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ABSTRACT

Reciprocity has generally been understood as a process of giving and taking, within an exchange of emotions or services, and has long been recognised as a central part of human life. However, an understanding of reciprocity in professional helping relationships has seldom received attention, despite movements in mental health care towards more collaborative approaches between service users and professionals. In this review, a systematic search of the published papers was conducted in order to explore how reciprocity is conceptualised and understood as part of the dyadic therapeutic relationship between professionals and service users. Eleven papers met our inclusion criteria and a narrative synthesis was used to synthesise the key concepts of reciprocity. The concepts of: 'dynamic equilibrium', 'shared affect', 'asymmetric alliance', and 'recognition as a fellow human being' were recurrent in understandings of reciprocity in professional contexts. These conceptualisations of reciprocity were also linked to specific behavioural and psychological processes. The findings suggest that reciprocity may be conceptualised and incorporated as a component of mental health care, with recurrent and observable processes which may be harnessed to promote positive outcomes for service users. To this end, we make recommendations for further research to progress and develop reciprocal processes in mental health care.

INTRODUCTION

The professional mental health care relationship can take various forms, but essentially the professional receives payment to provide care, and the service user adheres to treatment in order to receive the required outcomes. This exchange forms the basis of the health care contract. In theory, and in practice, this relationship is established and develops within a more complex array of direct and indirect exchanges of material and immaterial goods, behaviours, information and emotions (Catty, 2004). A recent review identified therapeutic models that orientate towards service users' personal and social resources to engender therapeutic change (Priebe et al., 2014). Several models encompassed a reciprocal helping relationship (e.g. open dialogue, self-help groups and therapeutic communities), in which equality and shared experience were essential. Notably, these models tended to occur in groups, and or with elements of peer support where both parties are considered to gain something from the interaction. In comparison to the group or peer-support approaches listed above, relationships between pairings of professionals and service users have traditionally been represented in a relatively unidirectional or paternalistic way.

Although all health care is delivered in helping relationships between professionals and service users, these help-giving encounters are particularly crucial in the delivery of mental health care where good communication and the therapeutic relationship arguably form part of treatment itself (Bamling & King, 2001; Catty, 2004; Peplau, 1962, 1997; Priebe and McCabe, 2008; Priebe et al., 2011a). For therapists, the quality of the relationship with the client has been linked to outcomes in a meta-analysis across various psychotherapeutic treatments, irrespective of treatment type, outcome measure, or other moderator variables (Martin et al., 2000). Research has also evidenced the

relationship between the communication style and behaviour of nurses, and other professionals, to the experienced therapeutic relationships and outcomes from the perspective of the patient (Horberg et al., 2004; Shattell et al., 2007). Similarly, poor therapeutic relationships have been associated with dissatisfaction, and even disengagement from mental health services (Priebe at al., 2005; Sweeney et al., 2014). This further highlights the significance of establishing good professional - service user relationships that are acceptable by both parties, in terms of meeting their needs in a mutually beneficial way. Creating therapeutic alliances with service users applies this notion of reciprocity to some extent. Indeed, a service user being viewed as a partner in therapy, through shared decision-making and joint learning, suggests elements of reciprocal value and involvement (Priebe et al., 2011a).

Despite apparent movement in mental health care towards more collaborative approaches between service users and professionals, reciprocity has yet to be conceptualised in terms of these dyadic encounters. In general terms, reciprocity has long been acknowledged as playing an important role in the maintenance of stable interactions over time, such as intimate relationships, friendships, professional and informal helping relationships (Buunk & Schaufeli, 1999; Gouldner, 1960; Jung, 1990; Kolm, 2008; Neufeld and Harrison, 1995; Perkins & Haley, 2013; Trivers, 1971). It has also been linked to perceived levels of social support and satisfaction with life (Antonucci et al., 1990). In order to encourage these beneficial aspects of reciprocity in professional mental health care, we first need to understand how this concept applies to these particular encounters. In particular, if reciprocity does exist in these relationships, on what terms is it recognised and understood by both parties in therapeutic interactions. The purpose of this review is to describe how the term reciprocity has been

used in mental health care, as documented in dyadic relationships between professionals and service users.

METHOD

In this review we sought to identify published papers that conceptualised reciprocity in professional mental health care relationships. Papers were included if they contained studies that explicitly described or explored the dyadic relationship between mental health care professionals and their patients / clients / service users as reciprocal. As a consequence, there were no restrictions on study design or review papers, year of publication, study setting (i.e. inpatient or community), or language of publication. Search restrictions were placed on studies within adult populations (aged 18 years or over), and to service users samples with a primary diagnosis of a psychiatric disorder for which they were or had been receiving mental health care.

Exclusion Criteria

Studies were excluded if they did not define or conceptualise all or part of the interaction between mental health professionals and service users as reciprocal in some respect. We excluded studies that focused on reciprocity in terms of social networks between multiple individuals, or described reciprocity as part of an individual's social capital, instead of the interaction or relationship between two individuals. We also excluded studies and reviews that defined reciprocity in the context of caregiver relationships, close personal relationships, non-professional befriending relationships, or peer-to-peer support relationships.

Search Strategy and Data Sources

Whilst this review did not aim to produce a comprehensive account of reciprocity across all relationships in mental health care (only professional - service user dyads) we did nonetheless utilise an inclusive and systematic approach to search for relevant papers. This was to ensure that a range of service contexts and diversity of professional disciplines were captured in our review. Searches were conducted in the following databases through to February 2015: Medline (1946-2015) accessed via ProQuest, CINAHL via EBSCO (1937-2015), PsycINFO (1806-2015), Embase (1980-2015), and the Allied and Complementary Medicine Database (AMED, 1985-2015) accessed via Ovid. The Cochrane Library and Google Scholar were also searched for relevant reviews and research articles in the area of reciprocity in mental health care. Reference lists from potentially relevant papers were screened and followed up.

Search terms employed in the databases were a combination of descriptors for reciprocity (e.g. recipr*) AND descriptors for mental illness or psychiatric disorders (e.g. psychiatr* OR mental*, mental health, OR mental disorder, OR mental illness, OR mental disease, OR depress*, OR schizophren*). Terms were identified from searching titles, abstracts, keywords and medical subject headings. Filters were placed on adult populations only where the option was available, and searches were modified for individual databases and interfaces as required. All references were imported into EndNote version X7 bibliographic software (Thompson Reuters). Duplicates were removed and titles were initially reviewed by EA for inclusion. Potentially relevant abstracts and full-text articles were blind screened by EA and SS independently. Disagreements between reviewers at the abstract and full-text stage were resolved by consensus with a third reviewer (SP).

Data Extraction

Papers that met the inclusion criteria were subject to independent data extraction by two of the reviewers (SS and EA). Data was extracted on the methodological aspects of the studies described in the papers including: objectives, study design, sample population, setting, means of analysis, findings and interpretations. Chiefly, data was extracted and tabulated on how the concept of reciprocity had been defined, understood or interpreted in reference to professional - service user encounters. The components of reciprocity, as identified in the paper, were extracted and subdivided into two categories: those that were behavioural in content (i.e. verbal and non-verbal interactions and communication), and those that were psychological in content (i.e. emotions, cognitions, values, and beliefs).

Data Analysis

Analysis of the conceptual categories involved a two-stage narrative synthesis approach, which was adapted from the second and third stages of the approach outlined by Popay and colleagues (2006). The first stage involved a preliminary synthesis based on the descriptions and views of reciprocity, and the corresponding psychological and behavioural features. These were first explored as detailed textual descriptions and then tabulated and summarised for discussion amongst the reviewers and their wider research groups. This inductive approach enabled reviewers to generate themes around the different conceptualisations of reciprocity. In the second stage, these initial themes were interrogated against the full-text papers, with modifications to interpretation made in accordance with the evidence therein. Themes were further explored through relationships within and between the studies, as were the associated psychological and behavioural components in an attempt to clarify the practical application of reciprocity in the professional - service user dyad. Much of the second stage focused on the

similarities and differences between the concepts through an iterative process of continuous discussion, critical reflection, and feedback from other researchers in order for the reviewers to refine the parameters of the thematic concepts.

RESULTS

Screening and Selection

Based on the devised search strategy, 5188 unique records were retrieved and assessed for eligibility to be included in the review. Of the retrieved records, 4729 were excluded upon inspection of the titles, and an additional 438 were excluded during the screening of abstracts. Full texts were retrieved for the remaining 21 articles, of these, 10 were excluded for not identifying or describing reciprocity in the context of dyadic relationships between mental health professionals and service users. The flow diagram in Figure 1 depicts the screening and selection strategy for identifying potentially relevant papers for this conceptual review.

Study Characteristics

Eleven papers met the inclusion criteria and provided sufficient information to extract a conceptual understanding of reciprocity in the context of professional - service user relationships in mental health care. All papers were published between 1996 and 2014, the majority of which were from Norway (4) and the United States of America (4), with the remaining three papers comprising of one study each from Australia, England, and Sweden.

Studies within these 11 papers mainly comprised of findings from qualitative analyses of primary data (10), and one historical case study with data from a secondary source

(D'Antonio, 2004). Study designs employed varied from analyses of recorded therapeutic sessions (Beeber & Caldwell, 1996; Goodman et al., 2014), to in-depth case studies and observational accounts (D'Antonio, 2004; Hem & Petterson, 2011; Petterson & Hem, 2011), and to open-ended interviews (structured and unstructured) and focus groups (Berggren & Gunnarsson, 2010; Cohen, 1998; McCann & Clark; 2004; Petterson & Hem, 2011; Eriksen et al., 2012; Erikson et al., 2013; Rugkasa et al., 2014).

The service user and staff experiences described in these studies mostly came from an assortment of community mental health care settings, including specialist residential care facilities (Cohen, 1998) and mental health care provided in a primary care setting (Beeber & Caldwell, 1996). Only one of the studies was based on the experiences of service users whilst in a contemporary inpatient setting (Goodman et al., 2014), and the only historical inpatient study came from the daily diaries of staff working in an Asylum between 1814 and 1840 (D'Antonio, 2004). Where specified, the sample sizes were small in these studies ranging from two service user case studies (Hem & Petterson, 2011) to 48 mental health professionals in several focus groups (Rugkasa et al., 2014). Although all the studies conceptualised part, if not all, of the professional - service user relationship as reciprocal, only five analysed the dyad taking experiential evidence from both the professional and the service user perspective (e.g. Cohen, 1998: McCann & Clark, 2004), whilst four of the studies focused primarily on the professional's perspective (e.g. Eriksen et al., 2013; Rugkasa et al., 2014), and the remaining two were directed on the service user's perspective alone (Berggren & Gunnarson, 2010; Hem & Petterson, 2011). See Table 1 for summarised study design characteristics and identified conceptualisations of reciprocity.

Conceptual Understandings of Reciprocity

The narrative synthesis led to recurrent concepts arising in the identification and description of reciprocity between professionals and service users, which stemmed along four broad themes: dynamic equilibrium, shared affect, asymmetric alliance, and recognition as a fellow human being. Although they are presented as distinct themes here, it should be noted that there is overlap in their presentation. The frequency, distribution and relationship between these four themes across the studies is summarised in Table 2. In exploring these dyadic relationships, several recurrent behavioural and psychological components were represented in these reciprocal encounters between professionals and service users, in the context of mental health care. These components are presented alongside the four conceptual understandings of reciprocity, where present, in order to further elucidate the professional - service user reciprocal relationship in practice.

Dynamic Equilibrium

Most frequently, reciprocity in professional mental health care was conceptually understood as the presence of shared interactions or shared exchanges, where the professional and service user behave and respond to each other. Although both parties may not have the same understanding or subjective experience of the exchange at any given moment, they share behaviours and reactions at an equal and constant rate, akin to dynamic equilibrium[1]. In doing so, they maintain engaged in the interaction with an awareness of the other, whilst meeting their own personal needs.

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[1] In chemistry 'dynamic equilibrium' refers to a forward reaction that is equal to the reaction rate of the backward reaction, but the concentrations do not have to be equal. It differs from a static equilibrium where reactions are at rest and there is no motion between reactants and products.

In two of the studies, it was the patterned and repetitive nature of these shared interactions that made them reciprocal relationships (Beeber & Caldwell, 1996; Goodman et al., 2014). In the broadest sense, reciprocity as conceptualised by dynamic equilibrium only required a loose mutually-observed or shared understanding between the service user and professional in the encounters. According to Beeber and Caldwell (1996) 'antagonistic behaviours' where the service user perceives the nurse as antagonistic, but still attends treatment, and where the nurse feels helpless but remains in the relationship, would still be regarded as reciprocity. It was the mutually-observed repetitive encounters, with the partial fulfilment of both parties' needs that made this interaction reciprocal in their conceptualisation.

This broad conceptualisation of reciprocity as shared interactions also encompassed more directive styles within the professional - service user dyad. For example, 'directive therapist with compliant patient' as identified by Goodman and colleagues (2014) or 'complementary behaviours' as categorised by Beeber and Caldwell (1996) both fitted this conceptual understanding of reciprocity. The dynamic equilibrium in these cases are based on the mutual understanding of the professional (e.g. nurse or therapist) as 'helper', meeting their personal need to be in 'control' or to be 'active' in providing guidance. Whilst the service user perceives them self as the 'helpless person', meeting their need to repeatedly seek help and guidance from the 'expert helper' and to be remain compliant to treatment (Beeber & Caldwell, 1996; Goodman et al., 2014; McCann &Clark, 2004).

These studies contrasted with studies that viewed the service user as playing a more 'active' or guiding role in the dynamic equilibrium of reciprocity (Berggren & Gunnarsson, 2010; Petterson & Hem, 2011). In a more structured sense, these

interactions were conceived as direct relationships of giving and taking in turn, whether the gift was material or symbolic (Rugkasa et al., 2014). Whereas, others comprehended the role of reciprocity in dynamic equilibrium terms as more of a fluid process between the professional and the service user with no clear or definitive turn-taking, but instead as a collaborative interaction that shifts and moves in tandem (Berggren & Gunnarsson, 2010; Goodman et al., 2014; Hem & Petterson, 2011; Petterson & Hem, 2011). To meet the criteria for reciprocity these interactions required a certain level of mutual dependency to meet a shared goal, such as working together in domestic labour or social work (Cohen, 1998; D'Antonio, 2004), or for both the personal needs of the professional and the service user to be partially or fully fulfilled from the interactions (Beeber & Caldwell, 1996; Rugkasa et al., 2014).

Encompassed in these interactions were several verbal and non-verbal behavioural components. Most notably was sharing experiences and doing tasks and activities together (Berggren & Gunnarsson, 2010; D'Antonio, 2004; Rugkasa et al., 2014). This included involving service users in decision-making processes, as well as depending on service users to take responsibility and complete tasks in the absence of supervising staff (Cohen, 1998; D'Antonio, 2004). Conversations in these interactions involved the sharing of common ground in talk, and defining problems and goals in a collaborative way, with a focus on dialogue over monologue (Cohen, 1998; Hem & Petterson, 2011; Petterson & Hem, 2011). Professionals and service users in reciprocal relationships were also willing to listen to the opinions and perspectives of the other, as expert and insightful, with professionals consulting with service users during an episode of care and reaching agreement on aspects of treatment (McCann & Clark, 2004; Petterson &

Hem, 2011). The communication style reflected a combination of open and honest dialogue with a willingness to listen to the views and stated preferences of the other.

In addition, certain psychological processes underscored these dynamic equilibrium in interactions conceptualised in reciprocity. Most notably, the development of a mutually trusting relationship over time was viewed as a prerequisite for reciprocity in the professional - service user relationship (Hem & Petterson, 2011; McCann & Clark, 2004; Petterson & Hem, 2011; Rugkasa et al., 2014). Related to this was the role of obligations and expectations in reciprocal encounters. In order to fulfil the needs of both the professional and the service user in a dynamic equilibruim negotiating behaviours, such as compromises and deal-making, were also used and defined as 'reciprocal obligations'. By achieving the service user priorities first, professionals were able to meet their own priorities afterwards by using the service user's obligation to comply in turn for previous expectations being met, or exceeded. For example, behaviours such as the professional buying a coffee or doing a practical task for a service user would be followed by the service user feeling obligated to agree to continued participation in treatment (Rugkasa et al., 2014).

Shared Affect

Over half of the studies conceptually understood reciprocity in professional − service user relationships as conveying shared affect, with a certain level of emotional involvement mutually expressed, addressed, and understood for reciprocity (Beeber & Caldwell, 1996; Berggren & Gunnarsson, 2010; Eriksen et al., 2013; Goodman et al., 2014). The shared affect in the professional mental health care relationship entailed a balanced approach to emotional involvement by having as much concern for oneself as

for the other, but also maintaining a distinct sense of self from the other at the same time (Hem & Petterson, 2011; Petterson & Hem, 2011), akin to maintaining professional distance.

Empathy, non-judgemental reflection, and acceptance of the service user's feelings from the perspective of the professional in the mental health care relationship were identified as the main psychological components for obtaining the shared affect in reciprocity (Beeber & Caldwell, 1996; Goodman et al., 2014; Hem & Petterson, 2011; Petterson & Hem, 2011). Goodman and colleagues (2014) suggest that for 'therapist empathic attunement' the acceptance of the service user's feelings should be done with unconditional positive regard. In contrast to focusing on empathy as the main emotional or cognitive facilitator for reciprocity, one study conceptualised reciprocity as driven by a desire to reduce or avoid anxiety, where these reciprocal interactions give relief from anxiety (Beeber & Caldwell, 1996).

Certain verbal behavioural components were also identified as inciting shared affect in reciprocity. Conversations that consisted of sharing emotive experiences, such as personal shortcomings and happy occasions, or sharing personal information were regarded as part of the process for reducing the emotional distance needed for reciprocity (Berggren & Gunnarsson, 2010). Open conversations encouraged a willingness to affect and to be affected by the other that gives both parties the courage and care to challenge each other, an example given was of a nurse confounding the self-devaluing talk of a service user (Eriksen et al., 2013)

Asymmetric Alliance

Under half of the studies acknowledged the asymmetric relationship or alliance between professionals and services users as part of the dyadic qualities of reciprocity in mental health care (Eriksen et al., 2013; Goodman et al., 2014; Hem & Petterson, 2011; McCann & Clark, 2004; Petterson & Hem, 2011).

Reciprocity was conceptually understood as an alliance, as opposed to a partnership, because of the asymmetry of one being the care giver and the other being the care recipient. However, this asymmetric alliance was not on the grounds of one person being the expert and the other being the lay person in the relationship (McCann & Clark, 2004). The professional may guide the consultation with the service user, but decision-making had to be shared with the service user throughout the encounter for reciprocity to be regarded as asymmetric alliance (Goodman et al., 2014; McCann & Clark, 2004). In this understanding of reciprocity, what was considered as equal or fair had to be adjusted for the particular situation. In principle, the professional and service user are considered equals, but this does not entail an equal sharing or 'like for like' exchange in practice (Eriksen et al., 2013; Hem & Petterson, 2011; McCann & Clark, 2004; Petterson & Hem, 2011). .

Recognition as a Fellow Human Being

Four studies conceptualised the reciprocity between mental health professionals and service users as based on the recognition of each other as a fellow human being, with the same value and rights to promote their own interests and to share experiences (Berggren & Gunnarsson, 2010; Eriksen, et al., 2013; Eriksen et al., 2012; Petterson & Hem, 2011). The asymmetric qualities of the relationship do not feature in this conceptualisation to the same extent as they do for asymmetric alliance above. The basis

of the reciprocal relationship in this conceptualisation is shared equality as fellow human beings, and not on the basis of one being a mental health care professional and the other a service user. The main component within this conceptualisation is the respect and value given to the other as a fellow human being, with no superiority given to one over the other in terms of status (Berggren & Gunnarsson, 2010; Eriksen, et al., 2013; Eriksen et al., 2012). One service user case study viewed professionals as "someone who cares about their job and somebody who cares about people" (p.222, Petterson & Hem, 2011). This is conceptually distinct from describing a professional as someone as who cares *for* their job. There is recognition of the professional's humanity in the context of the being a provider of care, which conceptually extends the understanding of the interaction beyond the asymmetric alliance outlined in the previous theme.

Behaviourally, the verbal interactions were conversational in style and less goal-oriented, with a focus on everyday matters and sharing of personal information with no emotional distance. Although termed as a 'professional friendship' in one of the studies, this reciprocal relationship had greater limits than a 'private friendship' with the example given of the service user not calling the professional as home (Berggren & Gunnarsson, 2010). Recognition as a fellow human being in reciprocal relationship did not represent a complete withdrawal of professional boundaries and an absence of context.

DISCUSSION

In this synthesis reciprocity was recognised and understood as part of the therapeutic relationship between mental health professionals and service users through a set of four

recurrent and related concepts: dynamic equilibrium in interactions; sharing in feelings (including the reduction of feelings such as anxiety); maintaining an alliance with awareness of the inherent asymmetry in the bounded relationship; and recognising and relating to each other as fellow human beings. Although thematically distinct in our synthesis, the concepts of dynamic equilibrium and shared affect were most common to the understandings and illustrations of reciprocity in these professional dyads. Simply put, patterned and repetitive interactions between professionals and services users that met their practical and or emotional needs were considered reciprocal (Beeber & Caldwell, 1996; Berggren & Gunnarsson, 2010; Goodman et al., 2014; Hem & Petterson, 2011; Petterson & Hem, 2011).

In practical terms, the roles and goals of professionals and service users were distinct, and somewhat separate, however there was a level of interdependence in these relationships with one relying on the other in order to have their needs fulfilled, professionally or personally. Furthermore, recognising each other as fellow human beings within a professional - service user relationship does not require a 'like for like' exchange in terms of resources given or received because of the bounded nature of the reciprocal relationship (Eriksen et al., 2013; Petterson & Hem, 2011; Rugkasa et al., 2014). The equality in these reciprocal relationships comes from respect for the fellow human being, as much as the asymmetric alliance between two parties that share trust, decisions, and obligations in professional-guided services (Rugkasa et al., 2014).

Essentially it is the bounded nature of these relationships and differences in perspective on the shared experiences (in terms of learnt and lived expertise) that separates the reciprocity conceptualised in these professional - service user dyads from that found in peer-support approaches. The reciprocity in peer-to-peer approaches is considered

synonymous with both parties having mental health problems and lived experience. The reciprocity was through the equality obtained from having a shared psychiatric history, shared feelings, or having encountered similar experiences. Peer-to-peer approaches tended to define reciprocity as a fairly equal exchange of support for support, in order to develop solutions and explore feelings together in a 'normalised' way. Equality, empathy, exchanging turns and engaging in activities together were defined as tantamount to reciprocity in these peer support approaches (Bracke et al., 2008; Bronstein, 1986; Castellano, 2012; Lewis et al., 2012; Miyamoto & Sono, 2012; Repper, 2011). Likewise, reciprocity in the context of befriending schemes, where the befriender was not a mental care professional, viewed the two people as being on the same level, having something of value to offer each other in the context of a 'reciprocal friendship'. These relationships were contextualised in contrast to professional relationships (and relationships with family) though, insofar as the client entering the befriending scheme is perceived as 'giving back' to someone, and creating symmetry in the relationship (Davidson et al., 1999). The asymmetric alliance as conceptualised in this review would support the lack of symmetry in professional relationships, but the value and respect in befriending relationships speaks to the lack of superiority noted in the conceptualisation of reciprocity as recognition of a fellow human being.

Alongside these conceptual understandings of reciprocity were several consistent behavioural and psychological characteristics linked to the practice of reciprocity in professional mental health relationships. Although it was not clear how much of an 'active' role the service user should play in these interactions, working together on an activity, involvement in consultations, and sharing decision-making were all common to reciprocal relationships. Conversations were also clearly viewed as dialogues with the

sharing of opinions and perspectives from both parties, and not necessarily in a structured turn-taking manner. The sharing of limited personal information, experiences, or common ground may form part of these conversations. Openness, honesty and showing a willingness to listen were also important and linked to the building and maintaining of trust in reciprocal encounters (Berggren & Gunnarsson, 2010; Hem & Petterson, 2011; McCann & Clark, 2004; Petterson & Hem, 2011), as were the use of obligations and expectations in regular interactions (Rugkasa et al, 2014). In addition, empathy, non-judgemental reflection, positive regard, acceptance and emotional involvement were all recognised as contributing to reciprocal relationships in mental health care. Furthermore, these behaviours fit well with the existing literature on what makes for good communication and therapeutic relationships in mental health care (Catty, 2004; Laugharne & Priebe, 2006; Priebe et al., 2011a).

It is important to acknowledge that although the concepts and associated characteristics outlined above provide a synthesised understanding of reciprocity in professional mental health care relationships, it is based on a limited evidence base. Despite searching widely, all of the studies were limited to qualitative and conceptual analyses. The sample sizes were consequently small and gave limited scope for generalisability. There is also the potential that our interpretation of the papers might have overly simplified the complex dynamics associated with reciprocity in professional mental health care. However, whilst the importance of the therapeutic relationship is well documented, concepts are missing when trying to map the features and components that are particularly relevant to making the therapeutic relationship significant (Catty, 2004; Kirsh & Tate, 2006; Priebe et al., 2011b). Reciprocity presents as a promising candidate, even if it may require challenging operationalisation to be used in future

research and practice development we have nonetheless identified a relatively rich aspect that seems not to have been captured explicitly in other concepts.

The aim of this review was to highlight and bring together the concepts that were recurrent from the disparate empirical work in the area of reciprocity. Larger quantitative studies on the mechanisms of reciprocity in practice were largely missing, as was the development of a measure to assess for reciprocity in mental health care relationships; both of which have limited our ability to study the relationship between reciprocity and reduction of mental distress and satisfaction with treatment. Indeed, there is also compelling evidence linking reciprocity in social relationships to outcomes in both physical and mental health and wellbeing in general populations (Brown et al., 2005; Chandola et al., 2007; Siegrist, 2005; Vaananen et al., 2005; von dam Knesebeck & Siegrist, 2003; Wahrendorf et al., 2013; Wong et al., 2011). In addition, the extent of reciprocity in the professional - service user dyad may also influence how the professionals' perceive their satisfaction with the work, commitment to service user's care, and even burnout.

CONCLUSIONS

This review identified a basis for reciprocity in professional mental health interactions, specific exploration and assessment of these concepts is required to utilise its inherent value. The current gaps in the literature, in terms of the existence of assessments of reciprocity in the professional - service user relationships, limits our capability to assess the impact of reciprocity on outcomes and service satisfaction for both service users and professionals alike. We therefore recommend the development of observational and self-report measures, through further qualitative and quantitative exploration that seeks

to incorporate the recurrent concepts, behaviours and cognitions identified in this conceptual review. A better understanding of the reciprocal interactions between mental health providers and service users could help to advance our understanding of reciprocity as a potential source for improving service user satisfaction and engagement with services.

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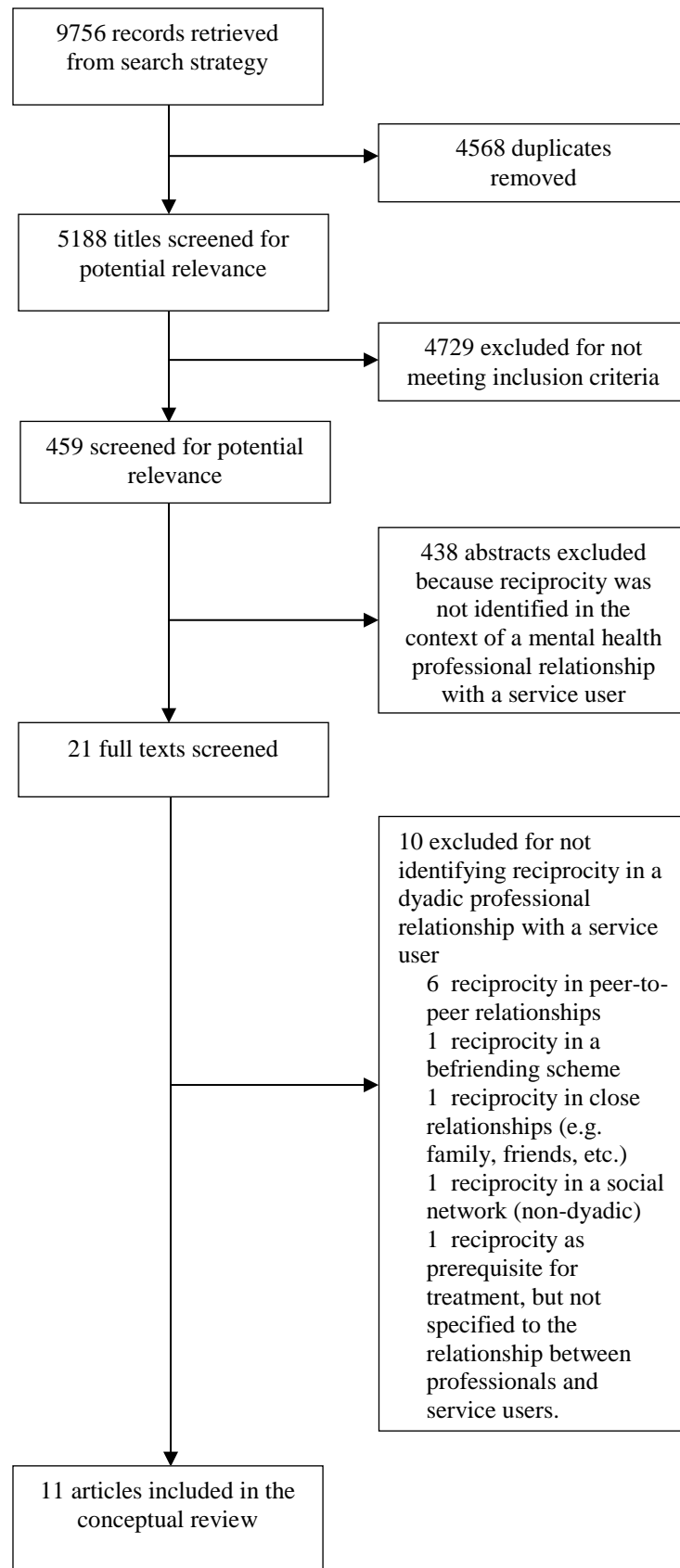Figure 1: Flow diagram of study search and selection strategy

Table 1: Study characteristics and identified conceptualisations of reciprocity in professional - service user encounters

Authors	Year	Country	Participants / Setting	Methods	Conceptualisation of reciprocity in the professional - service user encounters as utilised in the paper.
Beeber & Caldwell	1996	USA	6 females with depressive symptoms and 2 psychiatric nurse in a primary care setting	Analysis of taped clinical sessions (4 month period) using Peplau's (1989) theoretical model and concept of pattern integrations	Reciprocity was sought through shared interactions, by pairing a client's behaviour with the nurse's response. Clusters of behaviours had to be repetitive, give relief from anxiety, and partially meet the needs of both the nurse and the client to be considered reciprocal.
Berggren & Gunnarsson	2010	Sweden	23 (17 female/6 male) service users with mental health conditions in receipt of help, support and advice from a Personal Ombudsman (PO)	Phenomenological Analysis of interviews (between 50mins - 2 hours) focusing on the lived experience of service users' relationships with POs in the community	Reciprocity was referred to as part of the 'professional friendship' between the PO and service user, in which the PO offers a relationship that was partly defined by interactions that are mutual and emotionally reciprocal in terms of sharing of life experience together.
Cohen	1998	USA	22 Social workers or trainees and 24 clients (mixed gender,	Structured open-ended interviews and focus groups	Reciprocity is conceptualised as a component of relational social work where the relationship is characterised by

			but mostly males) with histories of homelessness and psychiatric hospitalisations living in residential care settings	were analysed using empowerment theory and feminist theory	mutuality.
D'Antonio	2004	USA	Secondary source - daily diaries from male lay superintendents of an Asylum from 1814-1840	Analysis of historical data from males that worked in the Asylum, with a focus on the their detailed accounts of the other staff, and patients working under 'moral treatment' methods	Reciprocity was sought in the relationships between staff and patients under 'moral treatment' in the Asylum's domestic economy, where the domestic labour was dependent on both the staff and the clients working together.
Eriksen, Arman, Davidson, Sundfor & Karlsson	2013	Norway	8 Community-based mental health nurses	4 multi-staged focus groups with the same participants, analysed using Interpretative Phenomenological Analysis	Reciprocity was seen in the processes of the relationship between professionals and service users as both affecting, as well as being affected by the other. Both contribute to and receive from the relationship, even if it is unequal.

Eriksen, Sundfor, Karlsson, Raholm & Arman	2012	Norway	11 community-based mental health service users with 3 or more visits a week	1 or 2 interviews with each participant, analysed using Interpretative Phenomenological Analysis	Reciprocity is seen as part of the relationship between the professional and the service user where there is personal involvement and recognition of each other as a fellow human being with value and right to promote their own interests.
Goodman, Edwards & Chung	2014	USA	4 therapists and 5 female patients with borderline personal disorder (BPD) and comorbid Axis 1 disorders in an inpatient setting following a crisis	Analysis of 127 audiotaped psychodynamic therapy sessions (over a 6 month period) coded using Psychotherapy Process Q-Set (Jones, 2000) a Q-sort method.	Reciprocity was conceptualised as patterns of interactions between the therapist and patient, coined as interaction structures, which can be collaborative relationships, where feelings are shared and understood, or where feelings are projected onto the therapist, or the therapist is active and the patient is submissive. Together the patient and therapist sense which interaction structures to change over time in order to reduce patient distress, with the interaction structures being fluid over time.
Hem & Petterson	2011	Norway	2 male patients during time on a psychiatric ward	Case studies of 2 in-depth interviews with patients about the nurse-patient relationships	Reciprocity is conceptualised as part of 'mature care' which portrays care as relational and not one-sided (i.e. dialogue not monologue) and involves as much concern for oneself as for

				whilst on a psychiatric ward	the other. Acknowledging that reciprocity in this context means asymmetry, with one party giving more than the other.
McCann &Clark	2004	Australia	24 community mental health nurses and 9 (5 male, 4 female) young adult clients experiencing an early acute episode of schizophrenia	Unstructured, conversational interviews and observations with staff and clients during visits were analysed using Grounded Theory	Reciprocity as an alliance, rather than a partnership because of the asymmetric relationship, with a shared understanding in decisions about care.
Petterson & Hem	2011	Norway	Conceptual account that is illustrated with 2 male patient case studies that are based in the community	Observations and interviews with the patients and their nurses, doctors etc.	Reciprocity is conceptualised as part of 'mature care' which portrays care as relational and not one-sided (i.e. dialogue not monologue) and involves as much concern for oneself as for the other. Acknowledging that reciprocity in this context means asymmetry, with one party giving more than the other.
Rugkasa, Canvin, Sinclair, Sulman &	2014	England	48 community mental health professionals	Focus groups in 6 teams	Reciprocity as a process of reaching agreement through giving and taking in turn, which can be done through material and/or symbolic gifts.

Burns

Table 2: Thematic concepts of reciprocity in professional mental health care relationships

	Conceptions of Reciprocity in Professional - Service User Encounters			
	Dynamic Equilibrium	Shared Affect	Asymmetric Alliance	Recognition as a Fellow Human Being
Beeber & Caldwell (1996)	✓	✓		
Berggren & Gunnarsson, (2010)	✓	✓		✓
Cohen (1998)	✓			
D'Antonio (2004)	✓			
Eriksen, Arman, Davidson, Sundfor & Karlsson (2013)		✓	✓	✓
Eriksen, Sundfor, Karlsson, Raholm & Arman (2012)				✓
Goodman, Edwards & Chung (2014)	✓	✓	✓ (in part)	
Hem & Petterson (2011)	✓	✓	✓	✓
McCann & Clark (2004)	✓		✓	
Petterson & Hem (2011)	✓	✓	✓	
Rugkasa, Canvin, Sinclair, Sulman & Burns (2014)	✓			