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ORIGINAL PAPER

The Art of Helpful Relationships with Professionals: A Meta-ethnography of the Perspective of Persons with Severe Mental Illness

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Abstract Relationships with professionals have been shown to be helpful to persons with severe mental illness (SMI) in relation to a variety of services. In this article, we aimed to synthesize the available qualitative research to acquire a deepened understanding of what helpful relationships with professionals consists of, from the perspective of persons with SMI. To do this, we created a meta-ethnography of 21 studies, through which ten themes and an overarching interpretation were created. The findings show that helpful relationships with professionals are relationships where the persons with SMI get to spend time with professionals that they know and trust, who gives them access to resources, support, collaboration and valued interpersonal processes, which are allowed to transgress the boundaries of the professional relationship. The overarching interpretation shows that the relationship that persons with SMI form with professionals is a professional relationship as well as an interpersonal relationship. Both these dimensions entail actions and processes that can be helpful to persons with SMI. Therefore, it is important to recognize and acknowledge both the functional roles of service user and service provider, as well as the roles of two persons interacting with each other, in a manner that may go beyond the purview of the traditional professionalism. Furthermore, the helpful components of this

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relationship are determined by the individual preferences, needs and wishes of persons with SMI.

Keywords Helpful relationships · Alliance · Severe mental illness · User's perspective · Meta-ethnography · Meta-synthesis

Introduction

Referred to using concepts such as the therapeutic alliance, working alliance, therapeutic relationship, helping relationship and helping alliance, the relationship with professionals is an integral part of the services of support and treatment directed toward persons with severe mental illness (SMI). This relationship has previously been established as an important predictor of outcome in psychotherapy [1, 2], and has been viewed as one of the most important 'common factors' that explain the success of professional interventions when the specific factors connected to the design and theory of these interventions does not suffice to explain the outcome [3]. Services of support and treatment that is directed toward persons with SMI take place within a wealth of organizational contexts such as psychiatric inpatient care, community mental health services and support provided in people's homes [4]. Despite of these differences in context, it has been indicated that the relationship to professionals can be associated with a more positive outcome also within these kinds of services [4–9].

In later years, there have been an increased focus on the application of evidence based methods and interventions within the field of psychiatry [10]. It has been argued that this focus tends to neglect the large amount of evidence of the importance of the relationship between professional and user in pursuing positive outcome [11] and that an understanding of the helpful components of the relationship between user and professional is of great importance to ensure that service users get to take part of the best services available [12]. It has further been argued that this part of professional training and profession should be a part of a conscious approach to developing the skills needed for professionals [13]. Therefore, it is important to understand what such a helpful relationship consists of.

Corroborating with the view of the importance of the user/patient/client perspective when investigating and developing services, we have in this article put the experience-based knowledge of persons with SMI in focus to investigate the components of helpful relationships with professionals. Although there have been several qualitative studies examining this subject, there has to our knowledge been no previous systematic summary of this research. This article therefore aims to synthesize the available qualitative research to provide a picture of what persons with SMI view as helpful in relationships with professionals.

Method

In order to create an integrative and new interpretation of qualitative findings that is more comprehensive than the findings of individual studies [14], we conducted a meta-synthesis of published qualitative studies that provide knowledge of what persons with SMI find to be helpful in the relationship with professionals. To go about this task we chose to use the

methodology of meta-ethnography as formulated by Noblit and Hare [15], as it provides the means to create an overarching interpretation of the data, preserving the richness of the participants' original accounts by not only aggregating but reinterpreting the existing data [16].

Identifying and Selecting Studies

Inclusion Criteria

Studies were included in the sample for the synthesis if they were peer-reviewed, qualitative studies published in English after 1990, where a majority of participants were persons over 18 years of age that had been classified as having a SMI, and if the study have a main focus on what persons with SMI described to be helpful in relationships with professionals. The definition of SMI tends to vary within research, and adjacent concepts are frequently used. Here, we included studies if at least 50 % of the participants were classified as suffering from SMI or had been diagnosed with schizophrenia, non-organic psychosis, personality disorder, bipolar disorder or major depression.

With reference to the need for an approach where evaluation of quality takes place as a reflexive dialogue, that acknowledges the pluralism that exists within qualitative research concerning approaches to epistemology and methodology [17], we did not use a checklist to evaluate the quality of the studies to be included. Furthermore, in line with the approach presented by Sandelowski et al. [18] we chose to be inclusive and did not exclude any studies on the basis of quality alone. Instead, we used the screening questions as recommended by Campbell et al. [16]; 'Does the article report findings of qualitative research involving qualitative methods of data collection and analysis and are the results supported by the participants' quotes?' and 'Is the focus of the article suited to the synthesis topic?' (p. 674). We excluded any studies regarding which the answer to any of the questions was 'no', as this enabled a screening that started by considering the relevance of the articles in relation to the review subject [19].

Searching and Selecting Studies

Systematic searches were carried out in Medline, CINAHL, PsychINFO, PsychARTICLES, Social Sciences Citation Index (SSCI), Sociological Abstracts, and Social Services Abstracts. After mapping relevant search terms, a search strategy was developed by the first author with the assistance of a medical librarian. The search strategy was deliberately made broad to capture the varying concepts used regarding the subject, using both thesauri of the databases as well as free search terms covering the population ('mental illness', 'psychiatry', 'mental health services'), and relationships with professionals ('helping relation*', 'helping alliance', 'working alliance', 'therapeutic alliance', 'client relation*', 'professional relation*', 'working relation*'). We also limited the search to only include qualitative studies, by using limiters in the database when available or search terms in a full text (qualitative OR "grounded theory" OR "thematic analysis" OR "content analysis" OR "field notes" OR narrative* OR "audio recording" OR "focus group*" OR interview OR etnograph* OR phenomenologic* OR perspective* OR experience* OR view* OR opinion* OR perception*), adapted from a previous qualitative synthesis [20]. The searches were made in full text and were limited to studies published in peer-reviewed journals in English from 1990 onwards.

Carried out in November 2013, the electronic searches produced a total of 5,587 hits between the databases, which were screened and reviewed by title (and abstract when necessary) independently by the first author. This resulted in the exclusion of the overwhelming majority of hits as they were not qualitative studies and/or did not study the population of interest in the synthesis, narrowing the number of potentially relevant articles to 142. These potentially relevant articles were then reviewed by abstracts, leaving 56 articles that appeared to meet the inclusion criteria. These articles were then read in full text by the research team. Of these, 21 matched the inclusion criteria and the research question at hand, and were included in the synthesis. Thirty-five studies were excluded for not studying the population of interest or because they were deemed to insufficiently focus on the subject. Additionally, a manual search was carried out in the reference lists of the relevant studies and published issues of key journals. These manual searches did not result in the inclusion of any further studies (Table 1).

Analysis

Starting the analysis, the studies were read and re-read, and the first author identified and recorded key concepts, themes, metaphors and verbatim quotations of the study participants. Through this the studies were compared and contrasted, and were established to be essentially similar and therefore comparable. This led to the decision to reciprocally translate the studies into each other, translating themes and concepts of one study into the themes and concepts of another [15].

The translation was a cooperative process in which the members of the research team read, analyzed and discussed the included studies. The themes and constructs identified in the studies were compared, juxtaposed and dismantled to create a new and cohesive translation of the findings from the studies. In the creation of a meta-ethnography, the new interpretation created (a third order construct) is twice removed from the original context because it is based on the researchers' interpretations (second order constructs) of the interviewees descriptions of their view of the subject at hand (first order construct), which makes it important to keep the contextual richness of the data [15]. To do this, we continuously returned to the full text studies to be certain not to overlook details from the original studies in the creation of the translation, discussing and analyzing the formulations and interpretations in the group. Through the process of translating the results of the studies, we created an interpretation of what we had found in the included studies, and developed ten themes that guided the third order concepts and metaphors (see Table 2). Through these reciprocal translations, we also constructed an overarching interpretation to encompass the findings from the included articles and to build up a whole from the parts.

Description of the Included Studies

Twenty-one studies published between 2001 and 2012 were included in the synthesis, the details of which are displayed in Table 1. Seven studies were conducted in the USA, five in Sweden, four in the UK, one in Norway, one in South Africa, one in Australia, one in Canada and finally, a multinational study was conducted in Italy, the USA, Sweden and Norway. All but two studies were purely qualitative in their methodology; the two exceptions being combined qualitative and quantitative studies. All but one study used individual interviews as the technique for data collection, while one study used focus group methodology.

Table 1 Description of the included studies

Citation	Country	Aim	Design	Context	Participants
Andreasson and Skärsäter [21]	Sweden	To describe patients' experiences of care in compulsory treatment for acute onset of psychosis	Phenomenography Open-ended interviews	Two units for psychotic disorders at a psychiatric clinic in southern Sweden	12 persons diagnosed with a psychotic disorder; schizophrenia (5), delusional disorder (2), schizoaffective disorder (1), non-specified non-organic psychosis (3). Experience of being compulsorily admitted 7 men, 5 women. 3 between 18–35 years of age, 5 between 36–46 years of age and 4 between 47–65 years of age
Borg and Kristiansen [22]	Norway	To explore helping relationships with professionals from the perspective of service recipients	Qualitative, open-ended and in-depth interviews Phenomenology	Persons in recovery from SMI	15 persons in recovery that had been treated for SMI. Diagnosed with schizophrenia (9), schizoid personality (1), paranoid psychosis (1), affective psychosis (2), personality disorder (1), borderline psychotic personality (1) 7 women, 8 men. Age range 29–63
Buck and Alexander [23]	USA	To explore early alliance formation between consumers with schizophrenic-spectrum disorders and their case managers from the consumers' perspective	Structured interviews Grounded theory	19 suburban and semi-rural based services agencies providing Intensive Case Management. Participants that were recruited to the study used case management services and were interviewed after 9 months in service	55 persons, 50 % diagnosed with schizophrenia and 50 % diagnosed with schizo-affective disorder Equally divided between men and women. No data on the participants' age

Table 1 continued

Citation	Country	Aim	Design	Context	Participants
Denhov and Topor [24]	Sweden	To explore service users' experiences of helping relationships with professionals	Grounded theory Secondary analysis of qualitative data three previous studies Qualitative, open-ended interviews	Study 1: persons who were shortly to be discharged from 4 psychiatric 24-hour care units Study 2: persons who visited psychiatric outpatient care on randomly selected days Study 3: persons in recovery, with diagnosis of SMI and with previous hospitalization but not in the two years prior to study	Total: 71 persons with SMI, 33 men and 38 women Study 1: 29 persons with SMI; chronic schizophrenia, schizophrenia, psychosis, mania, visual and hearing hallucinations, substance abuse, anxiety, depression and suicidal tendencies. 16 men and 13 women. Age range 19–80 Study 2: 20 persons with SMI; Burnout, borderline personality disorder, depression, crisis, psychosis. 9 men, 21 women. Age range 25–70 Study 3: 12 persons with SMI; Schizophrenia, psychosis, bipolar disorder, personality disorder. 8 men, 4 women. Age range 24–51
Galon and Graor [25]	USA	To describe the social process of engagement in primary care treatment from the perspective of persons with severe and persistent mental illness	Grounded Theory Semi-structured interviews	Urban Community Mental Health Center that specifically serves persons with severe and persistent mental illness in the Midwest, USA	32 persons with severe and persistent mental illness, diagnosed with schizophrenia (14), bipolar disorder (15), depression (5), anxiety, (1) attention deficit disorder (4) 17 women, 15 men. Age range 24–68 years, average 42, 34 (SD 12.5)

Table 1 continued

Citation	Country	Aim	Design	Context	Participants
Green et al. [26]	USA	To examine the clinician-patient relationship in the context of relational continuity	Part of mixed-methods, exploratory, longitudinal study of recovery for persons with SMI Data derived from information collected at baseline: Two in-depth interviews Questionnaire (data not included in synthesis)	A non-profit, prepaid, group model, integrated health plan, that provides outpatient and inpatient medical, mental health, and addiction treatment	177 persons with SMI; schizophrenia, schizoaffective disorder, affective psychosis or bipolar disorder 92 women, 85 men. Average age 48, 8 (SD 14,8) years, ranging from 16 to 84 years
Järkestig Berggren and Gunnarsson 2010	Sweden	To describe what service users find to be significant features of their working with their personligt ombud (PO)	Narrative, open-ended interviews Phenomenology	Persons taking part in a personligt ombud (PO) service	23 persons with severe mental health impairments, extensive experiences of psychiatric and social services, none had been admitted to hospital care in the previous two years prior to being interviewed 6 men, 17 women. Age range 19–62 years
Langley and Klopper [27]	South Africa	To develop a practice-level model for the facilitation of the mental health of the client diagnosed as having borderline personality disorder	Individual and focus-group interviews (with both service users and professionals)	Psychiatric Community Services	6 persons with borderline personality disorder 5 women, 1 man. No data on participants' age (14 professionals)

Table 1 continued

Citation	Country	Aim	Design	Context	Participants
Laugharne et al. [28]	UK	To investigate the experiences and attitudes of patients with psychosis in relation to trust, choice and power	In-depth interviews Thematic analysis	An enhanced care program with mental health services in Cornwall, and a day hospital for acute treatment in east London	22 persons with a psychotic illness; schizophrenia or schizo-affective disorder (6), bipolar disorder, (7) psychosis (7), under care of secondary mental health services 10 women, 12 men. Age range 21–62
Lester et al. [29]	UK	To explore elements of satisfaction with primary care for people with schizophrenia	Semi-structured interviews	Participants identified through caseloads of six North Birmingham Community Mental Health Localities	45 persons with schizophrenia, had used primary care services at least at one occasion during preceding 12 months 20 female and 25 male. Age range 28–65 years (median 47, 8/mean 47,7)
Nehls [30]	USA	To explore case management services from the perspective of community mental health center clients with borderline personality disorder	Interviews Interpretive phenomenology	Persons who had been assigned to a case manager for at least 6 months, recruited from a community mental health center	18 persons with borderline personality disorder 17 women, 1 man. Age range 33–51 years
O'Brien [31]	Australia	To construct an interpretation of the experience of nurse-patient relationships in the context of community psychiatric nursing	Hermeneutic phenomenology Interviews 4 clients interviewed 3 times, 1 client interviewed twice	All participants had formed a relationship with a community nurse	5 persons with serious and persistent mental illness, diagnosed with a mental illness according to the DSM-IV, with a duration of at least 2 years All women. Age range 22 to 67 years

Table 1 continued

Citation	Country	Aim	Design	Context	Participants
Priebe et al. [32]	UK	To explore views of disengagement and engagement held by patients of assertive outreach teams	In-depth interviews Thematic analysis and grounded theory	Specialized assertive outreach teams, covering inner-city and suburban areas, and both statutory and voluntary services	40 persons that had previously disengaged with secondary mental health services, but had later engaged with an assertive outreach team. 33 diagnosed with schizophrenia or psychosis-related disorder and 7 as having psychotic symptoms as part of a mood disorder 11 women, 29 men. Mean age 40 years
Tidefors and Olin [33]	Sweden	To investigate how patients, based on earlier experiences, described their wishes and needs regarding the psychiatric care system	Focus-group interviews Inductive thematic analysis	All participants were in regular, ongoing contact with an open psychiatric care unit specializing in treating individuals with psychotic disorders	15 persons with a psychotic disorder 4 men, 11 women. Age range 20–45 years
Topor and Denhov [34]	Sweden	To investigate how persons diagnosed with SMI describe important aspects of time in establishing and maintaining helpful relationships with professionals	Semi-structured interviews Grounded theory	Persons in recovery; not having been hospitalized for at least 2 years prior to the study, and a self-assessment of having recovered or being in a recovery process	58 persons with SMI; schizophrenia, bipolar disorder and personality disorder 29 women (50 %) 29 men (50 %). Age: 5 (9 %) 18–30, 23(40 %) 31–44, 22 (38 %) 45–60, 8 (13 %) 61–
Topor et al. [35]	Multinational study; Italy, USA, Sweden and Norway	To examine the specific aspects that characterize other people's actions when helping in the recovery process	Open-ended, narrative interviews	Persons in recovery; who regarded themselves as recovered and had not been hospitalized for the previous 2 years	12 persons with schizophrenia (9), major depression with psychotic features or paranoid psychosis (3) 5 men, 7 women. No data on age of participants

Table 1 continued

Citation	Country	Aim	Design	Context	Participants
Tunner and Salzer [36]	USA	To examine opinions of forty individuals diagnosed with schizophrenia as to what constitutes quality treatment	Semi-structured interviews Grounded theory	Two large community mental health agencies in Philadelphia	40 persons with schizophrenia-spectrum disorder, had been a consumer at the CMHC and currently receiving case management services for at least a year and had received psychiatric services at the agency for at least a year 18 men, 22 women. Age range 22–68 (mean age 47, 8).
Ware et al. [37]	USA	To describe concepts of good care in relationships with psychiatrists, therapists and case managers from the perspectives of low income persons with psychiatric disabilities	Semi-structured interviews Grounded theory	Medicare managed mental health care	51 persons with psychiatric disabilities and a diagnosis of schizophrenia, enrolled in Medicaid 12 women, 39 men. Age range 26-59 years, mean age 40, 5 years
Williams and Tufford [38]	Canada	To explore professional caregiving from the perspectives of persons diagnosed with schizophrenia to develop professional competencies for promoting recovery	Semi-structured interviews	Persons with schizophrenia, recruited through advertisements in community services	40 persons with schizophrenia 19 women, 21 men. No data on age of participants
Wright et al. [39]	UK	To explore the nature and meaning of engagement for practitioners and service users within assertive outreach services	Philosophical hermeneutics In-depth, semi-structured interviews (with both service users and professionals)	Assertive outreach team	13 persons with bipolar disorder (3), schizophrenia (8), schizo-affective disorder (2) 7 male, 6 female. Mean age 29 (14 professionals)

Table 1 continued

Citation	Country	Aim	Design	Context	Participants
Young et al. [40]	USA	To explore consumer perspectives on the role of personal growth-related risk-taking in the recovery process, to examine consumer perspectives on clinician's roles in taking on new activities and opportunities, and to explore clinical approaches that patients identify as most helpful in making significant changes	In-depth, semi-structured interviews 4 per participant over a 24 month period (Based on the same data set as Green et al., 2008)	A non-profit, pre-paid, integrated group model health plan serving ca 480,000 members, that provides comprehensive inpatient and outpatient medical, mental health and addiction treatment services to its members	177 members of the health plan with serious mental illness. 52 % female, 48 % male

Settings varied among the studies, and whereas a number of studies did not have any connection to any particular type of service, settings covered in the studies were assertive outreach services, inpatient psychiatric units, psychiatric community services, primary care services, and case management services. One study was set in a service called *Personligt ombud* (PO), which is provided by a professional in a freestanding organizational position with the assignment of providing support to identify and formulate the needs of the service users and to supervise the coordination of the support and care from different caregivers. Participants in the studies described relationships with a number of different kinds of professionals that they had met during their contact with support and care services. Whereas many studies described professionals in general, the findings included descriptions of relationships with case managers, psychiatrists, community psychiatric nurses, therapists, POs and primary care providers. Six studies had the explicit aim of investigating participants' perceptions of relationships with professionals or specific aspects of this

Table 2 Themes and concepts/metaphors

Theme	Concepts/metaphors
To know and to trust	Know Trust
Time and availability	Long-lasting relationships Sufficient time Availability Affective availability
Advantages tied to the professional position	Holder and provider of competence, skills and knowledge Distinctive role in relation to social network Authority in relation to other professionals and organizations
Provider of support	Provider of support Helping individuals to look and move forward A secure and stable person in troubled times
Someone to be with and talk to	Company Talk Listen
Working together to see to the needs of the individual	Flexibility and sensitivity Working together Share decisions
Being recognized as human being	Treated as a human being Acknowledge totality of person Acknowledge strengths and positive sides of life Respect Accept
To matter to the professional	Caring Showing genuine interest Understanding Conveying empathy
Beyond the roles of service user and service provider	To meet as two persons Getting extra things Continuing after formal contact has ended
Shared humanness	Professionals appreciated as individuals 'Fit' together Sharing a common ground

relationship, whereas the remainder of studies examined specific aspects of this relationship, helpful aspects of other people in general, or subjects such as engagement and disengagement in services, experiences of care and treatment, or examined users' experiences of using specific services, or specific subjects connected to the delivery of services.

An approximate total of 750 persons with SMI were interviewed in the included studies, five being the smallest sample used and 177 the largest. Approximately 377 (50.3 %) of the participants were women and 373 (49.7 %) were men, and the age range was 16–84. All participants were described as having some kind of SMI. Not all studies provided information about the diagnoses of the participants, but common diagnoses among the participants were schizophrenia, schizoid personality, schizoaffective disorder, paranoid psychosis, affective psychosis, personality disorder, borderline personality disorder and bipolar disorder.

Results

In this section, the ten themes created through the reciprocal translation are presented, followed by the overarching interpretation. The themes are interconnected to each other and should be understood as distinguishable parts of a whole. Many of the themes contain actions and processes that can be understood both as helpful by themselves, as well as preconditions to facilitation of further helpful components in the relationship.

To Know and to Trust

This first theme reflects components of the relationship that can be understood as basic in the establishment of a relationship. Individuals in the studies say they find it helpful if they know the professionals they meet [24, 33–35], and if the professionals know them and are familiar with their situation [24, 26, 29, 31, 34, 35, 37, 38, 40].

> I've been spared those really serious psychoses whenever I've come to staff who know me from before. Things have worked out quite good because then you talk about it for a couple of hours and then things calm down. Those times I've known who the staff were, it went really well. [24, p. 419].

Furthermore, trust is a concept used to describe relationships with professionals that are helpful [22, 27, 29, 41]. This entails to feel trust in professionals [21, 22, 24–28, 31–33, 35], as well as having mutual trust in the relationship, where the trusted professional trusts the individual in return [26, 28, 32, 35, 40].

> Know the person you're with, the patient or the doctor, either one… you have to establish a good relationship with them… You have to trust the person. I don't know if that's the doctor being able to trust the patient being able to do more, because it works both ways… The patient has to trust the doctor [40, p. 1434].

Time and Availability

For the relationship with professionals to be helpful to individuals, there is a need for time and space to be provided within it. One basic, helpful component is the opportunity of having long-term relationships [22, 24, 26, 28–30, 32, 34, 37]; something that is described as providing continuity [22, 24, 26, 28, 29] and consistency [32]. Trust can take a long time

to develop [27, 31] and this can be facilitated by long-term relationships [24, 26, 28, 29, 32]. Having relationships that lasts over time also makes it possible to really get to know each other [24, 26, 29, 34, 37, 40], and gives the professionals better background knowledge to help with treatment and support [26, 30, 40]. It is also appreciated to have sufficient time for helpful processes and actions to take place [22, 24, 26, 27, 31–34, 38]. "I had Lotta; at first I didn't like her, but after a while I liked her much better. It takes time to get to know someone" [34, p. 243].

To have regularity in seeing professionals can promote a feeling of security regarding seeing the professional again and when that will happen [28, 33]. Furthermore, for professionals to be physically available, to be accessible and acknowledge requests when they occur [23, 24, 27, 29, 31–34, 37, 38, 41] and be able to help when challenges arise [22, 23, 27, 30, 31, 36, 39, 41] is described as helpful. In addition, what can be called affective availability is described in the studies. This pertains to the fact that a professional is available for the individual because s/he cares about them, being there as a person for them [23, 26, 27, 30, 31, 41]. "She was there for me, not for her job or the system, but because she wanted to be" [23, p. 476].

Advantages Tied to the Professional Position

Several helpful components can be described as connected to the professional position in itself. Professionals are appreciated as helpful by individuals by being a holder and provider of knowledge, competence and skills tied to the professional role [21, 24–28, 31, 33, 35, 38, 41]. Moreover, professionals can serve as an important source of information for individuals. By providing information about things such as the care system, mental illness, medication, and rights and obligations, professionals can provide individuals with a wider understanding of the situation and how to handle it [21, 28, 29, 31, 33, 35–38, 41]. "She understands me, but she's trained for that. She has trained to be a nurse, she's trained in psychiatry. That's how she has the kind of knowledge that an ordinary person in working life doesn't have'' [35, p. 28].

Furthermore, professionals play a distinctive role in relation to others in the social network, and the relationship with professionals is described as distinctive from personal friendships [22, 24, 31, 35, 41]. Certain aspects that are described as distinctive of the professional position are cited as helpful, such as that the professional is bound by confidentiality [24, 27, 36], is not connected to the social network of individuals, has unending patience, and is someone with whom problems and needs can be discussed [24]. Furthermore, the distinctive position of professionals is also described as helpful as it entails being persons that individuals can talk to about things that they do not dare speak with others about because of the risk of being misunderstood [31] or stigmatized [41].

The professional position also entails a certain position in relation to other organizations and professionals. This can be of help to individuals by making the professional capable of claiming or mediating resources or support to them [21, 29, 33, 35, 36, 41]. By acting like allies [21, 31, 41] and working together with [38] or exerting influence over [22] other professionals and organizations, professionals can be helpful by making sure individuals get the support and care they need. "… the authority I needed. She could push a little if they don't listen to me…" [22, p. 500].

Provider of Support

Participants in the included studies express appreciation for the concrete support that professionals have provided in terms of help with medication [36], practical, everyday life support [21–23, 30–33, 35, 36, 39, 41], support directed at the individuals' social life [23, 31, 32, 35, 36, 38, 41], and particularly support that is experienced as related to their life as a whole and not narrowly focused on mental illness [30, 31, 38, 41].

The supportive role of professionals can entail giving positive feedback [25, 26, 36], helping individuals to look and move forward, encouraging them to reach established goals [26, 33, 36, 38, 40], and conveying hope about the success of treatment and for the future [22, 26–28, 33, 39, 41]. This supportive role can also mean being a secure and stable person in troubled times, being there to help, being someone to lean on in times of crisis [22, 27, 28, 30, 31, 33, 39, 41], and being calm and confident when individuals experience distress [21, 27, 38]. The supportive role is also demonstrated by the professional taking control and making decisions when individuals are not able to do so for themselves [21, 27–29, 31].

> I wouldn't feel safe I would be anxious all the time if I didn't have like [care coordinator] around you know I do see him as a safety net you know sometimes I do fall on him and he catches me [39, p. 828].

Someone to be with and Talk to

An elaborate part of the appreciated support can be understood as being someone that individuals can be with and talk to. The company of professionals is something that is described as positive by participants—'company of professionals' meaning having someone to be with [21, 22, 33] or doing social things with [23, 28, 32, 38, 41].

Talk is something that is cited as helpful in a number of ways. Talking to professionals is by itself appreciated [24, 33, 38, 39]. Individuals in the studies cite it as helpful to be able to talk freely to professionals, not fearing that they will take measures that are unwanted [32, 37], and for individuals to feel that they are able to disclose sensitive information [40]. Also appreciated is to have comfortable relationships with trusted professionals where issues can be discussed openly, having the opportunity to address challenging questions within the relationship [22, 30], as it is important to have good communication about the situation and matters that might arise [26, 32, 40]. Participants in the studies describe talk about problems and distress as something that is helpful to them [32, 35, 41], but also express a specific appreciation for talking about things not directly connected to problems, illness or treatment [22, 27, 28, 35, 38], and for talking about ordinary and everyday subjects [21, 31]. Talking can be helpful through the fact that it can give different perspectives that can help individuals in understanding and handling the issues [21, 24, 31, 35–37, 39, 41], and can help individuals to focus on other things than the distress they experience [21, 27]. Furthermore, for the professional to listen to the individual is appreciated in itself [24, 28, 30, 32, 33, 36, 37, 39] and just telling someone about matters that are on their mind is described as helpful since it has a "venting" function [24, 30].

> I think they could talk to me more often. I think it's good, if you're lost in your own psychotic thoughts, then it's good to be a little distracted… get something else to think about… It doesn't have to be about illness. It can be about the weather, sports, or whatever. I think they could do that more. Talk to the patients [21, p. 18].

Working Together to See to the Needs of the Individual

For the relationship with professionals to be helpful, the priorities and needs of the individual should be the focus of the relationship and of the provision of support, and professionals should be flexible and sensitive in relation to the individual's own view of his or her situation and preferences [21, 22, 26, 27, 29–35, 40, 41]. "Treats me as the best person to know how I'm feeling" [37, p. 557].

This sort of sensitivity and flexibility can be needed in providing treatment and setting boundaries in the relationship [21, 26, 27], in making appointments [34, 37], and in giving information [21, 31, 33, 38]. Individuals point out the helpful qualities of professionals being sensitive to changing needs in times of crisis [21, 22, 31, 33, 34, 41], in different stages in the relationship [24, 34] and in relation to their nationality and culture [36].

To have actual influence over the support and treatment provided through the relationship, working actively on the therapeutic agenda rather than being passive receivers of care is also something that is described as helpful [21, 22, 25, 26, 30–33, 35, 37, 39, 40]. Participants express appreciation for the professional sharing power within the relationship [22, 31, 35], acknowledging and strengthening the individual's independence [21, 36] and helping individuals realize their ability to act on their own behalf [25, 30, 41].

> Anyhow, I felt that I was involved somehow… they were very good… had good contact with them, thought they listened to me, to my own thoughts about what I wanted to do, and they tried to encourage me to do it [33, p. 5].

To share decisions within the relationship is described as an important part of gaining influence and cooperating with the professional [21, 25–33, 35, 37, 40, 41]. Participants in the studies cite several actions taken by professionals that facilitate this sort of collaboration and flexibility, such as providing information regarding the situation and available options [21, 25, 26, 28, 29, 33, 37, 38], being honest regarding these options in treatment [25], and helping individuals to formulate their needs and goals when needed [33]. At the same time, some of the interviewees explicitly expressed wanting professionals to make the decisions regarding support and treatment [28, 29].

Being Recognized as a Human Being

To be allowed to be more than a user, patient, diagnosis or a crazy person is something that is helpful to individuals diagnosed with a SMI. It is helpful to be treated as a human being [21, 22, 24, 27, 30–33, 37, 38]. This can partly be understood as having the totality of the individual's person acknowledged by professionals, being treated like a person who actually has a life beyond mental health problems and care relationships, that has other things, situations and people that are important in life, and getting to talk about and have needs recognized that are connected to other things than mental illness [22, 27, 34, 35, 37–39].

> He wants to know about everyday things, not just how are your pills.… It is broader. That makes up you know, it's a better relationship and you feel oh, you know I wouldn't mind sharing what I do.… But when it was very patronising I just put shutters up [32, p. 441].

This totality entails more than symptoms and problems, and it helpful to have strengths and positive aspects recognized, by being treated as persons who have a healthy side to their life [21, 22], and as capable individuals who have strengths worth acknowledging [25, 30, 33, 34, 36–38]. Furthermore, individuals describe it as helpful to be accepted for who they are [25–27, 31, 36], to be believed [25, 26, 39], and to be respected, by having their experiences, thoughts and opinions really listened to in the relationship and in treatment [21, 22, 25, 27, 30–33, 35, 37, 38].

> …he was a good doctor. He would listen to me because I studied vitamins so he would like to catch up on the latest fields that I read about.… And he didn't laugh at me or anything. He would listen to me and ask me questions about stuff. And we had a very good rapport together. And he respected me very much [38, p. 196].

To Matter to the Professional

Some of the helpful components found recurrently in the studies are connected to individuals getting to experience that they matter to professionals.

As one part of this, to get to feel that the professional cares about how they are doing is described as helpful [21, 22, 24–28, 30, 34–38]. This caring and concern can mean that individuals experience that professionals remember them, think about them and what they are doing, and check on them to make sure they are well [25, 26, 34, 35, 38] and convey a willingness and dedication to really help them [21, 22, 35, 36].

Furthermore, to convey a genuine interest in the individuals and what they have to say by listening carefully, being focused and paying attention during meetings is regarded as helpful [21, 22, 24–27, 30–34, 37, 40]. Having professionals understand their experiences of things [22, 25, 26, 31, 33–36, 38, 39], having the professional try to understand [27, 31], and convey empathy for the situation that the individuals are in and the suffering they are experiencing [21, 22, 25–27, 31, 37] are also cited as helpful.

> She has a good tone (to her voice), smiles, gives eye contact, and addresses me by name. Nobody wants to feel like a case file, nobody wants to feel like a number. Everybody wants to feel like they are special…like you are actually taking an interest in me [25, p. 277].

Beyond the Roles of Service User and Service Provider

Relationships that are appreciated as helpful are described as mutual and equal, and allow for professionals and individuals to step out of the standardized and hierarchical roles of the professional relationship and be allowed to meet as two complex persons [27, 35, 38]. In relation to this sort of relationship, the professional is viewed as being 'like a friend' rather than solely a professional [22, 26, 41], a comparison that is used when describing helpful relationships with professionals [24, 25, 30, 31, 35, 37]. This can be understood as connected to the experience of the professional finding a value in the relationship [35], and to the relationship being emotionally reciprocative [41].

> I considered all the psychiatrists and therapists… they were just there because they were making a buck. But with him, I don't see it that way.… I consider him as a friend and as a therapist. He's there if I need to talk to him, and he's there if I don't need to talk to him. So it's just the best relationship [30, p. 8].

To do something extra is another way in which professionals are described as helpful; a way that can go beyond the standardized roles of the formal relationship. For professionals to give more time when needed, giving of their personal time or fitting clients into a busy schedule [22, 24, 26, 34, 35], giving a gift or lending money [22, 24, 26, 35, 41] or giving a ride [37, 41] are described as examples of acts that seem small but have a symbolic value. This symbolic value lies in the fact that they go beyond what individuals would think of as reasonable to expect from professionals, and because they sometimes cross the boundaries set up for the relationship and support of the organization, making the individuals feel valued and cared for by professionals. This can also give the sense of being special to the provider, getting special treatment in comparison to other users [34, 35]. "She didn't have to do that" [37, p. 556].

To have the relationship with the professional continue after the formal contact has ended is another, very concrete way, of stepping out of the roles of professional and user. This is something that can be helpful, as it can provide an opportunity for the individuals to get support when problems arise [31] or to form a new kind of relationship where contact is maintained without the need for support [34].

Shared Humanness

The helpful components of relationships with professionals are also attributed to individual professional helpers, who are described by their unique ways of being and acting as individuals, and by certain interpersonal competencies, such as being kind, patient and involved [22, 24, 27, 29, 34, 35]. In some of the included studies, the helpful components of the relationship were linked to whether individuals and professionals 'fit' together, having to do with a chemistry or connection, specifically being related to individual characteristics of the professionals, as well as their approach to the relationship and provision of support [22, 24, 26, 28, 31, 37, 38]; "I connected with him…I took to him straight away- I can't tell you why" [31, p. 181].

For individuals to get to experience that they share common ground with professionals is something that is also described as helpful. This can mean having a mutual relationship, where both contribute to the relationship, and share characteristics or experiences on the basis of being human, rather than being service users and service providers [35, 38]. Examples of this is to share things like physical attributes, religion, race or ethnicity [37], gender, age, religious or world views with the professional [26], or knowing personal or family facts about the professional [26, 28, 41], about the professional's history [31], or about experiences of mental illness that the professionals themselves or someone close to them have [24]. Having these kinds of things in common with professionals and knowing these things about professionals can give a sense that they are better able to understand them and their experience [24, 31]. They can also be a way of deemphasizing the differences in power and status [35, 37] and can strengthen the picture that individuals have of themselves [26, 41].

> I've got a very good CPN… she knows a lot about my personal circumstances, she knows I've got two daughters and knows I want to be part of their lives… She's got a nice personal touch to her, she tells me about her family and things [28, p. 498].

Participants in the studies state that this sort of closeness varies between different relationships, some wanting more of a interpersonal distance than others [26], and some say they prefer not to know things about professionals' personal experiences of mental illness [24].

Overarching Interpretation: The Two Dimensions of the Relationship with Professionals

The helpful components of relationships between persons with SMI and professionals within support and care services as described above can be seen as a dynamic interplay of interpersonal processes. The professional and his or her attitudes, behavior and actions within the relationship play a crucial role in making these interpersonal processes helpful to individuals. Professionals can be helpful with regards to the resources they hold, by acknowledging the user as an individual and by transgressing the boundaries of the professional relationship. The helpful components of this relationship seems to be related to having and creating the time and space to get to know and trust individual professionals and having them behave, act and provide support in certain ways, ways that we have come to understand as being encompassed in two co-existing dimensions within the relationship. These dimensions can be described as follows:

- The professional dimension. In this dimension of the relationship, the person needing help becomes a user and receiver of care and support, and the other person has a designated role as a professional and a provider of care and support. This entails helpful components that make this relationship distinct from other relationships.
- The interpersonal dimension. This is a relationship between two persons; thus there is potential for valued interpersonal processes to take place within it. Many components that can be helpful to individuals relate to these interpersonal processes, and are connected to the professional and individual as persons rather than their roles as service user and service provider, and go beyond these roles and boundaries that is defined by the situation and organization.

The helpful components of the relationship as identified in the included studies can be understood as being encompassed by these two dimensions, and can be found within them both. Some of the components are connected more directly to one or the other dimension, while others are connected to both the dimensions. Other components are explicitly connected to the distinction made between the two, specifically to actions that the users themselves refer to as going beyond boundaries or actions that are specifically connected to the professionals' distinctive role as a professional. This puts light not only to the way the distinction between the professional and the interpersonal is visible to service users, but also to the fact that it can play a significant part in their understanding of what is helpful within this kind of relationship.

While both these dimensions contain potentially helpful components, one or the other is on its own not sufficient to understand the helpful aspects of this relationship. This underlines the importance of recognizing and acknowledging the existence of both the functional and predefined roles of the service user and service provider, as well as the roles of two persons interacting with each other. The two dimensions can thus be seen as two different poles, where the standardized and regulated roles and processes are on one side and the personal and interpersonal roles and processes are on the other. To facilitate a helpful relationship, actions and processes within the relationship should be allowed to move between these two poles. The individual user and his or her preferences, needs, preconditions and opinions are central to the understanding of how this movement should be directed within relationships.

Limitations

One methodological issue regarding the creation of this meta-synthesis is connected to searching and including studies. Within the aims and frames of meta-ethnography, the emphasis lies on creating a wider image of the studied subject rather than making a comprehensive search [19], which is set in contrast to including a large number of studies [18]. Nevertheless, we have attempted to obtain a comprehensive picture of the available research by systematically searching the field. This is a difficult task, with an imminent risk of missing or leaving out relevant studies.

The studies included in the synthesis differ from each other in a number of ways. Creating a synthesis of this kind provides potential for a wider understanding of what it is in relationships with professionals that can be helpful for persons with SMI, but is a difficult task as the themes in the different studies are elusive and complex. To create an overarching description inevitably takes away some of the value of the original descriptions. Moreover, the process of synthesis includes the risk of the third order interpretation going beyond the empirical contents of the studies [42]. With this in mind, we have attempted, in as thorough a way as possible, to provide transparency with regard to the creation of the meta-ethnography.

Discussion

The results of this meta-ethnography show that it can be helpful to individuals to have a relationship where they get to spend time with professionals that are known and trusted, who give them access to appreciated support, collaborative work and valued interpersonal processes, which is allowed to go beyond the boundaries of the professional relationship. Our overarching interpretation connects the helpful components of this relationship both to the specificity of it being a professional relationship, and to the fact that it is also an interpersonal relationship between two human beings. The helpful components lie in both these dimensions of the relationship, and are determined by the specific preconditions, needs, wishes and preferences that the individual has. Understanding how relationships with professionals can be helpful is thus not about establishing a fixed image of what persons with SMI want, but rather being open to the fact that this can vary.

The importance of allowing for actions and processes *both* in the professional and the interpersonal dimension of the relationship might be seen as self-evident, but stands in contrast to a traditional understanding of the professional role. In accordance with such an understanding, the distinction between professional and amateur is made out by certain rules that the professional must adhere to, and that creates a distance between the professional and the service user [43]. According to Parsons [44], these rules ensures that the professional role is a neutral one, which is intended to make it possible for the service user to tell the professional about his or her private life. To uphold this professional neutrality, professionals are not to talk about themselves or their personal lives, nor engage in reciprocal relationships with their patients, as this is thought to pose a serious threat to the treatment outcome and explain failure in therapy [44]. While other ideals of the professional role more often recognize the need to balance this neutrality and distance by the professional being human in the relationship with service users, this personal closeness is expected to be supplemented by a professional distance to avoid the risk of becoming too close to the user [45]. The findings of this synthesis clearly shows that the professional role in itself can be of help to persons with SMI, but also stretches the notion of helpful

components to also entail actions and processes that clearly go beyond this neutrality and distance. This ideal of a neutral and distant professionalism may from this view actually be limiting the helping potential of the relationship, as they do not go in line with the full picture of what persons with SMI themselves cite as helpful. The lack of congruity between professionals' notion of professionalism and what users' actually want from professionals have been noted also in earlier studies [45, 46].

Having the possibility to have a relationship where the professional and the individual can step out of the strict roles and boundaries of these formalized relationships is identified as helpful to individuals in this meta-ethnography, as well as elsewhere [43]. At the same time, some of the included studies give examples of how individuals have different preferences when it comes to interpersonal distance and having a personal touch in the relationship [26, 34]. This once again underlines the importance of not trying to find a 'one size fits all'-remedy for how relationships can be helpful, but to be open to different ways to make them this way.

The relationship that persons with SMI form with professionals entails an asymmetrical power relationship, where the professionals have power over the individuals. This power is closely connected to the fact that the professionals' knowledge is regarded as being superior to the lay knowledge of service users, and something that is common to all professional helpers in relation to their clients [47]. This asymmetry of power can be understood as something that permeates the relationship, because it is connected to the hierarchical relation between the professional and theoretical discourse that professionals hold through their training and their formal position within services, and the discourse of the service user which is further down in the discursive hierarchical order [48]. For professionals to collaborate with the individuals can from this angle be understood as an equalization of the power, by which the discourse of users of services becomes a significant factor within the relationship. At the same time, the power that the professional holds as an expert within the organization and the resources that come with this are also described as things that can be helpful to individuals. Participants in the studies thus express an appreciation for relationships where they are allowed to use the resources of the professional and the power he or she has, but in a way that is based on the terms of the individuals, with power being shared with him or her.

Meanwhile, participants in the studies also expressed appreciation for having the possibility of professionals making decisions when they, because of illness, cannot do so by themselves [21, 27–29, 31], and some preferred the professionals to make decisions regarding support and treatment [28, 29]. This pinpoints the need for professionals to be sensitive to individuals' preferences, needs, wishes and opinions, and to differing contexts and situations, also with regard to the process of decision-making. Individuals differ, and for the relationship to be helpful, the task of professionals can be interpreted as being open to this fact and being willing to act in accordance with it.

Although the different contexts and the relationships that are described differ regarding the professions the professionals have, and although the participants in the studies differ in terms of their personal characteristics and the kind of SMI they were described as having, the findings in the included studies were found not to refute each other. With this stated, it is important to keep in mind the impacts that context and individual conditions have. One thing that could imply such a difference between contexts and the implications they have on the relationship and its form and the conditions that they offer for it to develop, is that not all themes or components are mentioned in all the studies. This could be interpreted to mean that different services and contexts offer possibilities of helpful relationships which occur in different ways and to different extents.

Factors such as gender, ethnicity, sexuality or social class, and the structures tied to them are important for the understanding of mental health and illness [49, 50]. In this metasynthesis, no comparisons regarding such characteristics of participants were possible because of the lack of these perspectives and comparisons within the included studies. Studies with a gender perspective on SMI have specifically described some differences in how men and women experience relationships with professionals to be helpful [51]. Fully taking these sorts of factors into account, also within studies of the relationship with professionals, is important in order to obtain a comprehensive understanding of the complex meanings that this relationship can have to individuals.

It is important to note that while this synthesis takes into account the important and often neglected perspectives of persons with SMI, the perspective of professionals is also an important one to consider in order to grasp the full picture of this relationship. Further, the scope of this meta-ethnography has been limited so that it does not include descriptions of the unhelpful or hindering components of such relationships. Several of the included studies touch on this subject, and several other studies provide a deeper understanding of these components and dimensions of relationships with professionals [52, 53], and to know about the unhelpful components is an important part of the understanding of these relationships and the helpful potential described here.

Although it is not only methods and manuals that ensure positive outcomes among users of services, this synthesis does not mean to imply that it is only the relationship with professionals that does so. Methods and theories are important parts of service delivery [3]. Further, according to Frank and Frank [54] the existence of a positive relationship and the professional's adherence to a certain technique can reinforce each other; the relationship can facilitate the professional's adherence to a certain technique or manual, which in turn can contribute with a feeling of security in both professional and user, contributing to building trust and enabling the continued work. Thus, research on common factors as well as research aiming to identify efficient interventions can contribute to the development of efficient services.

Within our results, the helpful factors are to a great extent associated with the professional's ability to be sensitive to the individual and the situation, and to take this into account when deciding how to behave and act within this relationship, something that would demand some level of improvisation from the professional when it comes to actions and decisions within the relationship. The relationship is a dynamic interplay between the two individuals that have been given the roles of service user and service provider in a given context, demanding that both of them improvise in relation to each other. How this can relate to the effort to develop standardized and manual-based methods and interventions that is often stressed within research is a fruitful question that would be a suitable subject for future research.

Conclusion

The findings of this synthesis show that relationships between persons with SMI and professionals in different services of care and support should be recognized as being a relationship between a service user and a service provider, as well as a relationship between two persons. Both these dimensions of the relationship entail actions and processes that can be helpful to persons with SMI, and the helpful components of this relationship can be found both within and without the purview of traditional professionalism. Furthermore, the findings emphasize that the preferences, needs, opinions and wishes of

persons with SMI is central in order to understand what helpful relationships with professionals consist of.

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References

1. Horvath AO, Del Re AC, Flückiger C, Symonds D: Alliance in individual psychotherapy. Psychotherapy 48:9–16, 2011.
2. Martin DJ, Garske JP, Davis M: Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. Journal of Consulting and Clinical Psychology 68:438–450, 2000.
3. Wampold BE: The great psychotherapy debate: Models, methods and findings. Mahwah, Erlbaum, 2001.
4. McCabe R, Priebe S: The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. International Journal of Social Psychiatry 50:115–128, 2004.
5. DeLeeuw M, Van Meijel B, Grypdonck M, Kroon H: The quality of the working alliance between chronic psychiatric patients and their case managers: Process and outcomes. Journal of Psychiatric and Mental Health Nursing 19:1–7, 2012.
6. Catty J, White S, Koletsi M, Becker T, Fioritti A, Kalkan R, et al.: Therapeutic relationships in vocational rehabilitation: Predicting good relationships for people with psychosis. Psychiatry Research 187:68–73, 2011.
7. Hewitt J, Coffey M: Therapeutic working relationships with people with schizophrenia: Literature review. Journal of Advanced Nursing 52:561–570, 2005.
8. Howgego IM, Yellowlees P, Owen C, Meldrum L: The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. Australian and New Zealand Journal of Psychiatry 37:169–183, 2003.
9. Priebe S, Richardson M, Cooney M, Adedeji O, McCabe R: Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. Psychotherapy and Psychosomatics 80:70–77, 2011.
10. Gray GE, Pinson LA: Evidence-based medicine and psychiatric practice. Psychiatric Quarterly 74:387–399, 2003.
11. Norcross JC, Lambert MJ: The Therapy Relationship. In: Norcross JC, Beutler LE, Levant RF (Eds) Evidence-Based Practices in Mental Health–Debate and Dialogue on the Fundamental Questions, Washington, American Psychological Association, pp. 208–218, 2006.
12. Anthony W, Rogers ES, Farkas M: Research on evidence-based practices: Future directions in an era of recovery. Community Mental Health Journal 39:101–114, 2003.
13. Davidson L, Chan KKS: Common factors: Evidence-based practice and recovery. Psychiatric Services 65:675–677, 2014.
14. Finfgeld DL: Metasynthesis: The state of the art -so far. Qualitative Health Research 13:893–904, 2003.
15. Noblit GW, Hare RD: Meta-ethnography: Synthesizing qualitative studies, London, Sage Publications, 1988.
16. Campbell R, Pound P, Pope C, Britten N, Pill R, Morgan M, et al.: Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. Social Science and Medicine 56:671–684, 2003.
17. Stige B, Malterud K, Midtgarden T: Toward an agenda for evaluation of qualitative research. Qualitative Health Research 19:1504–1516, 2009.
18. Sandelowski M, Docherty S, Emden C: Qualitative metasynthesis: Issues and techniques. Research in Nursing & Health 20:365–372, 1997.
19. Britten N, Pope C: Medicine Taking for Asthma: A Worked Example of Meta-ethnography. In: Synthesizing Qualitative Research. Choosing the Right Approach, New York, Wiley, 2012.
20. Waibel S, Henao D, Aller M-B, Vargas I, Vàzquez M-L: What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies. International Journal for Quality in Health Care 24:39–48, 2012.
21. Andreasson E, Skärsäter I: Patients treated for psychosis and their perceptions of care in compulsory treatment: Basis for an action plan. Journal of Psychiatric and Mental Health Nursing 19:15–22, 2012.
22. Borg M, Kristiansen K: Recovery-oriented professionals: Helping relationships in mental health services. Journal of Mental Health 13:493–505, 2004.

23. Buck PW, Alexander LB: Neglected voices: Consumers with serious mental illness speak about intensive case management. Administration and Policy in Mental Health 33:470–481, 2006.
24. Denhov A, Topor A: The components of helping relationships with professionals in psychiatry: Users' perspective. International Journal of Social Psychiatry 58:417–424, 2012.
25. Galon P, Graor CH: Engagement in primary care treatment by persons with severe and persistent mental illness. Archives of Psychiatric Nursing 26:272–284, 2012.
26. Green CA, Polen MR, Janoff SL, Castleton DK, Wisdom JP, Vuckovic N, et al.: Understanding how clinician-patient relationships and relational continuity of care affect recovery from serious mental illness: STARS study results. Psychiatric Rehabilitation Journal 32:9–22, 2008.
27. Langley GC, Klopper H: Trust as a foundation for the therapeutic intervention for patients with borderline personality disorder. Journal of Psychiatric and Mental Health Nursing 12:23–32, 2005.
28. Laugharne R, Priebe S, McCabe R, Garland N, Clifford D: Trust, choice and power in mental health care: Experiences of patients with psychosis. International Journal of Social Psychiatry 58:496–504, 2012.
29. Lester H, Tritter JQ, England E: Satisfaction with primary care: The perspectives of people with schizophrenia. Family Practice 20:508–513, 2003.
30. Nehls N: What is a case manager? The perspective of persons with borderline personality disorder. Journal of American Psychiatric Nurses Association 7:4–12, 2001.
31. O'Brien L: The relationship between community psychiatric nurses and clients with severe and persistent mental illness: The client' s experience. Australian and New Zealand Journal of Mental Health Nursing 10:176–186, 2001.
32. Priebe S, Watts J, Chase M, Matanov A: Processes of disengagement and engagement in assertive outreach patients: Qualitative study. British Journal of Psychiatry 187:438–443, 2005.
33. Tidefors I, Olin E: A need for "good eyes": Experiences told by patients diagnosed with psychosis. International Journal of Qualitative Studies on Health and Well-being 6:1–9, 2011.
34. Topor A, Denhov A: Helping relationships and time: Inside the black box of the working alliance. American Journal of Psychiatric Rehabilitation 15:239–254, 2012.
35. Topor A, Borg M, Mezzina R, Sells D, Marin I, Davidson L: Others: The role of family, friends, and professionals in the recovery process. American Journal of Psychiatric Rehabilitation 9:17–37, 2006.
36. Tunner TP, Salzer MS: Consumer perspectives on quality of care in the treatment of schizophrenia. Administration and Policy in Mental Health 33:674–681, 2006.
37. Ware N, Tugenberg T, Dickey B: Practitioner relationships and quality of care for low-income persons with serious mental illness. Psychiatric Services 55:555–559, 2004.
38. Williams CC, Tufford L: Professional competencies for promoting recovery in mental illness. Psychiatry 75:190–201, 2012.
39. Wright N, Callaghan P, Bartlett P: Mental health service users' and practitioners' experiences of engagement in assertive outreach: A qualitative study. Journal of Psychiatric and Mental Health Nursing 18:822–832, 2011.
40. Young AT, Green CA, Estroff SE: Personal growth in the recovery process: Findings from the STARS study. Psychiatric Services 59:1430–1436, 2008.
41. Berggren UJ, Gunnarsson E: User-oriented mental health reform in Sweden: Featuring "professional friendship." Disability & Society. 25:565–577, 2010.
42. Kinn LG, Holgersen H, Ekeland T-J, Davidson L: Metasynthesis and bricolage: An artistic exercise of creating a collage of meaning. Qualitative Health Research 23:1285–1292, 2013.
43. Topor A: Managing the contradictions—Recovery from severe mental disorders. Stockholm University, 2001.
44. Parsons T: Illness and role of the physician: A sociological perspective. American Journal of Orthopsychiatry 21:452–460, 1951.
45. Hem MH, Heggen K: Being professional and being human: One nurse's relationship with a psychiatric patient. Journal of Advanced Nursing 43:101–108, 2003.
46. Moyle W: Nurse–patient relationship: A dichotomy of expectations. International Journal of Mental Health Nursing 12:103–109, 2003.
47. Rogers A, Pilgrim D: Mental health and inequality. Basingstoke, Palgrave McMillan, 2002.
48. Foucault M: Two Lectures. In: Gordon C (Ed) Power/Knowledge: Selected Interviews and Other Writings 1972–1977. Brighton, Harvester P, pp. 78–108, 1980.
49. Morrow M, Weiser J: Towards a social justice framework of mental health recovery. Studies in Social Justice 6:27–43, 2012.
50. Sparks E: Depression and Schizophrenia in Women. The Intersection of Gender, Race/Ethnicity, and Class. In: Ballou M, Brown LS (Eds) Rethinking Mental Health and Disorder—Feminist Perspectives. New York, Guildford, pp. 279–305, 2002.

51. Schön U-K: Recovery from severe mental illness, a gender perspective. Scandinavian Journal of Caring Sciences 24:557–564, 2010.
52. Koekkoek B, Van Meijel B, Van Ommen J, Pennings R, Kaasenbrood A, Hutschemaekers G, et al.: Ambivalent connections: A qualitative study of the care experiences of non-psychotic chronic patients who are perceived as "difficult" by professionals. BMC Psychiatry 10:96, 2010.
53. Ådnøy Eriksen K, Arman M, Davidson L, Sundfør B, Karlsson B: Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. International Journal of Mental Health Nursing 23:110–117, 2014.
54. Frank JD, Frank JB: Persuasion and healing—A comparative study of psychotherapy. 3rd edn. Baltimore and London, The John Hopkins University Press, 1993.

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