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Equality and differences: group interaction in mixed focus groups of users and professionals discussing power

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ABSTRACT
Using focus groups, the group interaction provide an important source of data about the group process. The aim of this study is to explore how users and professionals in mixed focus groups interact when discussing power in user-professional relationships. By analysing three mixed focus group discussions where both mental health service users and professionals participate, the article contributes to the discussion on focus group interaction in mixed focus groups. The analysis is inspired by Stevens' twelve-question guide for group interaction. The results show how the participants related to the vignettes, how they related to each other, and contradictions and disagreements in the focus groups discussing the vignettes. Despite the participant's background as users and professionals, the vignettes engaged the group discussions and became a tool for equality within the groups. By discussing power in user-professional relationships in mixed focus groups, the vignettes were interpreted from perspectives as user, mental health workers and researchers. Mixed focus group interaction can make a valuable contribution to developing knowledge in the field of mental health service research.

KEYWORDS
Focus groups; interaction; heterogeneous focus group; mental health; community mental health service; vignettes; power

Introduction

Focus group interviews have become increasingly popular within health science research, but information on social interaction in the group and its influence on data and analysis has been underreported (Grønkjær, Curtis, Crespigny, & Delmar, 2011; Moen, Antonov, Nilsson, & Ring, 2010). Group interaction is the main feature of focus group interviews and the main source of data (Jayasekara, 2012; Morgan, 2012). Interaction between participants may stimulate discussion to disclose otherwise hidden topics (Papastavrou & Andreou, 2012). Homogeneity between group participants could be necessary to ensure meaningful conversation or openheartedness, while diversity is needed to reveal different perspectives and ideas (Forsyth, 2013; Krueger & Casey, 2009; Stewart & Shamdasani, 2015). This raises questions about power relations within focus group interviews, particularly for studies in the field of mental health where the asymmetric power balance between users and professionals is a concern. Focus group studies involving both users' and professionals' perspectives tend to separate the two (Burton et al., 2015; Rose, Evans, Laker, & Wykes, 2015). What is unique in the present study is the exploration of group interaction among users and professionals discussing power in mixed focus groups.

The aim of the study is to explore how users and professionals in mixed focus groups interact when discussing power in user-professional relationships.

Framework

Focus group interviews take place within a complex and dynamic social context where group interaction is of great importance for the co-constructions of meaning. Among the advantages of focus groups relative to individual interviews, focus group interaction may produce a wider range of information, insights and ideas, and the participants' responses can be more spontaneous and less conventional because no individual is required to answer a question in a group interview (Stewart & Shamdasani, 2015). Comments by one participant may trigger responses from other participants and stimulate participants to express their ideas and expose their feelings (ibid.) Belzile and Öberg (2012) claim that there is a tacit division between researchers who view participants mainly as individuals sharing held truths, and researchers who view participants as social beings co-constructing meaning in the focus group. Constructivists view knowledge and truth as created, not discovered (Schwandt, 2003). Our perspective is that meaning and categories that frame everyday life are social constructs and that focus group interviews are socially constructed, negotiated events. Constructs from focus groups are influenced by group interaction, internal factors and external framing (Stewart & Shamdasani, 2015). Stewart and Shamdasani (2015) present three key elements of the design in focus group research: research

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environment factors, group composition and interpersonal influences. *Research environment* involves factors such as size and design of the room to create a common ground to feel safe, interpersonal distance and adequate time to discuss without interruption. In the present article, the analysis will concentrate on group composition and interpersonal influences.

When discussing *group composition*, homogeneity and heterogeneity are frequent concerns. Research on focus group dynamics indicates that greater homogeneity is associated with a greater willingness to communicate with each other, less conflict and greater cooperation (Stewart & Shamdasani, 2015). According to Morgan (2012), too many researchers still think of homogeneity in terms of demographics and background characteristics. However, participants who have experiences from the same field have less need to explain themselves to each other and may more easily react appropriately to the group discussion (Morgan, 2012). Others find heterogeneous groups more effective due to differences in skills, perspectives and knowledge (Paulus & Nijstad, 2003). More important than homogeneity is group compatibility, i.e. that group members have similar personal characteristics such as needs, personality and attitudes (Stewart & Shamdasani, 2015). Thus, the nature of the topic and the group composition's influence on results ought to be considered in each study. What a participant says and how he or she says it is shaped by their expectations of how other participants will react to what they say. Expectations about other participants' behaviour are often embodied in stereotypies (Stewart & Shamdasani, 2015), and will impact upon how the participants relates to each other. Group cohesiveness refers to the degree to which members experience fellowship with other group members and with the group as a whole. It occurs when bonds link members of a social group to one another or to the whole group, and can be divided into four components: social relations, task relations, perceived unity and emotions (Forsyth, 2013).

A person's social status may influence the group (Mizil, Lee, Pang, & Kleinberg, 2012). Being identified as a user in mental health care service, a professional or researcher may bring out stereotypies that influence social *power* and the group interaction. Social power is having the potential to influence others in a group setting (Forsyth, 2013). Perceptions of power may influence individual behaviour and the reactions of others (Stewart & Shamdasani, 2015). Theoretically, power has been understood in two contradictory ways: as possessed or as exercised. On the one hand, power gives negative associations like restricting another person, domination, control and coercion. In another interpretation, power is seen as a productive positive element in social life (Miller & Tilley, 1984). In this article, we regard power as positive and productive rather than repressive, following a Foucauldian perspective. In this regard, power should be seen as a verb rather than a noun; "to be able to", rather than something which is or which can be held onto (Allen, 2011). "The exercise of power is not simply a relationship between partners, individual or collective; it is a way in which certain actions modify others" (Foucault, 1982, p. 788). From a Foucauldian view, power is mobile, reversible and unstable (Foucault, Bertani, & Fontana, 2004), constantly performed and negotiated in all human relationships (Foucault, 1980). Resistance and power are closely related by this view; "where there is power, there is resistance" (Foucault & Gordon, 1980, p. 95). Using Foucault's understanding of power, power and resistance are inherent in all user-professional relationships as well as in focus group interaction.

The study

This article is the second stage of a qualitative two-stage study. During the first stage, 10 users and 10 professionals were interviewed individually about their experiences with power in service user-professional relationships in community mental health care service (Femdal & Knutsen, 2017). Despite policy goals for more user involvement and empowerment in mental health services, the study found negotiations and use of power between users and health professionals. To explore this phenomenon further, vignettes from these interviews became the basis for the present focus group study and people with experience as users and professionals were invited to focus group interviews.

Vignettes

The use of vignettes in focus groups provides an opportunity to expose personal issues and experiences indirectly (Hughes & Huby, 2004; Spalding & Phillips, 2007). In this sense, vignettes are a valuable technique for exploring individuals' beliefs and opinions in regard to specific subjects (Barter & Renold, 1999). Vignettes could contain texts or images, interaction or statements (Hughes & Huby, 2004).

In the present study, we developed five vignettes with short quotations from the individual interviews. All vignettes are about power in mental health user-professional relationships (Table 1). Two show a short conversation between a participant and the interviewer, two show an individual quote, and one shows different concepts used on the person who is assisted by community mental health care service.

Table 1. Five vignettes from the individual interviews.

Subject	Content
1 Place	Moderator: Is it like having a guest? User: No, it's not like that. I don't have to feel stressed doing housework before Caroline (the professional) comes. You want to make a good impression when you are having guests. It's not like that when the professionals come. You don't have to make up an excuse and delay the visit – just because you couldn't handle the housework. She is not a friend. It's something else.
2 Knowledge	User: He doesn't give me the answer right away. He says I have to find the answer myself. He's asking me questions. (...) It's quite frustrating. Can you not just give me the answer? At the same time I am thankful he treats me that way. He shows me respect. He has faith in me. It's good to know that I can do it myself.
3 Power	Professional: We don't use power here.
4. "She represents me"	User: I don't feel I can take care of my own interests when I am going to meetings at NAV (*The Norwegian Labour and Welfare Administration*). I feel so small. That is why I want Mona to come with me. She says, "Tor needs this and Tor needs that". It's the only thing that works. It's the only way I can make NAV listen. I think that is a positive way of using power. Moderator: Do you think they listen to her more because she is a professional? User: Absolutely! (...) I guess they would listen to me, too – but not the way they listen to Mona. (...) Moderator: Do you influence what she's going to say at the meetings? User: Yes, we discuss it before the meetings. She speaks my case.
5 Concept (what to call the person who is assisted by the mental health care service)	Professionals: User, person, client, disabled Users: Patient, user, client

Recruitment and participants

Users and professionals with extensive experience from community mental health care services were considered to have valuable experience and qualified for participation in focus groups. In order to participate in the study, users had to be registered as a user by community mental health care service for two months or more, being assisted at least once every other week, be aged 18 to 67, be diagnosed with schizophrenia/psychosis, bipolar disorder or moderate to severe depression and be able to give an informed consent. Professionals had to have a BA degree in a health or social profession, and having held a 50–100% position in a community mental health care service for at least six months. Users and professionals could not be in or previously have been in a therapeutic relationship. Professionals were asked about participation from their team manager, while users were informed about the study by their contact person at the community mental health care service.

Three focus groups were sampled from different regions. Each group included two users and two professionals. All but two participants were female. One male user and one male professional participated in groups 1 and 2, respectively.

The focus group interviews

All interviews took place at the community mental health care centre. The first author, who is a mental health nurse and a trained interviewer, moderated all focus groups. Moderator used a script to ensure similar introduction and carrying out of each focus group. However, some vignettes were given more time in some groups than in others. After a short introduction to the interview, the vignettes served as a basis for the focus group discussion. Each vignette was printed on paper and given to the participants, one vignette at a time. The moderator read the vignette aloud, after which the group discussion took place. The participants were encouraged to talk to one another, exchange anecdotes, ask questions, and comment on each other's experiences and points of view.

To observe the group interaction when discussing the statements, the moderator were non-directive, letting the discussion flow naturally as long as it remained on the topic of interest. When the discussion stopped or were out of focus, the moderator asked questions and probed comments. Use of eye contact, facial expressions, nodding and pauses may have encouraged participation. As a final question to each group, the moderator asked what is was like to participate in the group interview. Each interview lasted about 90 minutes and was audio recorded.

Data analysis

Immediately after each interview, the moderator wrote field notes. The first author transcribed the interviews verbatim and interview transcripts were read carefully by both authors. Analysis was based on a twelve-question guide for group interaction (Stevens, 1996). These questions asked how closely the group adhered to the issues presented for discussion, and why, how and when related issues were brought up was explored. Following Stevens, we looked for statements that evoked conflict and contradictions in the discussion, as well as common experiences and alliances formed among group members. Finally, topics that produced consensus, how emotions were handled, how the group resolved disagreements and which interests were represented in the group were identified. The authors read the

interviews individually several times, compared them with field notes, and discussed analyses towards consensus. Three main themes with subthemes were developed, as shown in Table 2. All interviews were coded following Stevens' twelve questions, and subsequently by the main themes and subthemes in Table 2.

Ethical considerations

The study was approved by the regional committee for Medical Research Ethics in Norway (REK-midt 2011/2057). Participants were informed orally and in writing about the purpose of the study and that participation was voluntary. All participants gave their written informed consent, and discussed the meaning of confidentiality. A professional was asked to assess the user's condition on the day of the interview and was available for contact afterwards, in case of any reactions. The reason for the restriction not to include participants with a therapeutic relationship in the same group was to ensure that participation in the study would not influence the interviews or further treatment.

Results

The results of this study are presented through three main themes: how focus group participants related to the vignettes, how they related to each other, and contradictions and disagreements. Each main theme have sub themes, highlighted using italics in the text. The last section of the results is a description of how participants reflected upon their participation in a mixed focus groups.

How the participants related to the vignettes

When introducing new vignettes, the groups varied in who began the discussion. Most often, it was one of the users who started. All participants in all three focus groups became actively involved in discussing vignettes. Discussion about the first vignette in each group had to be initiated by several questions from the moderator, while subsequent vignettes were debated with less moderator instruction. When presenting a new vignette, the participants usually began their reflections with *how persons behind the vignettes might have thought or felt*. In two groups, professionals read out parts of vignettes during the discussion in order to explore intentions behind the quotations in the vignette. This allowed participants to learn about each other's general views on the subject, before disclosing more personal experience.

After such initial discussions, personal experiences dominated the groups. Participants recognised situations in the vignettes and related to them on a personal level, sharing their experiences with the group.

> User 2: I think he [*the person from the vignette*] is right. It is more likely to win approval if you bring a professional.
>
> User 1: Yes.
>
> User 2: If you show up alone, they seem to look down on you. Standing there with your application. Looking down on you.
>
> User 1: I agree with you.
>
> User 2: I can speak for myself, as long as the person [*a professional*] is there with me. It helps. It is just like... well, I guess it is true what you say.
>
> Professional 2: I provide services to many people. The user and I cooperate. "I can help you contact NAV [*The Norwegian Labour and Welfare Administration*]". "I can accompany you and arrange a meeting". This is how we are supposed to cooperate. It may be that I have more power as a professional, but it is only used as part of the cooperation with the user. Power is not negative. It is about making things happen. I believe that this is what

Table 2. Development of the themes and sub themes presenting the results.

Steven's twelve question guide to analyze group interactions (1996, p. 172) (presented in random order)	**Three main themes presented in the article**	**Sub-themes presented in the article**
• How closely did the group adhere to the issues presented for discussion? • Why, how and when were related issues brought up? • What statements seemed to evoke conflict? • Was a particular view dominant?	How the participants related to the vignettes	* how persons behind the vignettes might have thought or felt * spoke from different positions * be the knowledgeable
• Were alliances formed among group members? • Was a particular member or viewpoint silenced? • How did the group resolve disagreements? • Whose interests were being represented in the group?	How the focus group participants related to each other	* talked over each other, interrupted each other, or asked questions * talking about their own experiences * positions from outside the focus group setting influenced interaction * support and comfort across backgrounds * Influenced by the moderator
• How were emotions handled? • What were the contradictions in the discussion? • What common experiences were expressed? • What topics produced consensus?	Contradictions and disagreements	* disagreement led to development of discussions * changed their minds

the cooperation is about, if we want to achieve something. I think that is terrific.

User 1: I have experienced that when you go on your own, you will not be heard at all. Whereas, when I am accompanied by a professional, I achieve many things. They are very different situations.

(Discussion of vignette 4, group 2)

Participants *spoke from different positions* discussing the vignettes. Statements about power and empowerment in mental health services seemed to lead them to draw on experiences from their own positions as users and professionals. Two forms of argumentative power appeared in the discussions: professional knowledge, and the right of users to define the field. One example of this was one group, discussing vignette 3, which lead to criticism of diagnostic stigma within traditional psychiatry. Based on their positon within community mental health services, these professionals distanced themselves and their approach from traditional psychiatry. However, in the end, a user's voice concluded the discussion by confirming the professional opinions.

Professional 2: (...). We are not too concerned with diagnoses. Diagnoses are important for understanding that some people are more vulnerable than others. We need diagnoses to understand how we can help them. Beyond that, we are not concerned about diagnoses.

User 1: There are many professionals in the mental health care service... They follow the textbook when a person has a diagnosis. (...)

Professional 2: When we discuss matters with a user, we rarely talk about diagnoses.

Professional 1: We talk about how a person functions. About vulnerability and things like that.

Professional 2: Yes, about how people are.

Professional 1: Of course, if a person has been psychotic, we know medication can be important. It is not that we disregard it; we are concerned about providing the right treatment. Beyond that, we don't focus on it. We rarely talk about it. Hardly ever.

User 1: I have never experienced you [*the professionals from this centre*] being focused on a diagnosis. Never felt that someone used the diagnosis against me.

(Discussion of vignette 3, group 2)

In all three groups, user experience became a productive power through allowing users to *be the knowledgeable*.

User 1: We are lucky to have you. I do not think other municipalities offer as good service as you do. They can't afford to visit a cafe and so on.

Professional 1: You seem to know more about that I do.

User 1: Yes, I know that for sure. I know all about it.

(Discussion of vignette 1, group 2).

How *the focus group participants related to each other*

Initially, each focus group started politely with participants answering questions from the moderator. They allowed other participants time to finish talking before the next participant started. After a short while, however, the discussion loosened up as participants became more enthusiastic. Excitement and insecurity were evident when each interview started, laughter followed humorous statements, and enthusiasm and involvement came out when participants disagreed with each other. Occasionally, participants *talked over each other, interrupted each other, or asked questions* that moved the discussion in a new direction. Some participants were quiet when others became exited. One of the groups distinguished itself in this regard, where one user dominated the discussion and the other user became silent. The silent user took part in the discussion again only after another group participant asked a direct question.

Positions within and outside the group played out in different ways. While participants drew on their outside positions, throughout group interaction they also found new positions in relation to each other. The complexity of positions within and outside the group, and between equality and power became evident when using "you" and "us" within different contexts. Sometimes "we" referred to both users and professionals, establishing the present focus group as a "we". In other contexts, asymmetry between users and professionals became evident through using "you" and "us", thus classifying users and professionals in separate groups. Disparity between "you" and "us" was more evident when the participants were *talking about their own experiences* when discussing the vignettes.

During discussions which revealed that some of the focus group participants were in need of help, while others were providers of such help, *positions from outside the focus group setting influenced interaction*. Some debates showed that users and professionals had different perspectives on a topic. In one group, users and professionals had different views on the meaning of time in mental health services. This sparked a debate about time and the relationship between users and helpers, with users having experienced a lack of time with their helpers, and professionals explaining why.

Moderator: How can service providers know what to do, if the user is supposed to find the answer themselves or if they need some help to do so? How do you know, how do you find out?

> Professional 1: Through being patient. By waiting. Not telling the person what is wrong or right.
>
> User 2: It is about time and patience. Sometimes I feel… It is about time. You feel they don't have time for you, they look at the clock. In addition, you have hardly started. I have noticed that a lot, especially at the hospital. It takes time to feel better. Before you do, they send you home again. Then it's back again. That is my experience.
>
> Professional 1: As a therapist, or what can I say… as a helper. Therapist wasn't quite right (Laughter). About time… How observant you are regarding time, that you notice we are looking at the clock. It is as if you are time bound. How to use time effectively without telling people what to do.
>
> (Discussion of vignette 2, group 3)

However, giving accounts of personal experiences sometimes led to exposing vulnerabilities among both users and professionals. In these situations, members of the group gave each other *support and comfort across backgrounds*. This was not restricted to users being vulnerable and professionals supporting them. In addition, professionals expressed helplessness in their role as mental health workers. In our interpretation, this shows how the focus group setting created homogeneity across backgrounds, despite heterogeneity of positions and power outside the group.

> Professional 2: It is very easy to give advice as a service provider. I do not want to be a service provider who gives advice. I want to be a service provider who listens and asks questions, and who has the patience and awareness to help the person find the advice that works for him or herself. However, I am not sure I manage to do so. And I know I cannot manage to do this all the time (…). I know I am not supposed to do so.
>
> User 1: There are many service providers who give advice. Many.
>
> (Discussion of vignette 2, group 2)

In some situations, some professionals asked questions to other participants, acting as co-moderators. In our interpretation, this widened the discussion, by bringing in new perspectives or challenging other participants. Group interaction was also *influenced by the moderator*. The participants' associations carried discussions further as they responded to each other's statements and reflections. Sometimes participants made associations beyond the aim of the study. When this occurred, the moderator carefully tried to re-direct the discussion by asking questions about the last vignette or by returning to previously debated subjects. Moreover, as the groups discussed vignettes, they included the moderator by looking at her and waiting for her to respond to their discussion. The participants' inclusion of the moderator even turned the discussion to a matter of the moderator's concern in one group:

> User 2: Mmm. Participant, right? I would rather be called user than client. User, patient. I have also heard the term user-patient. Also, resident. When I call the community mental health care service… I don't think "client"… it sounds so cold.

Mmm

> Professional 1: (Turning to the moderator) Now I am curious about what you are going to use in your work. (Laughter)
>
> Moderator: I can feel the pressure! (Laughter) I am grateful to hear your opinions. Somehow, I have to solve it.
>
> User 1: Can you use the phrase "person with user experience"? That way you emphasise the experience, not primarily the fact that we are users. In addition, you can use "person with experience as a professional". (Laughter)
>
> (Discussion of vignette 5, group 3)

Solving the problem of what to call the participants also became a joint task within the group and seemed to stimulate the creativity of the participants even more.

Contradictions and disagreements

No major conflicts arose during the focus group interviews. Nevertheless, there were still contradictions and disagreements. Group participants disagreed on the meaning of time and whether help was best given at the professional's office or in the user's home. However, group participants agreed that it was acceptable to disagree within the group.

In all three focus groups, *disagreement led to development of discussions*. When participants contradicted and disagreed with each other, new arguments were introduced and negotiated. Some users argued against each other users or professionals. When that happened, some became exited and kept arguing, while others became silent. Occasionally, the discussion took a new turn, such as when a user opposed the view of a professional who was claiming that knowledge transfer is a major issue in the relationship between user and helper.

> Professional 1: I believe professionals ought to share their knowledge and expertise with others. This way, the person needing help can make his or her own decisions. Knowledge is necessary to make choices.
>
> Professional 2: Expertise is needed to govern, to be able to do something about it yourself, to find your own way to become healthier… You need knowledge.
>
> User 2: And time.
>
> User 1: I have an example. I know that to go outside and get some fresh air is good for a person suffering

> from depression. I have known that all along. My therapist urged me to exercise at the gym after work. However, I couldn't even manage to take a shower. At another place, I met a wonderful professional who understood that it was enough for me just to go outside and get my mail from the mailbox. You need to find the person's own level, and work from there.
>
> User 1: And all along, I knew fresh air was healthy. I already had this knowledge.
>
> User 2: I was in exactly the same situation. To get out of bed, if only for 15 minutes a day. I know that.
>
> (Discussion of vignette 2, group 3)

While participants knew who were users and professionals in the group before the interviews started, contradictions, disagreements, and interruptions came from both positions. Opposition across positions suggests that participants felt safe and on equal terms. Different views and negotiations on who had the best arguments made discussions dynamic.

In one of the focus groups, a participant *changed her mind* during the discussions, exemplified here by a professional changing her opinion after a user contradicted her:

> Moderator: Does it affect the conversation whether it takes place at the professional´s office or in a person's home?
>
> Professional 2: It doesn't matter.
>
> User 2: It's a little more compassionate when it's at home. It's about time…it's often like…
>
> Professional 1: An assembly line.
>
> User 2: Yes, an assembly line.
>
> Professional 2: It's much better to visit a person at home. Not only do you see the person, you see their surroundings as well. You have other things to talk about than "How are you doing today?" And… You see what their home looks like. There are many things in a home you can use to make a good connection.
>
> (Discussion of vignette 1, group 3)

Group reflections on participation in mixed focus groups

Each focus group ended with a group reflection on participation in the group. A few participants had previous experience from focus group interviews. Regardless of previous experiences, all participants were positive to participation. For some, it had been important that the moderator underlined that there was no right or wrong answers, and the importance of their reflections. Participants used words like "exiting", "positive experience", "good as gold" and "a friendly atmosphere". Some users contacted the moderator afterwards and offered to participate again if needed.

Both users and professionals said they were excited about discussing power in a mixed focus group. The mixed group had led them to discover new things about each other's perspectives and that they have a lot in common. They were convinced that the discussion would have turned out differently if users and health workers had been in separate groups, and that that it was interesting to listen to what it was like from user's and professional's position. Participation in a mixed focus group had provided room for reflection on their own insights and experiences. In their concluding remarks on the focus group, these participants suggested that all users and health workers should discuss power on a regular basis.

Discussion

In this focus group study, users and professionals in community mental health care services met to discuss power by using vignettes concerning power in mental health care services. Discussing vignettes provided an opportunity to expose personal experiences after discussing more generally about the subject in question. Thus, the vignettes became a tool for equality within the group, even when having different background within mental health care. Participants interpreted and discussed vignettes as a group, but associations were based on their lived experiences, and the fact that some were users and others professionals often emerged. Discussions of power within mental health care services can be difficult when facing individuals who are attributed a different status than yourself. These focus group participants gave positive feedback about what it was like to participate in the mixed focus group, and suggested that all users and health workers should discuss power on a regular basis.

A main strength of this study is its innovative design with mixed focus groups. Although it might be stressful for people who require mental health care services to participate in a focus group interview, all participants in our study took part in the discussions. Our results are not generalizable to all users, but our study suggests that mixed focus groups could provide important knowledge of different perspectives to mental health services.

Group size and number of groups depend on the purpose of the research and types of participants (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). Recommendations for group size vary from 5–8 (Krueger & Casey, 2009) to 8–12 participants (Stewart & Shamdasani, 2015). However, feedback from participants in the present study suggest they felt safe participating in a smaller group. A smaller group size is recommended when people have more expertise on a

topic or when they are likely to have strong feelings about a topic (Krueger & Casey, 2009). Because of the limited number of groups, we cannot generalize about differences between group interaction with mixed gender groups compared with groups with only women or men.

The small group size allowed only one moderator. The interviewer influenced the group interaction through her interaction with the groups, and her presence and the way she moderated the groups started and concluded the group discussions. As a stranger to the groups, the moderator's presence may create an atmosphere of artificiality and potentially inhibit the free flow of discussion (Stewart & Shamdasani, 2015). However, the interviews took place at the community mental health care centre, a place familiar to participants. By providing feedback and offering encouraging comments, the moderator may have contributed to a safe atmosphere.

Mixed focus group interviews are rarely done in health care research. Some claim homogeneity among group participants is necessary to ensure meaningful conversation (Forsyth, 2013; Krueger & Casey, 2009; Stewart & Shamdasani, 2015) and that homogeneity in group composition is a social glue that adds fluidity and depth to the discussions (Lehoux, Poland, & Daudelin, 2006). Homogeneous groups are supposed to secure that participants feel safe and open to share their perceptions and options with people of "equal power". In our study, group compatibility seemed more important than homogeneity. Group compatibility is influenced by participants' perception of social status, and a person's social status may influence the group (Mizil et al., 2012). Participant interaction might be limited if power differentials exist between the participants of the focus group because participants in less powerful positions might tend to agree with their more powerful colleagues in order to avoid perceived reprisals (Krueger & Casey, 2009). In our study, participants supported, contradicted, and challenged each other across backgrounds as users or professionals. These shifting interactions can be understood as how power constantly performed and negotiated in the interaction between the participants, in according to Foucault (1980).

Focus groups are homogenous when participants discuss experiences from a position they have in common (Kitzinger, 1995). While having different positions outside the focus group, our participants leaned on having experiences from a common field.

Social power means having the potential to influence others in a group setting (Forsyth, 2013). Results from the present study suggest that both users and professionals can use power of definition. The study took place within a community mental health care-setting, where user involvement and empowerment are policy goals. In such settings, professionals might be expected to have an other-oriented understanding of the users and to be sensitive to many aspects of the users' situation (Lorem & Hem, 2012). Acknowledging the personhood of a client can lead to growth and development in the client as well as in the professional (Eriksen, Arman, Davidson, Sundfør, and Karlsson (2013). Our results suggest that being allowed to validate or oppose professional opinions can provide users with productive power in user-professional relationships. This is an example of how power can be productive and not just repressive (Foucault, 1980).

Compared to individual interviews, the power balance is different in focus group interviews, where power is spread over several participants, the focus is on the group rather than the individual, and issues being discussed are not necessarily identified with the person who is speaking (Barbour & Kitzinger, 1999; Hess, 1968). In our study, all participants were actively engaged in the focus group discussions, and group participants supported each other regardless of their status as user or professional. Interactions between participants might stimulate discussions that disclose otherwise hidden topics (Papastavrou & Andreou, 2012), and diversity in groups can reveal different perspectives and ideas (Forsyth, 2013; Krueger & Casey, 2009; Stewart & Shamdasani, 2015). The focus group composition might limit or open access to certain data, thereby setting the stage for the knowledge construction that will take place (Kitzinger, 1994). In our study, group interaction was influenced by participants changing their positions during the interviews, sometimes seeking equality with the other participants and sometimes talking as users or professionals. Disagreements between participants functioned as a catalyst to keep the discussion going as participants contributed with more explanation and opinions. Rather than viewing such disagreements as a problem, researchers might instead use disagreements as a resource in the analysis (Barbour, 2007). Disagreements and agreements are involved in negotiations during interviews and demonstrate how power is negotiated, as suggested by Foucault (1980). In focus groups, all participants have the potential to influence others in the group setting (Forsyth, 2013). Disagreements and contradictions can be understood as an expression of resistance. Resistance is part of productive power (Foucault, 1980), to be able to disagree or oppose.

Conclusion

Mixed focus group interaction can make a valuable contribution to developing knowledge. It contributes to the knowledge of focus group interaction by showing how group interaction is influenced by different

positions in a field. Further research is required to learn more about power in user-professional relationships by using other research methods.

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