Professional Culture of Mental Health Services Workers: A Meta-synthesis of Current Literature

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Abstract This paper attempts to define the construct of a professional culture of mental health services workers using a bottom-up approach to derive a theoretical construct from empirical data. A systematic search was conducted to identify qualitative studies on mental health staff. A final sample of 18 studies meeting quality requirements was synthesized using a meta-ethnographic approach. The results show that mental health services workers share some common elements of professional culture, such as the importance of an interpersonal relationship with users, the relevance of values in professional practice and the need to maintain a mindful and reflective attitude towards work.

Keywords Professional culture · Mental health service · Professionals · Professionalism · Qualitative research

Introduction

In middle- and high-income countries, the staff of mental health services is usually comprised of specialized workers such as psychiatrists, nurses, social

workers, psychologists and support workers; the staff is organized in multi-professional teams with compositions determined by local-level regulations [52], and it is aimed at providing a wide array of interventions according to a multidisciplinary and collaborative framework. A better understanding of the psychosocial aspects that characterize each profession could foster the development of interventions to foster multidisciplinary work, prevent burnout and design more effective professional training.

In defining the concept of “profession”, researchers emphasize the specific knowledge and expertise of members of a defined professional category [19, 58] associated with specific task-oriented behaviours and social roles. Such task-related behaviours include a high level of expertise, autonomy or freedom to control the management of each task, commitment to the task, identification with peers, a system of ethics and a means of maintaining standards [43]. Brock [6] states that becoming a professional implies gaining qualifications and knowledge through further and higher education, as well as practical experience through apprenticeship and work experience. Individuals both within a profession and between professions are constantly attempting to distinguish themselves and their profession and thus acquire more capital to promote their ability to act [5, 30].

According to Bloor and Dawson [4], the creation of a specific professional group leads to the development of a system of values, schemata and knowledge,

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shared among the members of that professional group, that orient professional behaviour and, moreover, professional coping to unforeseen and changing situations. Shared cognitive and behavioural schemata constitute the “professional culture” of a certain professional group, orient their sense-making and behaviour and contribute to the definition of the organizational culture in which those professionals work [4]. Moreover, for healthcare workers who are used to work in multi-professional teams, as in mental health services, professional culture could also be considered the product of person-organization fit [60] since personal endorsement of the shared culture among in-group members fosters identification with that social group [56] and with the organizational culture [48]. Professional culture also encompasses further constructs such as professional identity, professional role, attitudes and beliefs towards clients, professional values, cultural artefacts and affective issues related to team work, inter-professional collaboration and professional interpersonal contacts with clients [29, 36].

Scholars have published relevant research papers focused on training issues of professionals and specialized workers, such as psychiatrists [3, 59], clinical psychologists [32, 44], nurses [24, 34], social workers [25, 35] or covering specific psychosocial construct related to the mental health work, such as professional identity [26], attitudes toward evidence based practice [55], organizational culture in mental health [49, 50] or ward atmosphere [46]. However, there are no studies that attempt to develop a holistic model of professional culture of mental health service workers (MHSWs).

The research presented here is a first attempt to develop a framework to conceptualize the professional culture of MHSWs through the identification of core themes that recur in their professional discourses. We chose not to focus on the professional culture of a single professional group because the professional roles in mental health care do not coincide perfectly with professional qualifications obtained in the formal education process but are often also determined by the work context, concurrently with the idea that professional culture in mental health care should also be considered to be intertwined with team membership and with broader organizational culture [4, 48].

Because professional culture is the result of an individual and collective sense-making process and

relies on subjective meanings, qualitative methods such as focus groups or semi-structured interviews that involve interpretation of subjective meaning, experience, beliefs, and attitudes could be more suitable to explore this topic than a quantitative approach [39, 61].

Method

Article Search and Selection

The search for articles was guided by two research questions:

- Question 1: Do mental health workers share common professional issues that could define a shared professional culture?
- Question 2: Are different professional categories associated with specific cultural issues?

The ProQuest platform was used to retrieve article references from the MEDLINE, PsycARTICLES, PsycCRITIQUES, PsycINFO, Social Services Abstracts and Sociological Abstracts databases. The research string, reported in Table 1, was devised to cover all possible topics related to the meaning of the work in the mental health services and consisted in four groups of keywords. The first group included elements of professional culture, such as professional identity, values and beliefs, staff social environment and climate, according to the Bloor and Dawson definition presented above [4]. The second keyword group listed all the possible categories of MHSW, such as psychiatrists and mental health nurses, and a third group of keywords was included to filter studies that may not be related to the mental health services staff. Finally, the fourth group of keywords excluded articles related to child and adolescent mental health services, correctional facilities, forensic units and alcohol/drug abuse treatment services to avoid creating an excessive variability of work contexts that may have hindered the process of article synthesis and articles related to professionals in training, assuming that professional culture may not have completely developed since the end of the training process. Two additional search criteria were included: (1) the articles must be peer reviewed and published in a scientific journal; (2) publication year must be ≥ 2001 .

Table 1 Research string

Keyword group	Keyword and strings
#1 Elements of professional culture	TI (“professional identit*” OR “occupational identit*” OR “work identit*” OR “professional culture*” OR “subcultur*” OR “professional role*” OR climate OR “organizational culture*” OR “psychosocial environment “ OR teamwork OR vision* OR values OR paradigm OR belie* OR “professional knowledge” OR “professional behaviour*” OR “professional behaviour*” OR practice OR sensemaking OR “sense making” OR discours* OR professional* OR “professional relationship” OR “professional interaction*” OR collaboration OR interprofessional OR “Social representation*” OR coping OR ritual* OR heroe* OR leader* OR attitude*)
#2 Professional roles	AND TI (“ mental health nurs*” OR “psychiatric nurs*” OR psychologist* OR psychiatrist* OR “occupational therapist “ OR “social worker” OR “psychiatric educator*” OR psychoeducator* OR “rehabilitation officer*” OR counselor* OR counsellor* OR “psychotherapist*” OR “mental health staff” OR “ mental health team*” OR “mental health practitioner*” OR psychoanalyst* OR “psychiatric practitioner*” OR “support worker*” OR “paraprofessional*” OR “psychiatric team*” OR “mental health professional”)
#3 Mental health care specification	AND TI, SU (“mental health” OR psychiatry OR “mental disorders” OR “psychosocial rehabilitation” OR “mental illness”)
#4 Exclusion criteria	NOT TI, AB, SU (pediatr* OR paediatr* OR forensic OR child* OR adolesc* OR education* OR resident* OR train* OR student* OR school*)

TI = title; AND, NOT = Boolean operators; AB = abstract; SU = subject; * = wild character

The article selection procedure followed two phases: abstract screening and full text evaluation. The aim of abstract screening was to exclude articles that would not be relevant to the research scope; the following exclusion criteria were used:

- the abstract was not available or could not be retrieved;
- the article did not present data or results (e.g., essay or a commentary);
- the study participants were not mental health professionals working in clinical settings for adults;
- the study was not focused on existing MHSW practices and experience (e.g., validation of a new scale or questionnaire, randomized clinical trial of a new intervention);
- the study did not adopt a qualitative methodology for data collection and analysis; mixed quali-quantitative studies were also included;
- the study refers to mental health services workers of Low- and Medium-Income Countries: this criterium was set to avoid excessive variability in work contexts that may have compromised the comparability of narratives and themes.

In the second phase, full text articles were independently read by two authors to evaluate their quality

and relevance to the research scope. Quality evaluation was performed using the National Institute for Health and Clinical Excellence (NICE) quality appraisal checklist for qualitative studies [40]. The NICE checklist consisted of 14 criteria listed in Table 2, evaluating methodology, coherence within the research aims and framework, quality of the data presentation and ethical aspects.

Given the lack of consensus in the literature about the quality appraisal of qualitative papers [9, 15, 54], articles that did not fully meet at least 8 criteria out of 14 were excluded. FR and MM met together to compare their evaluations and to discuss disagreement between quality scores.

Lastly, all the studies that passed the quality evaluation were further assessed regarding their relevance in depicting professional culture; i.e., selected articles contained key concepts that could be related to the two research questions.

Article Analysis and Synthesis

This approach allows researchers to develop an “inductive and interpretive form of knowledge synthesis” [41], combining results of several qualitative studies and translating findings from one study to another. Meta-ethnomethodology compares results from multiple qualitative studies, but unlike

Table 2 Overview of studies

Study	Country	Participants	Methodology
Gibb [21]	Australia	33 Mental health nurses	Semi structured interviews, focus group and grounded theory analysis
Akerjordet and Severinsson [1]	Norway	7 Mental health nurses	Semi structured interviews and hermeneutic analysis
Morant [37]	France and England	11 Psychiatrists; 7 clinical psychologists; 23 psychiatric nurses; 8 social workers; 3 occupational therapists; 8 other	Focus group and thematic content analysis
Lloyd [31]	UK	10 mental health nurses	Semi structured interviews and thematic analysis
Goodwin and Happell [23]	Australia	30 mental health nurses	Focus group and content analysis
Crawford et al. [12]	UK	34 community mental health nurses	Semi structured interviews and thematic analysis
Patterson et al. [42]	Australia	8 mental health nurses	Semi structured interviews and thematic analysis
Robertson et al. [45]	Australia	16 Psychiatrists	Semi structured interviews and grounded theory analysis
Deady and McCarthy [14]	Ireland	18 mental health nurses	Semi structured interviews and thematic analysis
Burks and Robbins [8]	USA	17 Clinical psychologists	Semi structured interviews and thematic analysis
Ennis et al. [18]	Australia	12 mental health nurses	Semi structured interviews, grounded theory analysis and theoretical sampling
Shepherd et al. [51]	UK	26 Consultant psychiatrists	Semi structured interviews and thematic analysis
Carpenter-Song and Torrey [10]	USA	Psychiatrists and prescribing mental health practitioners**	Semi structured interviews, focus group and grounded theory analysis
Dalum et al. [13]	Denmark and USA	18 Non-medical Mental Health Practitioners (Managers, nurses, case managers, social workers)	Semi structured interviews and situational analysis
Morriss [38]	UK	5 Social workers	Group and single interviews, ethnomethodological approach
Valenti et al. [57]	Multiple countries*	78 psychiatrists, 73 nurses, 46 clinical psychologists, 36 social workers, 4 occupational therapists, 11 other professional roles	Focus group and thematic analysis
Ericsson et al. [17]	Sweden	25 House support workers	Focus group, thematic analysis, constructionist approach
Buckland [7]	UK	10 Approved mental health professionals with social workers background	Interviews, Foucauldian discourse analysis

*Canada, UK, Croatia, Germany, Chile, Mexico, Italy, Spain, Norway, Sweden

**Participants' number not reported

traditional reviews, it enables researchers to re-conceptualize existing literature and attain new interpretations that may differ remarkably from the

component parts [16, 41]. According to Noblit and Hare, the data analysis process involves different interpretative steps of lines-of-argument synthesis

methodology [41]. Lines-of-argument synthesis relies on the examination of similarities and differences between cases and on the development of holistic schemes to integrate them. Like Geertz's clinical inference method [20], the lines-of-argument synthesis extracts from a set of qualitative studies a shared "structure of signification". As in the Grounded Theory model [22], synthesis is accomplished by repeated comparison between studies, discovering and depicting similarities and differences to build up integrative schemes.

In the present study, the synthesis was performed according to the following steps:

1. the first author (FR), a clinical psychologist with experience in psychosocial rehabilitation services and clinical research, read all articles and retrieved the "key concepts" from the text that could be related to the research questions, such as professional behaviours, representation of professional role and users, work-related experiences, and recurring issues; key concepts could be direct quotes from participants retrieved from the article's text or extracts of text from the results section;
2. key concepts were input into a spreadsheet and compared by FR and the co-author (MM, a scholar experienced in qualitative research), to generate a list of "second-order concepts" that represents the collection of how the same issue recurred in each study, with a minimal degree of content elaboration;
3. a third-order synthesis was then formulated by FR and MM by establishing the relationship between clusters of first-order concepts; the third-order synthesis is an attempt to create a conceptual model of the professional culture starting from the second-order synthesis.

All the phases involved repeated discussions among the authors and several iterations of the framework until agreement was reached.

Results

Article Selection and Overall Characteristics

The database search retrieved 599 abstracts, analysed by FR applying the screening criteria, leading to the exclusion of 561 articles.

Figure 1 synthesizes the paper selection process. The resulting 32 articles, plus two more supplementary studies identified through additional purposive research, were further analysed to evaluate the overall quality.

The quality of most of the papers was evaluated as satisfactory: 27 articles met 8 or more quality criteria. According to the NICE checklist, the most common methodological weaknesses involved the lack of description of a researcher's role and context (criteria #5 and #6), and reliability issues (criteria #7 and #10).

Researchers then decided to exclude 9 more articles because the content was not judged as useful to describing professional culture. The final article sample consisted of 18 studies. Their characteristics are described in Table 2.

More than half of the studies selected occurred in Europe, and the UK was the country with the most contributions. Mental health psychiatric nurse was the most represented professional category, reported in 12 articles, followed by psychiatrists (5), social workers (4 articles) and by psychologists, occupational therapists and support workers (2 articles).

From Key Concepts to Second-Order Concepts

Below, we present each second-order concept as a narrative synthesis, and Table 3 provides an overview of them. Second-order concepts are described using key concepts, and when available in the original article, we included samples of participants' narratives, quoted as specifying the professional category and the bibliographic reference. The terms "user", "client" or "patient" are used as synonyms.

Interpersonal Contact with Clients

The issue of interpersonal contact with users/clients recurred in seven studies [1, 8, 10, 12, 21, 23, 42]. Some authors reported the experience of different MHSWs (mostly mental health nurses but also clinical psychologists and psychiatrists) having an authentic

Fig. 1 Papers' selection process

and genuine interpersonal encounter with their users [1, 8, 23]. The occupational role of the MHSW may involve the experience of “being with” the client [8, 10, 21] and sharing reciprocal feelings of confidence and trust [12, 23].

My relationship with the patient, I think that is really key. Do they feel I am listening to them? And do I care about them? I think that, more than anything, shapes what the outcome is going to be. I would say mutual trust that leads also into motivation for the person to make changes (psychiatrist in Carpenter-Song and Torrey [10, p. 261]).

Moreover, the interpersonal closeness is not taken for granted; the relationship must be “cultivated” [10], and authenticity requires some self-disclosure from the professional and the acceptance of the user's mental illness [42], while assuming an “expert” role may hinder acceptance [8]. Spiritual and religious

beliefs may also play a relevant role in authenticity [8]. However, “closeness” is not always appropriate to the professional role; giving medication to clients [10] and psychological therapies [8] may require professional distance, and some boundaries are necessary to avoid role-blurring between nurse and clients [12] and avoiding being considered as friends [42].

You [the beginning mental health nurse] need to learn how to maintain your professionalism; you need to gain rapport and trust, but you need to not overstep that boundary. You need to maintain your boundary and say [...] ‘I’m not going to be like what a best friend relationship is.’ That’s a skill you need to acquire. (mental health nurse, in Patterson et al. [42, p. 413]).

Theoretical models, learned during professional training, influence interactions with clients [13, 45] and frame the cognitive conceptualization of a client's problems [45].

Table 3 Concepts' grid of the examined studies

	Gibb [21]	Akerjordet and Severinsson [1]	Morant [37]	Lloyd [31]	Goodwin and Happell [23]	Crawford et al. [12]	Patterson et al. [42]	Robertson et al. [45]	Deady and McCarthy [14]	Burks and Robbins [8]
Interpersonal contact with clients	N	N		N	N	N				CP
Emotional work	N	N						MP	N	CP
Mindful/reflective practice		N					N	MP		CP
Empowerment and negotiation	N		UN	N		N		MP		
Safety and danger	N						N			
Coercive practices	N								N	
Complexity, uncertainty and flexibility			UN		N			MP		
Value based practice		N		N						CP
Social model versus medical model								MP		
Language and professionalism					N					
Team membership				N					N	

	Ennis et al. [18]	Shepherd et al. [51]	Carpenter-Song and Torrey [10]	Dalum et al. [13]	Morriss [38]	Valenti et al. [57]	Ericsson et al. [17]	Buckland [7]
Interpersonal contact with clients			MP	UN				
Emotional work	N							SW
Mindful/reflective practice								
Empowerment and negotiation		MP		UN	SW			
Safety and danger	N					UN		SW
Coercive practices						UN		SW
Complexity, uncertainty and flexibility	N					UN	SU	
Value based practice					SW	UN		SW
Social model versus medical model				UN	SW		SU	SW
Language and professionalism					SW	UN		
Team membership			MP				SU	SW

The letter in each cell indicates the professional category whose concept is related in each article

N nurses, *MP* psychiatrists, *SW* social workers, *CP* clinical psychologists, *SU* support workers, *UN* unspecified MHWs

I can guide the client from my theoretical knowledge (mental health care professional, in Dalum et al. [13, p. 423]).

Emotional Work

Emotions and feelings play an important role in the work of the mental health practitioner, as evidenced in six studies [1, 7, 8, 14, 18, 21, 45]. There were different kinds of encounters in clinical work where feelings were central, ranging from a fruitful encounter, which led to a feeling of joy, to feelings of emotional distress associated with conflict and distrust [1]. Feelings and emotions play a role in several job processes, as they contribute to evaluation and decision-making [1, 7, 21], can interfere with the interpersonal relationship with clients [8] and they may hinder or foster users' escalation of anger and aggression [18]

Well actually for all that I'd have to admit that the most important thing is my gut. So I'm going through all those processes and measuring it up, but, but, sometimes I just sit there and think how do I feel about this person walking out of here? [...] So the law does inform my decision-making, but fundamentally I would have to say, bizarrely perhaps, it's my heart, whatever that is (approved mental health professional and social worker, in Buckland [7, p. 56]).

They [clinical leaders] actually were really calm with them [consumers] and they were really quiet and they took them away from the environment that was a bit heady and sat down with them and engaged them (nurse, Ennis et al. [18, p. 59]).

Emotions and feelings may also lead to professional hazards, such as burnout [14, 45].

'confronting' 'squeamish' 'dread' 'burnt out' 'frustrated' 'dislocated' 'exasperation' 'I am not the same person I was' 'agonizing' 'tiring' 'desensitized' 'stung very badly' 'victimized', 'a prolonged, draining and demanding process' 'traumatizing' 'left me shuddering' 'brutalized' 'overwhelming' 'emotionally draining' 'sobering' 'horrifying' 'anxiety' 'wearing down'

(descriptions of the effect of clinical work on psychiatrists, in Robertson et al. [45, p. 414])

I'd be reasonably good to leave my work at work, reasonably good. Now obviously we're all the same, there are times you wake up in the morning, maybe half an hour before the alarm clock goes off, you think this thing now is just too much (nurse in Deady and McCarthy [14, p. 215])

Mindful and Reflective Practice

Among professional skills, being able to monitor and control one's own mental states and behaviour is considered a core competence [1, 8, 18, 45].

If I feel that I am not being authentic, for me I want to look at that and see [...] if there's something that's going on with me or something that's going on with the client that's impacting me in a strange manner to help understand them better [...]. I think it's a part of what we're teaching our clients, to be more aware of how they're feeling and to be able to express it (psychologist, in Burks and Robbins [8, p. 92]).

Confident – confident, self-assured... a good sense of themselves. Very considered and calm and not buying into that expressed emotions, sort of, situation, but thinking about things in a systematic and well planned thought out structured sort of way, I guess. And you don't see them flustered (nurse, in Ennis et al. [18, p. 59]).

MHSWs who received training in psychotherapy (mainly psychologists and psychiatrists) claim to be trained not to let their own values undermine their relationship with clients [8], and recognizing the need for clinical supervision is considered a necessary skill for nurses [1].

Empowerment and Negotiation

MHSW's role may involve users' empowerment and advocacy of people's rights, as seven studies noted [12, 13, 21, 31, 37, 45, 51]. Staff may encourage users to take responsibility for themselves [31, 42], helping them to take back control of their lives [31]. This role requires workers to be able to inspire hope and

optimism in the client regarding recovery and treatment [13, 51], listening to clients' goals, dreams and hopes [13] and valuing patient narratives [45] coherently with a recovery-oriented paradigm of mental health care [13].

We are acknowledging the seriousness of their pain that they have a response in doing something about it and we are offering them hope, genuine hope, because we are valuing what's down there and together we are sharing that information and we're pushing that information into some kind of meaningful activity (mental health nurse, in Gibb [21, p. 246]).

However, the lack of user insight limits shared decision-making [31,51] and staff may adopt paternalistic attitude as consequence of a perceived lack of patient capacity or risk of harm [57].

I think it depends doesn't it if somebody is on a section 3 and they are quite unwell you know and not listening to, you know to the important decisions [...] or they are not taking it in the information because, you have that conundrum of whether, okay do we forcibly medicate this person because they are really poorly or do we wait and maybe they will somehow become able to understand the information (mental health nurse, in [31]).

Some patients are just too unwell to make that kind of decision, they can have no capacity at all to make that kind of decision at the time of admission, in which case we just have to go with what we feel is advisable at that time (psychiatrist, in Shepherd et al. [51, p. 6]).

The ability of negotiate decisions with clients and caregivers is considered a core skill for nurses, psychiatrists and social workers [23, 31, 38, 51].

It's more about creating a different perception of power within the relationships of not being so much the holder of information and knowledge but having a much more equal sharing to dialogue and actually finding out from that carer where their concerns are (mental health nurse, in Goodwin and Happell [23, p. 280]).

Safety and Danger

Safety is a recurrent theme in MHSWs' narratives, as reported in six studies [7, 10, 18, 21, 42, 57]. Safety is a concept that could be related to users' need of protection [21, 42, 57], to the staff, in terms of risk of aggression and aggression management [18, 42], and to public safety [7, 10, 57].

If we fear for the patient's life or the life of another person at risk from the patient, we can't leave it. We have to communicate with someone the patient knows, which sometimes is someone from a community service (psychologist, in Valenti et al. [57, p. 1305]).

Prevention skills means you don't put yourself at great risk; you don't go to the furthest room down the end of the passage when you have got a high-risk person, and if the person is starting to elevate during an initial assessment, you cut the assessment short rather than persist agitating the person even more (nurse, in Patterson et al. [42, p. 414]).

The issue of safety as related to the risk of aggression emerge in particular in nurses' narratives [18, 42], while public safety concerns seems to be related to role of psychiatrists and approved mental health professionals/social workers [7, 10, 57].

Coercive Practices

Four studies described MHSWs viewpoints regarding coercive practices [7, 14, 21, 57]. Some professionals believe that informal coercion is a useful therapeutic strategy but may be reluctant to label their own practice as "coercive" [57].

I feel like I have differing views even within myself. So, I don't like the thought of using coercion, because I believe autonomy is very important where people have capacity, but at the same time I can't imagine not using what are some of the most...the strongest clinical tools I have (psychiatrist, Valenti et al. [57, p. 1302]).

Patients' lack of insight and acute psychosis justify more intense coercive actions, and compulsory detention may have positive effects on people [7]. Other

MHSWs think that clinicians have no right to force patients [7, 57].

Where does the free will of a psychiatric patient begin and where does it end? Can we really say “You should do this”? (social worker, in Valenti et al. [57, p. 1304]).

So the things like that I think probably, personally, compulsory, compulsorily medicating people is wrong, I think in fifty years time they’ll turn round and think we were barbaric (approved mental health professional and social worker, in Buckland [7, p. 54]).

Moreover, the decision to use compulsory powers may be associated with stress and feelings of responsibility, and who exerts compulsory power feels the pressure from society to avoid “incidents” [7]. Clinicians’ emotional responses to escalation with patients could also induce more intensive coercive measures, in a mutual escalation [57].

Complexity, Uncertainty and Flexibility

Working in the mental health field requires the mental health worker to address high levels of uncertainty and complexity related to the nature of mental illness [37] and to the perceived unpredictability of clinical situations [18]; MHSWs hold uncertain representation of mental illness and work and outcomes [37]; furthermore, defining what is a good performance is often very difficult [17].

For any MHSW, but more frequently for psychologists and psychiatrists, the adoption of a theoretical perspective of the mind and of mental illness (e.g., psychoanalysis, recovery model, systemic approach, etc.) provides a cognitive strategy to manage uncertainty and complexity [37].

However, complexity could also be seen as intellectually challenging [10].

The most interesting thing is the intellectual challenge. The complexity is fascinating. Sorting through all of the different dimensions of thinking about human beings and, you know, strengths and challenges that we all face and the folks that I am trying to help (psychiatrist, in Carpenter-Song and Torrey [10, p. 262]).

Moreover, working in the mental health field may require some sort of eclecticism and ability to perform the professional role in a flexible way [10, 17, 37, 42] to adapt to this complex object of work.

Nothing is standardized – there are no fixed rules at all – it’s all quite fuzzy round the edges (psychiatrist, in Morant [37, p. 828]).

I mentioned flexibility; I think that it applies across a whole range of aspects. The ability to adapt to new technologies and new ways of dealing with people [...] I think as you become more experienced, you can meet the same end using slightly different techniques, and that should be encouraged (mental health Nurse, in Patterson et al. [42, p. 415]).

Value-Based Practice and Professional Morality

Mental health work may be guided by strong professional values, as reported in seven studies [1, 7, 8, 14, 31, 38, 57]. Examples of values associated with professional practice include accepting people with mental disorders [42], supporting users’ recovery [10], taking care of marginalized people [10], doing the job with commitment and responsibility [1], and valuing clients’ experience [45].

So be accepting of patients with a mental illness, because we are not going to break the stigma unless we ourselves break the stigma (mental health nurse, in Patterson et al. [42, p. 415]).

The issue of responsibility recurs in staff narratives about values [1, 21], as an object that metaphorically could be “taken” or “given” [21, 31] and passed from staff to client and viceversa; the decision to give or take responsibility is taken according to workers’ personal values and may be associated with moral dilemmas [57].

That level of responsibility we have in the community is enormous. Initially it can be overwhelming, but we learn to value our judgments, when and when not to engage others (mental health nurse, in Gibb [21, p. 245]).

They lack capacity and I have responsibility for them because they are at risk, their family is at risk and then there is no other option for me than

to go against their wishes. (psychiatrist, in Valenti et al. [57, p. 1304]).

Moreover, adherence to professional values may determine in participants' responses the definition of the professional ingroup-outgroup, since individuals of the same profession who do not behave coherently with professional values are not considered as "real" professionals. One's own professional values may conflict with those of the work context [7] and may lead to moral distress when quality of care is lower than standard [14].

It's the emotional feelings you have. The moral distress arises because the clients aren't getting a good quality service and that can lead to moral distress for me. So, how can I treat myself and how can a client who has his own moral distress, how can a chemical treat that kind of moral distress? (nurse in Deady and McCarthy [14, p. 215]).

Social Model Versus Medical Model of Mental Health Care

MHSWs working according to a social model of mental health care expressing discomfort towards the medical model recurs in five articles [7, 13, 17, 38, 45]. Most of the discomfort is expressed in relation to a rigid approach to the diagnostic process, defined as "putting labels" on people [45] and "categorizing" clients' needs [38].

They were putting the cluster before the client or as they would call them, the patient. 'Oh they can have that because he's clustered at seventeen'. That's totally wrong. That's cart before the horse, every time (social worker, in Morriss [38, p. 1078]).

Moreover, the social model considers the client as an individual to empower, while in the medical model professionals consider patients as help-seekers who must be "fixed" [13].

I know that you can always get sucked back into that old maintenance [medical] model or wanting to set goals for the client. Rather than really letting them set their own goals. (mental health care professional, in Dalum et al. [13, p. 423]).

Overtly, some MHSWs (mostly social workers or support workers) describe themselves as being resistant to psychiatry [7, 17]. Notably, the complementary stance, i.e., MHSWs expressing discomfort towards the social model, wasn't reported in the articles.

Language, Communication and Professionalism

The theme of language and communication recurs in six studies [23, 31, 37, 38, 42, 57] regarding different issues. Communication seems to characterize the professional representation of the mental health nurse's role [23, 31].

I think something that we do though is offer all avenues of communication. We let people know what shifts we're available to case manage and we let people know what our service is able to offer. If we're not there, there will be someone to speak to. There's after hours contact numbers available. So there are still channels that they [consumers and carers] are able to contact people and have all that information filtered back (mental health nurse, in [23]).

Another issue related to the theme of language is the adoption of diagnostic terms. Some MHSWs, especially psychiatrists and mental health nurses, find diagnostic labels a useful tool for managing users' problems [37, 45].

I think symptoms and diagnoses are all very handy for giving a name to a collection of problems that a client is suffering. So, it's a name we can all agree on, therefore we know what we're talking about when we use it (psychiatric nurse, in Morant [37, p. 829]).

Labels the patient and it can set a course of action in terms of treatment or in terms of the person's or other people's opinions of that patient or whatever [...]. I use the fact that it is a label, I use it as a focus for describing what's going on (psychiatrist, in Robertson et al. [45, p. 413]).

However, other MHSWs express some concern about the rigid or defensive use of diagnostic labels that may hinder users' acceptance and de-humanize care [38, 45].

Once people are adults and talking about their experiences of child abuse, I think that we tend to deal with our discomfort by stigmatizing the victim, and no matter what we label them, whether it's the good old fashioned hysteric, or it's your contemporary borderline, what we are doing is dealing with them from a very defensive position that culture is unhappy with confronting (psychiatrist, in Robertson et al. [45, p. 413]).

By adopting professional jargon, the mental health worker could exhibit technical competence and be accepted by other colleagues [38], or express professional differences and power, especially when using medical jargon [7].

Conversely, some workers prefer not to use professional jargon (e.g., diagnostic labels), since it may create a “barrier” (cf. Professional distance and boundaries) between them and their clients [23].

I think we can over-use jargon [...] But from the consumer–carer perspective [...] it's difficult for them to relay their concerns. They feel that they can't get the message across (mental health nurse, in Goodwin [23, p. 282]).

[Newly graduated nurses need to] know that you use technical jargon towards medical staff, but towards patients, it's going to be different [...] you need to use different communication styles to gain rapport and trust (mental health nurse, in Patterson et al. [42, p. 413]).

Team Membership

Mental health work, especially in hospital and in residential settings, relies on teamwork [10]. Being “accepted” as a team member is highly desirable for MHSWs [17], since teamwork may foster coping with a stressful hospital environment [31] and may promote positive feelings about work [7].

The joy of going to work is all about the work group that you enjoy being in. [...] I think it is about security and joy in the work group (support worker, in Ericsson et al. [17, p. 373]).

However, conflict between team loyalty and professional values may occur when the worker notices colleagues performing poor quality practice [17]; fear of being isolated from a team or professional group

may pressure the worker not to report malpractice [14].

I thought at the time, said, should I do more about this, this can't be right, compared with what's going on, so I just thought about it [...] and I spoke to I suppose a few close friends, colleagues about it, and the advice I got was, that if I had taken it further, that my life as a nurse working wouldn't have been worth it, it would have been made very difficult, and people in the past who had made comments [...] were outcast, so I thought an awful lot about it [...] but I didn't do anything about that (psychiatric nurse, in Deady and McCarthy [14, p. 217]).

Third-Order Synthesis

According to the line-of-argument method [41], each third-order synthesis recombined concepts retrieved from the examined articles to create new structures of meaning. Thus, second-order concepts were combined in three different third-order syntheses that contribute to the definition of the professional culture of MHSWs. Table 4 presents the three synthesis, distinguishing common occupational cultural dimensions for mental health care workers and role-specific aspects, coherently with the research questions.

The first theme is “Interpersonal distance”, the metaphoric mapping of the relationship with clients, that could be associated with positive interactions or with professional lack of efficacy and risks. MHSWs are exposed to the interpersonal relationship with users' sufferings, complex problems and critical issues; within this interpersonal space, the MHSWs may remain “closer” to the client, sharing feelings of authenticity but also exposing themselves to moral distress and burnout or maintaining a “longer distance”, thus avoiding role-blurring in administering medication and psychological interventions [8, 10, 12, 21, 23].

MHSWs' professional role and their interpersonal relationship with users involve dealing with power issues and requires MHSWs to be conscious of their role and power and to manage it with professional competence and ethical awareness [1, 21, 51]. Thus, “Power games” is a second metaphorical map that involves the distribution of power between the MHSW and the user/client, due to the combination of

Table 4 Third-order Synthesis

Third order synthesis	Common cultural themes	Differences between professional roles
“Interpersonal distance”	<p>The MHW acts inside an “interpersonal space”, and a core competence is the ability of monitoring and moving through an interpersonal <i>distance</i></p> <p>However, the interpersonal relationship is simultaneously a core element of professional culture <i>and</i> a menace</p> <p>Incorrect management of interpersonal distance with users may cause loss of professional identity (role blurring), emotional interference, and burnout and compassion fatigue.</p>	<p>Psychologists and psychiatrists seem to place more emphasis on the connections between interpersonal contact, emotional issues and the need for a reflective and mindful attitude</p> <p>Nurses are more prone to describe themselves as very interpersonally connected with users and aim at promoting user empowerment; according to our model, their professional culture can be described in terms of a short distance from the users with an imbalance of power to users.</p>
“Power game”	<p>Dealing with power is a core issue in MHSW practice, and this “give and take” power dynamic could be metaphorically described as a “zero-sum game”; the more power the MHW has, the less power the client has, and vice versa</p> <p>Managing professional power requires high levels of responsibility and a strong commitment to a system of values that could legitimate the acquired power and set ethical professional standards</p> <p>Language could also be used by MHSWs to justify coercive measures and to resolve the cognitive dissonance associated with professional moral dilemmas.</p>	<p>Compared with psychologists and other categories, psychiatrists seem to be more involved with issues of power with users; this power is associated with diagnosis, compulsory admission and prescribing authority</p> <p>For MHWs with rehabilitative roles, language is associated with communication with patient and caregivers, but for professionals (mostly psychiatrists) who address evaluation and treatment-planning during more acute phases, professional language is associated with diagnostic labels.</p>
“Professional identity over uncertainty”	<p>The complex and uncertain nature of mental illness is reflected on representations of MHWs’ roles and identities</p> <p>Strategies to foster a clear professional identity are:</p> <ul style="list-style-type: none"> - the adoption of a shared professional language - the adherence to a specific system of professional values - identification with the team. 	<p>Psychologists and psychiatrists tend to identify with theoretical models acquired through professional training</p> <p>Social workers and mental health nurses are prone to identify with a system of values and a social mission</p> <p>Identification with the team is more frequent for support workers and mental health nurses identify with the team</p> <p>MHSWs with lower power roles in treatment-planning, such as social workers or support workers, express negative attitudes towards psychiatry and medical classification. Social workers may be keen to endorse the social model of mental illness and a social paradigm of intervention, which, even though it helps build up their professional identity, may produce some sort of distress and resistance towards the medical context.</p>

professional roles and users’ needs and stage of illness. In the “power games” the use of language is an essential aspect: it expresses professional vision and values, fosters team membership and an identification with the professional category, contributes to defining the interpersonal distance with users and is associated with professional roles [7, 23, 38, 45, 57].

The third theme is “Professional identity over uncertainty”, a metaphor that depicts how the complex

and uncertain nature of mental illness is reflected on representations of MHWs’ roles and identities. Through professional training, socialization with colleagues and work experiences, MHSWs build up their professional identity by acquiring the professional language and developing professional vision and values [1, 7, 8, 14, 31, 38].

Event though the three themes have been presented sequentially, they should be considered as mutually

interrelated. Professional identity of a MHSW embeds (implicitly or explicitly) a representation of the “right” interpersonal distance that must be kept from the users. Conversely, the wrong management of interpersonal distance by a mental health worker may result in role blurring with users, leading to the perception of a weak professional identity. Regarding power, the higher the imbalance of power between the MHSW and the client, the longer will be the distance with him/her. Power is also an element that constitutes the professional identity: for example, MHSWs that deliver empowerment interventions, especially within the Recovery framework, possess a professional identity in which power is a property of the users instead of the professional. Thus, our synthesis suggests that, professional culture of MHSWs should be depicted and analyzed through the three themes of Interpersonal Distance, Power Games and Professional identity over uncertainty, that, metaphorically, could be viewed as three sides of the same figure.

Discussion

The review identified three interrelated dimension that contribute to professional culture for the staff of MHSWs, i.e. “Interpersonal distance with users”, “Power games” and “Professional identity over uncertainty”, along with specific inter-professional differences.

Notably, our study partially replicates and extends findings of previous studies and theoretical models of professions, such as Hillman’s [27] characteristics that differentiate professions from occupations: the relevance of a theoretical basis [27, 33, 58] emerged for psychologists and psychiatrists, and the recovery model oriented nurses and social workers; the issue of professional authority that emerged for psychiatrists linked to diagnosis and prescribing authority [5, 27]; the relevance of ethics in regulating relations of professional persons with clients and colleagues [27] was common to all professional roles, with the exception of support workers; professional jargon as a mean for maintain and re-legitimize professional power [5], that explains why categories with lower professional power express discomfort with the use of medical professional language.

Thus, we can affirm that for MHSWs, professional values and interaction with clients play a most

important role in defining their professional culture. In addition, we found that the theme of complexity, present in Freidson’s theory of profession [19], also emerged in our analysis; however, while in Freidson’s theory—related to the professional category of physicians—the constitution of a profession occurs to manage a very complex context of human action, in the case of mental health care, even though complexity is managed through theoretical models, professional values and flexible practices, MHSWs are exposed to large levels of uncertainty.

Limitations

Findings of the meta-synthesis must be evaluated by taking into account several limitations. A first limitation concerns the impact of researchers’ background, presented in the methods section, on data interpretation. It may have influenced the process of first order concept identification, focusing more on narratives concerning psychological constructs and themes. A second limitation concerns sample representativeness of professional categories. The selected articles show a major representation of nurses (possibly due to the large amount of research in this field conducted in Nursing Schools), while other categories are represented only somewhat or not at all (e.g., psychologists, occupational therapists, educators). We can assume that the reasons for this lack of heterogeneity in the sample can be a consequence of historical and cultural factors. For example, while our search identified studies on attitudes and the practices of psychologists, these were excluded because they were carried out using quantitative methodology, perhaps reflecting the preference of academic psychologists for quantitative research over qualitative methods [53]. A third limitation involves the influence of the organizational and broader cultural context on workers’ professional culture. The theoretical model suggests that professional culture and organizational culture may somehow be interwoven [4, 48]. However, our sample of articles examined did not allow us to evaluate the effect of the organizational context in which data were collected about MHSWs narrations i.e. differences between hospital wards and community services. A fourth limitation relies in the nature of the examined qualitative data. Our analysis is based on professional narrations, useful for gathering workers’ experience and professional *sensemaking* [62]; however,

narratives do not fully account for real behaviour and can be subject to bias, e.g., the social desirability bias or discrepancies between explicit and implicit attitudes, which could affect data reliability. For example, although workers claim to be led by a strong sense of responsibility and strong values, this does not mean they always act according to professional ethics.

In addition, our results may further be affected by sampling shortcomings; it is therefore possible that the MHSWs who participated in the selected studies were more concerned about or sensitive to the issues presented by the researchers than the average MHSW and that this may have led us to overestimate some key concepts, e.g., the presence of recovery model values or the importance of interpersonal relationships with users. At the same time, relevant issues, that are familiar to clinicians, such as sexual life of clients [28] and spiritual beliefs, didn't emerge in our findings, and should require further investigation.

Future Research

Future research may be performed to address the limitations of this research. A quantitative approach, like a survey design, may be more suitable to test differences between mental health professionals, specialized workers and healthcare staff that didn't receive a training in mental health care, and may also evaluate influence of the work context, such as hospital setting or community care, on work cultures.

Moreover, further research may explore professional culture issues of staff working in Low- and Middle-Income Countries and compare with our findings, that are based on mental health services of High Income Countries. Even though we hypothesize that the three core topics emerged in our research could be also valid for other cultural environments, we may expect to find relevant differences and specific issues like, for example, the cultural integration between “Western” theoretical models and local cultural categories [3], the asylum-based model of mental health care or the lack of specialized staff [2, 11, 47].

Conclusion

To our knowledge, this meta-ethnography is the first to provide an overview of the issues composing the

professional culture of mental health workers. Our results lay the theoretical foundations for a holistic model of professional culture that may be applied in future qualitative and quantitative research related to mental health service evaluation, personnel psychology, staff training and clinical supervision.

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