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'To see each other more like human beings… from both sides.' Patients and therapists going to a study course together

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Abstract
Background: The relationship between patient and therapist has long been of central importance in mental health and substance abuse services, and in recent years the perspectives of equal footing, collaboration and partnership have been emphasised. In this paper we present the experiences of participating in a common study course for mental health or substance abuse patients and their therapists.
Objectives: To explore the participants' experiences of the course, and its impact on the relationship between the patient and therapist and on the processes of empowerment and recovery.
Methods: A semi-structured, qualitative focus group interview was conducted and analysed within a thematic and phenomenological framework, with hermeneutic phenomenology as the approach.
Results: The following themes emerged through the analysis: recognising common humanity and common strength; being accepted as a person, an inviting control-free zone; and doing things differently.
Conclusion: The significance participants attach to discovering common humanity and reciprocity in the therapeutic partnership and the positive impact of training together draw attention to the potential for more collaborative ways of competence building and service transformation.
Implications for practice:
- Identify the possible impact of common study courses on therapeutic relationships
- Recognise the potential of involving patients and service users in practitioners' training and competence building
- Recognise the impact of context on therapeutic relationships

Keywords: Mental health, study course, therapeutic relation, recovery, empowerment

Introduction
The relationship between patient and therapist has long been of central importance in mental health and substance abuse services. In the field of psychotherapy, Jerome Frank (1963) was one of the first to explore the factors that seemed to be common to successful therapies, independent of the theoretical perspectives of the therapist. Frank argued that psychotherapeutic change was predominantly due to a number of non-specific factors, which are brought into focus by the development of the relationship between patient and therapist. He claimed that a safe and supportive relationship that boosted morale would enable a person to find hope and recommit to the necessary changes. Frank identified the non-specific factors in the therapeutic relationship as:

- Feeling understood
- Being respected
- Having someone be interested
- Being encouraged to face difficulties and overcoming them
- Being accepted and being forgiven

Frank's focus on non-specific factors in therapy has been followed up by Duncan, Miller and Sparks (2004) and Lambert (2007), and in recent times there has also been an emphasis on systemising the clients' experiences of the therapeutic process through structured feedback.

Within recovery research, similar factors are shown to have been experienced as helpful by the patient involved (Davidson, 2003; Borg and Kristiansen, 2004; Glover, 2005; Slade, 2009). These are:

- Establishing and maintaining mutual relationships
- Shared decision making
- Nurturing hope
- Confidence and commitment
- Having choices
- Community involvement and becoming an empowered citizen
- Support in everyday life contexts, with an emphasis on tailored information and open communication

A more empowered patient and service user role and a more collaborative practitioner role have gradually developed in mental health services, drawing on national policies as well as empirical and theoretical knowledge (Campbell, 1997; Deegan, 2005; Boevink, 2012; Anderson, 2012).

The World Health Organization has outlined empowerment as an 'important element for improving health outcomes' (Jakab, 2012, p 2) and a proactive partnership and self-help strategy to help improve health outcomes and the quality of life among people with long-term health problems (Neuhauser, 2003). Essential components of empowerment are typically described as self-efficacy, participation and collaboration, a sense of control, meeting personal needs, understanding the environment, personal action and an access to resources (Dempsey and Foreman, 1997). Empowerment can be experienced as both an outcome and a process, and additionally as the development of a person's ability to wrestle their way out of a seemingly hopeless situation to find new meanings in life (Boevink, 2012). Mental health professionals have an expertise in psychological support and processes of change, as well as knowledge about mental illnesses, addiction and about helpful relationships, all of which are valuable resources. However, an awareness of power issues in treatment is essential, and there is a need to change traditional authoritarian attitudes among mental health professionals. Moreover, it is vital to find ways of addressing and overcoming obstacles to empowerment and recovery in order to prevent health professionals themselves becoming barriers in a person's recovery process.

In Norway, the recent Coordination Reform (Hanssen, 2008-2009) puts an emphasis on collaboration and partnerships. As we understand it, collaboration is founded in human relationships – developing dialogues and working in partnership. We support the definition of Strong et al. (2011), who stress negotiating and sharing initiatives, knowledge, and judgment in counsellor-client dialogues. Some of the recommendations of the Coordination Reform are related to strengthening the relationship between service user and practitioner, as well as strengthening service user participation in service development on all levels. Despite good intentions, repeated policy programs and research findings, service users still raise issues such as not feeling respected, not being listened to, and professionals talking over their head and not valuing person-centred approaches (Glover, 2005; McCormack and McCance, 2006; Borg and Davidson, 2008).

This paper draws on the results from a research project in which the goal was to address the challenges embedded in therapeutic relationships by inviting the therapists and their patients to the same study course as pairs in a collaborative practice. The study course was inspired by Boevink (2011) with the following objectives:

1. For the patients to strengthen their awareness of personal and social resources, and their role as active agents in treatment settings
2. For therapists to strengthen their recognition and awareness of the patients' skills and competencies
3. For both parties to learn about empowerment and recovery-oriented collaborative practices, with the aim of strengthening the therapeutic alliance

Furthermore, the hope was to transfer the knowledge and skills learned from the course into therapy and everyday life.

The concrete aim of this paper was to explore service users' and professionals' subjective experiences of attending the study course together, and the following two research questions were asked of patients and therapists:

1. How would you describe your experiences in relation to the content and the processes of the study course?
2. In what ways has the study course had an impact on your own awareness and role in the process of empowerment and recovery?

We describe the methodological approach of the study and our findings below.

Method

With its focus on subjective experiences and meaning, the study was carried out within the framework of a hermeneutic-phenomenological approach (Hummelvoll, 2008; Borg et al., 2010; Finlay, 2011). This approach was chosen to explore the first-person experiences of the participants, with the study being inspired by Finlay (2011), who described 'doing phenomenology' as a focus on lived experience and meaning, the use of rigorous, rich and resonant descriptions, a concern with existential issues and a potentially transformative relational approach. The meaning of any phenomenon is generated and created through dialogues in social relations, as words and stories are shared in a common and intersubjective discourse. The hermeneutic element of this is based on an understanding that the formation of knowledge includes a form of interpretation in one way or another (Kvale and Brinkmann, 2009). The phenomenological element consists of a desire to explore and describe the experiences as they are understood and told by the participants (van Manen, 1990), which is done by attempting to stay as close as possible to the stories as related by the participants. Based on a reflexive methodology, there is a reflection on the researchers' prior understanding of the participants' experiences, as well as how this might have influenced the analysis of the material (Alvesson and Sköldberg, 2009). By hearing and interpreting the stories, a meaning was created that arose from the participants' context, the interview context and from the understanding of the researchers.

Study context

The data for this paper were derived from a larger project entitled, 'Developing a common study course on empowerment and recovery for service-users and professionals', (Sjølyst and Revheim, 2011; Boevink, 2012). Areas focused on in the study course were collaborative relationships and equality in the therapy process, valuing human strength and resources, and finally the participants' experiences and understandings of recovery and empowerment. The instructors of the course were an experiential expert – a term typically used of a person with lived experience of substance abuse/mental health problems – and a mental health professional, who together developed the course content inspired by Boevink (2012).

In order to recruit pairs of a patient and a therapist, contact was made with a mental health centre and an outpatient clinic for persons experiencing mental health illness and substance abuse. The process of recruitment for the study course was done by informing the management and professionals about the ongoing project, while the therapists who wanted to participate were asked to inform and invite some of their patients to take part in the course. Furthermore, the course leader with a professional background had been working in the clinic for some years and knew the people and context well. A brochure describing the objectives and content of the course was sent to each prospective participant.

The site was a service user organisation, with the course lasting a day and a half. It started with introductory exercises to establish a group feeling of unity and equality. This was followed by an exercise in which the patients talked together about what was important in their treatment situations and everyday lives; here, the mental health professionals held the position of an audience and were able to observe how the patients learned from each other and talked together. Afterwards, the therapists were invited to reflect on and share their experiences of the patients' conversation. Later on, there was a discussion about the therapist's role, and the concept of empowerment was explored in more depth. Between the first and second days, each patient and therapist had to prepare a short presentation with the theme: How can patients become engaged and support themselves in their journey towards recovery and wellbeing? Day two started out the same as day one, with some exercises. The participants' homework was presented to the group and the concept of recovery was further explored.

Participants

There were five patient-therapist pairs, a total of ten participants in the study, including four female patients and one male patient between the ages of 27 and 43, with a mean age of 36 years. All patients had experienced severe mental illness or substance abuse that had lasted for several years and had been collaborating with their therapists for between three and 20 months, with an average of 12.4 months. The therapists, three female and two male professionals, were two psychologists, one social worker, one psychiatric nurse and one physiotherapy specialist. Their ages ranged from 41 to 57 years, with a mean of 48.8 years. On average, the therapists had more than 10.4 years of work experience related to mental health in hospital- and community-based services. The variation was from six to 20 years in relation to their work experience, and the therapists had been working at this outpatient clinic for between one and 11 years, with a mean of 4.8 years. The treatment setting was an outpatient clinic in a Norwegian community mental health centre that offers assessment, psychotherapy and counselling.

Data collection

The data collection is based on a focus group interview held in November, 2011. A focus group was chosen as design as it uses communication between research participants to obtain several perspectives on the same topic (Hummelvoll, 2008; Kvale and Brinkmann, 2009). Focus groups explicitly use group interaction; the method is particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way. The focus group interview involved semi-structured discussions related to participants' subjective experiences of the study course, and was based on the two research questions described above. The meeting was audiotaped and transcribed verbatim; the meeting lasted two hours and was led by authors 1 and 4.

Data analysis

The interview was analysed by going through the paper transcriptions, and a hermeneutic-phenomenological approach was used to analyse the data in which hermeneutic reflexivity on the researchers' part is combined with a phenomenological immersion and exploration into the meaning of the participants' lived experiences (Alvesson and Sköldberg, 2009; Kvale and Brinkmann, 2009). The analyses were conducted through a systematic text condensation (Malterud, 2003; Kvale and

Brinkmann, 2009), in which a structured reading of the material gives rise to interpretations whose trustworthiness depends upon the researchers' reflexivity on their own preconceptions and context of understanding (Alvesson and Sköldberg, 2009; Finlay, 2003). Because the aim of this paper was to explore how the participants experienced and understood the content and process of the study course related to empowerment and recovery, patterns of both qualities and differences were identified in order to discover what type of experiences the participants emphasised and how those experiences were connected.

The analyses were conducted using the steps set out in Table 1, which were informed by the models for qualitative data analysis as described by Finlay (2003); Malterud (2003) and Kvale and Brinkmann (2009).

Table 1: Steps used to analyse study data

1	Study authors 1 and 4 noted their initial impressions after conducting the interview, and discussed these observations to help develop a preliminary understanding of some basic patterns in the material. The researchers were particularly impressed and moved by the way the patients and the professionals shared feelings and personal experiences of their specific roles in the therapeutic settings they usually met in. The researchers also made note of the attention given to not running the study course in a hospital context, but in a 'free space'.
2	Authors 1, 2 and 4 sorted out the parts from the transcribed material that were relevant for the research questions, and the same researchers read edited parts of the transcribed material to help acquire a basic sense of the participants' experiences (Malterud, 2003).
3	Authors 1, 2 and 4 identified separable thematic units that represented different aspects of the participants' experiences, and then developed 'meaning codes' for those units, which are a concept or keywords attached to a text segment in order to permit its later retrieval (Kvale and Brinkmann, 2009). They subsequently edited the text into coded groups of text in accordance with those codes.
4	The first author summarised the meaning within each of the coded groups of text fragments into overall descriptions of meaning patterns and themes reflecting what, according to our understanding, emerged as the most important aspects of the participants' experience.
5	The three named authors turned back to the edited parts of the transcribed material to check whether voices and points of view should be added, could further develop the descriptions of themes or represented correctives to the preliminary line of interpretation.
6	The code groups and themes identified and agreed on by all three named authors were summed up and, based on the condensed text and chosen quotes from the data, patterns were described and explored. The knowledge and meaning of each code was interpreted and condensed, presenting the nuances of each code.

Author 3 contributed to the writing of the background, the methodological approach and the discussion, and revised the paper.

Ethical issues

The project was approved by the Norwegian Social Science Data Service in 2011 for both the protection of the research participants and the safeguarding and protection of the data. An ethical issue the course leaders as well as the researchers were aware of was the dilemmas involved in sharing personal information that usually 'belongs' in the therapy room with a larger group. These dilemmas were discussed openly in the study course as well as in the focus group interview.

Results

Our findings are presented through the following themes:

- Recognising common humanity and common strength
- Being accepted as a person
- An inviting control-free zone
- Doing things differently

Recognising common humanity and common strength

During the discussions among the participants, a sense of group safety that had grown through the study course was revealed. The organisation and process of the course had created a common ground and resulted in a strong group feeling and, as the participants explained it, this opened up sharing and dwelling together on challenging themes as well as discovering common experiences and solutions. One patient had this to say about the sameness that several mentioned:

> *'Yes, there are very many common situations and feelings, and very many common solutions too, I believe, on different problems.'*

Another patient reflected:

> *'If you've got any mental health or addiction problems, I have learned here that we think and feel the same way. Even the therapists do that. I see that sameness much more clearly when we are all together in the same room.'*

Attending a group consisting of therapists and patients with the objective of learning from each other was a new experience for all concerned, and all were surprised and rather overwhelmed by the sense of community. As one of the therapist participants put it:

> *'I believe that one of the important things is the culture that has developed in the group. It has never been a question of two kinds of people. And this I find really crucial. What happened there was trust, and I mean this is what we have created together.'*

The group culture seemed to open up greater freedom of sharing experiences by patients and therapists to be seen and listened to as fellow human beings. A participant with patient experience put it this way:

> *'Yes. We have equality here, and it feels different than when the therapist and I have our meetings.'*

One therapist said:

> *To me, this has been all about the trust we have created together by listening and speaking respectfully to each other. I believe that us being together and experiencing the sameness – and the differences – that's what has developed a common and trustful atmosphere in the group.*

The traditional asymmetrical relationship between therapist and patient seems to have been overruled in this new setting. Here, they were more like men and women all invited to share the difficulties and challenges of being a person with addiction problems, or being a person with professional responsibilities. As opposed to being "us" and "them", the discovery of a sameness as human beings exerted a great impact on both the therapists and patients. As a result, they could discover new sides of each other and be allowed to be a person.

Allowed to be a person

The role as a therapist or patient places the person in a specific position in terms of having many expectations of how to act and appear. The participants all had considerable experience with their roles, and the course context invited them into a different scenario in that they were all to be alike. This situation felt unusual and a bit insecure for some of the participants in the beginning, but soon the safety of the group process opened up for discovering one another as people. As one patient said:

'It is really interesting to get some insight into problem issues the therapists have to deal with, like all the challenges they have to sort out in various situations. This is something one doesn't realise at all if you don't hear about it.'

Another patient followed up by saying:

'It's just like what you say, you see the therapist more like a person instead of what you usually do… like a professional.'

And a third:

'You get a better impression at once of the person sitting there, it's a person and not a machine sitting there trying to help you, right?'

For their part, the therapists talked openly about the various aspects of taking on a professional role and the range of dilemmas they encountered, such as how private they could be with their patients and whether it was acceptable to reveal the helplessness and lack of confidence they at times could feel. The therapists also expressed how they could discover more of the patient as person in a study course context:

'…something I noticed as a major issue related to this course, is that there is really not much difference between patients and therapists. I recognise a lot of what the patients say, and I also hope that they in a way can feel familiar with what I say about myself.'

Another therapist said:

'But that is actually what makes a difference with this study course, and probably what the whole idea is here, just to see one another more as persons in both directions.'

For the patients, it was a novelty to learn about the professional's life and concerns instead of just being anxious that the professional should see them as a person with strengths and weaknesses. One talked about the problem of not knowing the person that was there to help them:

'But at the same time, it is a bit difficult at times when we come into your offices and are expected to open up and talk about our innermost problems and we don't know anything about you, do you see what I mean?'

The hope and desire for developing and maintaining a positive and helpful relationship were expressed from both sides. When describing helpful and positive therapeutic relationships, words/terms such as 'respect', 'being listened to', 'a good first meeting', 'having enough time' and 'partnerships' were used.

An inviting control-free zone

During the course days, the instructors put an emphasis on a safe and supportive environment, which seemed to allow the participants to share more of their inner thoughts and feelings than they had planned to. It somehow felt natural and right, and they appreciated listening to the stories others had to tell. One patient said:

'I find that simply being here and not in that (hospital) building, because that is something I'm not that comfortable with, just being here makes a difference.'

Control was a recurring topic that the participants discussed. In the therapy room, the power was in the professional's hands, but things were different here, with one patient explaining:

'I also think about the issue of control and if we had been in seven or eight individual therapy sessions, then in a way you would have more control. Here in this room, we have let go of control.'

Letting go of control seemed to make it possible to practice equality and partnerships in the study course, which helped uncover other ways of talking together. One of the therapists offered this reflection:

'Yes, it's rather amusing that, well this thing that the therapist is supposed to see the whole person,

not just the patient bit. And now you say the same thing about us. It's an advantage to see the whole person, not simply the therapist. Now we're talking about equality.'

Another issue several participants put forward was the fact that they not only talked, but that they also shared exercises and activities such as cooking, organising the room they were in and doing homework. Doing things together added positively to talking together, and the encouraging and inviting course context helped bring equality into focus. For this reason, the participants discovered how conversations and decision making became different than in the therapy room.

Doing things differently

The unusual structure and setting offered a new context for the participants to relate to one another, and many expressed how they had found it natural to be open and honest after a while. There were several elements in the organisation of the study course that the participants highlighted. One aspect in particular was all starting together as equals, which was completely different from the relationships that the two groups usually had with each other. Another aspect mentioned was the themes in focus, namely those of empowerment, recovery and user involvement. All were well-known to many of the participants yet they were rather vague and seen as not exhibiting much of a commitment. Through concrete examples of helpful relationships and therapy experiences, these concepts acquired a more concrete and practical meaning. As one patient said:

'I kind of feel that I've gotten to know my therapist in a different way because I've heard her opinions of things, which I haven't done before, because we've been dealing with other issues. So I feel I know a bit more about her.'

Another patient stated:

'It has meant a lot to me just to sit down with my therapist and have lunch and small talk. It's another way of opening up. We have been sharing and talking about things that we have never spoken of before. The everyday talk has made me see him as the person he is, not the one I thought he was.'

The equality in numbers in the study course was also valued, with one therapist stating:

'I found the fact that it is not only the patients, but also the therapists in the group that are central – and that we are equal in number.'

Another therapist said:

'To me, it was very important the way that the process of the group was led by the patients. As a therapist, I was asked or instructed to be quiet and just listen to what the patient was discussing and talking about. I got the opportunity to really shut up and listen, while not feeling that I had to say something important or clarifying. Just listen to them, their experiences and what that reflected in me.'

The concepts and perspectives of recovery and empowerment were also explored on a variety of levels, which seemed to help clarify and be useful for the participants, as they were discussed on an individual level and in relation to a patient or therapist. The concepts also had a practical use in discussions on the system level, such as the wards where they had been patients or therapists, or on the overall hospital level. By offering an atypical context in a different room and inviting patients and therapists openly to share experiences as equals, traditional positions and understandings seem to be altered. Hence, a new light could be shed on what could have been seen previously as facts and truths.

Discussion

Most notably, these findings may cautiously suggest that common study courses for therapists and patients possess the potential to strengthen both the therapeutic relationship and collaborative partnerships through having empowerment and recovery as their focal points. A key issue in these

findings is that we also learned about the need for therapists to have empowerment and autonomy in order to work together with the patients towards recovery. The research project identified some themes that appear to be both plausible and linked in the participants' experiences of the common study course.

Sameness and equality

One salient theme is the deep presence of the common humanity that was expressed in the focus group. As voiced by both therapists and patients, this opportunity to get to know each other as people with strengths and weaknesses was highly appreciated. The experiencing of a sense of equality and sameness, as well as the statements of this being of value for the therapeutic relationship, raises some interesting questions in relation to professional standards and practices. For one thing, the positive thoughts and feelings about equality and collaborative practices challenge the traditional therapist role, with its emphasis on distance and therapeutic neutrality. Both the therapists and the patients pointed out the advantages of learning more about one another as people and achieving some insight into the ordinary trivialities and struggles in their lives. One may well be reminded of Sigmund Freud (1912), who said: 'The [therapist] should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him' (Freud, 1912/Strachey 1958, p 118). One therapist talked about how little difference he felt there was between patients and therapists and all that he could recognise about himself and his situation in the patients' stories. A patient mentioned how useful it had been to obtain more of an understanding of the therapists' reflections and challenges – as well as about their general lives. This type of familiarity between professionals and patients is often warned about in psychotherapy literature, which typically refers to the fear of creating an overly involved or intrusive relationship and environment. Although these traditional views on therapy and the therapist's role still have a strong position in many treatment cultures, they were challenged more than 50 years ago by Jerome Frank (1963) as previously mentioned, and have again been challenged in recent years by Duncan et al. (2004) and Lambert (2007) to mention but two. The idea of neutrality and the distance of the therapist have also been confronted by the recovery movement. Recovery-oriented professionals are often described as highly collaborative therapists that promote equal partnerships, understanding and meeting the patient as a human being with competencies as well as problems, and as a citizen and an active agent in his/her life (Borg and Karlsson, 2011). These values and attitudes were much reflected on and discussed in the focus group, and the participants also mentioned that this type of common study course would probably not be an option for all therapists. Many might simply not be interested at all; as one participant said it requires an open attitude and motivation.

Places and contexts

What is it about bringing therapists and patients together into a joint arena that contributes insights to the participants about their common humanity? One response to this question may be that the idea of a common study course – and the course site itself – was created by people with a lived experience of mental distress or addiction. They suggested a common study course for pairs of therapists and patients, with the key learning areas being recovery and empowerment. The course leaders were clear about finding a place outside the psychiatric context as a learning site, as the typical meeting place for these patients and therapists was the 'illness arena'. One easily falls into a tradition in which patients talk about their problems and therapists offer help through their scholarly training and experience. There is a small amount of literature focusing on both therapeutic environments and the problems of creating positive environments in psychiatric hospitals (Campling et al., 2004). The therapeutic environment may itself be a source of the improvement achieved through therapy, such as in milieu therapy. In creating a therapeutic environment, professionals are encouraged to be aware not only of their physical environment, but also of the institutional, psychological and social environment in which treatment occurs, as they are encouraged to go beyond the relational issues such as trust, motivation and empathy or work alliance. In planning the study course, the leaders were aware of additional aspects of the environment, the place and the value of the atmosphere of a place, and decided to find an arena that was new to therapists and patients. The choice fell on the premises of a service user

organisation located in a tranquil setting by a river and offering an informal atmosphere. The course structure was initiated by the leaders, with an emphasis on equality, democracy and listening to one another, thereby inviting open reflections about difficult and unusual themes in an unusual context. Doing things together, such as the exercises and making lunches, as well as the structured leadership in the course, may have also offered a safe ground for exploring the relationships and talking more openly about life issues. Moreover, as voiced by several participants, the equal numbers of patients and therapists, in addition to the focus on concrete themes in the course, were inspiring and inviting factors.

Partnerships toward recovery and empowerment

The concepts of recovery and empowerment put an emphasis on autonomy, taking control of one's life and having choices, as well as social inclusion and hope. In this research, we learned about the ways in which the study course had an impact on the participants' awareness and roles in the processes of empowerment and recovery. To some extent, the positive aspects of working with these themes are self-evident when it comes to the participating patients. Even so, the common humanity that grew out of the course also revealed the need for empowerment and recovery for the therapists, who also felt the need for more autonomy, choice and hope in their daily practices. The limitations and challenges within a psychiatric treatment context, with procedures and practices that are not always empowering or necessarily recovery oriented, can be hard to face and live with for professionals. Several of the therapists found the course inspiring and motivating, not to mention the fact that they were working in a group and not individually. One mentioned that in this group context they all had to let go of some of their usual control, although the strength and safety of the group made it easier to let go of being in control all the time, which may have also inspired some to explore other sides of the patients and their life challenges.

Limitations

The interview offers insights into experiences from both patients and therapists. Nevertheless, this paper is based on a single focus group interview. A series of multistage focus group interviews with the participants would have offered the possibility to go into more detail and highlight more connections between their personal experiences and their roles as patients and professionals. Comparing the experiences of participants from different contexts may have also added greater richness and depth to the material.

Conclusion and implications

The structure and organisation of this course is an example of simple things that can be done to bring user involvement, professional roles and human competencies onto the agenda in service development. Training programs that use traditional methods with parallel courses for professionals and service users in their different arenas are likely to miss out on the reciprocity, sharing and awareness of common humanity that this course could offer. Additionally, in order to strengthen the collaborative practices in mental health and substance abuse services, the participants in this study provided insights about their need to work together in a variety of ways. A learning from this programme is that therapeutic relationships can have fruitful developments outside the therapy room. A few more issues are worth mentioning, one being the influence of contexts. The facilitation of meeting places and agendas outside the professional's domain and control seemed to help therapists and patients to loosen up and see one another in new ways – more as people with whom they could reflect about meaning, life and therapy. Both parties concluded that seeing one another more like human beings with strengths and weaknesses was positive for the therapeutic relationship. Being recognized as a valued member of the partnership, and being seen as a responsible person with important knowledge and experiences, offers growth and pride for both patients and therapists.

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