overdosing and being admitted into the mental health hospital." Participant 5 described an overall feeling of powerlessness: "I think the pain and the trauma that the caregiver goes through taking care of this person and feeling their pain and not being able to help."

Two participants described their most significant experience as the level of support they had received from providers and others. Participant 7 said the following:

> I'd tell you this clinic is, knock on wood, they really know what they're doing. They show respect, there's rapport. My cousin, even though I called him a loser,

> he's sometimes really want to go and they provide a safe place for him which is always comforting. When I drop him off I feel like he's at the best place and it gives us the peace of mind for our family and the clinical staff sometimes just go beyond the call of duty and extend themselves.

Participant 3 also expressed appreciation for professional providers:

> The significant experience that really stood out for me is the quality of care provided by the treatment provider. It's a very warm agency. They provide a safe environment and rapport as far as client/patient relationship is concerned. I've seen my loved one really adapting to this in the environment and opening up more, sharing, and also asking question and her progress is very, very impressive at this point.

For three participants, the most significant experience had been a potentially dangerous incident in which they could make a positive difference. Participant 2 took satisfaction in the positive influence of caregiver vigilance:

> When his medication starts to run out and I notice a difference in his behavior, then I ask him. He said, "I'm weaning ... I'm using less because I don't have a lot." I said, "Okay, we need to make sure that you get your medication because you can tell the difference in the behavior.

Participant 8 recalled successfully intervening in a crisis:

> When I was able to talk her down from an anxiety attack by text and phone and got her through the day successfully with the tools I've learned here in my

> treatment and knowing her and knowing me, I was able to figure out and come up with a plan that helped her come down from her attack and that was great.

For Participant 1, the most significant experience was a mindful shift in her caregiver approach after a habitual response threatened to exacerbate a crisis:

> One experience that comes to my mind was that my daughter had a bad breakup, and so as a result of that she had some episodes with alcohol. She had been drinking by herself in her room… So, initially I let fear and panic overtake me, and she sensed that in me. I ordered a breathalyzer, I threatened to take her car away and throw her out of the house, and that didn't work. But, when I calmed and came to my rational senses, I realized that fear and worry and panic were making things worse. I realize I needed to approach her with confidence and affirmation and encouragement, and be firm yet loving. She seems to sense that shift and she's regaining her stability and empowerment.

Subtheme 2: Emotions associated with the caregiver role included anxiety, frustration, and powerlessness. When participants were asked to describe the emotions that characterized their experience as caregivers, the responses they gave were negative—7 out of the 8 participants expressed negative emotions, anxiety, and frustration. Participant 6 spoke of troubling emotions, including anxiety about the patient’s lack of autonomy: “Feeling a lot of trouble and sadness, excessive worrying over her condition and when she will return to normal, back to doing things on her own without my supervision.” Participant 7 described feelings of powerlessness and pity for the patient:

> I say it kind of swings around. It's like ping pong from here to there. I feel anxious and sometimes disappointed because there's no clear answer on when is this ordeal is going to end. He feels trapped in this situation… I'm saddened because there's nothing I can do to speed up their recovery process.

Participant 3 described the disappointment of watching a loved one become impaired by illness:

> The number one emotion I should say is the disappointment due to the debilitating nature of this disease. Seeing your loved one not able to do what they used to do before and seeing them happy, outgoing, connecting to the environment of family so it's kind of disappointing just to see the person sink into this stage of mental health. It's a very sad situation just to watch a person deteriorate like that.

For Participant 8, feelings of powerlessness were associated with the patient's inconsistency, which were therefore mingled with frustration:

> Sometimes, it's a lot of frustration because she's very stubborn and I tell her she has to keep it going, that this is something that you can't be playing around with and her stubbornness and her, "I'm 18 now, you can't force me to do anything," I told her yesterday that I took great offense to that, because I'm still her parent and when she's in trouble, who does she go to? So, if she wants to be an adult, then don't come running to me. In so many words, or at least don't be rude about it. Come to me, but don't say, "Hey, I'm an adult, I can do whatever I want," and then say, "Hey, can you help me?"

Participant 2 also spoke of anxiety and frustration: “You run the gamut of support, guilt, fear, concern, worry. Yeah, sometimes you just feel frustrated.” For Participant 4, the caregiver role had resulted in what he described as “a sense of isolation, depression, anger.” Participant 5 described a more varied emotional experience, with strongly positive emotions arising in reaction to hopeful signs: “A lot of emotions. There's sadness, there's happiness that they're trying to seek help. There's frustration. Some of its joy when they're having good days and good moments.” Participant 1 described negative emotions that gave way to a sense of freedom due to a realization that emotions should not be dictated by the experiences of other people:

> I used to vacillate between fear, worry, and panic, and that would inevitably bring me into my own place of despair. I spent a good, significant amount of time blaming myself, and then I realized over time that my own joy and peace cannot be based on whether or not my children are doing well or not.

Subtheme 3: Challenges associated with the caregiver role included the patient’s behavior and the expense of treatment. For Participant 2, the most significant challenge that caregiving involved had been getting the patient to admit the need for treatment:

> Specifically, getting him to admit that there was a problem, getting him to a facility where he would seek the treatment, and ensuring that he gets the medication that he needs so that he can be balanced…With him, it's the attacks on me.

Similar to Participant 2, Participant 8 sometimes found the patient’s behavior provoking, and to such an extent that the most significant challenge was self-restraint:

> It's a lot of keeping my mouth shut when I feel like I should say something or ... so I have to bite my tongue a lot where, my ex-wife would calm me down and reel me in and say, "What you're doing is to make things worse, so chill out, take a breath." So, I do, and that helps … That's probably the biggest challenge I have … fighting myself to keep quiet at times.

For Participant 7, frustration with the patient’s behavior was exacerbated by exhaustion from complying with a time-consuming treatment plan:

> The challenges are astronomical but I just got to stick with the program. I'm just going to tell you a few right now. I'll just have to exercise patience and understanding toward his situation and taking one day at a time, but it's really, really getting on my nerves because the costs on time invested in the treatment is just beyond me … Sometimes, I just want to give up, I'm sorry … I don't even have a life and just hoping he gets well soon so I can return and focus on my work, if not … I'm going to be in a mess, so I'm just hoping that he comes around.

For Participant 6, the frustrations associated with the patient’s behaviors were aggravated by a sense of powerlessness and overwhelming responsibility:

> The most challenging thing as a caregiver I've experienced is the frustration of looking at a loved one deteriorating with no ability to help. It is overwhelming to be responsible for an entire household and that responsibility as a man …

> Enduring and tolerating the exhibition of my wife's new behaviors. Being patient is something I have learned throughout the period of her recovery.

For Participant 1, one of the most significant challenges was the effect of the patient’s behaviors on other members of the family:

> Some of the challenges are my other children are significantly affected by my daughter's depression and anxiety and addiction. They seem to avoid her… So, this has really affected my whole family, and at times caused division, judgment, and confusion, and finger-pointing.

Participant 3 also spoke of the patient’s effect on the family, but in this case the challenge was related to the enormous expense of treatment:

> Well obviously, as a caregiver the challenges are enormous. Astronomical when it comes to health care costs. That's really affecting the family and it's affecting me as the primary caregiver. Being able to make the payment insurance premium, meeting the deductible and also paying the co-insurance and copays weekly … and it's really affecting everything that we do financially at this point.

Participant 5 felt exhausted by the exertions of providing care: “It's very draining. It takes a lot out of the primary care, me, to continuously encourage and support and help guide them through their treatment plan.” Participant 3 had also made sacrifices to provide the necessary level of care:

> The most challenging aspect of being the primary care of my loved one is just getting her back well enough to return to work and normalcy because once she's able to regain her strength and cognitive balance, she'll be able to function as

> normal and that will be quite a relief on my end also so that I can return to my full-time work because I had to cut down to part-time position just to be able to help her out.

Participant 2 had been compelled by the patient’s occasional stubbornness to recognize that even the most committed caregiver was necessarily limited:

> He's independent, but he's not. He depends on me for everything, but when he wants to do it his way, it's his way and I'm just there. I can only go so far, as far as being in the caregiver, because I'm limited.

Subtheme 4: The influence of caregiving on family members was often negative. Although the influence on the patient’s family was not the most significant challenge for all participants, all participants were cognizant of the effect of the patient’s illness on other loved ones. For Participant 4, the sense of isolation from family members that resulted from being the patient’s sole caregiver had been challenging: “Family members have good intentions but don't carry the burden … Dysfunctional. It seems endless.” Participant 5 explained that the influence on family members could vary from person to person, but the caregiving role limited the caregiver’s resources in providing for other relatives:

> It varies from different family members. Some of them believe that the person that's going through it is just being coddled and spending too much time or effort trying to help them. Others are very encouraging and also support what I do as a caregiver and supports her for trying … It takes away from other family members because you are, it's a lot of effort and a lot of time.

Participant 7 expressed profound frustration with the detrimental effect of the patient’s illness on the entire family:

> You really want the honest truth? It's a mess. It really is. It's really a mess. It's fragmented. Rather than being a unit as we used to be, all the members are confronted with isolation, frustration. Everybody just has a pity party because it seems no one else matters, just him. It's kind of getting on everybody's nerves. Tying to include and please everyone at the same time, it's impossible. Other members need unnecessary attention, hello. I thought I can't do this anymore, which has caused distraction and pain. I've had it.

For Participant 6’s family, the patient’s illness had resulted in a feeling of distance, due in part to the suspension of family functions:

> The relationship with other members of the family seem to be distant, because most of the family functions were not done anymore. I've experienced some distance in the relationship with the children and their mother … family functions are disrupted. They were more formal dinners for the family, and there is not any formal dinners anymore.

Participant 1 described how a caregiver’s absorption in the patient could result in her neglecting other family members:

> I can see how a parent can be consumed with their child who's in treatment, neglecting their other children and their spouse … I do find myself preoccupied with my daughter in treatment, and can easily let her sickness consume me to the point of not reaching out to my other kids and ignoring my spouse, which is the

> worst thing I can do … Unfortunately, I would say that at times I feel like we're five separate units, and it seems like it's driving us apart rather than binding us together.

Participant 3 also described a family unit that had been fragmented by the illness, in this case due to pervasive misperceptions of the illness:

> The relationship in the family is a bit fragmented right now because of the disconnect due to the disparity and understanding the disease. I just wish that other family members could come on board or more curious to attend the family meeting and just to inquire about the disease so they can actually understand. So, there's that disconnect and it's very hard for one individual such as myself to impose on the family members … Unfortunately, in our society today, people don't really understand what it means for somebody to be depressed. When they hear the word depression, they immediately throw stones or judge the person’s inability to function. So, it's emotionally draining because society needs to be educated.

Participant 2 described the difficulty of accommodating a patient’s challenging behaviors when other family members were uncertain of how much leeway the patient deserved:

> It, sometimes, can be frustrating because he will communicate in ways that are attacking, and blaming, and other people can see it, but they know, at the same time, he is where he is in his mental state… You, kind of, have to take it. It brings a dynamic where everybody just overlooks the behavior of the one with the

> mental illness and they get away with a lot...Sometimes other people don't understand with mental illness, and so therefore they think that, when is it that the person's illness is actually taking over and when is it that they're manipulating and using that as a crutch or an excuse. Therefore, you get judged also for your tip-toeing around the grenades, and then other people feel resentment that, "Why does he get away with that and I don't?" Because they don't understand.

Participant 8 acknowledged that the patient’s illness was challenging for the whole family to cope with but indicated that the patient’s family members continued to support one another, as well as the patient:

> Very rough at times. A lot of drama, a lot of screaming. Usually none of that, none of the screaming involves her, that's her and her mother, that's how they communicate when that happens. A lot of frustration, a lot of stress, a lot of hurt feelings...Nothing has been damaged. We still are a loving family. Throughout it all, nothing has been ... there's been no damage that's been permanent. Only temporary.

Subtheme 5: Caregiving goals included support, advocacy, and education. Participant 1 wanted to continue to improve in the directions in which she was already moving: “I will continue to be less invasive, emotional, irrational, controlling, enabling, and more affirming, prayerful, positive and optimistic.” Participant 2 hoped that a better understanding of the illness would allow for a more objective view of the patient: “Continue to understand the mental illness as a whole and what that person is actually dealing with, so that you take your emotion out of it. That's sometimes very challenging to do.” Participant 8 also wanted to learn more and indicated ways in which a better understanding might be achieved:

> I think the only way you can improve your role is education, and opening your eyes and ears. See more, hear more, experience more and yeah. Self-education. Learning from others who are, who've been there, done that, who treat people with depression, and all that. I know that makes you a better person to deal with it.

Participant 6 noted that a change in treatment protocols would allow him to become more educated about the illness:

> I believe improving my role should've been to be educated a lot more in depression and its disorder, and I would have been allowed to be in the group session sometimes, but I think for the confidential level, I'm not allowed. I think a group session would be mandatory for the family also, because that might be a better tool to help us deal with our loved one.

Participant 3 wanted to educate other family members so that they could participate in caregiving:

> I'd like to improve my role as the primary care of this patient by requesting more family sessions and involve other family members in the treatment just to make sure that if I'm not available somebody else can actually take that responsibility to offer the same care as I'm doing right now to our loved one.

The goal of Participant 5 was to advocate more effectively on the patient’s behalf: “Support, advocate for her more, and listen to the team a little bit better, not feel like I can't make suggestions and comments to the team.” Participant 4 also spoke of the importance of continuing to advocate for the patient, naming as a primary goal: “communication with the professionals.”

Summary

The purpose of this qualitative phenomenological study was to explore the experiences and perceptions of the parents of patients with depressive disorder regarding intensive outpatient treatment. To achieve this purpose, semi-structured interviews were conducted with eight parents who were primary caregivers of adult outpatients with depressive disorder. One research question was used to guide the study: What are the experiences and perceptions of parents of patients with depression regarding their role as caretakers in intensive outpatient treatment?

Data, related to experiences and perceptions of outpatient treatment, were associated with four focus areas. Participants described the general responsibilities entailed by their role, and then they gave more detailed accounts of specific responsibilities. Specific responsibilities discussed by the participants included socializing the patient, adhering to a treatment plan, and mediating in relationships with professionals. Responsibilities varied from participant to participant, and these included monitoring the patient’s medication intake and participation in therapy, providing transportation, facilitating the patient’s supervised socialization, monitoring the patient’s independent socialization, providing financial assistance, advocating for the patient with professionals, and providing emotional support.

Data, related to experiences and perceptions of being a primary caregiver, were associated with five focus areas. In describing the most significant experiences associated with caregiving, participants remembered potentially tragic incidents in which they could intervene, the help they had received from providers, and their own experiences of frustration and pain. The emotions associated with caregiving included depression, hopelessness, anxiety, powerlessness, and frustration, but also happiness and joy. The most significant challenges caregivers had encountered included stubbornness and other difficult behaviors on the part of the patient, the drain the illness and its treatment exerted on time and other resources, and feelings of powerlessness and exhaustion. The influence on family of the patient's illness included financial and emotional strain, feelings of isolation, conflict, resentment, and perceptions that family members, other than the patient, were being neglected by the caregiver. When asked to describe their caregiving goals, participants spoke of gaining a better education about the illness for themselves and others and of advocating more effectively on the patient's behalf. Chapter 5 includes interpretation and implications of these findings.

Chapter 5: Discussion

Clinical depression is a mood disorder with potentially devastating effects on the patients' life. Similar to the causes of depression, its treatment is complex, and it remains an active area of research. Most clinicians embrace a multi-dimensional treatment approach, including pharmacological, psychological, and psychosocial interventions (Peters et al., 2012; van Grieken et al., 2014). The latter dimension, which could facilitate the success of the previous ones, was the focus of the present study.

Psychosocial treatment can include emotional, moral, physical, and financial support (Wong et al., 2014; Xiaolian et al., 2002). Family members usually provide care for outpatients with depressive disorder. Researchers have widely recognized that family support positively affected the treatment success of outpatients (Houston et al., 2014, Taylor, et al., 2015; van Grieken et al., 2014; Xiaolian, et al., 2002). However, little was known about the effects of this support on the caregiving family members.

Supporting an outpatient with depressive disorder can be a demanding and extremely stressful experience. Constant worries, treatment expenses, and disruptive behavior by patients can take a significant toll on caregivers. Consequently, the psychosocial support that caregivers provide can prove detrimental to their own mental health (Yap et al., 2013). This phenomenon, called caregiver burden, is increasingly recognized in the literature (Kumar & Gupta, 2014; McCann et al., 2015). Most researchers investigating the phenomenon call for psychosocial support for caregivers. However, to design effective interventions, it is crucial to understand the experiences and perceptions of those who care for depressive outpatients. Therefore, the present study sought to address this knowledge gap. Its purpose was to explore the experiences and perceptions of parents of patients with depressive disorder regarding intensive outpatient treatment.

Key Findings

The present study employed a hermeneutic phenomenological design. It used semi-structured interviews with eight parents who were primary caregivers of adult outpatients with depressive disorder. The guiding research question was the following: What are the experiences and perceptions of parents of patients with depression regarding their role as caretakers in intensive outpatient treatment? In this section, I will briefly summarize the main findings of the study. Two main themes were identified: experiences and perceptions of outpatient treatment and experiences and perceptions of being a primary caregiver. Moreover, those themes were associated with various subthemes.

The Experiences and Perceptions of Outpatient Treatment

The participants described their experiences and perceptions regarding various issues. From their accounts, many distinct subthemes could be derived. The identified subthemes included responsibilities, socializing the patient, adhering to a treatment plan, and relationships with professionals.

Responsibilities. The participants perceived different activities as part of their caregiver responsibilities, ranging from crisis intervention and emotional support to the management of everyday tasks. The extent of involvement varied, both Participants 4 and 6 expressed their watchfulness pertaining to the patient’s safety as they have expressed ideas of committing suicide. Some participants perceived their role as more limited than others; Participant 1 indicated the patient expressed a need to be independent; thus. the parent kept a respectful distance. They emphasized the patients' autonomy and focused primarily on crisis management and providing emotional support. Others were more involved and supported patients in various aspects of their lives and treatments, such as maintaining personal hygiene (e.g., Participant 6).

Socializing the patient. Participants also brought up socializing the patient as another distinct issue. Some regarded their role as facilitating social contacts, while others were primarily focused on preventing undesirable social interactions. Counteracting isolation was a common goal among those who encouraged social contacts. Participant 4 stated, "Encouraging socializing. Actually, getting out of bed. Going outside. Going for walks. Caring. Encouragement." Participant 4 reiterated the part of the problem of social isolation experienced by patients with major depression. The primary reason for imposing social constraints was preventing interactions with friends that were perceived as not conducive to the patient's wellbeing. Participants 1 and 7 assumed the role of limiting contact with friends who were perceived as having a negative influence on the patient. Conversely, Participants 5 and 8 seemed more optimistic and encouraged the patient to participate in social groups and with individual friends.

Adhering to a treatment plan. Participants also stated the adherence to treatment plans were a major component of the caregiving process. Experiences with the patients' treatment plans ranged from overwhelmingly negative feelings, due to exhaustion, to appreciating the chance to develop a more empathetic understanding of the patients' disease. For instance, Participant 2 stated that this aspect was “exhausting,” whereas Participant 5 perceived the fact that there was a specific plan together with other knowledgeable people who also looked after the patient’s well-being as making the task easier. Five participants (Participants 3, 5, 6, 7, and 8) perceived participating in the treatment plan positively and appreciated the fact that they gained more knowledge on the condition.

Relationships with professionals. The experience with professionals was another topic participants raised. Only one participant expressed reservations about the relationship with mental health care professionals, and this was a small element of an overall positive experience. Most participants gave positive accounts of their interaction with professionals. Participants 3 and 7 both appreciated the “mutual respect” that formed as part of their relationship with the professionals. Participant 5 expressed the desire for more involvement in the patients’ treatment plan; Conversely, Participant 5 experienced the involvement as taking its toll on her overall well-being and influencing the family. Dealing with the patients impacted severely on Participant 7’s family life: “Rather than being a unit as we used to be, all the members are confronted with isolation, frustration.”

Experiences and perceptions of being a primary caregiver. A variety of subthemes emerged regarding the experiences and perceptions of being a primary caregiver. Many participants brought up significant experiences. The emotions associated with the caregiving process were another subtheme that emerged. Participant 6 summarized the emotions as the following: “Feeling a lot of trouble and sadness, excessive worrying over her condition and when she will return to normal, back to doing things on her own without my supervision.” The depth of the experience was voiced be Participant 4 in the statement: “A sense of isolation, depression, anger.” The challenges emerging in the caregiving process were also raised and included having to change a work situation to part-time, in the case of Participant 5. The influence of the patients’ illnesses on the family life was another topic. In the case of Participant 1, it was described as the following: “Some of the challenges are my other children are significantly affected by my daughter's depression and anxiety and addiction.” Finally, the participants discussed their caregiving goals.

Significant experiences. The nature of the most significant experiences of caregivers varied. Some participants identified significant experiences that were extremely negative. Examples included patients’ self-harming or suicidal behavior, as well as the feeling of powerlessness when dealing with the disease. For instance, Participant 4 observed, “Watching for overdosing. Mood swings, aggression. Anxiety flare ups.” Others named instances of positive interaction with professionals. Participants 3 and 6 were especially positive about their experiences with the professionals who went “far beyond a sense of duty” and impacted positively on their caregiver role by dealing with their questions and concerns. A few participants regarded their own intervention in crisis situations as particularly significant, and they derived satisfaction from the positive difference their efforts had made. Of interest was the sense of achievement coming from Participant 8: “I was able to figure out and come up with a plan that helped her come down from her attack and that was great.”

Emotions. The emotions that participants associated with the caregiving process were overwhelmingly negative. Many recalled feelings of anxiety, depression, isolation, and powerlessness. Participant 6 indicated, “Feeling a lot of trouble and sadness, excessive worrying over her condition.” This summative description of Participant 5 outlined the emotional reactions of an overall feeling of powerlessness sharply: “I think the pain and the trauma that the caregiver goes through taking care of this person and feeling their pain and not being able to help.” Others mentioned that they had experienced feelings of disappointment, frustration, and anger. Participant 7 stated, “Unfortunately, honestly, his problems seem to absorb everyone's convenience right now.” And Participant 2 also spoke of anxiety and frustration: “You run the gamut of support, guilt, fear, concern, worry.”

Challenges. Most major challenge that caregivers experienced were brought about by patients’ behaviors. Whether caused by the difficulty to convince patients that treatment was necessary or by the need to cope with patients’ disruptive behaviors, most participants found the caregiver role demanding and exhausting. The expenses of the treatment posed an additional challenge. Participant 8 mentioned the inconsistency of the patient’s behavior that was particularly challenging—one moment needing help just to turn around stating that they did not need assistance. In the case of Participants 4 and 6, the patient’s isolation and lack of self-care was particularly concerning.

Impact on family. All participants reported that the patients’ illnesses took a toll on their family life. Although the extent of the influence of the patients’ behaviors on different family members varied, it was detrimental to the entire family’s functioning.

Difficulties could arise directly from patients’ behaviors or from caregiver’s absorption with their tasks of caring for patients. Participant 7 found that caring for the patient impacted on their family life: “Unfortunately, honestly, his problems seem to absorb everyone's convenience right now… Rather than being a unit as we used to be, all the members are confronted with isolation, frustration.”

Caregiving goals. All participants were determined to continue their role as caregivers. Many sought a better understanding of the illness, and they wished to assume a better informed, less emotional approach to their role: “I will continue to be less invasive, emotional, irrational, controlling, enabling, and more affirming, prayerful, positive and optimistic” (Participant 1). Moreover, Participant 1 had the desire to educate other family members about the illness, as varying levels of insight caused disparity in the family life. Participant 5 portrayed a positive parenting attitude by stating: “To continue to display and express my love toward her concerns by doing something to lift up her spirit.” Others, such as Participant 4, expressed their wishes to advocate on behalf of the patients, which included advocating with health care professionals.

Interpretation

Major depressive disorder is a mental health condition with high prevalence and persistence in modern societies (McClintock et al., 2010). The disease has been the target of considerable research efforts, seeking to understand both its causes and approaches to its effective treatment (Daly et al., 2013; Pigott et al., 2010; Regier et al., 2013; Tansey et al., 2012; Wray et al., 2012). The effect of the family environment on the mental health of depressive patients is an active area of research (De Silva et al., 2013; Houston et al., 2014; van Grieken et al., 2014; Xiaolian et al., 2002; Yap et al., 2013). Nonetheless, the present study explored a topic that had received little attention in previous research. There was a dearth in the literature, regarding the experiences and perceptions of parents who were the primary caregivers of adult outpatients with depression. Given the explorative nature of the present study, an open-ended and semi-structured research approach seemed appropriate. Therefore, a hermeneutic phenomenological design was employed, which provided a comprehensive understanding of the phenomenon under investigation (Marshall & Rossman, 2014).

The benefits of parent involvement in the treatment of depressive outpatients. There are significant benefits when parents are willing to accept the demanding task of being the primary caregiver of outpatients with major depressive disorder. Recent findings have shown that family support can drastically improve the prognosis of patients with depressive disorder (Anastasia et al., 2014; Joling et al., 2012; Pernice-Duca et al., 2015; Sangalang & Gee, 2012; Taylor et al., 2015; Xiaolian, et al., 2002; Zauszniewski et al., 2015). The positive effect of family support is dependent on caregivers' understanding and embracing their roles. As the results in the previous chapter showed, this was the case for the parents participating in this study. All participants associated their role with responsibilities, although the degree of their involvement varied.

The findings also helped explain how family support could improve the treatment diagnosis. Van Grieken et al. (2014) revealed many factors impeding the recovery process of patients. The results from the previous chapters showed that participants perceived these factors as relevant and sought to effectively counteract them. Among the problems, identified by van Grieken et al., patients often received inadequate treatment because they failed to understand the nature of their illness. Consequently, many cases of depression often remain untreated for an extended period, which can be detrimental to patients’ wellbeing and the prognosis of possible future treatments (Dowrick & Martin, 2015; Hankin et al., 2015; Jenkins & Goldner, 2012). The findings of the present study showed that parental support could help address this problem. The participating parents were aware that convincing patients that there was a need for treatment was among the challenges they faced.

Another obstacle preventing recovery from depression is the patients’ failure to properly comply with the treatment plan (van Grieken et al., 2014). However, the participants in this study stated that they considered ensuring the adherence to treatment plans as an important caregiving task. Embracing this task could yield positive external effects, as it helped them to gain a better understanding of the disease. Hence, parental involvement could facilitate patients’ compliance with treatment plans and improve their prognosis.

Another potential area can be inadequate relationships with health care professionals (van Grieken et al., 2014). Hence, it was significant that the participants, but one, overwhelmingly reported positive relationships with professionals treating the patient. Participant 8 was the only one who mentioned a negative perception of one element against the background of positive experiences with professionals. In fact, some participants even expressed the desire to be more involved in the collaboration with professionals than patients' privacy rights permitted. Good relationships of parents and professionals could facilitate the resolution of conflicts between patients and therapists. This act could, in turn, contribute to more productive and sustained interactions between the latter, which could improve the chances of treatment success.

Van Grieken et al. (2014) identified a final problem: the insufficient participation of significant others. The behavioral problems, associated with depressive disorder, often affected a patient's social life, as well as support and understanding from significant others. Once again, the participants in this study displayed an awareness of this issue, and they reported efforts to address the issue. Many stated that they sought to facilitate patients' socialization, thus preventing isolation and supporting integration. Moreover, many expressed that they considered it an important caregiving goal to educate others about depressive disorder, including family members, and to advocate on behalf of the patient. Therefore, caregiver support by parents can help reduce the stigma associated with depression, decrease patients' isolation, and increase the involvement of significant others. These contributions could further improve the chances of treatment success.

These positive effects of caregiving efforts by parents of adult outpatients with depressive disorder were consistent with the theoretical literature. The findings of this study supported the biopsychosocial framework (Engel, 1977; Peters et al., 2012), which stressed the importance of integrating biological, psychological, and social interventions into a single treatment program. In fact, the results provided additional support for the importance of the social component of this integrated approach. Moreover, these were consistent with family systems theory (Bowen, 1966). Family systems theory emphasizes that the family is the emotional unit of the individual. When the primary caregivers are family members, it is more likely that they will provide social support that improves the possibility of successful treatment. The detailed accounts, provided by the participants in this study (i.e., all parents of depressive outpatients), supported this theoretical position.

The costs of parent involvement in the treatment of depressive outpatients. Being the primary caregiver of a patient with depression is a demanding task. People suffering from depression tend to perceive the world in an altered way, which makes it difficult for them to function, and it may have a significantly negative effect on their quality of life (Dowrick & Martin, 2015; Hankin et al., 2015; Ishak et al., 2013; Jenkins & Goldner, 2012; Johansson et al., 2013). Moreover, depression often leads to behavioral patterns that are difficult to cope with, and take a profound toll on family members (McCleary, & Sanford, 2002; Yap & Allen, 2008). These challenges deserve attention, and are examples of a larger, more complex problem: caregiver burden (Kumar & Gupta, 2014; McCann et al., 2015).

Participants in the present study reported that the emotions they associated with the caregiving process were overwhelmingly negative. Feelings of anxiety, depression, isolation, and powerlessness were mentioned. Prolonged periods of stress and isolation are factors that could increase the risk of developing mental health issues, including depression in the caregiver (Aziz & Steffens, 2013; Dowrick & Frances, 2013). Hence, the results of the present study were consistent with the position, posed by Kumar and Gupta (2014), who suggested that family caregivers were at risk of developing mental health problems, and they needed intervention and support for themselves.

Zendjidjian et al. (2012) suggested that the caregiving process could negatively affect the quality of life (QoL) of caregivers. The parents, who participated in the present study, reported challenges that were consistent with this position. The behavior of patients and the demands of the caregiving process significantly increased the stress levels of caregivers. Moreover, they also proved detrimental to the well-being of other family members.

Von Kardoff et al. (2015) reported various factors that could take a toll on caregivers, including the financial expenses of treatment. Once again, the present study confirmed this finding. The tremendous treatment expenses were among the issues that participants perceived as particularly challenging.

Surprising, given the demands of the caregiver role and the focus on problems in the literature, were the positive feelings and the satisfaction that some participants expressed. Participants recalled feelings of satisfaction, when their efforts were effective. In other words, participants were most satisfied with their caregiver role, when they knew they made a positive difference in the patients' life. This finding not highlighted the motivation behind the sustained effort of caregivers, it also offered guidelines for their integration in the treatment process.

To summarize, there is a growing literature on caregiver burden, and important insights have been obtained in recent years (Burke et al., 2015; Cheng et al., 2013; da Silva et al., 2013; García-Alberca et al., 2012; Lin et al., 2013; Lum et al., 2014; Mohammed et al., 2015; Olawale et al., 2014; Otero et al., 2015). Nonetheless, the present study addressed a knowledge gap, since it was the first to focus on the experiences and perceptions of parents of adult outpatients suffering from depression. The results helped increase the understanding of how parents of adult patients were affected by caregiver burden. Their struggles explained why parents sometimes failed to provide adequate support for depressive outpatients. Conversely, the participants also reported a remarkable willingness to be educated about the disease and to be involved in the treatment process. Moreover, some reported satisfaction derived from the positive difference their efforts made. Overall, the insights, provided by the participants in this study, could prove helpful for the design of initiatives to support parents of adult outpatients in their caregiving efforts.

Limitations

Whenever an area of research is new and unexplored, quantitative methods may be difficult to implement. Quantitative approaches rely heavily on standardized methods of information gathering, which produce data that can be analyzed using statistical techniques. This degree of standardization is difficult to accomplish if a phenomenon is not yet well understood. Therefore, it was not a limitation *per se* that this study employed a qualitative design. Qualitative methods produce results that are not easily generalizable (Marshall & Rossman, 2014). However, these are usually the appropriate approach to obtain a comprehensive understanding of unexplored phenomena.

However, there are potential limitations specific to qualitative studies. A specific issue in the present case was that the eight participants in the study were not sufficient to achieve data saturation, the point at which data became repetitive and no additional information could be collected. According to Francis et al. (2010), data saturation is usually achieved with 10 participants and with higher confidence by using 13 participants. Hence, only eight participants in the present study was not sufficient to secure data saturation. Although the careful selection of participants, guided by the recommendations of psychiatrists and therapists from the chosen clinic, sought to secure a broad range of experiences and perceptions, the low sample size might have affected the available results.

The concepts of validity and reliability are usually reserved for quantitative studies. However, the objectivity in qualitative research can be diminished by problems of trustworthiness. Many strategies have been developed to address the different dimensions of trustworthiness in qualitative research (Morse, 2015; Poduthase, 2015). These have been thoroughly employed in the present study. To address the issue of credibility, I conducted a member-checking procedure. The participants recommended no changes. The problem of transferability was addressed by providing thick descriptions of the methodological procedure, as well as of the decisions and assumptions made. To enhance the dependability of the study, I accounted for all decisions through an audit trail. Confirmability was enhanced by detailing my personal biases and beliefs.

To summarize, the low sample size might have created a data saturation problem. Future studies would have to reveal if more participants lead to additional insights. Potential issues of trustworthiness have been carefully addressed and were not likely to be more problematic compared to in other qualitative research.

Implications for Further Research

The present study was the first to explore the experiences and perceptions of parents, who assumed the role as primary caregivers of adult outpatients with depression. It explored a new area of research and addressed a gap in the literature. The results and interpretations raised many questions that could motivate and inform future research. As discussed in the previous section, the low sample size and lack of data saturation posed a limitation for the present study, which might have impacted the results. Future qualitative studies, with more resources available, should address this issue and drastically increase the sample size.

Another line of research could further explore the obvious benefits of parent involvement in the treatment of outpatients with depression. Given the nature of the present study, the results were not easily generalizable. Therefore, future studies could investigate ways in which the experiences and perceptions of different populations differ. For instance, it would be instructive to learn whether the commitment that some of the participants in the present study displayed is limited to parents. It was possible that the approach to family support differed with other groups of caregivers (e.g. spouses or siblings). Apart from caregivers, other factors could also be varied in future research. For example, the experiences and perceptions of caregivers might differ with a different population of patients. For instance, one could observe differences in family support with adolescents or elderly patients. Additional qualitative research could address these questions.

The present study showed several reasons that helped explain why family support could increase the chances of treatment success. However, participants varied significantly in their extent of involvement. While some participants were willing to preserve the autonomy of patients, others sought to be involved in every aspect of the treatment process. Future research could examine which approach was more conducive to patient recovery. There was a limited and focused research question that could be addressed in a quantitative study. Such a study could seek to estimate the marginal effects of low, medium, and high levels of involvement.

Another line of research could further explore the phenomenon of caregiver burden. Caregiver burden directly affected those offering support and had the potential to undermine the treatment success. Future research should examine this connection to assess whether caregiver burden was related to recovery from depression. Again, the narrow focus of this research question suggests using a quantitative design.

Finally, family support seems to involve one fundamental conflict: it increases the chances of recovery of patients, but it is associated with distress that can decrease the mental health of caregivers. There is a need for support programs for caregivers, and this important implication will be addressed in the next section. However, such support measures are complex and the effect is uncertain. A series of program evaluations can address the effects of different initiatives on the well-being of caregivers.

Implications for Social Change

The findings of the present study have profound implications for research, therapeutic practice, and public policy. In the theoretical literature, a multi-dimensional approach to mental health care by integrating pharmacological, psychological, and psychosocial support has long been established (Engel, 1977). Similarly, several empirical studies have produced evidence that demonstrates the value of family support in the treatment of outpatients with depression (Anastasia et al., 2014; De Silva et al., 2013; Houston et al., 2014; van Grieken et al., 2014; Xiaolian, et al., 2002). The present study was consistent with these findings. The small sample size and lack of data saturation notwithstanding, it produced evidence that clarified why support from parents was conducive to treatment success. The support that parents of adult outpatients provide, their desires to facilitate positive or inhibit negative socialization, their positive relationships with professionals, and their facilitation of treatment plans, all contribute to increased chances of treatment success. Future research should further explore these areas, and the previous section recommended research strategies.

This wide range of responsibilities that parents of depressive outpatients are willing to accept should be acknowledged and effectively utilized by health care professionals. Indeed, health care professionals need to seek to effectively integrate parents, who are able and willing to help, in the treatment process. Psychoeducational initiatives, aimed at parents and other primary caregivers, should be offered and carefully administered, provided that adult patients gave their consent to such involvement. Caregivers should be thoroughly informed about a patient’s conditions and how they could assist in the implementation of treatment plans. Many parents reported that they cared about topics, such as patients’ level of autonomy and their socialization. Those could also be topics in interactions between parents, who were primary caregivers, and professionals. Such educational efforts promise to yield positive results, given the overwhelmingly positive attitude toward professionals that the study revealed.

The relevant literature produced significant evidence of caregiver burden (Burke et al., 2015; Cheng et al., 2013; da Silva et al., 2013; García-Alberca et al., 2012; Lin et al., 2013; Lum et al., 2014; Mohammed et al., 2015; Kumar & Gupta, 2014; Olawale et al., 2014; Otero et al., 2015, Zendjidjian et al., 2012). The present study was consistent with these findings. Participants reported negative emotions and experiencing stress, exhaustions, and frustration. Moreover, many participants mentioned that their role of caregivers came with challenges that proved detrimental to their own well-being, their family life, and their finances. Recommendations to explore this important issue further have been provided in the previous section.

These findings have important implications for clinical practice. Health care professionals must keep in mind that the integration of family support in the treatment of outpatients comes with significant challenges for caregivers. Parents and other caregivers must be informed about these challenges and coping strategies need to be developed.

Moreover, caregiver burden is an issue that is of interest for public policy makers. It is important that policy makers understand that family support yields significant positive externalities. There is ample evidence that family support makes the treatment of depression more effective, and the results from the current study are consistent with this position. Hence, supporting supporters will not only benefit patients and their families, but society as a whole. The social costs of depression are enormous (Greenberg, Fournier, Sisitsky, Pike & Kessler, 2015; Kessler, 2012). Depression does not only yield direct medical expenses, but also costs in the form of comorbidity, death from suicide, and work loss. Efforts to treat depressive disorders more effectively contribute to the reduction of these expenses. In other words, there is a public benefit from private wellbeing. Conversely, caregiver burden undermines family support, thus reducing the chances of successful treatment. In turn, this aspect will contribute to an increase of the public costs of depression. Therefore, battling caregiver burden is a public health issue. Hence, policy makers should aim to support parents, and others, who function as primary caregivers of adult outpatients with depression. Access to consulting needs to be facilitated, so that caregivers gain access to information and can develop strategies that can help them cope with the challenges of the caregiver role. Moreover, compensations and incentive plans need to be developed, which can help ease the financial burden of those who are primary caregivers, and thus effectively participate in the treatment of outpatients with depression.

Conclusion

The purpose of this study was to explore the experiences and perceptions of parents of patients with depressive disorder regarding intensive outpatient treatment. Previous research have shown that family support is an important component of an integrated treatment plan of outpatients with depression. This position is consistent with the conceptual framework provided by family systems theory and the biopsychosocial framework (Bowen, 1966; Engel, 1977). However, the present study was the first to focus on the experiences and perceptions of adult outpatients.

The findings were consistent with expectations from the literature. Many participants reported high levels of involvement. They provided various forms of support, maintained positive relations with professionals, were involved in patient socialization, and facilitated the adherence to treatment plans. These findings highlight why family support and parent support is an important component in the treatment of depression, which can contribute to its success (Anastasia et al., 2014; Joling et al., 2012; Pernice-Duca et al., 2015; Sangalang & Gee, 2012; Taylor et al., 2015; Xiaolian, et al., 2002; Zauszniewski et al., 2015).

There is also a growing literature on the problem of caregiver burden, which show that being the primary caregiver of an outpatient with depression is a stressful and challenging task (Burke et al., 2015; Cheng et al., 2013; da Silva et al., 2013; García-Alberca et al., 2012; Lin et al., 2013; Lum et al., 2014; Mohammed et al., 2015; Kumar & Gupta, 2014; Olawale et al., 2014; Otero et al., 2015, Zendjidjian et al., 2012). The findings of the present study were consistent with the literature. Participants reported negative emotions and challenging experiences associated with the caregiver role. A potential limitation of the study was due to its low sample size. It remained a possibility that data saturation was not accomplished.

This study concludes with the statement that family support holds great promise for the effective treatment of depression. However, caregiver burden potentially undermines it. The results of this study indicated that caregivers experienced ambivalent emotions toward their roles and patients. The patient was a family member whom they loved, and they reported feelings of achievement when situations were changed due to their interventions. Conversely, findings indicated experiences of exhaustion, strong emotions about the burden of having to support the patient, and concern for their own and the rest of the family’s well-being. There was an overwhelming sense of isolation, responsibility, and its duration, together with feelings of being taken for granted, a lack of understanding, and lack of support that surfaced in nearly every response. Therefore, researchers, clinical practitioners, and policy makers must increase their efforts to support those who help family members suffering from depression to intensify the search for effective ways to reduce the toll on those caregivers.

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