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All authors approved the final version to be published and agreed to be accountable for all aspects of the work. In accordance with the guidelines of the International Committee of Medical Journal Editors, all authors of this study meet the authorship criteria, and all of the authors are in agreement with the manuscript.

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Title

A qualitative emancipatory inquiry into relationships between people with mental disorders and health professionals

Abstract

Introduction:

A therapeutic alliance with people is essential for the efficacy of treatments. However, the traditional paternalistic values of the Mediterranean society may be incompatible with patient autonomy.

Aim:

To explore the therapeutic relationship from the perspective of people diagnosed with mental disorders with health professionals, including nurses.

Methods:

This emancipatory research was performed through focus groups, with people with mental disorders who had a variety of diagnoses and experiences of acute and community-based mental health services and other healthcare services. Data were analysed using the content analysis method.

Results:

Four main themes emerged: stereotypes and prejudice; quality of interactions and treatment; emotional and behavioural impacts; and demands.

Discussion:

According to the participants' descriptions, health professionals are not exempt from prejudice against persons with psychiatric diagnoses. They reported experiencing abuse of power, malpractice, and overmedication. Thus, in the Mediterranean culture, professional attitudes may represent a barrier for an appropriate therapeutic alliance, and people with mental disorders do not feel involved in making decisions about their health.

Implications for practice:

Knowing how people with mental disorders perceive their interactions with health professionals and the effects is necessary to move the care model towards more symmetric relationships that facilitate a therapeutic alliance.

Keywords: Emancipatory investigation, Nurse, Paternalism, Shared decision-making, Stigma, Therapeutic alliance

Relevance statement

The present study addresses one of the cornerstones of the therapeutic relationship: how persons with mental disorders perceive interactions with professionals. They report prejudice, paternalism, abuse of power, and lack of competence in their interactions with doctors and nursing staff. The participants' experiences suggest the need for a change to the care model. The new model should be based on establishing meaningful relationships and respecting individual freedom, which would facilitate an adequate therapeutic alliance.

Accessible summary

What is known on the subject:

- A therapeutic alliance with people with mental disorders could help increase the efficacy of treatment.
- The paradigm shift from a paternalistic model to one that respects the person's autonomy has led to professionals accepting the active role of people with mental disorders making decisions that affect their treatment.

What the paper adds:

- People with mental disorders perceive paternalistic and stigmatising attitudes from health professionals, and they do not feel involved in decisions about their health, which can render effective therapeutic alliances difficult.

- The findings reveal that although people in Mediterranean countries are used to paternalistic treatment from health professionals due to cultural factors, people with mental disorders are increasingly critical of how they are treated and demand greater autonomy and respect in the decision to undergo drug therapy.

What are the implications for practice:

- In their interactions with people with mental disorders, health professionals should include efforts aimed at improving shared decision-making capabilities and avoiding paternalistic or stigmatising attitudes.

Introduction

A good therapeutic alliance can improve the symptoms and functioning of people with mental disorders (Kreyenbuhl, Nossel & Dixon, 2009; Priebe, Richardson, Cooney, Adedeji & McCabe, 2011; Salazar-Fraile, Sempere-Verdú, Pérez-Hoyos, Tabarés-Seisdedos & Gómez-Beneyto, 2018; Shattock, Berry, Degnan & Edge, 2017). Some studies have suggested that the therapeutic alliance is an essential element for increasing the effectiveness of pharmacological or psychological treatments (Horvath, Del Re, Flückiger, & Symonds, 2011). In this way, a positive therapeutic relationship could even contribute to a reduced number of hospitalisations and to improve symptoms and performance levels (Priebe et al., 2011).

According to Bordin (1979), the therapeutic alliance has three main components: an emotional bond between the professional and the person; the consensus in the therapeutic objectives; and the consensus regarding the tasks to be developed. It is this last point that is closely connected with shared decision-making (SDM) (Matthias, Fukui & Salyers, 2017). SDM is an increasingly important element in perceptions of the quality of healthcare by people with mental disorders. Moreover, SDM is relevant in the recovery model and, more precisely, is a crucial element for the empowerment of persons with mental disorders (Treichler & Spaulding, 2017); it allows for the establishment of a balanced relationship between the two participants in which the person's values, objectives and preferences are considered by professionals (Bae, 2017). Additionally, SDM is associated with greater therapeutic adherence, more effective self-care (Klingaman et al., 2015), and higher satisfaction with the treatment received (Stiggelbout, Pieterse & De Haes, 2015).

Rationale

Stigma is composed of three elements: cognitive (stereotypes), emotional (prejudices) and attitudinal (behaviours) (Link & Phelan, 2001). Several studies have reported that health professionals hold the same stigmatising and discriminatory attitudes towards people with mental disorders as people not trained in healthcare (de Jacq, Norful & Larson, 2016; Vistorte et al., 2018; Ross & Goldner, 2009; Schulze, 2007; Wahl & Aroesty-Cohen, 2010). These negative and stigmatising attitudes can make it difficult to establish a productive therapeutic relationship. People with mental disorders perceive negative attitudes from health professionals, including indifference, misunderstanding, lack of sensitivity, paternalism, coercion, and prejudice (Ljungberg, Denhov & Topor, 2015; Newman, O'Reilly, Lee & Kennedy, 2015; Tingleff, Bradley, Gildberg, Munksgaard & Hounsgaard, 2017; Thornicroft, Rose & Kassam, 2007), which create barriers to interaction, lack of trust in the professional, and decreased follow-up visits.

To date, studies describing the relationship between people with mental disorders and health professionals from the perspective of the persons with a psychiatric diagnosis have been conducted in Anglo-Saxon and Northern European countries (Ådnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014; Webb, Clifford, Fowler, Morgan, & Hanson, 2000). There, the paradigm shift from the paternalistic model to one focused on the increasingly recognised importance of patient autonomy has led professionals to accept the active participation of persons with mental disorders in decisions that affect their treatment (Sandman, Granger, Ekman & Munthe, 2012). However, Mediterranean countries have cultural differences with Northern European countries, and there is little tradition of applying the ethical principle of autonomy in health care (Busquets, Roman & Terribas, 2012). Some studies have been developed to study the health professionals' attitudes towards people with a mental disorder in this cultural context (Chambers et al., 2010; Del Olmo-Romero et al., 2019) but none of them from the emancipatory paradigm.

Aim

This study aimed to explore the therapeutic relationships from the perspective of people diagnosed with mental disorders with a range of health providers, including nurses, in Spain.

Methods

Design

A qualitative design study was performed within the framework of the emancipatory theory. The emancipatory theory introduced by Habermas is encompassed within the critical hermeneutic theory that aims to achieve a social change in which the rights of the most disadvantaged people are restored. From the emancipatory methodology, nurses can contribute to correcting the imbalances and social injustices that occur during healthcare administered to the most vulnerable groups (Walter, 2017), among which are people with mental disorders (Disability Rights Commisión, 2006).

The emancipatory paradigm is based on the condition of equality of those involved in a given process. This inclusion facilitates the emergence of the personal experiences of all participants and thus contributes to transforming practices and organisations. It is therefore essential that, through collaboration, dialogue, and critical reflection, the views of the people affected are represented, from the very moment at which the research design begins, contributing their perspectives to the development of data collection tools, throughout the process of analysing the results and during the implementation of the results (Chinn & Kramer, 2007).

Several actions were performed to increase the validity of the study. The transferability was enhanced concerning the process of obtaining codes from the meaning units (as is shown in Table 2). In addition, the themes, sub-themes and categories are described and shown in Table 3. To enhance the credibility of the study, the verbatim transcripts were shown to several participants from each group to ensure that their comments had been accurately compiled (Mays & Pope, 2000).

Details of the study methods and results are reported in accordance with the COREQ checklist for the reporting of qualitative studies (Tong, Sainsbury, & Craig, 2007) (Appendix 1).

Researcher reflexivity

The present study arose from the personal concerns of C.M.-M. and V.S.-M. After years of practice as mental health nurses and contact with persons with mental health problems, they wanted to know how these felt that health professionals treated them, so they designed the study, collected and analysed the data, C.M.-M. wrote the draft version of the manuscript and V.S.-M. contributed to the final review of the document. J.B.-M., an active member of the group Dis-Cuerdos brought his own experience with a mental disorder to the research team. He contributed in developing the script, recruited the study participants, participated in the data analysis, and revised the final version of the manuscript, providing a sensitivity that differs from that of professionals when interpreting the results and helping reduce interpretative bias (Kvale & Brinkmann, 2009; Petersen, 2011). J.D.R.-P. and M.R.-M. participated in the design of the research, resolved discrepancies between researchers who collected the field data and contributed to the final review of the manuscript.

In performing the analysis, the authors followed the therapeutic alliance operationalisation of Bordin (1979). The biomedical ethical principles of Beauchamp and Childress (2013) were reviewed by the authors to determine which could affect people with mental disorders, and it was agreed that these factors included paternalism and coercive practices. Our analyses began from an emancipatory approach and therefore placed greater emphasis on the principle of patient autonomy versus that of beneficence, being more in line with the Hippocratic practice of medicine and particularly of psychiatry. To improve confirmability and dependability, during the entire analytical process, all of the questions and doubts that arose during the interpretation process were recorded in memos.

Participants and study context

Participants were selected from different social-health services and associations in the metropolitan area of Valencia (Spain) with the aim that the experiences reflected relationships with as many professionals as possible. Out of the 29 people who were asked to participate in the study, 25 individuals (six women and 19 men) were included. Those individuals who declined the invitation claimed to have prior commitments. All of the subjects independently performed daily living activities and had extensive experience with the use of mental health services. The sociodemographic characteristics of the participants are described in Table 1. The inclusion criteria were age older than 18 years; a psychiatric diagnosis (self-reported); experience of acute and community based mental health services as well as other healthcare services; and fully integrated community living. The exclusion criteria were substantial cognitive impairments or any physical or psychological problems limiting active participation in the focus groups.

Researcher J.B.-M. acted as a key informant and contacted a variety of other potential key informants, who were colleagues from various mutual support groups and day centres. The recruitment methods were convenience and snowball sampling. The week before conducting each group, the participants were invited, either personally or by telephone, and briefly informed of the aim of the study. Through this mode of recruitment, participants would feel less coerced in their decision to participate since they were going to be asked for personal experiences, and if they felt unsure of being treated respectfully, they could decline the invitation.

Data collection

Data were obtained through focus groups, since participants' perspectives can produce new information, and data can be additionally enriched by interactions among group members (Krueger & Casey, 2015). Moreover, people diagnosed with mental disorders might feel more comfortable and confident in this setting because it is not as intimidating as participating in face-to-face interviews (Morgan, 1997).

Three focus groups were conducted between April and July 2018, at which point C.M.-M. and V.S.-M. agreed that data saturation had been achieved, as no new information regarding the main objectives of the study was obtained. Although the participants in the groups had similar experiences, they were heterogeneous in terms of psychiatric diagnoses, ages and genders, and health districts, enriching the results obtained with different views (Roller & Lavrakas, 2015). Nine to 11 people were invited to participate in each group to balance potential absences; there were 6, 8, and 11 members in the first, second, and third groups, respectively. The sessions were not limited in time and ended when the group members decided that they could not provide more information.

Focus groups were held at a site offered to us by the Association ASIEM (Spanish acronym for the Association for the Integral Health of People with Mental Disorders). The place had easy access and was comfortable and familiar to most of the participants. At the beginning of each session, snacks were served to facilitate interaction among the group members and to make them feel comfortable expressing their opinions.

As a basis for the focus groups, a script was created by two mental health nurses, C.M.-M. and

V.S.-M., and by J.B.-M. The script did not require substantial changes during the study.

One of the researchers functioned as the group moderator (C.M.-M.). She briefly explained what the study was about and requested permission to obtain an audio recording of the full conversation. At the start of each discussion, the first question was "How would you define your relationship with health professionals?". The second researcher (V.S.-M.) acted as an assistant and took notes on the participants' nonverbal expressions to maximise the information obtained. A third researcher who had a lived experience in mental health issues (J.B.-M.) was also present in all the groups, and contributed to maintaining a safe and comfortable environment for the participants. At the end of each session, the attendees were thanked for their participation and were reminded that all the information provided would be confidential and that anonymity would be duly maintained. On average, the focus groups lasted for 165 minutes (range: 120-210 minutes).

Data analysis

The data were analysed following the content analysis method proposed by Graneheim and Lundman (2004). First, all of the audio recordings of the focus groups were transcribed verbatim using alphanumeric codes to identify the participants. A pre-analysis of the texts was performed through several readings by two independent researchers to gain an in-depth understanding of the content. The analysis was performed in three consecutive stages. First, an open coding stage was completed, in which two researchers independently re-read the text and selected (as units) meaning paragraphs, sentences or words that were related to the topic of study, in comparison to those researchers who developed the codes. Some examples of this process are presented in Table 2. Subsequently, the final codes were selected via a consensus by the researchers; with the use of axial coding, the codes were then grouped into the following categories: homogeneous, comprehensive, exclusive, objective and appropriate (Elo & Kyngäs, 2008). Finally, through an interpretative process in team meetings, the categories were grouped into subthemes, after which these subthemes were grouped into the four themes that were presented in this study. Both factors are described in Table 3. The content analysis was supported by ATLAS.ti software, version 8.0 (Scientific Software Development GmbH, Germany).

Ethics

The study was conducted following the Declaration of Helsinki (World Medical Association, 2013) and was approved by the Ethics Committee of the University of Alicante (2017-11-13). Before the focus groups started, all the participants were requested to sign informed consent. They were also advised that all the information provided would be confidential and that anonymity would be duly maintained. During the focus groups, some of the participants informed malpractice and abuse. Accordingly, after the sessions, they were offered to denounce those situations. They expressed they felt they were not in a vulnerable situation at that moment, and stated that the opportunity to describe their experience was enough and satisfactory for them.

Results

The analysis of transcription produced 350 meaning units grouped into 50 codes, and these codes, in turn, were clustered into 31 categories. Table 2 shows examples of how the codes were obtained from the meaning units. The 31 inductively created categories were grouped into four main themes (prejudice, quality of interactions and treatment, emotional and behavioural impact and demands) and nine subthemes. Table 3 shows a description of the themes, subthemes, and categories. The codes included in each category are detailed in Table 4.

Theme 1. Stereotypes and prejudice

This theme included categories in which the participants perceived that professionals had preconceived ideas towards people with a psychiatric diagnosis. In this study, we developed four categories that represent the participants' interpretations of mainly involuntary manners of the professionals, that revealed their stigmatising stereotypes and prejudice once the diagnosis was known by health professionals. For example, some manners included the person not being given credibility, as well as indications of inequities in discrimination. A degree of danger, a lack of capacity and everything that the person refers to can be explained by the disorder.

The category involving the person not being given credibility refers to actions that were taken by professionals in confirming the information that was provided. For example, in the Psychiatrist's Clinic, a participant stated that "*They always speak to me first, and then look at my mother to see if what I say is the truth or a lie*" (*Man 1).* Furthermore, prejudice was present once the diagnosis was known by physical health professionals. The participants had the impression that the professionals considered their intellectual abilities to be limited and that they needed to be accompanied by another adult. For example, during a visit to the cardiologist, a participant stated that "*my father got angry and told him, talk to him, he's intelligent"* (*Man 4).* Moreover, the participants reported that not all of them were perceived equally by the professionals. There were differences in discrimination depending on the psychiatric diagnosis, their physical appearance, and the degree of cognitive deterioration:
"If you are not cognitively affected by the disease, they put you in a situation of superiority over other people who take more medication or who have been more affected by the disorder" (Woman 1).

It is also important to note that participants perceived that health professionals interpreted their mood, behaviour or reactions as being a part of the disorder, with one participant stating: *"All negative attitudes... it all goes back to the disorder. If I do not feel like getting up, it's the disorder. No… it's that I'm tired… I'm exhausted, I can't, I need a day for me" (Man 1).* Professionals did not seem to understand that the person would experience reactions to life events (similar to those that the general population may experience), and the professionals would then hold judgement against their reactions, on the basis of stereotypes. When regarding the degree of danger, the participants perceived fear when they were unskilled professionals in treating persons with mental disorders: "*He [the doctor] was shaking; the first day, he didn't even look at me, and the second, he was shaking..." (Man 6).*

Theme 2. Quality of interactions and treatment

In this theme, we collected the expressions of people with psychiatric diagnoses regarding how they perceived the professionals behaved with them during therapeutic interactions. These voluntary and manifest conducts by the professionals were expressed by the participants as the natural consequence of the prejudice against them. Their perception was that they were treated with paternalism, sometimes including abuse of power, and they often observed personal incompetence, holistic malpractice treatment and the use of drugs as the only type of therapy being used as a treatment.

We identified four ways in which health professionals exercised abuses of power. The first is through underestimation by disrespecting or scorning them through their comments. For example, a general practitioner told a participant *"what are you going to study for if you're not going to work" (Man 9).* The second way involved professionals silencing the voices of people with mental disorders by refusing to consider their demands when regarding their treatment, with one participant stating *"Risperdal® was injected through a court procedure because I said I didn't want to take it. I was given no alternative" (Man 12).* The third way involved professionals not admitting hospitalisations to a person when they were voluntarily required, with one participant stating "*what they tell you is go home and say that you don't qualify for admission" (Man 5)*. Finally, the fourth way involved the participants perceiving a lack of help from professionals when they needed it, with a participant stating *"I didn't have any support", "that I know they never helped me" (Woman 3).*

Furthermore, some participants perceived that the professionals did not have the skills to perform their professional duties. In our study, we demonstrated that inadequate skills were evident in several ways. For example, ineffective communication was evident, which was due to a lack of empathy. For example, a psychiatrist told a participant *"so you'll study if you don't go to work"*. Additionally, communication barriers were evident in the following case: *"when you go to the psychiatrist he is often on the screen, and you don't want to share anything with him" (Woman 2).* The second inadequate skill involved a lack of concern, wherein the participants perceived that the health professionals ignored the adverse effects of treatment focusing only on controlling psychotic symptoms "*and then, important things, like not having functioned sexually for seven years; doesn't it affect you psychologically? But they don't ask" (Man 11)* Lastly, inconsistency in the treatment and overmedication. The participants perceived arbitrariness of decisions and randomness of the assigned professional; "*There are colleagues who said that this psychiatrist always medicated more" (Man 12) "all day long practically sedated", "I was flattened" (Woman 3)*

Participants described paternalism as one of the most frequent practice the health professionals showed towards them, and the participants described situations in which the professional interfered with the patient's autonomy. In our study, paternalism was demonstrated on one side through the use of power, wherein the superiority of the professional influences their decision making. Additionally, for the condemnation of the behaviours of the person with a psychiatric diagnosis, one participant stated that "*the psychologist criticised my attitude with my mother and he compared me to a monster, like a spoiled boy who did nothing to recover" (Man 7)*. Pressure to accept treatment or the administration of drugs without due consent was also described: *"I am in forced outpatient treatment. This is the second time that they have prescribed it to me, and I've told them it makes me feel bad" (Man 8)*

Malpractice describes situations of negligent attitudes and acts by the professionals. We observed several violations of protocol that occurred during mechanical restraint, with one participant noting: *"According to the protocol, they have to check on you every 15 or 30 minutes because if you are restrained, you cannot move. So, they do not comply with the protocol; since you're tied up, they know you can't move or attack, or anything, so they ignore you" (Man 13).* Additionally, subjugation occurs when actions are taken to impose the authority or discipline of the organisation, which was evident in the following case: "*I remember that I had a free hand and because I kept saying, "Please, come someone; please, come someone", the nurse came and tied me the other hand" (Woman 2).*

Finally, people with mental disorders perceived that professionals did not have holistic views and that they were only treated with the sole use of a biological therapy, with one participant stating *"I would get the injectable, go home almost vomiting and then I would think...if they had listened to me and talked to me, there wouldn't have been so many injections" (Man 12).*

Theme 3. Emotional and behavioural impacts

This theme includes subthemes and categories in which the people with mental disorders expressed how they felt and behaved for the way professionals treated them. The participants felt that prejudice and how the professionals treated them had an impact on their emotional status. This theme includes three subthemes: Effect on self-concept, fear and Lying as an alternative.

They expressed their self-concept was adversely affected by the multiple occasions in which they felt mistreated and undervalued: *"We listened to the professionals speak, and we did not participate; it was as if they had to teach us something. At the end of the course, you were given a grade, totally childish" (Man 12). "I remember telling things to a psychologist, and he just looked at me, laughed and said nothing. It's not that he didn't understand me, it's that he thought I was crazy and left me like that, I felt humiliated, and I left" (Man 6).* Moreover, they suffered losses of self-confidence, and it was demonstrated that perceptions of stigma had also been adversely affected, with one participant noting *"you don't want anyone to know you in the doctor's waiting room" (Man 5).*

In the subtheme of fear, the experiences of the participants who had described being afraid of the implications of their interactions with health professionals were measured, and we demonstrated that the fear that the participants have could be classified into mistrust and a fear of losing control of their lives, with a participant stating that they were *"unprotected", "vulnerable", "like all my rights had evaporated", "I was nothing" (Women 2*). Additionally, fear was represented as a fear of the consequences of expressing emotions and behaviours, with a participant stating *"It is not fear; it is dread. Fear translates mainly into barriers that we build ourselves, into obstacles that we cannot overcome, in limitations and the fact of a modus operandi that perhaps is not benefiting us but the one that has been* *instilled in us throughout the mental health circuit" (Man 11).* Moreover, they would not seek help from mental health professionals in the presence of mental distress.

"*If I have already been restrained twice, how do you expect me to feel safe going to the emergency room when I feel bad?" because for me going to the emergency room is a danger. [...] So, of course, if they tie you up, and you have that feeling, you do not want to go to the hospital for help because the hospital is a threat to you" (Woman 2).*

In terms of the behavioural impact, the participants reported that the manner in which they were treated modified their behaviour. Additionally, there was an inability to engage in dialogue or to reach agreements with health professionals, due to a fear of adverse consequences, as well as the fact that people with mental disorders would hide information or lie as a safeguard, with a participant noting: *"With medication, I've had side effects. I stopped taking it, and I have not taken it until now. They do check-ups and blood tests. However, since I had already told the doctor that I had these effects, and I had asked for it to be reduced, and said no, I did it on my own, and it worked well. Before the blood test, I take 3 or 4 pills as I used to, and that is it. When I find another solution or when two or three years have passed, I will tell them" (Man 14).*

Theme 4. Demands

In this theme, the participants provide suggestions for the improvement of health care for people with mental disorders. There was unanimity among the study participants in regards to what their demands were. There were three primary categories: information about the drugs (and their side effects), therapeutic needs and the humanisation of care.

In the category concerning the information about drugs and their side effects, the participants reported that they required more information about their drug regimens and their adverse effects, and one participant was of the opinion that *"I take quetiapine; I know what olanzapine is, I know what lithium is, but not because of what the doctor has told me", "And about side effects, of course, you will not be informed" (Man 7).*

In the categories concerning therapeutic needs and the humanisation of healthcare, the participants expressed that they required another type of therapy besides biological treatment. They did not receive any additional therapies that they thought would be beneficial for them. Some participants suggested that the professionals who were treating them did not care about what they considered to be essential; instead, the professionals only focused on treating the symptoms and did not treat the person's essential discomfort. "*This is missing in the health system for the person with a mental health condition; the patient is not listened to; psychiatric drugs are favoured, which are sometimes even forced. They don't listen, they don't work therapeutically with the patient or consider mental diversity. No, it's a waste of time" (Woman 5).* They feel they need to talk about their experiences and emotions in order to heal them *"I want to emphasise the value of therapeutic work. I was a person who, at the age of 40, was unaware of what had happened in her life, didn't even remember that had been sexually abused! And that's like revealing your own life, that you don't know" (Woman 5).*

In conclusion, they unanimously agreed that they would like to be treated more humanely by the health professionals:
"I think doctors in medical school should be trained for a few hours in…" (Man 1). "… Humanity" (All nod).

Discussion

The aim of this study was to explore relationships with health professionals from the perspectives of people with mental disorders in Spain. The focus groups had a longer duration than usual (Krueger & Casey, 2015). We believe the participants felt they were in an environment of trust, so they openly shared their experiences; in this sense, it was very beneficial to have the presence of a person with his own experience in mental disorder in the research group, since it facilitated the opening up at the end, and the participants told us that they had felt heard and understood.

The participants in this study perceived paternalistic attitudes and prejudices among health professionals. These attitudes are common and are independent of medical speciality (cardiology, oncology, urology, emergency, psychiatry) or profession (medicine, nursing, psychology).

In the Mediterranean culture, it has been reported as a frequent practice that the healthcare professionals act in a paternalistic manner, considering they knew what was better for the patients, ignoring their opinion (Aznar-Lou et al., 2016). Anglo-Saxon and Nordic societies are considered to be much more individualistic due to cultural differences, showing great respect for the patient's decision-making autonomy (Busquets et al., 2012). Therefore, one would expect different perceptions of persons from diverse cultural contexts about their relationships with health professionals. However, the results of our study show that relationships with health professional relationships are perceived as negative by people with mental disorders, similar to the findings of studies conducted in North America and northern European countries (Arboleda-Flórez & Stuart, 2012; Ljungberg et al., 2016; Newman et al., 2015). The perceptions of the participants in this study suggest that the difficulties in transforming the relationships with health professionals into a therapeutic alliance are independent of cultural traditions and that, in a context that has been traditionally paternalistic (such as the Mediterranean culture), people with a psychiatric diagnosis will demand a change in health care towards a practice that is based on the establishment of this therapeutic alliance.

Given the importance that the scientific literature attributes to the therapeutic alliance as a fundamental tool for treatment efficacy, it is striking that none of the three components described by Bordin (1979) are considered in practice. The participants in our study expressed that health professionals do not seek consensus regarding therapeutic goals or agreement on tasks. Instead, they assume a paternalistic role, with which they feel legitimised to impose their criteria on the therapeutic approach to the health problems of people with mental disorders. This role translates into coercive attitudes and rules and communication styles in which the professional acquires a superior hierarchical status, and the people with mental disorders perceive a loss of freedom to act and feel vulnerable (Norvoll & Pedersen, 2016). These attitudes become manifest in situations in which health professionals disagree with or intervene in the decisions, wishes, or actions of another person to provide them with a benefit or protect them from harm (Beauchamp & Childress, 2013). It should be remembered that coercion is not solely objective; it can also be perceived (Jaeger & Rossler, 2010). Consequently, as narrated by the participants in this study, people with mental disorders might feel coerced by the superiority of the professional behaviours such as addressing the companion when providing information or giving instructions about treatment and not clarifying the person’s doubts can be considered coercive (Szmukler, 2008) since people with mental disorders perceive that not accepting the professionals’ suggestions could have negative consequences.

The third component of the therapeutic alliance described by Bordin (1979), the need to establish an emotional bond between the health professional and the person, does not occur either. People with mental disorders who participated in this research felt that health professionals in all fields and specialities treat them differently when they learn that they are mentally ill, interpreting everything that happens to them (symptoms, behaviours, reactions) as related to their mental disorders. One of the main consequences of these prejudices is the erroneous interpretation of their suffering, both physical and psychological, and they believe that health professionals attribute the symptoms or problems of people with a psychiatric diagnosis to their mental disorder or consider them an adverse effect of psychiatric medication, consequently increasing the risk of underestimating the severity of the problem and delaying treatment (Henderson et al., 2014; Neauport et al., 2012).

The results of our study agree with those of a recent systematic review showing that these professionals commonly hold stigmatising attitudes towards the mentally ill, especially those with schizophrenia (Vistorte et al., 2018). Interestingly, when referring to their relationships with mental health professionals, the participants tended to refer to negative experiences and relationships despite health professionals in this field being specialised and being assumed to have better training and sensitivity in interacting with people with mental disorders. Some studies have argued that specialised mental health training decisively influences trainees negatively and leaves stigmatising attitudes towards people with mental disorders (Thornicroft, Rose & Kassam, 2007; Wahl & Aroesty-Cohen, 2010).

In the absence of a good therapeutic alliance, people with mental disorders do not feel involved in decision making about their illness and treatment. The participants in our study did not perceive that the professionals consider them part of the SDM process, although some studies have suggested that SDM can improve satisfaction and adherence to treatment (Klingaman et al., 2015). Our study participants perceived that decisions, especially those related to medication, were made unilaterally by the health professional, and they sometimes felt forced, punished, or even humiliated when they attempted to refuse medication or commented on it. These results are consistent with similar studies conducted in other cultural contexts (Bacha, Hanley & Winter, 2019; Raboch et al., 2010; Szmukler, 2008; Seo, Kim & Rhee, 2013; Tingleff et al., 2017; Thornicroft et al., 2007), in which people with mental disorders described similar perceptions of being chastised and humiliated in their relationships with health professionals.

The perception of not being able to comment on their treatments is especially relevant since it relates to a perception of inconsistency in prescribed treatments; the participants reported that the specific drugs and prescribed doses vary depending on the assigned psychiatrist. They even perceive inconsistencies between the intensity of the symptoms that they describe, and the drugs prescribed, including perceptions of being overmedicated. Several studies conducted more than a decade ago already showed high variability in drug prescribing in terms of drug types and dosages for people with mental disorders (Bitter, Roeg, van Assen, van Nieuwenhulzen & Weeghel, 2003); such variability is perceived by them when they change professionals (Schulze, 2007). It is difficult to understand the reasons for the many differences among professionals in therapeutic approaches to mental disorders, but they might be related to the heterogeneity of the categorical diagnostic classification system; this heterogeneity causes professionals to focus on identifying diagnostic labels based on sometimes nonspecific symptoms, rather than focusing on the individual experiences of people with mental disorders (Allasop, Read, Corcoran & Kinderman, 2019), a conclusion that is also consistent with the discourses of our study participants.

Bearing in mind that health professionals, and specifically mental health specialists, are the professionals whom people with mental disorders should seek out for help, it is striking that the participants' described experiences on admission to specialised psychiatric units were very negative. Some of the participants even claimed to feel deliberately punished by nursing professionals, mainly through the inappropriate use of mechanical restraints. Although rare, some studies have reported that participants have openly described having been physically restrained as punishment (Ljungberg et al., 2016; Tingleff et al., 2017). However, we found no studies in which participants perceived possible malpractice by health professionals, as described in our results. The participants were aware their vital signs should have been periodically checked while under mechanical restraints; however, they were not, and thus, their treatment did not comply with the usual restraint procedures. This situation reflects that an increasing number of people with mental disorders know the procedures and their risks, which can lead them to require more accountability from professionals, especially in terms of involuntary or traumatic procedures, such as physical restraints.

As described by Corrigan (2004) and Tingleff et al.,(2017), one of the most important consequences for the participants in this study is the development of different types of fear as a consequence of negative experiences. We have described feelings of fear that because they have been labelled with a psychiatric diagnosis, their expression of emotions or actions might be misunderstood; others might believe that the people with mental disorders might be aggressive or might always interpret their actions as symptoms of their disorder (Ljungberg et al., 2016; Newman et al., 2015). The perception that health professionals hold stigmatising attitudes causes the participants in our study to be reluctant to exercise their rights and denounce abuses of power or situations of possible professional malpractice, for fear of not being believed or having to repeat previously experienced situations, leading them to fear losing control over their lives and being considered disabled. All of these factors affect their self-esteem and self-concept, decreasing their confidence and decision-making capacity (Corrigan, 2004; Seo et al., 2013).

The behavioural reaction to this fear is defensiveness, and as a result, in a situation of physical illness or mental suffering, people with mental disorders do not seek professional help (Seo et al., 2013; Sickel et al., 2015). In our study, we found that they became cautious and ended up lying or hiding information from health professionals (Ådnøy et al.,2014; Bacha et al., 2019), serving to confirm to the professionals their stigmatising ideas regarding people with mental disorders.

The purpose of emancipatory research is to hear the voices of people who are suffering from a situation of social injustice and for them to participate in the entire process of change by proposing solutions to their problems (Walter, 2017). The participants were unanimous in asking for more humanity in the treatment of health professionals towards people with mental illnesses. The other demand was that professionals apply the SDM principle to determine treatment by consensus, which would require an adequate therapeutic alliance. However, SDM is a key element in mental health recovery (Klingaman et al., 2015) because it allows for proactive self-care (Zeber et al., 2008) and contributes to improved self-esteem and health-related quality of life (Newman et al., 2015). For the participants in our study, the health professionals responsible for their treatment did not routinely apply this principle in the field of mental health. Besides, in line with the results obtained by Cutcliffe, Santos, Kozel, Taylor and Lees (2015), the lack of consideration of the person's opinion worsens in cases of involuntary admissions to acute psychiatric care units or when compulsory treatment is ordered. It seems that clear strategies that consider the cultural changes required within organisations and among professionals, access to decision support tools, and integration of SDM with other recovery support interventions are needed for the implementation of SDM in health systems (Slade et al., 2017).

This study has some limitations. For the specific characteristics of our research and the vulnerability of the participants, there was a risk that, due to the stigma that people may experience from being diagnosed with a psychiatric disorder, the participants would selfcensor or refer to experiences that were similar to those of the majority of the group. By using an emancipatory framework, we attempted to reduce these biases and to maintain a balance between the perspectives of both the researcher and the affected person, to achieve a more objective view of the topic of the study. Conversely, as this was a qualitative study in which the perceptions of the individuals were measured, the generalizability of the acquired results to the rest of the population (who have similar characteristics) is difficult to achieve, despite having applied methods to increase the rigour of the study.

In conclusion, people with mental disorders who participated in this study perceived prejudice, paternalism, abuse of power and lack of competence from health professionals as being barriers to setting goals and to respecting their decisions about the necessary. This makes it difficult to establish an appropriate therapeutic relationship between the person with a psychiatric diagnosis and the health professional. These results may provide relevant reflections on how to conduct optimal clinical practice.

What the study adds to the existing evidence

This study is the first conducted in the Mediterranean context to explore the therapeutic alliance using emancipatory research. This type of research has allowed us to thoroughly explore the perceptions of people with mental disorders and provide evidence of a change in the way in which people with mental disorders understand their relationships with health professionals in the Mediterranean context. People with a psychiatric diagnosis are increasingly aware of their rights, the procedures that should be followed during hospital admissions, and different treatments, rendering them more critical of the work of health professionals. Also, they question the legality of some actions performed by health professionals and the asymmetric relationship between themselves and their care providers. People with mental disorders feel that health professionals still hold stigmatising attitudes, which result in a lack of attention to their treatment preferences and prevent the establishment of meaningful relationships. In addition, people with mental disorders report experiences of abuse of power, malpractice, and overmedication. They demand to play an active role in their treatment by participating in decision-making about their therapeutic regimens, specifically in terms of taking medication, and they demand to be heard by professionals who not only ask for their symptoms but listen to their needs.

Implications for practice

People with a diagnosed mental disorder who participated in this study required from health providers a humanisation of care, through 1) symmetric views and attitudes towards people with mental disorders, free of prejudice and paternalism; and 2) competence in care, adapting evidence-based practices to SDM.

The participants referred to having a negative perception of their relationship with health professionals; this perception poses a barrier to the establishment of a therapeutic alliance, which can have a negative impact on treatment adherence, the seeking of help, and the number of hospital admissions (Tessier et al., 2017). Health professionals must be aware of the people with mental disorders' perceptions of their actions and the effects that they have since awareness is the first step towards changing attitudes. Furthermore, this information indicates that health professionals, especially those in mental health, must have adequate training to create an emotional bond if they are to establish effective therapeutic alliances. Training activities should aim to reduce prejudices towards people with mental disorders and promote self-reflection and SDM.

Specifically, awareness-raising activities during professional training that are based on direct contact with people who have had mental health problems have proved effective in reducing stigmatising attitudes (Happell et al., 2014; Martínez-Martínez et al., 2019). Such training is vital during university education and before health professionals enter the work world to avoid a physician bias that confirms existing prejudices. These biases arise because, in the healthcare context, professionals only relate to people who have not recovered fully or have had recurrent hospital admissions, without being aware that many people with mental disorders have normalised lives in the community (Thornicroft et al., 2007).

In contrast, specific and continuous training in SDM, conflict resolution, nursing responsibility, self-reflection, and exploration of one's values (Registered Nurses Association of Ontario [RNAO], 2012) can provide professionals with the necessary skills to implement alternatives to prevent physical restraints, the use of which is more related to factors such as culture, tradition, or institutional policy than clinical reasons (Steinert, 2010). For example, noncoercive de-escalation has decreased hospital stays; this technique favours the establishment of a therapeutic relationship since both professionals and people with mental disorders consider it a success, in turn decreasing the possibilities of both physical and psychological harm (Richmond et al., 2012)

Finally, to promote SDM, nurses should participate in developing protocols and procedures that facilitate the active participation of people with mental disorders in their care and in defining their treatment and continuity of care plans. These procedures could include psychiatric advance directives stating the desires of the person if, at a particular time, they are deemed incompetent to decide which treatment option is more advisable for restoring their health. (Campbell & Kisely, 2009)

We believe that research should continue exploring the effects of therapeutic relationships and their influences on the criteria for assessing the quality of care received, ensuring the continuity of care, and reducing the number of admissions to acute care units. Specifically, studies should explore the people with mental disorders' perceptions of the amounts and types of medications administered to them and their effects since drug prescriptions vary widely in terms of type and dosage if the therapeutic goal has not been previously established (Bitter et al., 2003).

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Tables

Table 1. Sociodemographic data of the participants.

AGE (years) mean (SD)	46.33
N=25	N (%)
GENDER	
Men	19 (76.0)
Women	6 (24.0)
FORM OF COHABITATION	
Alone	11 (44.0)
With their own family	8 (32.0)
With their birth family	5 (20.0)
In a supervised flat	1 (4.0)
EDUCATIONAL LEVEL	
Compulsory/Basic	6 (24.0)
Vocational studies	5 (20.0)
Bachelor’s degree	5 (20.0)
Higher education	9 (36.0)
CURRENT ACTIVITY	
Studying	2 (8.0)
Part-time job	2 (8.0)
Full-time job	1 (4.0)
Unemployed	9 (36.0)
Disability pension	11 (44.0)

PSYCHIATRIC DIAGNOSIS	
Schizophrenia	12 (48.0)
Bipolar disorder	5 (20.0)
Major depression	5 (20.0)
Schizoaffective disorder	1 (4.0)
Borderline personality disorder	1 (4.0)
Schizoid personality disorder	1 (4.0)
ON TREATMENT WITH ANTIPSYCHOTICS	
Yes	19 (76.0)
No	4 (16.0)
Unknown	2 (8.0)
Number of individuals with somatic diagnoses	16 (64.0)
Number of individuals taking non-psychiatric	10 (40.0)
Number of hospital admissions in the last two	
Psychiatry	10 (40.0)
Other	0

Table 2. Examples of condensed and coded meaning units.

Meaning unit	Condensed meaning unit	Code
I’m afraid to say some things as they could be attributed to my mental disorder. They take what they are interested in.	You don’t report everything to the psychiatrist because you’re afraid he or she will attribute everything to the disorder.	Attributing behaviour to mental illness
They treat you like a child, in a childish way. I was with my partner, and instead of explaining what I had to do, with regards to the exams and the therapeutic regimen, the psychiatrist said: “Well, we explained it to your partner...”	He treated me like a child as the instructions were provided to my partner.	Infantilized
I am in forced outpatient treatment. I cannot choose not to treat myself right now. I am being injected with a drug, and they do not believe me when I say that this is the second time that I have been prescribed this precise drug and that it makes me sick, and they answered me that they do not remember. Now I will try to get to court to register my disagreement	I am in involuntary ambulatory treatment, and they do not believe me when I tell them that this drug makes me sick; they say they do not remember. I want to register my disagreement.	Involuntary outpatient treatment
I don’t trust her much, because when I have told her something, she has not been receptive. She makes her own decisions and decides to use her medication. If you tell everything to the psychiatrist, what will she do? Well, she will likely increase your medication. Therefore, I don’t provide her with information.	I don’t trust my psychiatrist because she doesn’t listen to me. If I tell her everything that is happening to me, she will increase my medication; therefore, I do not	Lying to the psychiatrist

	tell her.	
I went to my family doctor and told him that they had increased my percentage of disability, and he told me that it would be better because that way, I would get paid a higher pension. I didn't want to go back, and in fact, I only went back because I had bronchitis, but I hadn't been there for two years. It's not just what he says but how he says it.	The doctor's comments and the way he or she says things makes you feel uncomfortable.	Lack of empathy
I was admitted on March this year, and they also restrained me and left me from eight in the evening until 10 in the morning without anyone checking in, without giving me water or anything.	Health professionals did not check on the person's health status during restraint	Protocol violation

Table 3. Description of the themes, subthemes, and categories.

STEREOTYPES AND PREJUDICE	It includes categories in which the participants perceived that professionals had preconceived negative ideas towards people with a psychiatric diagnosis, through their involuntary manners.
Inequities in discrimination	It includes codes in which the participants state that the degree of discrimination varies according to different disorders.
Dangerousness	It includes codes in which the participants perceive fear in the professional
The person is not given credibility	It includes codes in which the participants state that the professional undertakes action to confirm by different means that the information provided by the person with a psychiatric diagnosis is true.
Lack of capacity	It includes codes in which the participants state that the professional attributes to them a lack of intelligence.
Everything the person refers to can be explained through the disorder	It includes codes in which the participants state that any feeling, action, or behaviour is attributed to and explained through the mental disorder.
QUALITY OF INTERACTIONS AND TREATMENT	It covers subthemes reflecting the participants' perception of prejudice in the professionals' voluntary therapeutic interventions and the treatment provided.
Abuse of power	It includes categories in which the participants describe situations in which the professionals use their position of superiority to impose their criteria.
Underestimation	It includes codes in which the participants state that they are seen from a position of superiority and treated

	with rejection by the professionals.
Silencing the person's voice	It includes codes in which the participants reflect that they are not listened to when expressing concerns or complaints.
Professional incompetence	It includes categories in which the participants describe perceiving that the care team lacks the abilities or the knowledge to perform their professional duties.
Ineffective communication	It includes codes in which the participants perceive that communication is not efficient and that there is a lack of empathy in listening attentively and being able to understand and synthesise the information provided by the person with a mental disorder.
Lack of concern	It includes codes in which the participants describe that the healthcare professionals show no interest or concern about the side effects of the medication.
Inconsistency in the treatment	It includes codes in which the participants state that the prescription of treatment is not consistent but arbitrary, depending on each professional.
Overmedication	It includes codes in which the participants report that they are taking more drugs than they need.
Malpractice	It includes categories in which the participants describe situations that expose negligent attitudes and acts by the professionals.
Subjugation	It includes codes in which the participants describe that the professionals perform actions to subject them to the authority or discipline of the organisation.
Protocol violation	It includes codes in which the participants state that healthcare professionals do not follow the protocols and procedures to ensure the safety of the person.

Paternalism	It includes categories in which the participants describe situations in which the professionals interfere with the autonomy and freedom to choose of the person.
Power	It includes codes in which the participants attribute the ability or superiority of the health professionals to influence decision making.
Pressure for treatment	It includes codes in which the participants perceive that the professionals perform interventions aimed at inducing the person to accept treatment.
Condemnation	It includes codes in which the participants state that health professionals disapprove of their actions through words or gestures.
Involuntary treatment	It includes codes in which the participants state that the healthcare professional imposes treatments against their will to avoid major harm.
Biological therapy	It includes categories in which the participants perceive that the professionals ignore their social and psychological domains.
Reduced concept of the disorder	It includes codes in which the participants express that they feel that the professionals do not see the person holistically.
Drugs as the only treatment option	It includes codes in which the participants state that the professionals prescribe drugs as the only treatment.
Holistic perspective	It includes codes in which the participants express that they feel well treated by the professional.
Holistic perspective	It includes codes in which the participants express that they feel well treated by the professional.
EMOTIONAL AND BEHAVIOURAL IMPACT	It includes subthemes and categories in which the participants express how they feel about the treatment received from the professionals.

Effect on self-concept	It includes categories in which the participants state that their perceptions are affected by how they are treated.
Mistreated	It includes codes in which the participants describe being treated inappropriately by the professionals.
Feeling undervalued	It includes codes in which the participants suffer as a consequence of being considered less capable by the professionals.
Self-stigma	It includes codes in which the participants describe internalising the negative characteristics linked to mental disorders.
Loss of self-confidence	It includes codes in which the participants describe underestimating their capacities.
Fear	It includes categories in which the participants describe being afraid of the implications of their interactions with the professionals.
Mistrust	It includes codes in which the participants describe losing confidence in the professionals.
Loss of control over one's own life	It includes codes in which the participants describe feeling unprotected or restricted in making decisions when they are with the professionals.
Fear of consequences	It includes codes in which the participants describe being afraid of the professionals' reactions to their expressions or behaviours.
Lying as an alternative	It includes a category in which the participants describe that to avoid negative consequences, one of their options to protect themselves is to hide information or lie to the professionals.
Lying	It includes codes in which the participants describe not telling the truth to the professionals.
DEMANDS	It includes categories in which the participants express care deficiencies and suggest interventions to improve how the professionals treat them.

Information about drugs and their side effects	It includes codes in which the participants indicate that the information provided about the medication and side effects of the medication is very scarce or non-existent.
Therapeutic needs	It includes codes in which the participants express the types of therapies that they believe they need.
Humanisation of healthcare	It includes codes in which the participants demand humanisation of the treatment.

Table 4. Themes, subthemes, and categories, with the frequencies of the codes in each category.

Theme/Subtheme		Categories	Codes	Grounding
Stereotypes and prejudice		Inequities in discrimination	Discriminatory treatment according to disorder	1
			Discriminatory treatment according to diagnosis	1
			Discriminatory treatment according to appearance	1
		Dangerousness	Fear of the professional	9
		The person with a psychiatric diagnosis is not given credibility	Contrasting information with a companion	2
			Control over taking medication	2
		Lack of capacity	Going to the companion	7
			Lack of intelligence	3
		Everything to which the person refers can be explained through the disorder	Attribution of physical symptoms to mental illness	8
			Reactions as symptoms of mental illness	7
			I treat you differently because I recognise you as having a mental illness.	8
			Attribution of behaviour to mental illness	5
		Categories 5	Codes 12	Grounding 54
Quality of interactions and treatment	Abuse of power	Underestimation	Disrespect	12
		Silencing the person's voice	Lack of negotiation over medication	17
			No admission when requested by the person	3
			Lack of help from the professionals	6
	Professional	Ineffective communication	Barriers to contact: not looking into the eyes	8

	incompetence		Lack of empathy	6
		Lack of concern	Not asking about symptoms	8
		Inconsistency in the treatment	Arbitrariness of decisions	4
			Randomness of the assigned professional	17
		Overmedication	Overmedication	6
	Malpractice	Subjugation	Punishment	2
		Protocol violation	Protocol violation	3
	Paternalism	Power	Professional superiority	27
		Pressure for treatment	Medical coercion	11
			Coercion	5
		Condemnation	Condemnation	2
		Involuntary treatment	Mechanical containment	18
			Involuntary outpatient treatment	3
	Biological therapy	Reduced concept of disorder	Symptoms asked by a psychiatrist	6
			Reduced concept of disease	5
		Drugs as the only treatment option	Medication as a treatment	9
	Holistic perspective	Holistic perspective		
		Categories 15	Codes 21	Grounding 181
Emotional or behavioural impact	Effect on self - concept	Mistreatment	Infantilized	6
			Feeling mistreated	3
		Feeling undervalued	Feeling ignored	12

			Feeling embarrassed	6
			Loss of opinion value	8
		Self-stigma	Self-stigma	10
		Lost self-confidence	Loss of self-confidence	1
	Fear	Mistrust	Distrust in the absence of drug information	3
			Not seeking help in the face of psychic discomfort	2
		Loss of control over one’s life	Unprotected	3
		Fear of consequences	Uncertainty	4
			Fear to express things	3
			Fear of emotions	3
	Lying as an alternative	Lying	Lying to the psychiatrist	10
		Categories 8	Codes 14	Grounding 74
Demands		Information about drugs and their side effects	Lack of information provided about drugs prescribed	20
		Therapeutic needs	Person’s therapeutic needs	18
		Humanisation of care	Humanity	3
		Categories 3	Codes 3	Grounding 41
	Categories 31		Total codes 50	Total Grounding 350

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	6
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	Title page
Occupation	3	What was their occupation at the time of the study?	Title page
Gender	4	Was the researcher male or female?	9
Experience and training	5	What experience or training did the researcher have?	6,9
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	9
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	N/A
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	6-7
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	10
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	7-8
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail,	8

		email	
Sample size	12	How many participants were in the study?	7
Non-participation	13	How many people refused to participate or dropped out? Reasons?	7
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	9
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	9
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	7-8, Table 1
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	N/A
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	9
Field notes	20	Were field notes made during and/or after the interview or focus group?	9
Duration	21	What was the duration of the inter views or focus group?	9
Data saturation	22	Was data saturation discussed?	8
Transcripts returned	23	Were transcripts returned to participants for comment and/or	6

Topic	Item No.	Guide Questions/Description	Reported Page No
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	10
Description of the coding tree	25	Did authors provide a description of the coding tree?	Tables 3 anc
Derivation of themes	26	Were themes identified in advance or derived from the data?	11
Software	27	What software, if applicable, was used to manage the data?	10
Participant checking	28	Did participants provide feedback on the findings?	N/A
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	11-18
Data and findings consistent	30	Was there consistency between the data presented and the findings?	11-18, Table and 4
Clarity of major themes	31	Were major themes clearly presented in the findings?	11-18, Tables and 4
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	11-18

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357