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DEPICTING PROFESSIONAL CULTURES OF MENTAL HEALTH WORKERS: DEVELOPMENT AND VALIDATION OF THE BICOCCA MENTAL HEALTH PROFESSIONAL CULTURE INVENTORY

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Abstract

The process of care in Mental Health services could be influenced by a number of different staff related factors, such as staff morale and burnout levels, staff technical and interpersonal skills, attitudes and values. Social processes are particularly relevant in the Mental Health sector, since workers deal with clinical conditions and care procedures that rely on professional social constructions. Mental health services staff in middle and high income countries is composed mainly by specialized workers such as psychiatrists, nurses, social workers, psychologists and support workers organized in multi-professional teams whose composition is determined by local level regulations. Beside the professional knowledge, each profession is also constituted by the social dynamics that are proper of a specific social group.

The creation of a professional role, such as mental health nurse or clinical psychologist, leads to the development of a system of values, schema and knowledge, shared among the members of that professional group and that orient professional behavior and coping. Those shared cognitive and behavioral schemata constitute the "professional culture" that could be considered as a subsystem of the broader organizational culture and it also linked with further constructs such as professional identity, professional role, attitudes and beliefs toward clients, professional values, cultural artifacts and affective issues related to therapeutic relationship, team working, inter-professional collaboration. Currently, there's lack of studies that try to develop a comprehensive model professional culture of mental health professionals. This dissertation makes an attempt to define the construct of professional culture of mental health professionals using a bottom up approach to derive theoretical construct from empirical data.

The Introduction presents the theoretical frame of professionalization in mental health care. Professionalization of mental health staff is the result of cultural changes in the history of the western countries that created a complexification of task and organization of mental health services. Theoretical definition of profession and professionalism are also presented.

In the second chapter is presented a synthesis of the current literature performed using

the meta-ethnographic approach to link together relevant qualitative studies on mental health staff work experiences. Results show that professionals working in mental health field share some common elements of PC such as the importance of the interpersonal relationship with users, the relevance of values in the professional practice and the need of keep a mindful and reflective attitude toward the work.

The third chapter describes the development of a new questionnaire, the Bicocca Mental Health Professional Culture Inventory (BMHPCI), including item generation procedures. A pilot study was conducted to determine whether linguistic or cultural differences could affect items' comprehension to prevent reductions of internal validity.

BMHPCI validation study is presented in chapter 4. Questionnaire validity and reliability was tested through a survey of a representative sample of mental health services workers. The instrument developed shows promising psychometric properties and statistically significant correlations with team climate and burnout scores. Statistically significant differences in BMHPCI subscales were found between professional roles and mental health settings.

1. Introduction: professional roles in mental health work

1.1 Emergence of professions in history of Mental Health Services

Historically, the emergence of occupation and professional groups entrusted to care people affected by mental illness followed the development of the mental health services (MHSs). Cultural beliefs regarding mental health have been informed and shaped by professional experts who produced professional discourses about what causes mental distress and how to manage and to treat it. Considering the most economically developed countries, Thornicroft and Tansella (1999) proposed a historical synthesis based on three periods.

The first period, labelled "The Rise of Asylums" (1880-1950) was characterized by the construction and the development of asylums to contain and provide the basic necessities for survival of people affected by a wide array of clinical and social problems. The 19th century saw the professionalization of asylums' staff, that was constituted only by doctors and nurses that worked according to a biological model of mental illness: for example, Dorothea Dix, a reformer of the mental health system in USA, argued that <<*insanity reasonability treated is as curable as cold or fever*>> (cit. in Scull, 2011).

In the second period, "The decline of Asylums" (1950 – 1980), the process of deinstitutionalization produced a shift from institution based services to community based care. Thanks to the seminal work of scholars and clinical leaders such as Erving Goffman (1961) and Franco Basaglia (1968), in this period the sociological model of mental illness gained cultural relevance among professionals and public opinion and fostered legal reforms concerning rights of people with mental illness. The development of modern antipsychotic drugs allowed staff to reduce patients' symptoms in a more effective way, and was associated with the introduction of new psychosocial treatment, including occupational therapy, therapeutic communities and residential facilities. The psychodynamic theories of mental health reached the highest level of popularity among

professional and new psychological model of mental illness and intervention appeared on the scene, e.g. family therapy and cognitive behavioral interventions. Thus, new professional figures entered in MHSs, including social workers, occupation therapists, counselors and psychologist, whose professional cultures stressed the importance of therapeutic relationship and social rehabilitation.

In the third period (1980 – now) MHS faced the need of more accountability and new concepts such as "evidence based treatments", quality of care, audits of clinical practice were introduced in the service organization, requiring staff to work in a more efficient way but also to deal with more bureaucracy. Moreover, the development of new patient centered paradigm of care, including the recovery model (Anthony, 1993) challenged the traditional professional roles, requiring professional to change their professional culture toward a more symmetric, person centered and empowering role.

During the last two decades, Mental Health Services in Europe, north-America and Australia have been shifting from a hospital based to community based systems of care, which are considered more suitable for delivering psychosocial rehabilitative intervention and for integrating with social services and nonprofit organizations (Thornicroft & Tansella 1999; Thornicroft & Tansella 2003; Becker & Kilian, 2006). The resulting system may include, at a local level, a network of several public, nonprofit or private organization and facilities (Community Mental Health Centers, Day Care Centers, Residential Facilities, etc.…) that operate with various degrees of autonomy each one with is organization, history and vision. In contemporary MHSs, care is provided by mental health workers (MHW) from different professional and occupational groups, working together in multi-professional teams in a combination of specialized units whose organizational structure and work procedures are ruled by national or regional policies, to create a wide array of inpatient, residential and community outpatient services to better respond to peoples' mental health care needs.

The process of care could be influenced by a number of different staff related factors, such as staff morale and burnout levels, technical and interpersonal skills, attitudes and values (Thornicroft & Tansella 1999), including stigmatizing ones (Gaebel et al., 2011).

Moreover, according to organizational psychology research, each organization is suitable for developing its own "organizational culture" (Schein, 2004; Glisson, 2008), a corpus of beliefs, rules and rituals that are shared by the staff and that are resistant to changes. Those social processes are particularly relevant for MHS, since they deal with clinical conditions that are socially constructed (Rosenhan 1973; Wiener 1975): every mental health professional defines – more or less explicitly - what kind of person should be defined "mentally ill", how it should be "treated" and how much autonomy "should be given" to him according to a system of beliefs and attitudes (Slade, 2009, pp. 8-34). Furthermore, significant organizational procedures could be strongly influenced by practitioners attitudes, for example, the implementation of evidence-based practices (Aarons, 2006), the use of routine outcome assessment procedures (Traurer et al., 2009) or the definition of rehabilitation goals (Clarke et al., 2009). Relevantly, some manuals about recovery oriented practices (Slade, 2009; Davidson et al. 2009) include at least one section about the importance of changing MHWs beliefs and attitudes.

However, there's lack of studies that try to develop a comprehensive model of those staff members' social psychological and organizational factors that could influence the process of care in mental health settings. It's not clear, for instance, what attitudes and beliefs are more relevant than others, how and in which phase of the professionalization process they are generated and which kind of processes they influence. Even though some instruments designed to assess social and organizational constructs such as organizational culture in mental health (Glisson 2008; Schiff, 2009) or ward atmosphere (Røssberg and Friis, 2003) have already been developed, they do not assess professional attitudes and behavior at the individual level.

This dissertation attempts to develop a new questionnaire to assess psychological factors that characterize MHWs practice: to do so, we will adopt the concept of professional culture, considering the professionalization MHWs as a core element to understand professional behavior. Before considering the implication of professionalism in mental health care, we propose a brief overview of theoretical definitions and models of the construct of profession and professionalism.

1.2 Defining professions and professional culture

Scholars developed several definitions of profession and professionalism based on the acquisition of specific knowledge through a training process. For example, Van Mook defines a profession as <<a vocation with a body of knowledge and skills (expertise) put into service for the good of others>> (Van Mook et al, 2009, p. 81). Freidson states that "the sole generic resource of professions is, like all labor, their capacity to perform particular kinds of work" (Freidson, 1993). Professionalism becomes a set of task-oriented behaviors that develop to manage complex issues, i.e. medical care (Southon and Braithwaite, 1998). Such task-related behaviors include a high level of expertise, autonomy or the 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 (Raelin, 1986). Brock (2009) states that becoming a professional implies gaining qualifications and knowledge through further and higher education, practical experience through apprenticeship and work experience.

Beside the professional knowledge, each profession is also constituted by the social dynamics that are proper of a specific social group. In Bourdieu's (1991) theory of social structuration, professions are seen as social systems in which each professional's role is determined by its position in relation to others and by its access to certain resources which include material resources (economic capital), access to levels of information (cultural capital) and access to social connections and expertise (social capital). This theory recognizes that individuals both within a profession and between professions (such as psychologist and psychiatrists) are in the constant process of attempting to distinguish themselves and their profession to acquire more 'capital' to promote their ability to act (Lingard et al. ,2004). Southon and Braithwaite (1998) suggest professional knowledge, skills and accepted practices cannot be established by each practitioner, but must be developed over time by groups of practitioners, whose training need to be carried out through close tutelage: continuing association with colleagues may be required to promote standards and to maintain currency. Scholars like Greenwood and Leich and Fennell described the trait-like characteristics that differentiate professions from occupations as:

a basis in systematic theory, authority recognized by the clientele of the professional group, broader community sanction and approval of this authority, a code of ethics regulating relations of professional persons with clients and colleagues, and a professional culture sustained by formal professional associations (Hillman, 2005).

Being a professional is not just about having qualifications, training, skill, knowledge and experience but involves also sharing attitudes, beliefs, values, power to interpret the working tasks and a representation of the own professional role. According to Bloor and Dawson (1994), the process of profession formation, i.e. the creation of a particular professional group, leads to the development of a system of values, cognitive frame and knowledge, shared among the members of that professional group and that orient professional behavior. Those shared cognitive and behavioral schemata constitute the "professional culture" of a certain professional group, orient their sense making and behavior and contribute to the definition of the organizational culture in which those professionals work.

The notion of professional culture is a fuzzy construct that lies between organizational psychology, anthropology and organization theory, and has been applied in a broad range of professional fields, describing, for example, the teacher's professional culture (Stodolsky et al., 2006), the social worker culture (Biasin et al., 2012), and inter-professional culture of nurses, teacher and support workers working with children (Messenger, 2013).

Schein (2004) states that if an occupation involves an intense period of education and apprenticeship, there will certainly be a shared learning of attitudes, norms, and values that eventually will become taken-for-granted assumptions for the members of those occupations. It is assumed that the beliefs and values learned during this time will remain stable as assumptions even though the person may not always be in a group of occupational peers. But reinforcement of those assumptions occurs at professional meetings and continuing education sessions, and by the practice of the occupation often calls for teamwork among several members of the occupation, who reinforce each other. Professional culture could be considered as a subsystem of the broader organizational culture (Schein, 2004) and it also linked with further constructs such as professional

identity, professional role, attitudes and beliefs toward clients, professional values, cultural artifacts and affective issues related to team working, inter-professional collaboration and therapeutic relationship with clients (Miscenko & Day, 2015; Lammers et al., 2013).

1.3 Professions in contemporary mental health care

Considering the perspectives on the development of professions, we suggest that, in the metal health field, professional disciplines have been sanctioned by the society to treat mental illness and distress according not only to the social representation of mental illness but also to the social and political context across the history. At the same time, a whole set of human experiences, such as misery, psychosis, anxiety, breakdowns, political divergence and homosexuality have been translated into terms as illness and disorder or have been freed from the medical taxonomy.

As discussed in paragraph 1.1, mental health services have been developing toward a more complexification of practices and organization, giving rise to more complex task requiring the emergence of more professional categories according to the Southon and Braithwaite (1998) model. Since the first use of the term "Psychiatrist" in 1808 by the German physician Johan Christian Reil, psychiatry has been developed its own cultural practices and rituals that shape the practitioner's behavior and attitudes to client, such as medication prescription, institutionalization power, assessment, consultations and codes of professional conduct. In 1836, the English apothecary Sir William Charles Ellis published *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity* (Ellis, 1836), stating that an established nursing practice calmed depressed patients and gave hope to the hopeless; Ellis was also one of the major advocates for mental health nursing that proposed giving the "keepers of the insane" better salaries and training to attract more talented people to this emerging profession. Clinical psychology also has been developing its own culture, which at times has been able to rock alongside the psychiatric one, as it operated in the context of a mental health team, while at other times opposed to psychiatry and create a new set of ritual and practices that can work independently, focusing on therapeutic relationship, psychological conceptualization of patient's behavior and talking therapies.

Different countries have different legal definitions, requirements and training regarding MHWs. For example, mental health nurses (MHN) is a well-defined professional category in Australia and England, while in Italy mental health services employ graduated nurses with no specific training in mental health. In England, social workers, psychiatric nurses and psychologist may "upgrade" to the professional category of Approved Mental Health Professional (AMHP), acquiring the professional power to perform clinical assessments and to make an application for patients' compulsory admission to hospital. Thus, professional roles and cultures of MHWs may be partially determined by the organizational context in which they work. For example, in many countries (like Italy or France) social workers and nurses do not necessarily have a specific training in mental health, their professional culture starts developing when they're university students but it's furtherly characterized by the work context in which they start working after the university degree.

Still considering differences at country level, professional practice may differ regarding professional cultures. Littlewood (2002) states that even though in Europe and North America mental health is largely related and measured as a health and illness issue, the emphasis on biology and medication is much greater in North America than in Europe. Van Os and colleagues (Van Os et al, 1993) found significant differences between diagnostic and clinical practices in England compared France; in the former, greater trust was placed in biological ad behavioral theories, whilst in the latter psychodynamic theories and family dynamics dominated the scene; moreover, in France, there was grater reluctance to diagnose schizophrenia after the age of 45, and English psychiatrist didn't label clinical problems that French psychiatrist commonly identified. In countries in which traditional medicine still plays an important role in the society, mental health professionals may co-exist or cooperate with traditional healers, sometimes trying to integrate native culture of healing within their professional culture (Oulanova & Moodley, 2010).

2. Professional culture of mental health workers: a meta-synthesis of current literature

2.1 Introduction

2.1.1 Professional cultures of mental health workers

In middle and high income Countries, staff of mental health service (MHS) is composed by specialized workers such as psychiatrists, nurses, social workers, psychologists and support workers organized in multi-professional teams with compositions determined by local level regulations (Thornicroft & Tansella 1999) and aimed to provide 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.

Scholars traditionally defined each profession on the basis of a specific professional knowledge and expertise. (Freidson, 1993; Van Mook et al, 2009. From his perspective, professionalism becomes a set of task-oriented behaviors with associated social behaviors. Such task-related behaviors include a high level of expertise, autonomy or the 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 (Raelin, 1986). Brock (2009) states that becoming a professional implies gaining qualifications and knowledge through further and higher education, practical experience through apprenticeship and work experience. Individuals both within a profession and between professions are in the constant process of attempting to distinguish themselves and their profession and thus acquire more 'capital' to promote their ability to act (Bourdieu, 1991; Lingard et al. ,2004).

According to Bloor and Dawson (1994), the creation of a particular professional group leads to the development of a system of values, schema and knowledge, shared among the members of that professional group and that orient professional behavior and moreover, professional coping to unforeseen and changing situations. Shared cognitive

and behavioral schemata constitute the "professional culture" of a certain professional group, orient their sense making and behavior and contribute to the definition of the organizational culture in which those professionals work. Professional culture could be also considered as a subsystem of the broader organizational culture (Schein, 2004) and it also linked with further constructs such as professional identity, professional role, attitudes and beliefs toward clients, professional values, cultural artifacts and affective issues related to team working, inter-professional collaboration and therapeutic relationship with clients (Miscenko & Day, 2015; Lammers et al., 2013).

Currently, there are no studies that attempt to apply these theoretical models to professional groups working in the field of mental health. The research presented here is a first attempt to develop a framework of professional culture of mental health workers (MHWs).

2.1.2 Study's scope and rationale

This main scope of this study is the identification of core themes that constitute professional culture of staff working in services for people with severe mental illness as they emerge from the existing literature of qualitative research. Qualitative research is a broad umbrella term describing several specific research methods and paradigms that rely on the collection, analysis, and interpretation of nonmathematical data (Morse, 2013). Because professional culture is the result of individual and collective sense making process and relies on subjective meanings, qualitative methods that involve interpretation of subjective meaning, experience, beliefs, and attitudes (Whitley et al., 2005) sound more suitable than quantitative approach to explore this topic.

Since the concept of professional culture has not been applied in the field of mental health work, we chose to use a meta-ethnomethodology approach to develop a new framework. This approach allows researchers to develop an <<inductive and interpretive form of knowledge synthesis>> (Noblit and Hare, 1988), combining results of several qualitative studies and translating findings from a study to another. Meta-ethnomethodology compares results from multiple qualitative studies but unlike traditional reviews, it enables the researchers to re-conceptualize existing literature and attain new

interpretations that may differ remarkably from the component parts (Noblit and Hare, 1988; Doyle 2003). The analysis was guided by two research question:

- *Question 1: what are the common themes that define the professional culture of mental health workers?*
- *Question 2: what are the peculiar elements that distinguish between different professional categories (e.g. nurses vs. psychiatrists)?*

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 formal education process, but often they are also determined by the work context, coherently with the idea that professional culture could be also considered as intertwined with organizational culture (Bloor and Davidson 1994; Schein 2004).

2.2 Methods

2.2.1 Article search and selection

The ProQuest platform was used as the main search tool, allowing to retrieve articles references from MEDLINE, PsycARTICLES, PsycCRITIQUES, PsycINFO, Social Services Abstracts and Sociological Abstracts database. The research string, reported in table 2.1, 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 Davidson definition presented in paragraph 2.1.1. The second keywords' group listed all the possible professional categories of MHWs, such as psychiatrists or mental health nurses. Since some of those professional categories, such as nurses, psychologists and social workers, may not necessarily work in a MHS, the third group of keyword was included to filter studies that may not be related to the mental health field. Finally, the fourth group of keywords excluded articles related to child and adolescent mental health services, correctional facilities, forensic units or 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 be totally 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 2.1. 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 behavior*" OR "professional behavior*" 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.

Articles selection procedure followed two phases, the abstract screening and the fulltext evaluation. The aim of the abstract screening was to exclude articles that would not be relevant for the research scope, using the following exclusion criteria:

a) the abstract not available and could not be retrieved;
b) the article didn't present data and results (e.g. essay or a commentary);
c) the study participants were not mental health professionals working in clinical settings for adults; in this phase studies that included both MHWs and others participants' categories were included;
d) the study wasn't focused on existing MHWs' practices and experience (e.g. validation of a new scale or questionnaire, randomized clinical trial of a new intervention);
e) the study didn't adopt a qualitative methodology for data collection and analysis; mixed quali-quantitative studies were also included in this phase.

In the second phase, full text articles were independently read by two researchers (FR and MM) to evaluate articles' quality and relevance for the research scope. Quality evaluation was performed using the National Institute for Health and Clinical Excellence (NICE) quality appraisal checklist for qualitative studies (National Institute for Health and Clinical Excellence, 2009). The NICE checklist consisted in 14 criteria, listed in table 2.2, evaluating methodology, coherence within the research aims and framework, quality of the data presentation and ethical aspects.

Table 2.2 Extract from the National Institute for Health and Clinical Excellence quality appraisal checklist for qualitative studies

#	Criteria	Example of evaluation question
1	Is a qualitative approach appropriate?	*Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?*
2	Is the study clear in what it seeks to do?	*Is the purpose of the study discussed – aims/objectives/research question/s?*
3	How defensible/rigorous is the research design/methodology?	*Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used?*
4	How well was the data collection carried out?	*Are the data collection methods clearly described?*
5	Is the role of the researcher clearly described?	*Has the relationship between the researcher and the participants been adequately considered?*
6	Is the context clearly described?	*Are the characteristics of the participants and settings clearly defined?*
7	Were the methods reliable?	*Do the methods investigate what they claim to?*
8	Is the data analysis sufficiently rigorous?	*Is it clear how the themes and concepts were derived from the data?*
9	Are the data 'rich'?	*Has the diversity of perspective and content been explored?*
10	Is the analysis reliable?	*Did more than 1 researcher theme and code transcripts/data?*
11	Are the findings convincing?	*Are extracts from the original data included?*
12	Are the findings relevant to the aims of the study?	*Relevant / Irrelevant / Partially relevant*
13	Conclusions	*How clear are the links between data, interpretation and conclusions?*
14	How clear and coherent is the reporting of ethics?	*Was the study approved by an ethics committee?*

Given the lack of consensus in the literature about the quality appraisal of qualitative papers (Campbell et al., 2011; Dixon-Woods; Toye et al., 2013), we decided to exclude articles that didn't fully meet at least 8 criteria out of 14. FR and MM met together to compare their evaluations and to discuss disagreement between quality scores.

Finally, all the studies that passed the quality evaluation were furtherly assessed regarding their relevance to depicting professional culture: selected articles should contain key concept that could be related to the research question ad described below.

2.2.2 Articles analysis and synthesis

The data analysis process involved different interpretative steps according to Noblit and Hare of lines-of-argument synthesis methodology: <<a lines-of-argument synthesis is essentially about inference: what can we say of the whole (organization, culture, etc.), based on selective studies of the parts?>> (Noblit and Hare 1988). Lines-of-argument synthesis rely on the examination of similarities and differences between cases and on the development of holistic schemes to integrate these. Noblit and Hare claimed that the basis of the lines-of-argument synthesis could be ascribed to clinical inference (Geertz 1973) and Grounded theory (Glaser and Strauss 1967). Like Geertz's clinical inference, the lines-of-argument synthesis extracts from a set of qualitative studies a shared "structure of signification". Following Glaser and Strauss, the synthesis is accomplished by repeated comparison between studies, discovering and depicting similarities and differences to build up an integrating scheme that should meet the following criteria: all the studies should "fit", it must "work", it must be parsimonious, have a sufficient scope and be "theoretically saturated".

In the present study, the synthesis was performed through the following steps:

1. A first researcher (FR) read all articles and retrieved from the text the "key concepts" that could be related to the research question such as professional behaviors, representation of professional role and users, work related experiences, recurring issues; key concepts could be direct quotes from participants retrieved from the article text or extracts of text from the results section;
2. Key concepts were imputed into a spreadsheet and compared by FR and MM to generate a list of "first-order concepts"; coherently with the line-of-argument methodology, each first order concept represents the collection of how the same issue recurred in each study, with a minimal degree of content elaboration;
3. second-order synthesis were then formulated by FR and MM by establishing

relationship between clusters of first order concepts; thus, second order synthesis represents

4. Finally, the third level of synthesis represented the effort to answer to research question 1 and 2 by reflecting upon first order concepts and second order synthesis; the third order synthesis is an attempt to create a conceptual model of the professional culture starting from second order synthesis.

All the phases involved repeated discussions between members of the research team and several iterations of the framework until agreement was reached.

2.3 Results

2.3.1 Articles selection and overall characteristics

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

Figure 2.1 Papers' selection process

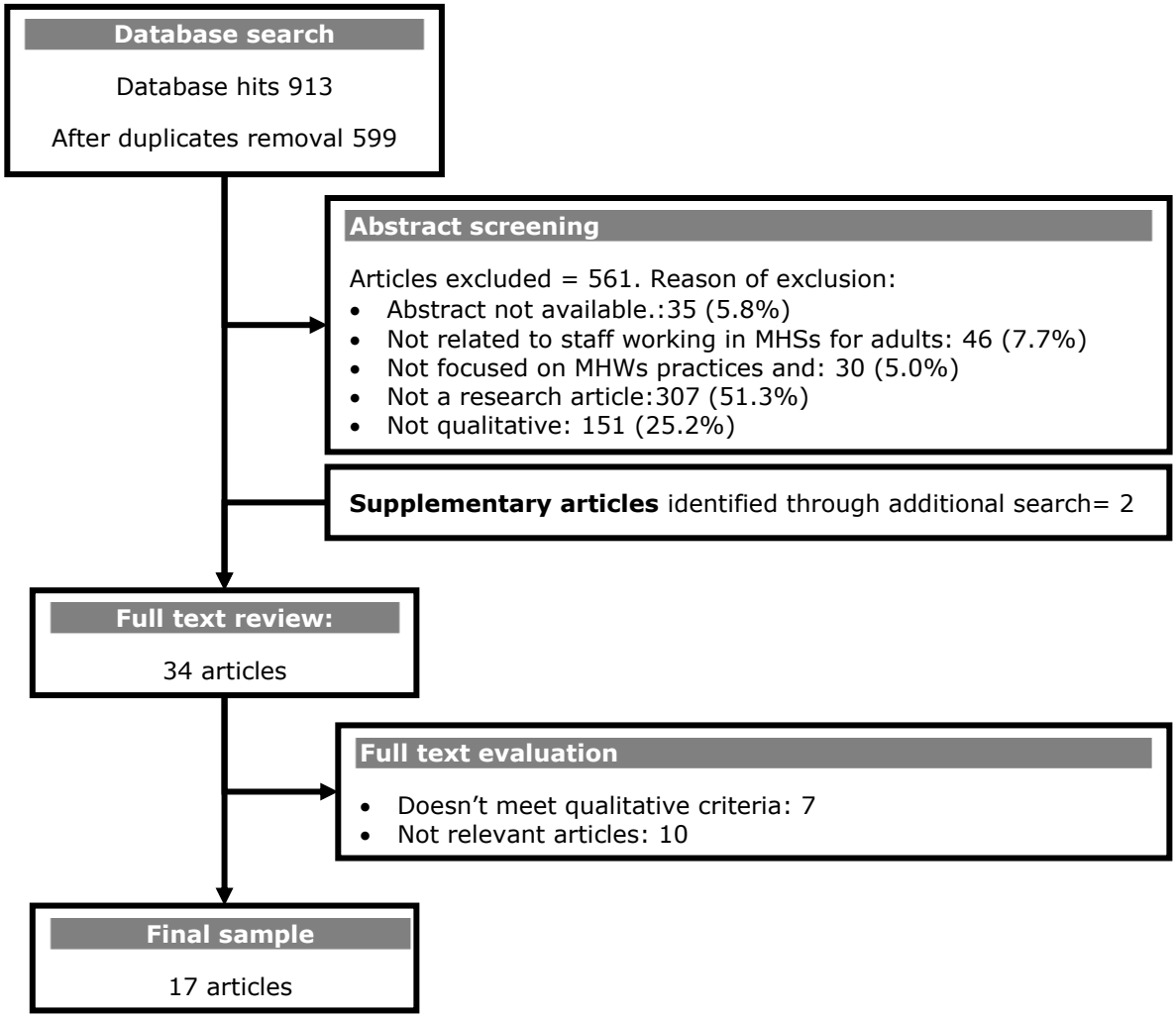


Figure 2.1 synthesize the paper selection process. The resulting 32 articles, plus two more supplementary studies identified through additional purposive research, were furtherly analyzed to evaluate the overall quality.

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

Researchers then decided to exclude 10 more articles, because the content wasn't judged as useful to describe professional culture. The final articles' sample consisted in 17 studies. Their characteristics are described in table 2.3.

More than half of the selected studies took place in Europe, and UK was the country with more contributions. Mental health / psychiatric nurse was the most represented professional category, reported in 11 articles, while psychologists, support workers and occupation therapists where less represented.

Table 2.3. Studies overview.

Study	Country	Participants	Methodology
Gibb, 2003	Australia	33 Mental health nurses	Semi structured interviews, focus group and grounded theory analysis
Akerjorder and Sverinsson, 2004	Norway	7 Mental health nurses	Semi structured interviews and hermeneutic analysis.
Morant, 2006	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, 2007	UK	10 mental health nurses	Semi structured interviews and thematic analysis
Goodwin and Happell, 2007	Australia	30 mental health nurses	Focus group and content analysis
Crawford et al, 2007	UK	34 community mental health nurses	Semi structured interviews and thematic analysis
Patterson et a 2008	Australia	8 mental health nurses	Semi structured interviews and thematic analysis
Robertson et al, 2009	Australia	16 Psychiatrists	Semi structured interviews and grounded theory analysis
Deady and McCarty, 2010	Ireland	18 mental health nurses	Semi structured interviews and thematic analysis
Burks and Robbins, 2012	USA	17 Clinical psychologists	Semi structured interviews and thematic analysis
Shepherd et al, 2014	UK	26 Consultant psychiatrists	Semi structured interviews and thematic analysis
Carpenter-Song and Torrey, 2015	USA	Psychiatrists and prescribing mental health practitioners**	Semi structured interviews, focus group and grounded theory analysis
Stentoft Dalum et al, 2015	Denemark and USA	18 Non-medical Mental Health Practitioners (Managers, nurses, case managers, social workers)	Semi structured interviews and situational analysis
Ericsson et al, 2016	Sweden	25 House support workers	Focus group, thematic analysis, constructionist approach
Morriss, 2015	UK	5 Social workers	Group and single interviews, ethnomethodological approach
Valenti et al, 2015	Multiple countries*	78 psychiatrists, 73 nurses, 46 clinical psychologists, 36 social workers, 4 occupational therapists, 11 other professional roles	Focus group and thematic analysis
Buckland, 2016	UK	10 Approved mental health professional with social workers background	Interviews, Foucauldian discourse analysis
Abendstrern et al, 2015	UK	9 Team managers, 8 Consultant psychiatrists, 8 Nurses, 5 Occupational therapists, 2 Clinical psychologists, 4 Support workers	Interviews, hermeneutic analysis

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

** participants' number not reported

2.3.2 First order concepts

Below, we'll present each first-order concept as a narrative synthesis. When available in the original article, we included samples of participants' narrative, quoted 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 the interpersonal contact with users/client recurred in eight studies clients (Gibb, 2003; Akerjorder and Sverinsson, 2004; Gibb, 2003; Goodwin and Happell, 2007; Crawford et al, 2007; Patterson et a 2008; Burks and Robbins, 2012; Carpenter-Song and Torrey, 2015). Some Authors reported the experience of different MHWs (mostly mental health nurses, but also clinical psychologists and psychiatrist) of having an authentic and genuine interpersonal encounter with their users (Akerjorder and Sverinsson, 2004; Goodwin and Happell, 2007; Burks and Robbins, 2012). The professional role of the MHW may involve the experience of "being with" the client (Gibb, 2003; Burks and Robbins, 2012; Carpenter-Song and Torrey, 2015), sharing reciprocal feelings of confidence and trust (Goodwin and Happell, 2007; Crawford et al, 2007).

> 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, 2015).

Moreover, the interpersonal closeness is not taken for granted: the relationship must be "cultivated" (Carpenter-Song and Torrey, 2015), and authenticity requires some self-disclosure from the professional and the acceptance of the users' mental illness (Patterson et al, 2008), while assuming an "expert" role may hinder acceptance (Burks and Robbins, 2012). Spiritual and religious beliefs may also play a relevant role for authenticity (Burks and Robbins, 2012). However, "closeness" is not always appropriate to the professional role: giving medication to clients (Carpenter-Song and Torrey, 2015) and psychological therapies (Burks and Robbins, 2012) may require professional distance. Moreover, some kind of boundaries are necessary to avoid role blurring between nurse and clients (Crawford et al, 2007) and avoiding to be considered as friends (Patterson et a 2008).

> 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, 2008).

Theoretical models, learned during the professional training, influence interactions with clients (Robertson et al, 2009; Dalum et al, 2015) and frame the cognitive conceptualization of client's problems (Robertson et al, 2009).

> I can guide the client from my theoretical knowledge.
> - Mental health care professional (in Dalum et al, 2015).

Emotional work

Emotions and feeling play an important role in the work of the mental health practitioner, as five studies point out (Gibb, 2003; Akerjorder and Sverinsson, 2004; Robertson et al, 2009; Burks and Robbins. 2012; Buckland, 2016). Different kinds of encounters in clinical work where their feelings are central, ranging from the fruitful encounter, which led to a feeling of joy, to feelings of emotional distress associated with conflict and distrusts (Akerjorder and Sverinsson, 2004). Beside the therapeutic relationship, feelings and emotion play a role in several work processes: they contribute to evaluation and decision-making (Gibb, 2003; Akerjorder and Sverinsson, 2004; Buckland, 2016) or they could interfere with the interpersonal relationship with clients (Burks and Robbins. 2012).

> When you come into crisis intervention I don't know where the intuition or instinct comes in. I think it's based on experience.
> - Mental health nurse (in Gibb, 2003).

> 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 / social worker (in Buckland, 2016).

Emotions and feelings may also lead to professional hazards, such emotional interference between work and family (and vice versa) life, or compassion fatigue (Robertson et al, 2009).

Mindful and reflective practice

Among the professional skills, being able to monitor own mental states and behavior is

considered a core competence (Akerjorder and Sverinsson, 2004; Robertson et al, 2009; Burks and Robbins, 2012).

> 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, 2012).

Although some MHWs, especially the ones who received a training in psychotherapy, are trained not to let their own values undermine the relationship with client (Burks and Robbins, 2012), recognizing the need of a clinical supervision it's considered a necessary skill for nurses (Akerjorder and Sverinsson, 2004).

Empowerment and negotiation

MHWs' role may involve users' empowerment and advocacy of people rights, as seven studies point out (Gibb, 2003; Morant, 2006; Lloyd, 2007; Crawford et al, 2007; Robertson et al, 2009; Shepherd et al, 2014; Dalum et al, 2015). Staff may encourage users to take responsibility for themselves (Lloyd, 2007; Patterson et a 2008), helping them to take back the control of their lives (Lloyd, 2007). This role requires workers to be able to inspire hope and optimism in the client regarding recovery and treatments (Shepherd et al, 2014; Dalum et al, 2015), listening to client goals, dreams and hopes (Dalum et al, 2015) and valuing patient narratives (Robertson et al, 2009), coherently with a recovery oriented paradigm of mental health care (Dalum et al, 2015).

> 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, 2003).

Table. 2.4. Concepts' grid of the examined studies. The letter in each cell indicates the professional category whose concept is related in each article.

	Gibb, 2003	Akerjorder and Sverinsson, 2004	Morant, 2006	Lloyd, 2007	Goodwin and Happell, 2007	Crawford et al, 2007	Patterson et a 2008	Robertson et al, 2009	Deady and McCarty 2010	Burks and Robbins, 2012	Shepherd et al, 2014	Carpenter-Song and Torrey, 2015	Dalum et al, 2015	Morriss, 2015	Valenti et al, 2015	Buckland, 2016	Ericsson et al, 2016
Interpersonal contact with clients	**MN**	**MN**		**MN**	**MN**	**MN**	**MN**			**CP**		**MP**	**UN**				
Emotional work	**MN**	**MN**						**MP**		**CP**						**SW**	
Mindful/reflective practice		**MN**						**MP**		**CP**							
Empowerment and negotiation	**MN**		**UN**	**MN**		**MN**		**MP**			**MP**		**UN**	**SW**			
Coercive practices	**MN**								**MN**						**UN**	**SW**	
Complexity and uncertainty			**UN**		**MN**			**MP**				**MP**			**UN**		**SU**
Value based practice		**MN**		**MN**					**MN**	**CP**		**MP**		**SW**	**UN**	**SW**	
Social model vs medical model								**MP**					**UN**	**SW**		**SW**	**SU**
Language and professionalism					**MN**		**MN**							**SW**	**UN**	**SW**	
Team membership				**MN**					**MN**			**MP**					**SU**

MN = nurses; MP = psychiatrists; SW = social workers; CP = clinical psychologists; SU = support workers; UN = unspecified MHWs

However, lack of user's insight limits shared decision making (Lloyd, 2006; Shepherd et al, 2014) and a perceived lack of patient capacity or risk of harm may justify a paternalistic attitude in the MHW (Valenti et al, 2015).

> 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 Lloyd, 2007).

> 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 Sheperd et al, 2014).

The ability of negotiate decision with client and caregivers is considered a core skill for nurses, psychiatrists and social workers (Lloyd, 2007; Goodwin and Happel,2009; Shepherd et al, 2014; Morriss, 2015).

> 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 Happel, 2009).

Coercive practices

Four studies described the point of view of MHWs regarding coercive practices (Gibb, 2003; Deady and McCarty 2010; Valenti et al, 2015; Buckland, 2016). Some professionals believe that informal coercion is a useful therapeutic strategy but may be reluctant to label their own practice as "coercive" (Valenti et al, 2015).

> 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 (in Valenti et al, 2015).

Patients' lack of insight and acute psychosis justify more intense coercive actions and compulsory detention may have positive effects on people (Buckland, 2016). Some other MHW think that clinicians have no right to force patients (Valenti 2015; Buckland, 2016).

> 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, 2015).

> 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 / social worker (in Buckland, 2016).

Moreover, the decision to use compulsory powers may be associated with stress and feeling of responsibility, and who exerts compulsory power feel the pressure of the society to avoid "incidents" (Buckland, 2016). Clinician's emotional responses to escalation with patient could also induce more intensive coercive measures, in a mutual escalation (Valenti et al, 2015).

Complexity and uncertainty

Working in the mental health field requires the mental health worker to deal with high levels of uncertainty and complexity related to the nature of mental illness: MHWs hold uncertain representation of mental illness and work and outcomes (Morant, 2006), and defining what is a good performance it's often very difficult (Ericsson et al, 2016).

For any MHWs, but more frequently for psychologists and psychiatrists, the adoption of a theoretical perspectives of the mind and mental illness (e.g. psychoanalysis, recovery model, systemic approach, etc…) provides a cognitive strategy to manage uncertainty and complexity (Morant, 2006).

> I tend to think more in terms of the complementarity of theories and therapeutic practices –that's what I do in practice. I prescribe medication and I use an approach which takes its reference points from psychoanalysis and a systemic approach to the family.
> - Psychiatrist (in Morant, 2006).

However, complexity could also be seen as intellectually challenging (Carpenter-Song and Torrey, 2015).

> 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, 2015).

Moreover, working in the mental health field may require some sort of eclecticism and ability to perform the professional role in a flexible way (Morant, 2006; Patterson, 2008; Carpenter-Song and Torrey, 2015; Ericsson et al, 2016) 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, 2006).

> 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, 2008).

Value based practice and morality

Mental health work may be guided by strong professional values, as reported in seven studies (Akerjorder and Sverinsson, 2004; Lloyd, 2007; Deady and McCarty 2010; Burks and Robbins, 2012; Morriss, 2015; Valenti et al, 2015; Buckland, 2016). Examples of values associated with the professional practice are: accepting of people with mental disorders (Patterson et al, 2008), supporting users' recovery (Carpenter-Song and Torrey, 2015), taking care of marginalized people (Carpenter-Song and Torrey, 2015), doing the job with commitment and responsibility (Akerjorder and Sverinsson, 2004), valuing clients' experience (Robertson et al, 2009.

> 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, 2008).

The issue of responsibility recurs in staff narratives about values (Gibb, 2003; Akerjorder and Sverinsson, 2004), as an object that metaphorically could be "taken" or "given" (Gibb, 2003; Lloyd, 2007) passing from staff to client and vice versa; the decision to give or take responsibility is taken according to workers' personal values and may be associated to moral dilemmas (Valenti et al, 2015).

> That level of responsibility we have in the community is enormous. Initially it can be overwhelming, but we learn to value our judgements, when and when not to engage others.
> - Mental health nurse (in Gibb, 2003).

> 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, 2015).

Moreover, adherence to professional values may determine, in participants' responses, the definition of the professional ingroup-outgroup, since individuals of the same profession who don't behave coherently with professional values, are not considered as "real" professionals. Own professional values may conflict with values of the work context (Buckland, 2016), and may lead to moral distress, when quality of care is lowers than standards (Deady and McCarty 2010).

Social model vs medical model of mental health care

MHWs working according to a social model of mental health care express discomfort toward the medical model recurs in five articles (Robertson et al, 2009; Dalum et al, 2015; Morriss, 2015; Buckland, 2016; Ericsson et al, 2016). Most of the discomfort is expressed toward a rigid approach to the diagnostic process, defined as "putting labels" to people (Robertson et al, 2009) and "categorizing" of clients' needs (Morriss, 2015).

> 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, 2015).

Moreover, the social model considers the client as an individual to empower, whilst in the medical model professionals consider patients as help seeker who must be "fixed" (Dalum et al, 2015).

> 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, 2015).

Overtly, some MHWs (mostly social workers or support workers) describe themselves as being in resistance toward Psychiatry (Buckland, 2016; Ericsson et al, 2016). Nobly, the complementary stance, i.e. MHWs expressing discomfort toward the social model, wasn't reported in the articles.

Language, communication and professionalism

The theme of language and communication recurs in six studies (Lloyd, 2006; Morant, 2006; Goodwin and Happell, 2007; Patterson et a 2008; Morriss, 2015; Valenti et al, 2015) with different issues. Communication seem to characterize the professional representation of mental health nurse role (Lloyd, 2006; Goodwin and Happel, 2007).

> 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 Lloyd,2006).

> It's to do with the willingness and the desire of the consumer and carer to communicate with us [and also] our attitude. It's being really reasonable in your expectations that helps the communication.
> - Mental health nurse (in Goodwin and Happel, 2007).

Another issue related to the theme of language is the adoption of diagnostic terms. Some MHWs, especially psychiatrists and mental health nurses, find diagnostic labels as useful tool for managing users' problems (Morant, 2006; Robertson et al, 2009).

> 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, 2006).

> 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, 2009).

However, other MHWs express some concern about the rigid or defensive use of diagnostical labels that may hinder users's acceptance and de-humanize care (Robertson et al, 2009; Morriss, 2015).

> 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, 2009).

By adopting a professional jargon, the mental health worker could exhibit technical competence and be accepted from other colleagues (Morriss, 2015) or expressing professional differences and power, especially when using a medical jargon (Buckland, 2016).

Conversely, some workers, prefer not using a professional jargon (e.g. using diagnostic labels) since it may create a "barrier" (cf. Professional distance and boundaries) between them and their clients (Goodwin and Happell, 2007).

> 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 and Happell, 2007).

> [Newly graduated nurse 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, 2008).

Team membership

Mental health work, especially in hospital and in residential settings, relies on team work

(Carpenter-Song and Torrey, 2015). Being "accepted" as a team member is highly desirable for MHWs (Ericsson et al, 2016) since teamwork may foster coping with stressful hospital environment (Lloyd, 2007) and may promote positive feelings about work (Buckland, 2016).

> 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, 2016).

However, conflict between team loyalty and professional values may occur when the worker notices colleagues performing poor quality practice (Ericsson et al, 2016); fear of being isolated from the team or professional group may pressure the worker to not report malpractices (Deady and McCarty 2010).

> 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.
> - Psichiatric nurse (in Deady and McCarty 2010).

2.3.3 Second order synthesis

Three second order synthesis emerged from the conceptual combination of first order concepts. Each synthesis will be presented below, reprising first order concepts and the realtive references.

Interpersonal professional space

The first combination of first order concepts involves the concept of interpersonal distance between MHW and clients, that it's linked with emotional work and mindful and reflective professional stance. Mental health work implies interpersonal contact with users, that could be a genuine and authentic encounter (Akerjorder and Sverinsson, 2004; Goodwin and Happell, 2007; Burks and Robbins, 2012), with reciprocal sharing of feelings and mutual trust (Goodwin and Happell, 2007; Crawford et al, 2007). However, the MHW must put some effort in keeping and appropriate interpersonal distance for the professional role (Carpenter-Song and Torrey, 2015; Burks and Robbins, 2012; Patterson et a 2008) and avoiding role blurring between nurse and clients (Crawford et al, 2007). This interpersonal relationship must be "cultivated" (Carpenter-Song and Torrey, 2015) and the

MHW must be aware of expressing attitudes that may hinder acceptance (Burks and Robbins, 2012).

Thus, maintaining a professional interpersonal distance requires the MHW to monitor internal states of mind and the quality of interactions with clients (Akerjorder and Sverinsson, 2004; Robertson et al, 2009; Burks and Robbins, 2012). MHW's emotional reactions and feeling must be monitored with particular care, since feelings could interfere with the interpersonal relationship with clients (Burks and Robbins. 2012) and hinder professional reasoning (Gibb, 2003; Akerjorder and Sverinsson, 2004). Emotions and feelings are generated by the interpersonal contact with clients: the closer distance, the higher emotional reaction, with an increased risk of burnout and compassion fatigue (Robertson et al, 2009). A training in psychotherapy (Robertson et al, 2009) and clinical supervision (Akerjorder and Sverinsson, 2004) increase MHW's ability to monitor the interpersonal interaction with clients and foster emotional intelligence. Even though interpersonal distance is an issue that recourse in the discourse of different professional categories (cfr. Table 2.4), psychologists and psychiatrists seem to put more emphasis the connection between interpersonal contact, emotional issues and the need of a reflective and mindful attitude.

The power game

The second synthesis involves the thematic connection between empowerment and negotiation, value-based practice and language. Mental illness may, temporarily or permanently, impair individuals' judgment and self-control, so MHWs have the responsibility to take decisions on behalf of users regarding treatments (Shepherd et al, 2014; Valenti et al, 2015), especially in the acute phase of illness. However, during the rehabilitation phase MHWs' role involve assuming an empowering attitude, that implies shifting from a paternalistic approach to a more collaborative stance, where users (and users' families) are encouraged to take responsibility of their lives (Lloyd, 2007; Patterson et a 2008). Thus, dealing with power is a core issue in the MHW practice, and this "giving and taking" power dynamic could be metaphorically described as a "zero-sum game": the more power to the MHW, the less to the client and vice versa.

As MHWs hold and manage professional power, this requires high levels of responsibility (Gibb, 2003; Akerjorder and Sverinsson, 2004) and strong commitment to a system of values that could legitimate the acquired power and set ethical professional standards. MHWs discourses is also influenced by power. For MHWs with rehabilitative roles language is associated with communication with patient and caregivers (Goodwin and Happell, 2007), but in professionals, mostly psychiatrists, that deal with evaluation and treatment planning in more acute phase, professional language is associated with diagnostic labels (Robertson et al, 2009). Notably, MHWs with lower power role in treatment planning such as social workers or support workers express negative attitudes toward Psychiatry and medical classification (Morriss, 2015; Buckland, 2016; Ericsson et al, 2016). Language could be also used by MHWs to justify coercive measures and to resolve cognitive dissonance associated with professional moral dilemmas (Valenti et al, 2015).

The search of professional "anchors" against uncertainty

The metaphor associated with the third synthesis that involves professional identity is the MHWs' search of "anchors" for strengthening professional identity.

The complex and uncertain nature of mental illness is associated with uncertain representations of MHWs' roles and identities (Morant, 2006; Ericsson et al, 2016). Thus, MHWs' adopt strategies to build up their professional identity. Some of them, mostly psychologists and psychiatrists identify with a theoretical model - usually acquired through professional training- that help them to create cognitive order despite of the complexity of patients' stories (Morant, 2006). Others, typically social workers and mental health nurses, identify with a system of values and a social mission (Akerjorder and Sverinsson, 2004; Lloyd, 2007; Deady and McCarty 2010; Burks and Robbins, 2012; Morriss, 2015; Buckland, 2016). Finally, MHWs that are more exposed to users' suffering, i.e. support workers and mental health nurses (particularly in hospital settings) identify with the team (Deady and McCarty 2010; Ericsson et al, 2016).

The adoption of a shared professional language also contributes to define professional identity, express professional membership (Morriss, 2015), adherence to a particular system of professional values (Buckland, 2016) and could be used to avoid (or fostering)

role blurring with clients (Goodwin and Happell, 2007).

2.3.4 Third order synthesis

Through second order synthesis we identified three core themes, that could be furtherly combined together in a third orders synthesis that could constitute a first attempt to conceptualize professional culture of mental health workers.

Treatment and rehabilitation of people with mental disorders is a job characterized by large degrees of complexity and uncertainty (Morant, 2006). MHWs are exposed to the interpersonal relationship with users' sufferings, complex problems and critical issues: within this interpersonal space, the MHW may keep himself "closer" to the client, sharing feelings of authenticity but also exposing to moral distress and burnout, or maintaining a "longer distance", avoiding role blurring to administer medication and psychological interventions (Gibb, 2003; Goodwin and Happell, 2007; Crawford et al, 2007; Burks and Robbins, 2012; Carpenter-Song and Torrey, 2015).

MHW's professional role and the interpersonal relationship with the users involves dealing with power issues. The "power game" requires MHW to be conscious of his role and power, and to manage it with professional competence and ethical awareness (Gibb, 2003; Akerjorder and Sverinsson, 2004; Shepherd et al, 2014). Through professional training, socialization with colleagues and work experiences, the MHW builds up his professional identity acquiring the professional language and developing professional values and vision (Akerjorder and Sverinsson, 2004; Lloyd, 2007; Deady and McCarty 2010; Burks and Robbins, 2012; Morriss, 2015; Buckland, 2016).

Language is an essential aspect of professional culture: it expresses professional vision and values, foster team membership, identification with the professional category, contributes to define the interpersonal distance with users and is associated with professional roles and power (Goodwin and Happell, 2007; Robertson et al, 2009; Morriss, 2015; Valenti et al, 2015; Buckland, 2016).

2.4 Discussion

The meta-ethnography gave some insight about core themes that constitute professional culture for MHWs, i.e. interpersonal distance with clients, power and identity

management.

This conceptual framework could is a first attempt to depict professional cultures of mental health workers and could also give some cues for comparing professional cultures of different professional categories. Psychologists and psychiatrists may adopt a theoretical model to explain the functioning of the mind and psychopathology more frequently than the other professional categories. Thus, we can affirm hypothesize that psychologists and psychiatrists identify themselves more with ideas than with actions. Compared to psychologist 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. Nurses describe themselves as very interpersonally connected with users and aimed at promoting user empowerment: according to our model, their professional culture can be described in terms of a short distance with the users when with an imbalance of power to users. Social workers' may be keen to endorse the social model of mental illness and a social paradigm of interventions, that, even though it helps building up the professional identity, it may produce some sort of distress and resistance toward the medical context.

The third-order synthesis meets the Glaser and Strauss (1967) criteria that a good integrating framework should have: all the studies *fit* in it, it *works* for deciphering PC, it's *parsimonious* since it's composed only by three core themes, it is coherent with the study aim and it's theoretically saturated.

Notably, our study partially replicate and extends finding of previous studies and theoretical model of professions. In our analysis, the issue of professional knowledge, relevant for many scholars in defining professional cultures (Van Mook et al, 2009; Messenger 2013) emerged only for psychologists and psychiatrists regards the adherence to a theoretical model of mind functioning and mental illness. Thus, we can affirm that, for MHWs, professional values and interaction with clients play a most important role in defining PC compared to other professional categories like lawyers or teachers. Also the theme of complexity, present Freidson's theory of profession (Freidson, 1993), was found in our analysis: however, while in Freidson's theory -that was related to the professional

category of physicians- the constitution of a profession happens to manage a very complex context of human action, in the case of the mental health care, even though complexity is managed through theoretical models, professional values and flexible practices, MHWs are exposed to large levels of uncertainty.

Our findings also partially reprise Hillman (2005) characteristics that differentiate professions from occupations: the theme of theoretical basis emerged for psychologist and psychiatrists and recovery oriented nurses and social workers; the issue of professional authority emerged for psychiatrists linked to diagnosis and prescribing authority; the relevance of ethics in regulating relations of professional persons with clients and colleagues was common to all professional roles with the exception of support workers; the last characteristic, i.e. the relevance of professional association, didn't emerge in our synthesis but was substituted with the issue of team membership.

The themes of power and it's link with professional language it's coherent with sociological theory of Pierre Bourdieu's (1991) theory: Bourdieu considers professional power as culturally and symbolically created, and constantly re-legitimized through actions and language. Notably, MHW with lower professional power express discomfort with the use of medical professional language.

Findings of the meta-synthesis must be evaluated considering several limitations. A first limitation concerns sample representativeness of professional categories. The selected articles show a great representation of nurses, while other categories are little or not at all represented (e.g. psychologists, occupational therapists, educators). We can assume that the reasons for this lack of sample's heterogeneity can be a consequence of historical and cultural factor. For example, our search identified studies on attitudes and practices of psychologists, but were excluded because were done with quantitative methodology, perhaps reflecting the preference of academic psychologists toward quantitative research to qualitative methods (Toomela, 2010). On the other hand, professional categories of psychologists and psychiatrists have been constituted since longer time than others, and so it is possible that the interest of researchers may be oriented on more recent categories, such as psychiatric nurses or social workers.

A second limitation involve the influence of the organizational context on workers' professional culture. Theoretical model suggests that professional culture and organizational culture may be somehow interweaved (Bloor and Dawson, 1994; Schein, 2004). However, our sample of articles examined didn't allow us to evaluate the effect of the organizational context in which data were collected on MHWs narrations.

A third limitation relies in the nature of the examined qualitative data. Our analysis is based on professional narrations, useful for gathering workers experience and professional sense making (Weick, 1995); however, narratives do not fully account for real behavior and can be subject to bias, e.g. the social desirability bias or discrepancies between explicit and implicit attitudes that could affect data's reliability. For example, workers who claim to be led by a strong sense of responsibility and strong values does not mean that may always act according to professional ethics.

In addition, our results may be further be affected by sampling shortcomings, already reported in paragraph 2.3.1. Is therefore possible that the MHWs that participated to the selected studies were more concerned or sensitive to the arguments presented by the researchers than the average, and that this may led to overestimate some key concepts e.g. the presence the recovery model values or the importance of the interpersonal relationship with users.

Despite these limitations, we believe that this study may have provided a first try to create a model to analyze the professional culture that can be used to design future research.

3. Development of the Bicocca Mental Health Professional Culture Inventory

3.1 Research rationale and aims

Professional culture is a fuzzy construct that lies between organizational psychology, anthropology and organization theory, and scholar have been applied it for depicting different professions, for instance the teachers (Stodolsky et al., 2006), social workers (Biasin et al., 2012), but also inter-professional culture of nurses, support workers and teacher working with children (Messenger, 2013). Currently, there are no studies that explicitly address the issues of the professional culture of professionals working in mental health services. Findings from a meta-synthesis of qualitative studies on MHWs (Rapisarda and Miglioretti, presented in the previous chapter) suggested that of professional culture of MHWs could be described in term of three core themes, i.e. interpersonal distance with clients, accounting of power and identity management. However, the meta-synthesis results are far from being exhaustive due to methodological weaknesses that do not allow to detect PC differences between different professional role and to estimate the influence of the organizational context. This research gap could be filled by adopting a quantitative methodology, for example using a questionnaire to assess professional culture dimension in a representative sample of MHWs across different settings.

Even though researchers have been developing reliable instruments to assess cultural dimension related to mental health staff, e.g. <<…the degree to which recovery oriented practices were perceived to be implemented in mental health and addiction agencies >> (O'Connell et al., 2005) or <<"beliefs about mental illnesses", "goals and outcomes of psychiatric rehabilitation," and "practices of psychiatric rehabilitation" that best reflected the consensus of authors and organizations>>, we think that this approach has some limits:

1) instruments based on the recovery model could only capture the degree of coherence between practices and the recovery principles, but do not provide insights on psychosocial dimension that are not included in that paradigm (e.g. the attitude

toward evidence based practices);

2) cultures are defined by using a "top-down" process: cultures are theoretically defined (like "the biological psychiatry", "the recovery model", the "deinstitutionalization model", etc…) before collecting empirical findings to test the construct;
3) single construct measures are useful for research purposes, but may not be as feasible to adopt in organizational interventions.

Because of such evidences, we designed a new self-administered instrument to assess mental health staff members' professional behaviors, deciding to adopt the notion of "professional culture" considering it as a hybrid construct between the individual and the organizational level and that could be directly associated with professional practices. This chapter describes the pilot phase of the development of this new questionnaire, the Bicocca Mental Health Professional Culture Inventory (BMHPCI). According to Vallerand (Vallerand, 1989) the pilot phase is a preliminary step to the validation phase; the aim of the pilot phase is items pre-testing the items, to reduce the risk of low response rate in the validation phase. The terms "user", "client" or "patient" are used as synonyms.

3.2 Methods

3.2.1 Questionnaire development

The BMHPCI has been inspired by Bloor and Dawson's, definition of professional culture as a system of values, schema and knowledge, shared among the members of that professional group and that orient professional behavior (Blooor and Dwason, 1994). We considered professional culture of MHWs as a subsystem of the broader organizational culture (Schein, 2004) and linked with further constructs such as professional identity, professional role, attitudes and beliefs toward clients, professional values, cultural artifacts and affective issues related to therapeutic relationship with clients, team working and inter-professional collaboration (Miscenko & Day, 2015; Lammers et al., 2013). We also adopted an operationalization of culture in terms of quantitative dimension, similar to the seminal work of Hofstede (Hofstede 1980; Taras et al, 2010). In this frame of reference, cultures could be defined by scores on multidimensional scales, obtained by surveys designed to be

used in different countries.

The BMHPCI has been developed by a conjoint team of researchers from Milan, Italy, and from Montreal, Canada. All the development phase, from item creation to data analysis, was conducted together by the conjoint team, with the purpose to create a really cross-cultural questionnaire. The selection of themes and issues was driven by the scope to assess professional behavior that can influence quality of care. Items were created to describe an array of behaviors, feelings and cognitive appraisals that a staff member could experience in his/her work with users, with a preference for items focusing on behavior, instead of focusing explicit beliefs. For that reason, most of the items weren't suitable for describing professional culture of staff members that do not work in direct contact with users (e.g. administrative staff).

Researchers reviewed the scientific literature and collected suggestions from clinical researchers and professionals in Milan and in Montreal, creating 71 items, clustered in the following nine thematic groups:

1) *Personal involvement with the users*: as we reported in the capitol 2, personal involvement in the relationship with user is central to define the PC, as reported by several authors (Gibb, 2003; Akerjorder and Sverinsson, 2004; Gibb, 2003; Goodwin and Happell, 2007; Crawford et al, 2007; Patterson et a 2008; Burks and Robbins, 2012; Carpenter-Song and Torrey, 2015);
2) *Collaboration with the Social Network*: professional role may require to work with clients' families and taking contacts with members of the informal social network, like friends or colleagues (Goodwin and Happell, 2007);
3) *Collaboration with the Formal Network*: some professional roles in mental health care require staff to collaborate with staff from other services, and inter-organization collaboration could be a delicate issue in MHS practice (Glisson and Hemmelgarn 1998): this group of items investigate participants' attitudes and behavior regards inter-service collaboration;
4) *Evidence based practices and outcome assessment*: MHWs have different attitudes and knowledge of evidence based practice and this could be affect organizational

culture of MHS (Traurer et al., 2009); moreover, differences in the adoption of goal-setting methodology (Clarke et al., 2009) could be found between different MHWs: this group of items attempt to evaluate this issues;

5) *Users' involvement in the process of rules setting and decision-making*: as we reported in chapter 2, MHWs' may differ in the management of professional power; this group of items assess MHW role in fostering or hindering users' empowerment;
6) *Management of the aggressive behavior*: this group of item focused on staff's perception of patient's hostility (De Benedictis, et al, 2011) and cognitive appraisals to challenging behavior (Lambrechts et al, 2010);
7) *Spirituality and religion*: spirituality may be a relevant issue for users, and MHWs attitudes toward religious beliefs may play a role in the experience of care (Wilding et al, 2006; Curlin et al, 2007); this group of item addreeses MHWs attitudes and behaviors toward spirituality in MH care;
8) *Users' sexuality*: this group of items assess MHWs' attitudes and professional behaviors toward actively broaching sexual issues with clients (Cort et al., 2001; Saunamäki et al, 2010) with some specific items for homosexual and transsexual people (Bowers and Bieschke, 2005):
9) *Transcultural openness*: this final group of items assesses beliefs and attutudes that coul foster or hinder the process of care with people from other countries and cultures (cfr. Sandhu et al, 2013).

Researchers adopted a five points Likert-scale, ranging from "0 = never" to "4 = always", as response method.

The Italian-to-French translation was made by an Italian-Canadian colleague (dr. Martine Vallarino, from the University of Pavia) and preliminary first French-to-Italian back translation was made by prof. A. Lesage that also reviewed of all the items. Further revisions were also made by prof. M. Corbière and dr. A. Felx.

3.2.2 Procedure and participants

The enrollment followed a "snowball" strategy, asking staff members to invite one or more colleagues to join the research. To obtain adequate sample heterogeneity that could

be considered representative of the professional composition of staff members of a mental health service (cfr. Regione Lombardia Sanità, 2009) the snowball sampling was guided by the research team to reach those quotas in each Country:

- psychiatrists, clinical psychologist, social workers, support workers: at least one of each;
- nurses and occupational therapist/educators: at least 3 of each group;
- setting: at least 5 from hospital ward or from residential facilities in order to have no more of two thirds of the participants working in the same setting;
- gender: no more of 2 thirds of the participants of the same sex.

Each participant received from one researcher a folder containing the consent form and a copy of the BMHPCI. After 7 days, the researcher met again the participants for collecting the documents.

In Canada, the data collection started in December 2013 at the Centre de Recherche de l'Institut Universitaire en Santé Mentale de Montréal and ended in February 2014. In Italy, data collection took place from April 2014 to September 2014.

The pilot study was approved by the Ethics Committees of the Centre de Recherche de l'Institut Universitaire en Santé Mentale de Montréal and of the University of Milan – Bicocca.

3.2.3 Data collection and analysis

All participants were asked to fill the BMHPCI. At the end of each page, some additional questions asked participants to indicate which items weren't well written or that might be perceived as disturbing. Additional comment fields were also added at the foot of the page to give participants the opportunity to write text feedback and to propose new items.

Descriptive statistics were computed for each item. Then, each item was evaluated as good or critical by evaluating some quality indexes; "critical" items met at least one of the following criteria:

- more the 10% of missing data in the Italian and / or in the Canadian sample;
- more than 10% "abstentions" in the Italian and / or in the Canadian sample;
- with standardized Skewness ($z_{skewness} = \frac{skewness}{SE_{skew.}}$) > |1.96| in the Italian and / or in the

Canadian sample;

- with ($z_{skewness} = \frac{skewness}{SE_{skew.}}$) > |1.96| in the Italian and / or in the Canadian sample.

A consensus conference was held, involving both Italian and Canadian researchers, critical items were definitely eliminated or reformulated, also considering participants' qualitative comments.

3.3 Results

A final sample of 69 MHWs was enrolled in the pilot study. Because of the voluntary participation, all the MHWs who accepted to participate filled in the BMHPCI. A statistical analysis of the sample was beyond the scope of this study, however sample's descriptive statistics (table 3.2) show that the two sample are quite similar in term of participants' age and gender, while some differences may be found for education level (higher in the Italian sample), professional role (more psychologist and psychiatrists in the Italian sample, more support workers in the Canadian one) and setting (staff from mental health centers wasn't enrolled in the Canadian pilot study).

Table 3.2 Pilot study, sample description.

	ITA N = 38	CAN N = 31	Total N = 69
Age, mean (SD)	45.2 (8.6)	41.7 (11.1)	43.5 (9.9)
Sex, n (%)			
Male	12 (31,6%)	11 (35,5%)	23 (33,3%)
Female	25 (65,8%)	19 (61,3%)	44 (63,8%)
Missing	*1 (2,6%*)	*1 (3,2%*)	*1 (1,4%*)
Educational level, n (%)			
Medium school	3 (7,9%)	3 (9,7%)	6 (8,7%)
High school	4 (10,5%)	10 (32,3%)	14 (20,3%)
University degree	20 (52,6%)	13 (41,9%)	33 (47,8%)
Post degree	9 (23,7%)	3 (9,7%)	12 (17,4%)
Missing	*2 (5,3%*)	*2 (6,5%*)	*4 (5,8%*)
Professional role, n (%)			
Educator	8 (21,1%)	9 (29,0%)	17 (24,6%)
Social Worker	2 (5,3%)	0 (0,0%)	2 (2,9%)
Nurse	8 (21,1%)	8 (25,8%)	16 (23,2%)
Psychologist	7 (18,4%)	2 (6,5%)	9 (13,0%)
Psychiatrist	7 (18,4%)	2 (6,5%)	9 (13,0%)
Support Worker	6 (15,8%)	8 (25,8%)	14 (20,3%)
Missing	*1 (2,6%*)	*2 (6,5%*)	*3 (4,3%*)
Type of unit, n (%)			
Mental Health Center	16 (42,1%)	0 (0,0%)	16 (23,2%)
Day Care Center	1 (2,6%)	1 (3,2%)	2 (2,9%)
Residential Resource	11 (28,9%)	11 (35,5%)	22 (31,9%)
Hospital Ward	10 (26,3%)	19 (61,3%)	29 (42,0%v

Thirty-eight items (53.5%) showed satisfactory properties both in the Italian and in the Canadian sample, as shown in table 3.3. Among the remaining 33 items, 13 (18.3%) met at least one exclusion criteria in the Canadian sample, 12 (16.9%) in the Italian sample, and 9 (12.7) in both samples. Items' full text is reported in appendix 1.

High standardized Skewness was the most frequent exclusion criteria met, 18 items in the Italian sample and 16 items in the Canadian sample; high standardized Kurtosis was find in 7 items in the Italian sample and in 14 items in the Canadian one.

Nine items scored more than 10% abstentions in the Italian sample, and 3 in the Canadian one, while 2 items showed more than 10% missing data in the Italian sample, while in the Canadian sample the missing criteria wasn't met by any item.

Table 3.3 Items' quality evaluation (*continues*)

Item's ID	Italian Sample					Canadian Sample					Item's outcome
	MISS	ABS	$Z_{skew.}$	$Z_{kurt.}$	PEV	MISS	ABS	$Z_{skew.}$	$Z_{kurt.}$	PEV	
1-1	0	0	0.6	-0.7	0	1	0	-1.3	0.5	4	Maintained unmodified
1-2	0	0	0.2	-0.5	0	1	0	**-4.9**	**8.1**	2	Deleted
1-3	**4**	1	-0.1	-1.3	2	1	0	-0.5	-1.5	**5**	Deleted
1-4	0	0	**3.5**	0.7	0	1	1	**5.4**	**5.1**	3	Modified
1-5	**4**	**4**	0.8	-1.0	3	1	**5**	0.6	-1.7	**9**	Modified
1-6	0	1	0.2	-0.4	0	1	0	-0.5	0.1	1	Maintained unmodified
1-7	0	1	-0.6	-1.5	1	1	0	0.3	-0.2	1	Maintained unmodified
1-8	0	1	1.5	-0.5	0	1	0	-0.6	-0.4	3	Maintained unmodified
2-1	1	0	-1.0	-0.3	1	0	0	-1.3	0.1	0	Maintained unmodified
2-2	0	2	-0.7	-0.3	2	0	0	0.1	-1.0	2	Maintained unmodified
2-3	0	1	-0.3	-1.5	0	0	1	-0.4	-0.8	2	Maintained unmodified
2-4	2	1	**-2.3**	-0.6	0	0	1	0.2	-0.8	2	Maintained unmodified
2-5	0	1	**2.5**	0.4	0	0	**4**	0.1	-0.9	**4**	Deleted
2-6	0	0	**2.5**	0.9	1	0	1	0.9	-0.8	1	Deleted
2-7	0	2	-1.8	0.3	0	0	1	-1.0	-1.0	0	Maintained unmodified
2-8	1	1	0.3	1.4	2	0	2	-1.0	-0.8	3	Maintained unmodified
3-1	0	0	-1.1	-1.2	0	0	1	**-2.8**	0.3	0	Maintained unmodified
3-2	0	1	**-2.7**	1.8	0	0	1	-1.8	-0.4	1	Maintained unmodified
3-3	0	0	-1.2	-0.4	0	0	0	**-2.6**	**2.1**	0	Deleted
3-4	0	1	0.1	-1.3	0	0	0	-0.6	-1.2	2	Maintained unmodified
3-5	0	3	**2.6**	0.2	1	0	0	1.8	-1.2	2	Deleted
3-6	0	0	-0.5	-1.2	0	0	1	-1.4	0.6	0	Maintained unmodified
3-7	0	2	0.1	-0.2	0	0	1	0.7	**-2.3**	1	Modified
3-8	0	1	-0.4	-1.9	0	0	0	-0.3	-1.5	1	Maintained unmodified
4-1	1	0	**-3.8**	**3.8**	0	0	0	-1.1	0.3	0	Deleted
4-2	0	1	-0.9	-0.6	0	0	0	-1.7	1.4	1	Maintained unmodified
4-3	0	0	-1.8	0.7	0	0	0	-1.8	0.0	0	Maintained unmodified
4-4	0	1	0.7	-1.1	0	0	0	1.3	-0.2	2	Maintained unmodified
4-5	0	**4**	1.6	-0.6	2	0	3	0.5	-1.2	2	Deleted
4-6	0	**5**	**2.2**	0.0	1	0	2	**2.3**	1.2	2	Deleted
4-7	0	1	-1.3	-0.8	0	0	1	0.8	-0.2	1	Modified
4-8	0	**4**	0.5	-1.1	0	0	0	**-2.2**	0.3	1	Deleted
5-1	2	1	-1.5	-0.7	1	0	0	-1.6	0.8	2	Maintained unmodified
5-2	2	0	-1.6	0.1	0	0	1	-2.1	-0.3	2	Maintained unmodified
5-3	2	0	**-3.5**	1.4	0	0	1	**-6.5**	**9.8**	2	Deleted
5-4	2	0	0.4	-1.4	0	0	1	**-5.0**	**6.0**	0	Deleted

Items' quality indexes: MISS = count of missing responses; ABS = count of abstensions; $Z_{skew.}$ = standardized Skewness; $Z_{kurt.}$ = standardized Kurtosis; PEV = count of negative quality evaluation scores.

Table 3.3 Items' quality evaluation

Item's ID	Italian Sample					Canadian Sample					Item's outcome
	MISS	ABS	$Z_{skew.}$	$Z_{kurt.}$	PEV	MISS	ABS	$Z_{skew.}$	$Z_{kurt.}$	PEV	
5-5	2	1	**-3.4**	**4.8**	1	0	0	**-3.0**	**3.4**	0	Deleted
5-6	2	1	**2.9**	0.5	1	0	0	1.3	0.5	1	Deleted
5-7	2	1	0.3	-1.1	2	0	1	-1.1	0.7	1	Maintained unmodified
5-8	2	0	0.4	**2.8**	0	0	0	**-2.5**	1.7	1	Deleted
6-1	0	0	-0.2	-1.7	2	0	0	0.8	-0.6	1	Maintained unmodified
6-2	1	1	**-2.8**	1.3	4	0	0	-0.2	-0.6	1	Modified
6-3	1	**7**	-1.0	0.4	3	0	2	-0.1	0.5	2	Deleted
6-4	0	1	-1.6	0.4	0	0	1	-1.5	1.4	0	Maintained unmodified
6-5	0	0	-0.4	-1.1	0	0	0	**-2.3**	**3.4**	1	Deleted
6-6	0	0	1.1	0.8	0	0	1	-1.7	1.4	0	Maintained unmodified
6-7	0	**4**	-0.8	-1.4	4	0	0	-0.7	-0.5	3	Deleted
6-8	0	1	0.0	-1.5	1	0	0	1.8	0.0	2	Deleted
7-1	0	0	0.3	-1.1	0	1	1	-1.0	-1.3	0	Maintained unmodified
7-2	0	2	-1.3	-0.4	0	1	3	-1.9	**2.0**	1	Deleted
7-3	0	**13**	0.3	-0.5	0	1	**5**	-0.8	-0.5	0	Deleted
7-4	0	1	0.0	0.7	0	1	2	-1.2	-0.8	0	Deleted
7-5	0	0	1.7	1.1	1	1	0	0.5	-0.8	0	Maintained unmodified
7-6	1	3	-1.4	-1.7	3	1	1	-0.9	-0.4	0	Modified
7-7	0	0	0.3	-1.0	0	1	5	**2.2**	0.4	0	Deleted
7-8	-1	**5**	**12.7**	**35.5**	1	1	0	**3.7**	**2.1**	1	Deleted
8-1	0	0	0.0	-1.8	0	1	0	-1.2	-1.2	0	Maintained unmodified
8-2	0	1	**3.4**	0.9	0	1	0	0.2	0.3	0	Deleted
8-3	0	0	-0.9	-0.3	0	1	0	-0.8	0.2	1	Maintained unmodified
8-4	0	3	-0.9	-1.0	2	1	1	-0.6	-0.3	0	Maintained unmodified
8-5	0	3	**14.5**	**43.2**	1	1	2	**10.4**	**26.2**	0	Deleted
8-6	0	2	-0.4	-0.1	1	1	2	1.5	-0.8	2	Deleted
8-7	0	1	1.3	-0.7	0	1	0	1.5	0.5	1	Maintained unmodified
8-8	0	**8**	**2.4**	0.4	1	1	3	0.8	-1.8	1	Deleted
9-1	0	0	-1.4	-0.9	1	0	1	0.3	-1.4	0	Maintained unmodified
9-2	0	3	-1.6	-0.4	0	1	2	**-2.2**	0.9	1	Deleted
9-3	0	1	-1.7	-0.1	0	0	0	-1.3	**2.5**	0	Deleted
9-4	0	1	0.7	-0.9	0	0	0	1.1	1.1	0	Maintained unmodified
9-5	1	1	**-2.1**	1.4	1	0	0	**-3.2**	**4.8**	0	Deleted
9-6	0	1	-0.9	**-2.0**	1	0	1	**4.8**	**5.4**	0	Deleted
9-7	0	1	**4.2**	**3.0**	1	0	0	1.6	0.6	1	Deleted

Items' quality indexes: MISS = count of missing responses; ABS = count of abstensions; $Z_{skew.}$ = standardized Skewness; $Z_{kurt.}$ = standardized Kurtosis; PEV = count of negative quality evaluation scores.

3.4 Discussion

Results from this pilot study confirmed the necessity of pilot-testing the BMHPCI questionnaire: 46.5% of the items showed unsatisfactory properties, and, among that group, high Skweness and or Kurtosis was scored for 43.6% of the items, while frequency of abstensions and missing data were relatively low. These findings suggest that, even though most of the items pilot BMHPCI draft was written clearly and without annoying participants, almost half of them obtained non-normal distribution, with -in many cases- low variability in the answers.

Researchers from the Italian-Canadian conjoint team (Filippo Rapisarda, Massimo Miglioretti, Alain Lesage) of research discussed items' quality indexes and performed the following changes (reported in table 3.3) to develop a new questionnaire draft:

- items 1-3, 2-5, 4-6, 4-8, 5-3, 5-5, 5-8, 7-3, 7-8 and 9-5 showed unsatisfactory properties both in the Italian and Canadian sample and were definitely deleted;
- items 1-2, 2-6, 3-3, 3-5, 4-1, 4-5, 5-4, 5-6, 6-3, 6-5, 6-7, 7-2, 8-2, 9-2, 9-3, 9-6, 9-7 scored unsatisfactory properties just in one Country and were definitely deleted;
- items 1-4, 1-5, 3-7, 6-2, showed unsatisfactory properties, but researchers decided to keep a modified version; participants comments provided useful insight for the item reformulation;
- even though items 4-7 and 7-6 didn't met exclusion criteria, researchers performed slight changes to improve item quality;
- because 5 items out of 7 of the group *Transcultural openness* were deleted, the conjoint team decided to directly delete the entire group, believing that this issue deserved a more specific investigation.

Moreover, the research team formulated the following 7 more items, to obtain at least 4 items in each existing group. Finally, two additional groups of items were added, respectively:

- *expressed emotion*: high expressed emotion refers to affective attitudes and behaviors toward patients and colleagues characterized by critical comments, hostility, and emotional over involvement (Moore and Kuipers, 1992; Berry et al, 2011);

- *professional identity and recognition*: this group of item explore the perceived degree of professional recognition by colleagues (Zeeman and Simsons, 2011).

With such changes, the final outcome of this preliminary process was a new bi-lingual questionnaire draft, composed by 49 items, adopted in the consecutive validation phase, describe in chapter 4.

4 Validation of the Bicocca Mental Health Professional Culture Inventory

4.1 Rationale and aim

In middle and high income Countries, mental health services (MHSs) staff is composed by specialized workers such as psychiatrists, nurses, social workers, psychologists and support workers organized in multi-professional teams whose composition is determined by local level regulations (Thornicroft & Tansella 1999). According to Bloor and Dawson (1994), the creation of a particular professional group leads to the development of a system of values, schema and knowledge, shared among the members of that professional group and that orient professional behavior and moreover, professional coping to unforeseen and changing situations. Shared cognitive and behavioral schemata constitute the "professional culture" of a certain professional group, orient their sense making and behavior and contribute to the definition of the organizational culture in which those professionals work. Southon and Braithwaite (1998) suggest professional knowledge, skills and accepted practices cannot be established by each practitioner, but must be developed over time by groups of practitioners, whose training need to be carried out through close tutelage: continuing association with colleagues may be required to promote standards and to maintain currency. Professional culture is a fuzzy construct that lies between organizational psychology, anthropology and organization theory, and scholar have been applied it for depicting different professions, for instance the teachers (Stodolsky et al., 2006), social workers (Biasin et al., 2012), but also inter-professional culture of nurses, teacher and support workers working with children (Messenger, 2013).

The process of care in mental health services could be influenced by several different staff related factors, such as staff morale and burnout levels, technical and interpersonal skills, attitudes and values (Thornicroft & Tansella 1999). Social processes are particularly relevant for mental health care, since mental health workers (MHW) deal with clinical conditions that are socially constructed (Rosenhan 1973; Wiener 1975): every mental health professional defines – more or less explicitly - what kind of person should be defined

"mentally ill", how it should be "treated" and how much autonomy "should be given" to him according to a system of beliefs and attitudes (Slade, 2009, 8-34). Furthermore, significant organizational procedures could be strongly influenced by MHWs' attitudes, e.g. the implementation of evidence-based practices (Aarons, 2006), the use of routine outcome assessment procedures (Traurer et al., 2009) or the definition of rehabilitation goals (Clarke et al., 2009). From a theoretical point, the construct of professional culture could partially explain some of this psychosocial process; however, there are no studies that attempt to apply these theoretical models to professional groups working in the field of mental health.

Currently, there are no studies that explicitly address the issues of the professional culture of professionals working in mental health services. This research gap could be filled by adopting a quantitative methodology, for example using a questionnaire to assess professional culture dimension in a representative sample of MHWs across different settings.

Even though researchers have been developing reliable instruments to assess cultural dimension related to mental health staff, e.g. <<…the degree to which recovery oriented practices were perceived to be implemented in mental health and addiction agencies >> (O'Connell et al., 2005) or <<"beliefs about mental illnesses", "goals and outcomes of psychiatric rehabilitation," and "practices of psychiatric rehabilitation" that best reflected the consensus of authors and organizations>>, we think that this approach has some limits:

- instruments based on the recovery model could only capture the degree of coherence between practices and the recovery principles, but do not provide insights on psychosocial dimension that are not included in that paradigm (e.g. the attitude toward evidence based practices);
- cultures are defined by using a "top-down" process: cultures are theoretically defined (like "the biological psychiatry", "the recovery model", the "deinstitutionalization model", etc…) before collecting empirical findings to test the construct;
- single construct measures are useful for research purposes, but may not be as feasible

to adopt in organizational interventions.

Because of such theoretical and methodological concerns, we designed a new self-administered instrument to assess mental health staff members' professional behaviors, adopting the notion of "professional culture" as a hybrid construct between the individual and the organizational level and that could be directly associated with professional practices.

The study aim is to validate this new instrument, called Bicocca Mental Health Professional Culture Inventory. The questionnaire has been created and developed in by a conjoint Italian-Canadian research team, with the purpose of obtaining a fully cross-cultural questionnaire. From item creation to data analysis every phase was conducted in parallel in Italy and in Canada. Because the construct of professional culture has not been applied to professional categories of mental health services workers, this study will focus on construct validity concerns.

The terms "user", "client" or "patient" are used as synonyms.

4.2 Methods

4.2.1 Subjects and enrollment procedures

Participants' were enrolled according to the following inclusion criteria:

- working in a unit/service which provides treatment or rehabilitation for people with severe mental illness; staff doing an internship or a voluntary job was also be included;
- having face-to-face contact with the users during working hours.

In order to obtain a good spectrum of mental health organizations, participants were recruited from different services and units, including community mental health centers, residential facilities, day care centers and hospital wards, form public, private and no profit organizations. With the term 'unit' we define a team of workers that provide a specific service with a reasonable level of organizational autonomy and that could not be split in further subgroups.

In Italy, participants were enrolled in the following services in the northern Italy:

- public Mental Health Departments of:
  - "Azienda Sanitaria Locale Torino 1", in the city of Turin;

- "Azienda Sanitaria Socio Territoriale di Lecco", in the district of the city of Lecco;
- "Azienda Sanitaria Socio Territoriale Santi Carlo e Paolo" and "Azienda Sanitaria Socio Territoriale Fatebenefratelli e Sacco" in the city of Milan;

- residential and day care units managed by the following Social Cooperative Organizations:
  - l'Arcobaleno SCS, in the towns of Caloziocorte, Casatenovo, Garlate;
  - Novo Millennio SCS, in the city of Monza;
  - Lotta Contro l'Emarginazione, in the city Sesto San Giovanni.

In Canada, all participants were enrolled from the *Centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal* mental health and addiction program, in the Montreal District. The mental health program is the largest regional one in the province of Quebec, with a budget of nearly 100 million dollars, and 1200 staff from all professional disciplines and non-professional. Northern Italy and Quebec have a similar Mental Health system with similar historical trajectories (Thornicroft and Tansella 1999): the two regions have a public system, financed by the public welfare, in which mental health care is delivered mostly in community settings, and sustained a process of deinstitutionalization during the second half of the 20th century.

While some professional categories of MHWs in Italy and Canada can be considered comparable, some other may differ due to different regulations. Table 4.1 shows main similarities and differences between Italy and Canada, and presents professional categories that were used in the data analysis.

Professional category	Common characteristics	Differences
Nurse ITA: *infermiere* QUE: *infirmiere*	A university degree in Nursing is required to work as licensed nurse.	None
Counselor ITA: *educatore, tecnico della riabilitazione psichiatrica* CAN: *psychoeducator*	A university training is required to work as *educatore* and *tecnico della riabilitazione psichiatrica* in Italy and as *psychoeducator* in Quebec.	In Italy, *tecnico della riabilitazione psichiatrica* is a counselor specialized in working with people affected by mental illness.
Psychiatrist ITA: *psichiatra* CAN: *psychiatre*	In Italy and Canada a university degree in Medicine, a further specialization in Psychiatry and registration to the Professional Order of Physicians are required to became a Psychiatris.	None
Psychologist ITA: *psicologo* CAN: *psychologue*	A university degree in Psychology and a registration to the Professional Order of Psychologists are required to practice as licensed psychologist.	In Italy, psychologists require post university specialization to practice psychotherapy.
Support worker ITA: *operatore socio sanitario* CAN: *preposè au beneficiaire; educator*	A specific professional training is required to work as support worker.	In Canada, *educators* frequently upgrade to other professional roles (e.g. *psychoeducators*) through further training.
Occupational therapist ITA: *terapista occupazionale* CAN: *ergothérapeute*	A university degree is required to became an occupational therapist.	In Quebec, registration to the Professional Order of Occupational Therapists is required.
Social worker ITA: *assistente sociale* CAN: *travailleur social*	A specific university degree and registration to the Professional Order of Social workers is required to became a licensed social worker.	None

4.2.2 Instruments

The survey was composed by five sections.

Section A, "Preliminary information", was composed by an *ad hoc* set of items collecting general information about participant's demographics (gender, age, etc.), job profile (professional profile, years of working experience, etc.) and main work setting. Work settings were classified as:

- Mental health centers: office based units that ensure long term clinical and social interventions, often displaced outside the hospital to foster connection with the community;
- Day care centers: semi-residential units that provide social rehabilitation;
- Residential facility: an umbrella term that comprehends residential facilities that host clients for medium to long term care with different intensity levels of care, from 24h staff monitoring to supported homes;
- Hospital ward: hospital unit that admits patients in the acute phase of illness (Italy and Canada) or that require intensive long term assistance and rehabilitation (Canada only);

- Community and home care: assertive community treatment teams or psychosocial rehabilitation programs that do not require systematic office based contacts.

The BMHPCI is a 49 items bi-lingual questionnaire (Italian and French) that has been developed by a conjoint Italian-Canadian team. BMHPCI's items have been generated inspiring to the following issues and constructs:

1) *Personal involvement with the users*: personal involvement in the relationship with user is central to define the professional culture, as reported by several authors (Gibb, 2003; Akerjorder and Sverinsson, 2004; Gibb, 2003; Goodwin and Happell, 2007; Crawford et al, 2007; Patterson et a 2008; Burks and Robbins, 2012; Carpenter-Song and Torrey, 2015);
2) *Collaboration with the Social Network*: professional role may require to work with clients' families and taking contacts with members of the informal social network, like friends or colleagues (Goodwin and Happell, 2007);
3) *Collaboration with the Formal Network*: some professional roles in mental health care require staff to collaborate with staff from other services, and inter-organization collaboration could be a delicate issue in MHS practice (Glisson and Hemmelgarn 1998): this group of items investigate participants' attitudes and behavior regards inter-service collaboration;
4) *Evidence based practices and outcome assessment*: MHWs have different attitudes and knowledge of Evidence based practice and this could be affect organizational culture of MHS (Traurer et al., 2009); moreover, differences in the adoption of goal-setting methodology (Clarke et al., 2009) could be found between different MHWs: this group of items attempt to evaluate this issues;
5) *Users' involvement in the process of rules setting and decision-making*: as we reported in chapter 2, MHWs' may differ in the management of professional power; this group of items assess MHW role in fostering or hindering users' empowerment;
6) *Management of the aggressive behavior*: this group of item focused on staff's perception of patient's aggression (De Benedictis, et al, 2011) and cognitive appraisals to challenging behavior (Lambrechts et al, 2010);

7) *Spirituality and religion*: spirituality may be a relevant issue for users, and MHWs attitudes toward religious beliefs may play a role in the experience of care (Wilding et al, 2006; Curlin et al, 2007); this group of item addresses MHWs attitudes and behaviors toward spirituality in MH care;
8) *Users' sexuality*: this group of items assess MHWs' attitudes and professional behaviors toward actively broaching sexual issues with clients (Cort et al., 2001; Saunamäki et al, 2010) with some specific items for homosexual people (Bowers and Bieschke, 2005):
9) *Expressed emotion*: refers to negative affective attitudes and behaviors toward patients and colleagues characterized by critical comments, hostility, and emotional over involvement (Moore and Kuipers, 1992; Berry et al, 2011);
10) *professional identity and recognition*: this group of item explore the perceived degree of professional recognition by colleagues (Zeeman and Simsons, 2011).

Maslach Burnout Inventory. The MBI (Maslach and Jackson, 1981) is the mostly adopted self-administered instrument to assess burnout in health organizations. The MBI construes burnout as a three-dimensional construct that includes emotional exhaustion as the core dimension, depersonalization or cynicism (which refers to a detached attitude toward one's job), and reduced personal accomplishment or sense of efficacy (feelings of lack of achievement or productivity at work. (Maslach, Jackson, and Leiter, 1996). The three subscales measure three dimensions of the burnout– engagement continuum: emotional exhaustion, cynicism and personal efficacy (6 items). Items are framed as statements of job-related feelings, which are rated on a 6-point frequency scale ranging from 0 (never) to 6 (every day). Burnout is reflected in higher scores on exhaustion and cynicism and lower scores on personal efficacy This research project employed the MBI – General Survey Version (Bakker et al, 2002; Schaufeli et al., 1996). The Italian version was validated by Sirigatti and Stefanile (1988), while the French-canadian version was by Dion and Tessier (1994).

Team climate inventory. The TCI (West, M.A.et al.1996) evaluated dimensions of the team climate. Our study adopted a 19-item version validated by Beaulieu et al (2014).

Authors reported Cronbach's alphas for the four components that ranged from 0.88 to 0.93. Authors did not perform a test-retest analysis. The Italian version was validated by Ragazzoni et al (2002).

4.2.3 Data collection and confidentiality

Data collection procedures differed slightly from Italy to Canada.

In Italy, data collection took place from October 2015 to September 2016. The principal investigator (FR) explained the project and confidentiality issues to the services directors. If the Director authorized data collection, researchers presented the research directly to MHWs during routine staff meetings. Even if some staff members decided to fill in the questionnaire directly during presentation meetings, researcher let a two week time to fill complete the task. All the participants were requested to sign a proper consent form designed according to the standards required by the Ethical Committee of the University of Milan - Bicocca. Questionnaires were anonymous, and they were printed and presented to participants separately on different documents. Once filled, participants were asked to place the questionnaires and the consent form into different envelopes.

In Montreal., the research team (Alain Lesage, Amelie Felx, Luigi De Benedictis, Jean-Francois Pelletier, Yves Leblanc) drew with the help of human resources and mental health program directorate a list of names and position of all the 1200 staff and 73 physicians from the CIUSSS-Est-de-l'Ile-de-Montréal mental health and addiction program. Principal investigator from the Italian team (FR) assigned numeric codes to each Canadian staff members. Only investigators know participants coded. AF will explain the project and confidentiality to the program's managers and units' heads before letters will be sent to the selected staff by random batches of 400. A research coordinator and researchers manage questionnaires mailing from the list. They sent an envelope containing an invitation letter, a Consent Form and the questionnaire to the randomly selected batch of participants. The envelope cover only displayed codes and not staff names. Staff members were free to participate by filling in the documents (or not, refusing to participate) ; and send the envelopes by internal mail to the attention of the main investigator (AL). The research coordinator registered the participants' codes written on the questionnaire

received, and sent a digital scanned copy of each questionnaire to FR for data entry. The first batch of 400 questionnaires were sent end of October 2016, and to physicians end of November. Due to limited response rate to reach a sample of 300, decision was made in December to send questionnaire to the other 800 staff. As of January 16th, a total of 873 questionnaires have been sent to staff and physicians, and 117 questionnaires were received and used for analysis of this thesis.

The study received the approval of the Ehics Commettees of the University of Milan Bicocca and the *Centre intégré universitaire de santé et de services sociaux* (CIUSSS) Est-de-l'Ile-de-Montréal. Both ethics commettees supervised the design of the Content Forms and the design of confidentiality procedures.

4.2.4 Data analysis

Database preparation involved the overall check of data quality, including the exclusion of bad respondents, and replacement of missing values. Participants who didn't indicate their professional role and/or main work setting and and/or who didn't answer five or more BMHPCI items were labeled as "bad responders" and were excluded from the analysis.

Data analysis was conducted in different steps. All the procedures are conducted simultaneously in the two countries to maximize the cross-cultural adaptation of the questionnaire.

The first step of analysis consisted in a preliminary modelling of the factorial structure. Because there is no a priori evidence regarding the number of factors underlying the BMHPCI, a principal component analysis (PCA) with Varimax rotation was performed to the overall sample, merging together Italian and Canadian data, explore the underlying dimensions. A correlation value of .40 was established as the lower bound for a variable to be included in the respective factor structure (Vallerand, 1989): i.e. items that will score a factor loading smaller than 0.4 on a single dimension were eliminated from the model.

The next step involved testing of cross-cultural validity, using a confirmatory factor analysis (CFA) to check if the factorial structure emerged in the PCA would be confirmed also in each Country subsamples. CFA models were considered well fitted if the Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) indexes were higher than .90

and the Root Mean Square Error of Approximation (RMSEA) was ≤0.08 (Hofmann, 1995).

Then, scale internal consistency and reliability were tested. Cronbach's *alpha* was performed for each scale. Test retest reliability was evaluated computing correlation indexes (Pearson's *rho*) for scale scores during a two-weeks period. Divergent validity was addressed by computing correlations indexes between BMHPCI scales and MBI scales and TCI total score.

In the fourth step, a multivariate analysis of variance (MANOVA) was be adopted to evaluate the influence of professional role and unit type on BMHPCI scales. Country and sex variables were added in the model as fixed factor, and age and years of work experience were included as covariates. If multivariate analysis would detect significant effects, univariate test and pairwise post hoc comparison with Bonferroni adjustment were performed.

All the data analysis was done using IBM SPSS Statistics v. 23, except for the CFA that was performed using R software with the Lavaan package retrieved from the project's website (http://lavaan.ugent.be/index.html).

4.3 Results

4.3.1 Sample description

Researchers collected a number of 357 non-empty questionnaires, 240 in Italy and 117 in Canada. Response rate was approximative 65% Italy and 40% in Canada. Fifteen cases met at least one exclusion criteria: 3 Italian participants didn't declare their professional role, 1 Canadian didn't reported the typology of service in which he or she worked, and 8 Italian participants left more than 4 items unanswered. Sample characteristics are shown in table 4.2.

Table 4.2 Sample characteristics

	Italian sample N = 229	Canadian sample N = 116	Sig.	Total sample
Sex			Ns	
Female	162 (70.7%)	75 (64.7%)		237 (68.7%)
Male	67 (29.3%)	41 (35.3%)		108 (31.3%)
Age				
Mean (sd)	45.7 (10.1)	43.7 (12.4)		45.0 (10.4)
Education*			P < .05	
Primary education	6 (2.6%)	0 (0.0%)		6 (1.7%)
Professional school	26 (11.4%)	8 (6.9%)		34 (9.9%)
High school	35 (15.3%)	29 (25.0%)		64 (18.6%)
Bachelor of arts	49 (21.4%)	37 (31.9%)		86 (24.9%)
Master's degree	48 (21.0%)	19 (16.4%)		67 (19.4%)
Postgraduate qualification	61 (26.6%)	23 (19.8%)		84 (24.3%)
Missing	4 (1.7%)	0 (00.0%)		4 (1.2%)
Profession**			P < .01	
Nurse	66 (28.8%)	28 (24.1%)		94 (27.2%)
Counselor	69 (30.1%)	11 (9.5%)		80 (23.2%)
Psychiatrist	42 (18.3%)	17 (14.7%)		59 (17.1%)
Psychologist	21 (9.2%)	6 (5.2%)		27 (7.8%)
Support worker	17 (7.4%)	23 (19.8%)		40 (11.6%)
Social worker	11 (4.8%)	13 (11.2%)		24 (7.0%)
Manager	2 (0.9%)	5 (4.3%)		7 (2.0%)
Administrative assistance	1 (0.4%)	3 2.6%)		4 (1.2%)
Other	0 (0.0%)	11 (9.5%)		11 (3.2%)
Work experience in MHS				
Years, mean (SD)	15.7 (9.3)	16.9 (12.3)	Ns	16.1 (10.4)
Main work setting**			P < .01	
Mental health center	119 (52.0%)	52 (44.8%)		171 (49.6%)
Day care center	19 (8.3%)	0 (0.0%)		19 (5.5%)
Residential resource	48(21.0%)	14 (12.1%)		62 (18.0%)
Hospital ward	26 (11.4%)	41 (35.3%)		67 (19.4%)
Other	1 (0.4%)	4 (3.4%)		5 (1.4%)
Community / home care	15 (6.6%)	3 (2.6%)		18 (5.2%)
Management	1 (0.4%)	2 (1.7%)		3 (0.9%)
Working hours				
Mean (sd)	33.1 (8.8)	33.7 (7.7)	Ns	33.3 (8.4)

* = significant Chi-square comparison, p < .05; ** = significant Chi-square comparison, p < .01

Approximatively two-thirds of the participants were female, with an average age of 45.0 (sd = 10.4), 64.6% of them had a university degree, worked in the mental health field for an average of 16.1 years (sd = 10.4) for an average of 33.3 (sd = 8.4) working hours per week. Among the professional roles, nurse, psychiatrists (including 5 residents in training) and counselors were the mostly represented categories, covering 64.6% of the sample size. Two more professional roles, respectively "managers" and "administrators", recurred in participants' and were added in the table. Significant difference between Italian and Canadian sample were found by chi square comparisons in education levels and in professional roles.

4.3.2 Factor analysis

Table 4.2 presents the components loading matrix, eigenvalues and proportion of explained variance of the principal component analysis (PCA). Thirty-one items presented saturation coefficients of <0.40 and were removed from the model; the resulting solution comprehended 18 items, grouped in five components:

- Component 1: four items describing the collaboration with professionals from other services, the adoption of theoretical models and a vision of ecological vision of the interventions; since what this four items shares is a common commitment to a methodological standard, this dimension was called "Rehabilitation Vision and Role'" (RVS);
- Component 2: this dimension groups together items that describe how frequently the MHW deal with users' sexual and spiritual issues in his or her practice, and was labeled Sexuality and Spirituality (SaS);
- Component 3: three items that describe MHWs attitude toward the involvement of users' families in the care process, therefore the label Familiy Involvement (FaI);
- Component 4: this dimension groups together items that describe whether the MHW communicates with users outside the working hours by phone or by internet, and was labeled "Availability in the Community" (AiC);
- Component 5: three items about the risk of being assaulted by clients, so the label Perceived Risk of Aggression (PRA).

Components' eigenvalues ranged from 1.08 to 4.18, and the total explained variance was 59.7%.

Two independent confirmatory factor analysis (CFA) were performed on both samples to verify whether the model previously obtained with the PCA fit in Italian and Canadian data (figure 4.2).

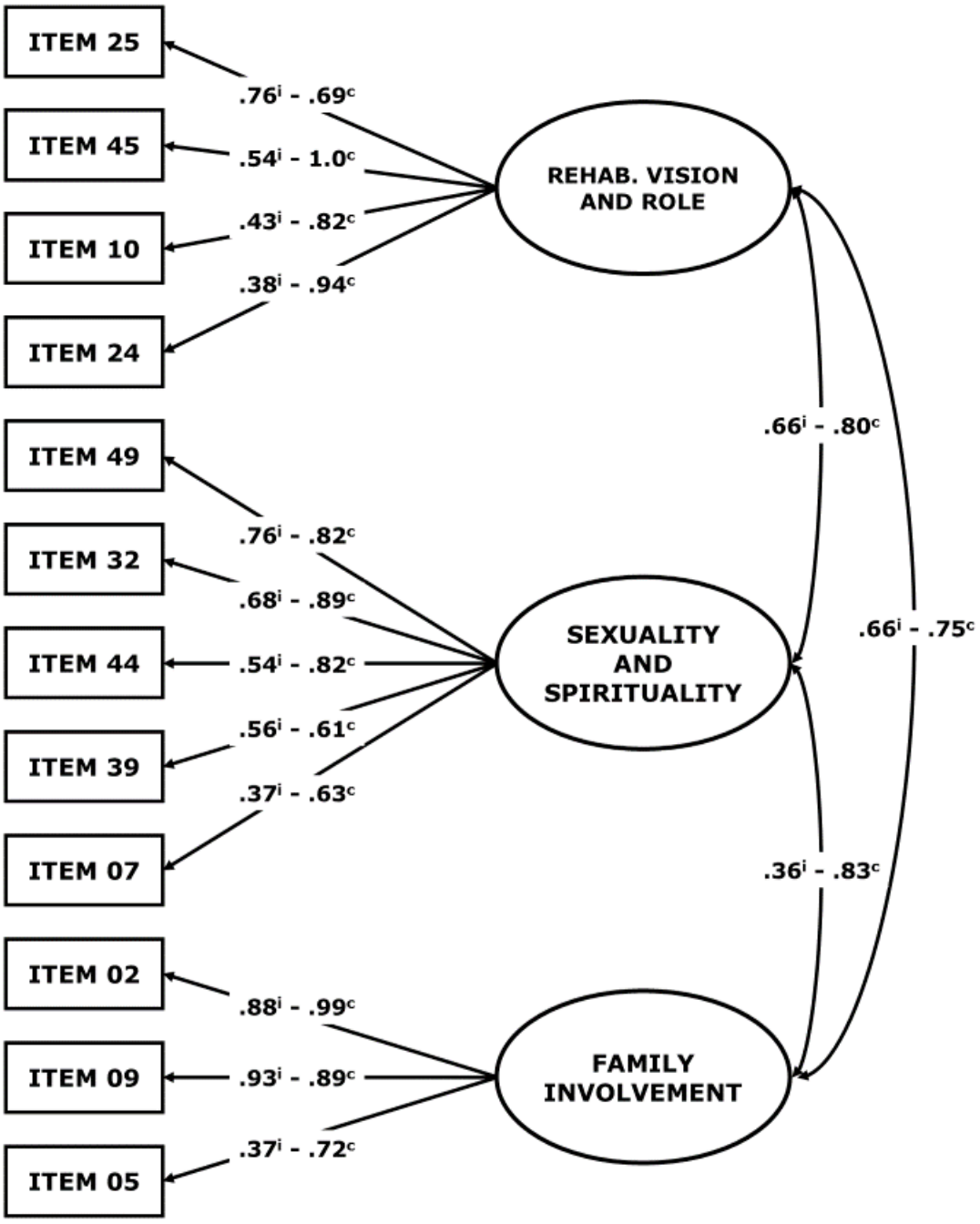
Table 4.3 Principal component analysis of the BMHPCI: item-components loadings and components properties.

	1	2	3	4	5	EiVal; Exp.Var
Component 1: "Rehabilitation Vision and Role"						**4.08; 15.6%**
Item 45: improving quality of life by intervening on social context	**.68**					
Item 24: giving relevance opinions from other services' staff	**.65**					
Item 10: working according to theoretical models	**.65**					
Item 25: keeping monthly contacts with staff from other services	**.62**			.38		
Component 2: "Sexuality and spirituality"						**2.09; 12.0%**
Item 44: talking with colleagues about users' spirituality		**.74**				
Item 39: talking with colleagues about users' sexuality		**.71**				
Item 49: talking with users about sexual education		**.67**				
Item 32: talking with users about sexuality		**.66**	.37			
Item 07: talking with users about spirituality and religion		**.63**				
Component 3: "Family involvement"						**2.26; 11.9%**
Item 02: keeping regular contacts with families			**.85**			
Item 09: fostering family members' involvement			**.81**			
Item 05: relying on families	.35		**.62**			
Component 4: "Availability in the community"						**1.27; 10.6%**
Item 21: being contacted by clients outside working hours				**.80**		
Item 13: giving personal phone number to users				**.77**		
Item 23: communication via web with users				**.69**		
Component 5: "Perceived Risk of Aggression"						**1.18; 9.6%**
Item 06: being subjected to threats and aggression					**.76**	
Item 11: being on alert to cope with aggression					**.75**	
Item 36: avoiding being alone with users with severe mental illness					**.73**	

EiVal = component's eigenvalue; Exp.Var = percentage of component explained variance

Several attempts before obtaining a model that could fit in both the samples have been performed. The availability scale didn't fit in the Canadian sample model because of the low variance of the items (standard deviation of item 13 was close 0) and was eliminated from the model. Also, the PRA scale performed poorly in both models, hindering the model overall fit, and was eliminated from the final model.

Figure 4.2 Factor loadings and inter-factor covariances.



I = Italian sample; C = Canadian sample

Analysis of modification indexes suggested some further modifications. Item 32 was moved from the RVS scale to the SaS scale because it obtained better factor loading and was more coherent with the item content. Even with this changes, model fit was only partially satisfactory both in the Italian model (CFI .92 = TFI = .89 RMSEA = .07) and in the Canadian one (CFI = .92 TFI = .90 RMSEA = .08).

The confirmatory model also showed moderate covariance's between the three scales. This finding allowed to sum up three scale scores into a total BMHPCI score.

4.3.3 Internal consistency and reliability

Table 4.3 shows scales validity and reliability scores. Cronbach's alphas ranged from .70 to .71 for each scale, and .78 for the total score, indicating an acceptable level of internal consistency. The correlation coefficients for test–retest reliability ranged from .84 to .93. As the satisfaction threshold is generally set at 0.60 (Vallerand, 1989), the five dimensions of the BMHPCI can be regarded as stable measures at a 2-week time interval.

Table 4.4 Cronbach's alphas, test retest correlation and inter-scale correlations for the BMHPCI scales.

	1	**2**	**3**	**Tot**
1. Rehabilitation Vision and Role	α = .70 $r_{t0.t1}$ = .90			
2. Sexuality and spirituality	.55**	α = .71 $r_{t0.t1}$ = .84		
3. Family involvement	.50**	.41**	α = .71 $r_{t0.t1}$ = .88	
BMHPCI Total score	.84**	.84**	.74**	α = .78 $r_{t0.t1}$ = .93
MBI – Exhaustion	-.05	.03	.10	.03
MBI – Cynicism	-.16**	-.05	-.07	-.11*
MBI – Professional Accomplishment	.22**	.14**	.14**	.21**
Team climate inventory	.01	-.02	-.06	-.03

α = Cronbach's alpha; $r_{t0,t1}$ = test-retest correlation; * = significant correlation, p < .05; ** = significant correlation, p < .01

Moderate correlation between the three scales were also found, coherently with the results reported in the confirmatory model.

Divergent validity was addressed calculating correlations with MBI scales and TCI total score. All BHMPCI scales were slightly correlated with Professional Accomplishment of the MBI and RVS scale and total score were slightly negatively correlated with MBI Cynicism scale. No significant correlation were found between BMHPCI and TCI total score.

4.3.4 Multivariate comparisons

MANOVA and univariate models were performed to test differences in professional categories, work setting and country. Professional categories of educator, occupational therapist and rehabilitation counselor were collapsed in the category "counselor"; managers, administrative officers and "other" professional roles were excluded from the model.

MANOVA assumptions were adequately met. The main multivariate effect was significant for professional role (Wilks' Lambda = .70; $F_{15,798}$ = 7.18, p <.001), work setting (Wilks' Lambda = .86; $F_{12,765}$ = 3.80, p <.001) and Country (Wilks' Lambda = .75; $F_{3,289}$ = 31.83, p <.001). Tests of between-subjects effects, shown in Table 4.3, confirmed MANOVA findings for all BMHPCI scales and detected a significant effect of sex for RVS scores ($F_{1,91}$ = 6.82, p <.001).

Post hoc analysis uncovered significant pairwise differences for professional roles. In pairwise comparisons psychiatrists and support workers were, respectively, the professional categories with higher and lower mean scores in all BMHPCI variables. Nurses and counselors have lower score in all BMHPCI dimensions compared to psychiatrists, but, higher compared to support workers, but counselors distinguish from nurses for significantly higher RVS scores. Psychologists and social workers' scores had highest levels of variability compared to the other professional categories and most of the comparisons were non-significant with some exceptions. Psychologists mean scores were close to psychiatrists for RVS and SaS, but were low in FaI. Social workers scored significant low scores in SaS compared to psychiatrists and psychologists, but higher than support workers.

Table 4.5 Univariate comparisons and estimated marginal means for BMHPCI scales.

	Rehabilitation Vision and Role	Religion and spirituality	Family involvement
Sex	$F_{(1, 291)} = 6.82^{**}$	$F_{(1, 291)} = .86$	$F_{(1, 291)} = 1.00$
Female	2.79 (.06)	1.63 (.06)	2.03 (.07)
Male	2.59 (.08)	1.55 (.08)	1.94 (.09)
Professional role	$F_{(5, 291)} = 9.20^{**}$	$F_{(5, 291)} = 11.16^{**}$	$F_{(5, 291)} = 9.24^{**}$
a Nurse	2.55 (.08) ^{bce}	1.62 (.08) ^{ce}	2.09 (.10) ^{ce}
b Counselor	2.87 (.07) ^{ae}	1.73 (.07) ^{e}	2.02 (.09) ^{ce}
c Psychiatrist	3.02 (.10) ^{ae}	1.98 (.10) ^{aef}	2.56 (.12) ^{abcde}
d Psychologist	2.91 (.13) ^{e}	1.93 (.13) ^{ef}	1.74 (.16) ^{c}
e Support worker	2.11 (.13) ^{abcdf}	.92 (.13) ^{abcde}	1.43 (.15) ^{abcf}
f Social worker	2.70 (.14) ^{e}	1.36 (.14) ^{cd}	2.09 (.17) ^{e}
Main work setting	$F_{(4, 291)} = 2.76^{*}$	$F_{(4, 291)} = 5.40^{**}$	$F_{(4, 291)} = 2.81^{*}$
a Mental health center	2.74 (.06)	1.51 (.06) ^{e}	2.04 (.07) ^{c}
b Day care center	2.69 (.16)	1.413 (.16) ^{e}	2.21 (.19)
c Residential resource	2.62 (.09)	1.59 (.09) ^{e}	1.69 (.11) ^{a}
d Hospital ward	2.46 (.09) ^{e}	1.33 (.09) ^{e}	2.00 (.10)
e Community / home care	2.96 (.15) ^{d}	2.11 (.15) ^{abcd}	2.00 (.18)
Country	$F_{(1, 291)} = 40.11^{**}$	$F_{(1, 291)} = 35.02^{**}$	$F_{(1, 291)} = 5.07^{*}$
Italy	2.42 (.06)	1.34 (.06)	2.10 (.07)
Canada	2.96 (.08)	1.84 (.08)	1.87 (.10)

F = Fisher's F; * = significant F test, $p < .05$; ** = significant Fisher's F, $p < .01$; ^{abcde} = subscripted letters indicate significant post hoc comparisons.

Significant pairwise comparisons highlighted cultural differences in work setting too. Staff working in community and home care setting is more methodologically oriented compared to staff working in hospital ward and has higher score in SaS compared to all the other settings. Mental health centers' workers have significant higher scores in FaI compared to staff working in residential facilities.

Between Country comparisons showed lower scores in RVS and SaS scales and higher scores in FaI in Italian MHWs compared to Canadian colleagues.

4.4 Discussion

The study's aim was the development of a new questionnaire to assess professional culture of mental health workers. However, since the construct of Professional Culture hasn't been studied in the mental health field, our discussion must start from evaluating the construct validity of the dimension emerged from the factor analysis, labelled

Rehabilitation Values and Role (RVR), Sexuality and Spirituality (SaS) and Family Involvement.

The first relevant finding is the composition of the RVR and SaS scales. The RVR scale grouped together two items about collaboration with personnel from other services, one item about adherence to theoretical models and one item about perceived relevance of social interventions. However, the CFA showed only mild factor loadings in the Italian sample, suggesting that there may be a cross cultural bias.

The SaS scale comprehended items about dealing with users' sexuality and spirituality in MHW's practice. Even though Turner and colleagues (Turner et al, 2006; Turner et al, 2007) suggested that the two issues may be linked when discussing with clients from different religious traditions, there are no studies that found this link between the two subject. Notably, the presence of two items about discussing such contents with colleagues suggests that this scale is not related with the therapeutic relationship with clients, but it could assess an element of professional vision.

The FaI scale was coherent with the cluster proposed by researchers during de development process, and confirms the relevance of the family involvement in describing professional culture of MHW (Goodwin and Happell, 2007; Beecher, 2009). Since Italian MHW report significant higher score on this variable, this result could be compared with a previous Canadian study that highlighted an higher relevance of family value in the Italian culture compared to the Canadian.

Moderate correlations between all the three scales suggests that BMHPCI items are coherent with a psychosocial paradigm of mental health care and rehabilitation, that values involvement of families and caregivers (Goodwin and Happell, 2007) and listening to clients narratives and existential issues, such us sexuality (Yerushalmi, 2013) and spirituality (Starnino and Canda, 2014). This do not comprehend more medically oriented practice e.g. discussion with clients about medication.

Those findings must be considered cautiously because of the partially acceptable model fitting. Model fitting could have been hindered by several factors. The item generation procedure wasn't adequately sustained by a conceptual mapping; moreover, since

professional culture hasn't been studied in mental health care, researchers could only have hypothesized the constructs relying on a free interpretation of the existing literature. Moreover, cross-cultural differences may have played a role, influencing item correlations in the two Countries.

Correlations with MBI and TCI also gave some further insights about BMHPCI underlining construct. All the correlations with TCI were non-significant, suggesting that BMHPCI scales are not related with group climate and dynamics. Moreover, all three scales were mildly correlated with Professional Accomplishment scale of the MBI. Since most of the BMHPCI items describes task-oriented professional behavior, it's arguable that higher score could be correlated with feeling of professional competence and successful achievement (Maslach and Jackson, 1981). RVR scale also showed a slight negative correlation with MBI Cynism scale: this finding could be understood considering that emotional detachment from work could be associated with lower endorsement of psychosocial rehabilitation principles, and vice versa. However, because correlation could only be interpreted as an index of association, further research could better explore casual influences between BMHPCI and MBI dimension.

Multivariate analysis showed RVR, SaS and FaI may significantly vary across professional categories, but pairwise comparison did only result significant for a limited number of combination due to the partially overlapping intervals of scores across different categories, expecially for psychologists, nurse, social workers and counselors. We could hypothesize that professional roles and tasks for these professional categories are more influenced and defined by the work context compared to psychiatrists and support workers. Despite of this limitation, results provide some insights on professional culture. Psychiatrists have the highest score in almost all the dimensions, confirming the relevancy that this professional role has in the care process. Psychologists RVR and SaS score are similar to the psychiastrists', but low FaI score suggests that, in MHSs, psychologists may put more emphasis on individual based assessment and interventions compared to psychiatrists. Support workers have the lowest score in all the BMHPCI dimensions compared to the other categories. Support workers' job involve helping users with daily

activities (Ericsson et al, 2016), and their professional role may not comprehend professional tasks described in BMHPCI. BMHPCI was less effective in determining nurses, counselors and social workers' profiles compared to the previous categories.

The study presents some further methodological limits. A first limit could be considered the cross-country comparability of professional categories, that could differ in training, roles, tasks and professional power across countries. This cultural limit seems to be particularly relevant for the professional categories that we merged under the label "counselor", i.e. educators, occupational therapists and rehabilitation technicians: while in Italy this professionals have almost identical roles in MHSs, in Canada's occupational therapist carries out certain activities, such as psychological assessment, that in Italy are under psychiatrists' and psychologists' authority.

Another methodological flaw concerns factor analysis. Scholars such as Worthington and Whittaker (2006) suggest to perform PCA and CFA on different data, reducing the risk of biasing the analysis: in our study, this would have required at least 300 subject in each Country, that was almost 180% of our sample. Moreover, confirmative factor analysis would have required at least 200 cases, but we performed it on the Canadian sample that was almost half of the requested size.

A further limit was the lack of proper instruments to test convergent validity. This issue is inevitable, since the research project involves the development of a new construct that theoretically does not allow comparison with similar ones. However, findings from correlations with MBI scales provided some conceptual links that contributed to define BMHPCI construct validity.

Despite the limitation, this study suggested that the Bicocca Mental Health Professional Culture Inventory could be considered a reliable instrument to depict professional culture of mental health workers in Italy and in Canada, especially for professional behaviors associated with psychosocial rehabilitation paradigm. Further research will be needed to better tune some questionnaires items, to compare scores of MHWs versus scores of the same professional categories working in other settings, e.g. services for people with severe developmental disabilities, elderly care, and to test construct validity with other

instruments.

5. References

Akerjordet, K., & Severinsson, E. (2004). Emotional intelligence in mental health nurses talking about practice. *International Journal of Mental Health Nursing, 13*(3), 164-170.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

Bakker, A. B., Demerouti, E., & Schaufeli, W. B. (2002). Validation of the Maslach Burnout Inventory - General Survey: An internet study. *Anxiety, Stress, and Coping, 15*(3), 245-260.

Basaglia, F. (1968). *L'istituzione negata*. Milano, Baldini Castoldi Dalai.

Beecher, B. (2009). Mental health practitioners' views of the families of individuals with schizophrenia and barriers to collaboration: A mixed methods study. Journal of Family Social Work, 12(3), 264-282.

Berry, K., Barrowclough, C., & Haddock, G. (2011). The role of expressed emotion in relationships between psychiatric staff and people with a diagnosis of psychosis: A review of the literature. *Schizophrenia Bulletin, 37*, 958-972.

Biasin, C., Clerici, R., & Finotti, C. (2012). The identity and professional culture of the educator at the beginning of the university path in Italy. European Journal Of Social Work, 15(3), 361-375.

Bourdieu, P. 1984. *Distinction: A Social Critique of the Judgement of Taste*. London: Routledge.

Bourdieu, P. 1991. *Language and Symbolic Power*. Cambridge, MA: Harvard University Press.

Bowers, A. M. V., & Bieschke, K. J. (2005). Psychologists' clinical evaluations and attitudes: An examination of the influence of gender and sexual orientation. *Professional Psychology: Research and Practice, 36*(1), 97-103.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesize qualitative research: A worked example. Journal of Health Services Research and Policy, 7(4), 209-215.

Buckland, R. (2016). The decision by approved mental health professionals to use compulsory powers under the mental health act 1983: A foucauldian discourse analysis. *British Journal of Social Work, 46*(1), 46.

Burks, D. J., & Robbins, R. (2012). Psychologists' authenticity: Implications for work in professional and therapeutic settings. *Journal of Humanistic Psychology, 52*(1), 75-104.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Donovan, J. (2011). Evaluating meta-ethnography: Systematic analysis and synthesis of qualitative research. *Health Technology Assessment*, 15, 1–164.

Carpenter-Song, E., & Torrey, W. C. (2015). 'I always viewed this as the real psychiatry': Provider perspectives on community psychiatry as a career of first choice. *Community Mental Health Journal, 51*(3), 258-266.

Carpentier, N., Dorvil, H., Lesage, A.D. (1991). Utilization of out-patient services by first and second generation Italian immigrants and French Canadian patients with previous psychiatric hospitalizations. *Santé Culture Health*, 8(3):285–305.

Casper, E. S., Oursler, J., Schmidt, L. T., & Gill, K. J. (2002). Measuring practitioners' beliefs, goals, and practices in psychiatric rehabilitation. *Psychiatric Rehabilitation Journal*, 25(3), 223-234.

Clarke, S.P., Crowe, T.P., Oades, L.G., Deane F.P. (2009) Do Goal Setting Interventions Improve the Quality of Goals in Mental Health Services? *Psychiatric Rehabilitation Journal*, 32 (4), 292-299.

Crawford, P., Brown, B., & Majomi, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies, 45*(7), 1055-1063.

Cort, E. M., Attenborough, J., & Watson, J. P. (2001). An initial exploration of community mental health nurses' attitudes to and experience of sexuality-related issues in their work with people experiencing mental health problems. *Journal of Psychiatric and Mental Health Nursing, 8*(6), 489-499.

Curlin, F. A., Lawrence, R. E., Odell, S., Chin, M. H., Lantos, J. D., Koenig, H. G., & Meador, K. G. (2007). Religion, spirituality, and medicine: Psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *The American Journal of Psychiatry, 164*(12), 1825-1831.

Dalum, H. S., Pedersen, I. K., Cunningham, H., & Eplov, L. F. (2015). From recovery programs to recovery-oriented practice? A qualitative study of mental health professionals' experiences when facilitating a recovery-oriented rehabilitation program. *Archives of Psychiatric Nursing, 29*(6), 419-425.

Davidson, M., Tondora, J., Lawless, M.S., O'connell, M.J., Rowe, M. (2009). *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*. Oxford, UK: Oxford University Press.

De Benedictis, L., Dumais, A., Sieu, N., Mailhot, M., Létourneau, G., Tran, M. M., . . . Lesage, A. D. (2011). Staff perceptions and organizational factors as predictors of seclusion and restraint on psychiatric wards. *Psychiatric Services, 62*(5), 484-491.

Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care, 46*(3), 209-220.

Dion, G., & Tessier, R. (1994). Validation de la traduction de l'inventaire d'épuisement professionnel de maslach et jackson. *Canadian Journal of Behavioural Science/Revue Canadienne des Sciences Du Comportement*, 26(2), 210-227.

Dixon-Woods, M., Fitzpatrick, R., & Roberts, K. (2001). Including qualitative research in systematic reviews: Opportunities and problems*. Journal of Evaluation in Clinical Practice*, 7, 125–133.

Doyle, L. H. (2003). Synthesis through meta-ethnography: Paradoxes, enhancements, and possibilities. *Qualitative Research*, 3(3), 321-344.

Ellis, W. (1838). *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*. London: Holdsworth.

Ericsson, U., Ehliasson, K., & Bengtsson Tops, A. (2016). Meaning in work and emerging work identities of housing support workers: A quest for a comprehensible plot. *Work, 53*(2), 367.

Freidson, E. (1993) The theory of professions state of the art. In Dingwall, R and Lewis, P. (eds) *The sociology of the professions: lawyers, doctors and others.* London: Macmillan.

Gaebel, W., Zäske, H., Cleveland, H., Zielasek, J., Stuart, H., Arboleda-Florez, J., Sartorius, N. (2011). Measuring the stigma of psychiatry and psychiatrists: development of a questionnaire*. European Archives of Psychiatry & Clinical Neuroscience*, 261,119-123.

Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books.

Gibb, H. (2003). Rural community mental health nursing: A grounded theory account of sole practice. *International Journal of Mental Health Nursing, 12*(4), 243-250.

Glaser, B., Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. Child Abuse & Neglect, 22(5), 401-421.

Glisson C, Schoenwald S, Kelleher K, Landsverk J, Hoagwood K, Mayberg S, Green P. (2008) Assessing the Organizational Social Context (OSC) of mental health services: Implications for research and practice. Adm Policy Ment Health and Ment Health Serv Res Special Issue: Improving mental health services, 35(1–2), 98–113.

Goffman, I. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York, Doubleday.

Goodwin, V., & Happell, B. (2007). Psychiatric nurses' attitudes toward consumer and carer participation in care: Part 1—Exploring the issues. *Policy, Politics, & Nursing Practice, 8*(4), 276-284.

Gorusch, R. L. (1983). *Factor Analysis (2nd ed.).* Hillsdale, NJ: Lawrence Erlbaum Associates.

Gray Southon, Jeffrey Braithwaite (1998). The end of professionalism? *Social Science & Medicine*, 46, 23-28.

Hargreaves, A. (1994). *Changing Teachers, Changing Times*. London: Cassell.

Hatcher, L. (1994). *A Step-by-Step Approach to Using the SAS® System for Factor Analysis and Structural Equation Modeling*. Cary, N.C.: SAS Institute, Inc.

Hillman, A. J. (2005). Reflections on service orientations, community, and professions. *Academy of Management Journal, 48*(2), 185-188.

Hofmann, R. (1995). Establishing factor validity using variable reduction in confirmatory factor analysis. *Educational and Psychological Measurement, 55*(4), 572.

Hofstede, G. (1980). *Culture's consequences: International differences in work-related values*. Beverly Hills, CA: Sage.

Lambrechts, G., Van, D. N., Eeman, L., & Maes, B. (2010). Staff reactions to challenging behaviour: An observation study. *Research in Developmental Disabilities, 31*(2), 525-535.);

Lammers, J. C., Atouba, Y. L., & Carlson, E. J. (2013). Which identities matter? A mixed-method study of group, organizational, and professional identities and their relationship to burnout. *Management Communication Quarterly, 27*(4), 503-536.

Lingard, L., Espin, S., Evans, C., & Hawryluck, L. (2004). The rules of the game: Interprofessional collaboration on the intensive care unit team. *Critical Care (London, England), 8*(6), R403-R408.

Littlewood, R. (2002). *Pathologies of the West: an anthropology of mental illness in Europe and America*. New York: Cornell university Press.

Lloyd, M. (2007). Empowerment in the interpersonal field: Discourses of acute mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 14*(5), 485-494.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour, 2*(2), 99.

Messenger, W. (2013). Professional cultures and professional knowledge: Owning, loaning and sharing. *European Early Childhood Education Research Journal, 21*(1), 138-149.

Miscenko, D., & Day, D. (2016). Identity and identification at work. *Organizational Psychology Review, 6*(3), 215-247.

Moore, E., & Kuipers, L. (1992). Behavioural correlates of expressed emotion in staff-patient interactions. *Social Psychiatry and Psychiatric Epidemiology, 27*(6), 298-303.

Morant, N. (2006). Social representations and professional knowledge: The representation of mental illness among mental health practitioners. *British Journal of Social Psychology, 45*(4), 817-838.

Morriss, L. (2015). Nut clusters and crisps: Atrocity stories and co- narration in interviews with approved mental health professionals. *Sociology of Health & Illness, 37*(7), 1072-1085.

Mors, J. (2012) *Qualitative health research*. Walnut Creek: Left Coast Press.

National Institute for Health and Clinical Excellence. (2009). Methods for the development of NICE public health guidance (2nd ed.). London: NHS National Institute for Health and Clinical Excellence.

Noblit GW, Hare RD. (1988). Meta-ethnography: synthesizing qualitative studies. Newbury Park: Sage.

Oulanova, O., & Moodley, R. (2010). Navigating two worlds: Experiences of counsellors who integrate aboriginal traditional healing practices. Canadian Journal of Counselling and Psychotherapy, 44(4), 346-362.

Patterson, C., Curtis, J., & Reid, A. (2008). Skills, knowledge, and attitudes expected of a newly-graduated mental health nurse in an inpatient setting. *International Journal of Mental Health Nursing, 17*(6), 410-418.

R Development Core Team (2012). *R: A Language and Environment for Statistical Computing. R Foundation for Statistical Computing*, Vienna, Austria. ISBN 3-900051-07-0, URL http://www.R-project.org/.

Ragazzoni, P., Baiardi, P., Zotti, A. M., Anderson, N., & West, M. (2002). Research note: Italian validation of the team climate inventory: A measure of team climate for innovation. Journal of Managerial Psychology, 17(4), 325-336.

Raelin, J.A. (1986). *The Clash of Cultures: Managers and Professionals*. Harvard: Harvard Business School Press.

Regione Lombardia Sanità (2009) *Il sistema di salute mentale della Regione* Lombardia. Milano: Regione Lombardia.

Robertson, M., Kerridge, I., & Walter, G. (2009). Ethnomethodological study of the values of australian psychiatrists: Towards an empirically derived RANZCP code of ethics. *Australian and New Zealand Journal of Psychiatry, 43*(5), 409-419.

Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179, 250-258.

Røssberg, J. I., & Friis, S. S. (2003). A suggested revision of the Ward Atmosphere Scale. *Acta Psychiatrica Scandinavica*, 108(5), 374.

Sandhu, S., Bjerre, N. V., Dauvrin, M., Dias, S., Gaddini, A., Greacen, T., . . . Priebe, S. (2013). Experiences with treating immigrants: A qualitative study in mental health services across 16 european countries. *Social Psychiatry and Psychiatric Epidemiology, 48*(1), 105-116.

Saunamäki, N., Andersson, M., & Engström, M. (2010). Discussing sexuality with patients: Nurses attitudes and beliefs. *Journal of Advanced Nursing, 66*(6), 1308-1316.

Schaufeli, W. B., Bakker, A. B., & Salanova, M. (2006). The Measurement of Work Engagement With a Short Questionnaire: A Cross-National Study. *Educational & Psychological Measurement*, 66(4), 701-716

Schaufeli, W. B., Leiter, M. P., Maslach, C., & Jackson, S. E. (1996). Maslach Burnout Inventory-General Survey (MBI-GS). In C. Maslach, S. E. Jackson, & M. P. Leiter*, MBI Manual (3rd ed.)*. Palo Alto, CA: Consulting Psychologist Press.

Schein, E. (2004). *Organizational Culture and Leadership. Third Edition*. San Francisco: Jossey-Bass.

Schiff, J. (2009). A Measure of Organizational Culture in Mental Health Clinics. Best Practice In Mental Health, 5(2), 89-111

Scull, A. (2011). *Madness: A Very Short Introduction*. Oxford: Oxford University Press.

Shepherd, A., Shorthouse, O., & Gask, L. (2014). Consultant psychiatrists' experiences of and attitudes towards shared decision making in antipsychotic prescribing, a qualitative study. *BMC Psychiatry, 14*, 10.

Sirigatti, S., Stefanile, C. (1988). Per una scala di misurazione del burnout. *Bollettino di Psicologia Applicata*, 187-188, 29-32.

Slade, M. (2009). *Personal Recovery and Mental Illness*. Cambridge, UK: Cambridge University Press.

Starnino, V. R., & Canda, E. R. (2014). The spiritual developmental process for people in recovery from severe mental illness. *Journal of Religion & Spirituality in Social Work: Social Thought, 33*(3-4), 274-299.

Stodolsky, S. S., Dorph, G., Nemser, S. (2006). Professional Culture and Professional Development in Jewish Schools: Teachers' Perceptions and Experiences. *Journal Of Jewish Education*, 72(2), 91-108.

Southon, & Braithwaite. (1998). The end of professionalism? *Social Science & Medicine, 46*(1), 23-28.

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., Andrews, J., & Barker, K. (2013). "Trying to pin down jelly"—Exploring intuitive processes in quality assessment for meta-ethnography. *BMC Medical Research Methodology*, 13, 46.

Toomela, A. (2010). Quantitative Methods in Psychology: Inevitable and Useless. *Frontiers in Psychology*, *1*, 29.

Turner, T. E., Fox, N. J., Center, H., & Kiser, J. D. (2006). Uniting spirituality and sexual counseling: Eastern influences. The Family Journal, 14(1), 81-84.

Turner, T. E., Fox, N. J., & Kiser, J. D. (2007). Uniting spirituality and sexual counseling: Semitic traditions. The Family Journal, 15(3), 294-297.

Trauer, T., Callaly, T., Herrman, H. (2009). Attitudes of mental health staff to routine outcome measurement. *Journal of Mental Health*, 18(4), 288-297

Valenti, E., Banks, C., Calcedo-Barba, A., Bensimon, C., Hoffmann, K., Pelto-Piri, V., Priebe, S. (2015). Informal coercion in psychiatry: A focus group study of attitudes and experiences of mental health professionals in ten countries. *Social Psychiatry and Psychiatric Epidemiology, 50*(8), 1297-1308.

Vallerand, R. J. (1989). Vers une méthodologie de validation trans-culturelle de questionnaires psychologiques: Implications pour la recherche en langue française. *Canadian Psychology/Psychologie Canadienne, 30*(4), 662-680.

Van Mook, W.N.K.A., de Grave, W.S., Wass, V., O'Sullivan, H., Zwaveling, J. H., Schuwirth, L. W., & van der Vleuten, C.,P.M. (2009). Professionalism: Evolution of the concept. *European Journal of Internal Medicine, 20*(4), 81-84.

Van Os, J., Galdos, P., Lewis, G., Bourgeois, M., & Mann, A. (1993). Schizophrenia sans frontiers: concepts of schizophrenia among French and British psychiatrists. *BMJ: British Medical Journal*, *307*(6902), 489–492.

Weick, K. (1995). *Sensemaking in Organizations*. London: Sage.

Weiner, B. (1975). 'On being sane in insane places': A process (attributional) analysis and critique. *Journal of Abnormal Psychology*, 84(5), 433-441.

Whitley, R., & Crawford, M. (2005). Qualitative research in psychiatry. Canadian journal of psychiatry, 50(2), 108-114.

Wilding, C., Muir-Cochrane, E., & May, E. (2006). Treading lightly: Spirituality issues in mental health nursing. *International Journal of Mental Health Nursing, 15*(2), 144-152.

Worthington, R. L., & Whittaker, T. A. (2006). Scale development research: A content analysis and recommendations for best practices. *The Counseling Psychologist, 34*(6), 806-838.

Yerushalmi, H. (2013). Sexuality, intimacy, and recovery. *Psychoanalytic Social Work, 20*(1), 62-75.

Zeeman, L., & Simsons, L. (2011). An analysis of discourses shaping mental health practitioners. *Journal of Psychiatric and Mental Health Nursing, 18*(8), 712-720.

Appendix 1. Items from the pilot study questionnaire

Item code	Italian and French text
1_1	Parlo con gli/le utenti dei miei pensieri, dei miei stati d'animo e delle mie esperienze vissute.
1_1	Je parle avec les usagers de mes pensées, de mes sentiments et de mes expériences.
1_2	Creo delle buone relazione con i miei utenti.
1_2	Je crée de bonnes relations avec les usagers.
1_3	Ottengo buoni risultati solo quando mi coinvolgo emotivamente con gli/le utenti.
1_3	J'obtiens de bons résultats dans mon travail seulement lorsque je m'implique émotivement avec les usagers.
1_4	Comunico al telefono o tramite internet con gli/le utenti anche fuori dall'orario di lavoro.
1_4	Je communique par téléphone ou par Internet avec les usagers en dehors des heures de travail.
1_5	Je ne suis pas content quand un des usagers me contacte en dehors des heures de travail.
1_5	Mi infastidisco quando un utente mi contatta al di fuori dell'orario di lavoro.
1_6	Sovraccarico ed esaurimento emotivo sono per me conseguenze inevitabili del mio lavoro con gli/le utenti.
1_6	La surcharge de travail et l'épuisement émotionnel sont des conséquences inévitables lorsqu'on travaille avec des usagers.
1_7	Evito atteggiamenti amichevoli verso gli/le utenti.
1_7	J'évite d'avoir une approche amicale avec les usagers.
1_8	Mi sento a disagio quando un/una utente mi tratta come se fossi un suo/a amico/a.
1_8	Je me sens mal à l'aise quand un usager me traite comme si j'étais son ami/e
2_1	Provo a coinvolgere attivamente i familiari degli/le utenti.
2_1	J'implique activement les proches des usagers dans mes interventions.
2_2	Riesco a migliorare davvero la qualità della vita di un/una utente soltanto quando intervengo sul suo contesto familiare e sociale.
2_2	Je peux vraiment améliorer la qualité de vie d'un usager si je tiens compte de son contexte familial et social.
2_3	Mantengo contatti regolari con i famigliari dei miei utenti..
2_3	Je garde un contact régulier avec la famille des usagers.
2_4	Quando stilo un progetto riabilitativo, prendo in considerazione la rete informale dell'utente (familiari, amici, vicini, colleghi,ecc)
2_4	Quand je fixe un objectif pour le rétablissement de l'usager, je prends en considération son réseau informel (proches, amis, voisins, collègues, etc.).
2_5	J'évite d'engager les amis ou des connaissances des usagers dans mes interventions.
2_5	Evito di coinvolgere nel progetto terapeutico o riabilitativo amici o conoscenti degli/delle utenti.
2_6	Evito di incontrare i famigliari degli/le utenti per non "inquinare" il rapporto professionale.
2_6	J'évite de rencontrer les proches des usagers afin de ne pas nuire à la relation professionnelle que j'ai établie avec ces derniers.
2_7	Posso fare affidamento sulle famiglie degli/le utenti.
2_7	Je peux compter sur les proches des usagers.
2_8	Evito di dare troppe informazioni ai familiari degli/le utenti.
2_8	J'évite de donner trop d'informations aux proches des usagers.

Item code	Italian and French text
3_1	Tengo conto del parere degli operatori degli altri servizi con cui è in contatto l'utente anche quando hanno visioni differenti dalla mia.
3_1	Je tiens compte de l'opinion des intervenants provenant d'autres services qui sont en contact avec les usagers que je rencontre, quelle que soit leur opinion.
3_2	Quando un/a utente è seguito da professionisti esterni alla mia struttura, mantengo con essi un contatto costante.
3_2	Lorsqu'un usager est suivi par des intervenants extérieurs à mon établissement je garde un contact constant avec eux.
3_3	Sono a conoscenza del lavoro svolto dai colleghi che seguono i miei/mie utenti in altre strutture o servizi
3_3	Je connais le travail réalisé par les collègues d'autres services ou établissements qui suivent les usagers.
3_4	Ogni mese dedico una parte del mio tempo per mantenere i contatti gli operatori di altri servizi che seguono i miei/le mie utenti.
3_4	Je dédie une partie de mon temps pour garder le contact avec les intervenants d'autres services qui suivent les usagers.
3_5	Non considero utile il punto di vista di persone che non hanno competenze specifiche nel campo della Salute Mentale
3_5	Je ne considère pas utile le point de vue des gens qui n'ont pas une expertise dans le domaine de la santé mentale
3_6	Il parere degli altri clinici che hanno seguito l'utente in passato mi è d'aiuto per impostare gli interventi terapeutici o le attività riabilitative.
3_6	L'avis d'autres cliniciens qui ont suivi l'usager dans le passé, m`aide à établir les interventions thérapeutiques ou les activités de réadaptation.
3_7	Quando parlo di un utente con qualcuno che lo segue in un altro servizio, ho l'impressione che la sua valutazione sia molto diversa dalla mia.
3_7	Quand je parle d'un usager avec quelqu'un qui le suit dans un autre service, j'ai l'impression que son évaluation est très différente de la mienne
3_8	Ho la sensazione di dover risolvere gli stati di malessere che il personale di altri servizi ha procurato ai miei/alle mie utenti.
3_8	J'ai l'impression de devoir résoudre les états de détresse que le personnel d'autres services de santé mentale a provoqué chez les usagers.
4_1	Nel mio lavoro riesco ad essere efficace solo se definisco degli obiettivi chiari e concreti.
4_1	Mon travail avec les usagers est basé sur des modèles théoriques clairs et bien documentés.
4_2	Il mio lavoro con gli utenti si basa su modelli teorici chiari e ben documentati.
4_2	Mon travail avec les usagers est basé sur des modèles théoriques clairs et bien documentés.
4_3	Mi aggiorno costantemente sulle tecniche ritenute più efficaci dalla comunità scientifica.
4_3	J'essaie d'être au courant des techniques jugées les plus efficaces par la communauté scientifique.
4_4	Utilizzo scale, questionari o test per valutare il cambiamento degli/le utenti.
4_4	J'utilise des échelles, des questionnaires ou des tests pour évaluer le changement chez les usagers.
4_5	Je trouve peu utile d'évaluer périodiquement les usagers à travers des questionnaires ou des tests psychologiques.
4_5	Trovo poco utile valutare periodicamente gli utenti con questionari o test psicologici.
4_6	Je préfère de ne fixer pas des objectifs thérapeutiques ou de réadaptation pour ne pas trop simplifier la richesse et la complexité de la relation thérapeutique.
4_6	Preferisco non fissare obiettivi terapeutici o riabilitativi per non semplificare la ricchezza e la complessità della relazione terapeutica.
4_7	I protocolli o i manuali di intervento si integrano bene con il mio modo di lavorare.
4_7	Les protocoles ou les interventions selon un manuel s'intègrent bien avec ma façon de travailler.
4_8	Valuto se gli obiettivi terapeutici o riabilitativi sono stati raggiunti.
4_8	J'évalue l'atteinte des objectifs thérapeutiques ou de réadaptation.
5_1	Cerco di dare il maggior numero di informazioni possibili agli utenti riguardo alla loro diagnosi.
5_1	Je donne le plus de renseignements possibles aux usagers concernant leur diagnostic.
5_2	Concordo insieme agli/le utenti le regole che entrambi dobbiamo rispettare.
5_2	J'établis avec les usagers les règles sur lesquelles nous nous entendons de respecter

Item code	Italian and French text
5_3	Coinvolgo gli utenti nelle decisioni riguardanti gli obiettivi terapeutici o riabilitativi
5_3	J'implique les usagers dans les décisions concernant leurs objectifs de réadaptation ou thérapeutiques.
5_4	Sprono gli utenti affinchè partecipino attivamente alle decisioni riguardanti la loro salute e guarigione.
5_4	Je pousse les usagers pour qu'ils participent activement aux décisions concernant leur santé et leur rétablissement.
5_5	Penso che gli operatori prendono sempre le migliori decisioni per il bene dell'utente.
5_5	Je pense que les intervenants prennent toujours les meilleures décisions pour le bien de l'usager.
5_6	Utilizzo con gli utenti un sistema di apprendimento basato su premi e punizioni.
5_6	J'utilise avec les usagers un système d'apprentissage basé sur les récompenses et les punitions.
5_7	Contestare le regole è una caratteristica del disturbo mentale degli utenti.
5_7	Je remarque que contester les règles fait partie du trouble mental des usagers.
5_8	A causa del loro disturbo, i miei utenti sono restii a seguire le indicazioni terapeutiche o riabilitative che vengono proposte loro.
5_8	En raison de leur trouble mental, je note que les usagers sont réticents à suivre la thérapie ou le projet de réadaptation conseillé.
6_1	Di solito evito di stare da solo/a con utenti con un disturbo grave, perché non so mai cosa può capitare.
6_1	J'évite de rester seul/seule avec des usagers atteints d'un trouble mentale grave, car je ne sais jamais ce qui peut arriver.
6_2	Gli utenti che seguo non sono pericolosi.
6_2	Les usagers dont je m'occupe ne sont pas dangereux.
6_3	La mia preparazione tecnica mi permette di gestire i comportamenti aggressivi degli/le utenti senza ricorrere a contenimenti fisici.
6_3	Ma formation me permet de gérer le comportement agressif des usagers sans recourir à la contention physique.
6_4	Gli atti aggressivi dei miei/delle mie utenti sono la conseguenza di stati di malessere intenso che non riescono a controllare.
6_4	Les actes agressifs des usagers sont le résultat d'états de détresse intense qu'ils n'arrivent pas à contrôler.
6_5	Le esplosioni di rabbia degli/le utenti sono legate anche al comportamento dell'operatore verso di loro.
6_5	Je remarque que les explosions de colère des usagers sont aussi liées au comportement des intervenants envers eux.
6_6	Se un comportamento aggressivo viene tollerato dall'equipe, l'utente di solito lo ripete per ottenere dei vantaggi.
6_6	J'ai observé que si le comportement agressif est toléré par l'équipe, l'usager le répète pour obtenir des avantages.
6_7	Mantengo un controllo costante per evitare che i miei utenti compiano atti pericolosi per la comunità.
6_7	Je maintiens un contrôle constant pour empêcher les usagers à commettre des actes dangereux pour la communauté.
6_8	Sono sempre in allerta, per non farmi cogliere impreparato da atti aggressivi non prevedibili da parte dei miei/delle mie utenti.
6_8	Je suis toujours sur le qui-vive, afin de ne pas être pris au dépourvu par des actes agressifs imprévisibles de la part des usagers.
7_1	Parlo con i miei/le mie utenti di argomenti che riguardano la spiritualità e la religione.
7_1	Je parle avec les usagers de sujets concernant la spiritualité et la religion.
7_2	Per i miei/mie utenti avere una Fede influisce positivamente sulla propria speranza di recupero.
7_2	Je pense que pour les usagers avoir une foi religieuse a une influence positive sur leur propre espoir de rétablissement.
7_3	Avere una fede protegge gli/le utenti dal compiere suicidio.
7_3	Je remarque qu'avoir la foi protège les usagers de commettre un suicide.
7_4	Per i gli/le utenti credenti, la loro esperienza spirituale ha un effetto positivo sulla loro vita
7_4	Pour les usagers qui sont croyants, l'expérience spirituelle a un effet positif sur leur vie.
7_5	Le convinzioni religiose degli/le utenti rendono difficile intervenire efficacemente su alcuni dei loro problemi.
7_5	J'ai de la difficulté à intervenir efficacement quand les usagers ont des croyances religieuses
7_6	Il fatto che l'utente sia credente influenza il suo stato di salute mentale.
7_6	J'ai remarqué que le fait que l'usager soit croyant influence son état de sa santé mentale.

Item code	Italian and French text
7_7	Non comprendo quanto la spiritualità sia importante nella vita di un/a utente.
7_7	Je ne comprends pas l'importance qu'accorde les usagers à la spiritualité.
7_8	Cerco di scoraggiare gli/le utenti credenti a pensare che la Fede possa aiutarli a stare meglio.
7_8	Je décourage les usagers à croire que la foi peut les aider à se sentir mieux.
8_1	Chiedo ai miei/alle mie utenti di parlare della loro sessualità.
8_1	J'accepte d'entendre les usagers parler de leur sexualité.
8_2	Mi inquieto quando vengo a sapere che due utenti di uno stesso servizio hanno rapporti amorosi o sessuali.
8_2	Je m'inquiète quand je découvre que deux usagers du même service ont une relation amoureuse ou des rapports sexuels.
8_3	Parlo con i miei/le mie utenti di argomenti quali la masturbazione, il rapporto sessuale e l'uso di contraccettivi.
8_3	Il m'arrive de parler aux usagers de sujets tels que la masturbation, les rapports sexuels et l'utilisation de contraceptifs.
8_4	Aiuto i miei utenti ad accettare la loro omosessualità come un aspetto importante e positivo della loro identità.
8_4	J'aide les usagers à accepter leur homosexualité comme un aspect important et positif de leur identité.
8_5	J'essaie de faire en sorte que les usagers homosexuels/lles ne parlent pas de leur homosexualité.
8_5	Cerco di fare in modo che gli utenti omosessuali non parlino della propria omosessualità.
8_6	Sentimenti amorosi o sessuali rivolti agli operatori da parte degli/le utenti sono indici di una cattiva relazione terapeutica.
8_6	Les sentiments d'amour ou de nature sexuelle adressés aux intervenants par les usagers sont des indicateurs d'une mauvaise relation thérapeutique.
8_7	Evito di parlare di sessualità con i miei/le miei utenti perché li imbarazza.
8_7	J'évite de parler du thème de la sexualité avec les usagers, car cela les gêne.
8_8	Penso che la transessualità di un utente sia legata ad un problema di salute mentale.
8_8	Je pense que la transsexualité des usagers est liée à un trouble de santé mentale.
9_1	Gli utenti provenienti da altri Paesi non rispondono bene ai trattamenti per via delle loro diverse convinzioni culturali
9_1	J'ai remarqué que les usagers qui viennent d'autres pays ne répondent pas bien aux traitements en raison de leurs différences.
9_2	Con utenti di altre culture riesco a fare un buon lavoro riabilitativo solo conoscendo a fondo la loro cultura di appartenenza.
9_2	Je peux faire du bon travail avec des usagers de différentes cultures seulement si je connais à fond leur propre culture.
9_3	Mi documento sulla cultura di appartenenza di alcuni dei miei/delle mie utenti.
9_3	Je me documente sur la culture d'origine de certains des usagers.
9_4	Faccio fatica a lavorare con utenti di altre culture o gruppi etnici.
9_4	Je trouve qui c'est difficile de travailler avec des usagers d'autres cultures ou d'autres groupes ethniques.
9_5	Trovo stimolante lavorare con utenti che hanno una cultura d'origine differente dalla mia.
9_5	Je trouve stimulant de travailler avec des usagers qui ont une culture d'origine différente de la mienne.
9_6	Sospetto che un/a utente proveniente da un altro Paese esageri il proprio disturbo mentale per ottenere dei vantaggi legali o finanziari.
9_6	Je soupçonne que l'usager d'un autre pays exagère la gravité de son trouble mental pour obtenir des avantages juridiques ou financiers.
9_7	Mi oppongo quando mi si chiede di modificare il mio modo di lavorare per venire incontro alle esigenze di utenti di altre culture.
9_7	Je m'oppose quand on me demande de changer ma façon de travailler pour répondre aux besoins des usagers provenant d'autres cultures.

Appendix 2. Bicocca Mental Health Professional Culture Inventory (Italian Version)

Indichi per ciascuna affermazione quanto frequentemente si verifica nella sua esperienza lavorativa, utilizzando la scala:

0 = mai 1 = raramente 2 = talvolta 3 = spesso 4 = sempre

Nel rispondere tenga conto che:

- nel testo ci si riferisce genericamente agli "**utenti**" per indicare le persone che usufruiscono del servizio presso cui Lei lavora;
- per facilitare la lettura, verrà usato **preferenzialmente il genere maschile** per indicare utenti, colleghi, e in generale tutte le persone nominate indipendentemente dal genere maschile o femminile;
- il presente questionario è stato costruito per essere somministrato in diverse tipologie di servizi di salute mentale (servizi residenziali, servizi ambulatoriali, centri diurni, servizi ospedalieri, ecc...) e in diversi contesti culturali, quindi alcune **frasi potrebbero non sembrarLe direttamente pertinenti** con la Sua esperienza (in tal caso**, risponda "0 = mai"**).

01. Cerco di dare il maggior numero di informazioni possibili agli utenti riguardo alla loro diagnosi.	⓪①②③④
02. Mantengo contatti regolari con i famigliari dei miei utenti.	⓪①②③④
03. Mi sembra che le mie riflessioni riguardanti i miei utenti non vengano comprese dagli altri colleghi.	⓪①②③④
04. Mi controllo per non mostrare agli utenti i miei sentimenti negativi.	⓪①②③④
05. Posso fare affidamento sulle famiglie degli utenti.	⓪①②③④
06. Sono oggetto di minacce o atti aggressivi da parte degli utenti.	⓪①②③④
07. Parlo con i miei utenti di argomenti che riguardano la spiritualità e la religione.	⓪①②③④
08. Aiuto i miei utenti ad accettare la loro omosessualità come un aspetto importante e positivo della loro identità. *(Se non le capita di lavorare con utenti di orientamento omosessuale, segni "0 = mai")*	⓪①②③④
09. Provo a coinvolgere attivamente i familiari degli utenti.	⓪①②③④
10. Il mio lavoro con gli utenti si basa su modelli teorici chiari e ben documentati.	⓪①②③④
11. Sono sempre in allerta, per non farmi cogliere impreparato da atti aggressivi non prevedibili da parte dei miei utenti.	⓪①②③④
12. Ho difficoltà a intervenire efficacemente sugli utenti con convinzioni religiose.	⓪①②③④
13. Do il mio numero di cellulare (personale) agli utenti in modo che mi possano chiamare al bisogno.	⓪①②③④
14. Gestisco facilmente i comportamenti aggressivi degli utenti. *(Se gli utenti non hanno comportamenti aggressivi segni "0 = mai")*	⓪①②③④
15. Parlo con gli utenti dei miei pensieri, dei miei stati d'animo e delle mie esperienze vissute.	⓪①②③④
16. Mi sembra che altri colleghi che non hanno la mia stessa formazione o ruolo professionale facciano comunque il mio stesso lavoro.	⓪①②③④
17. Mi coinvolgo nelle vicende legali dei miei utenti.	⓪①②③④
18. Utilizzo con gli utenti un sistema di apprendimento basato su premi e punizioni.	⓪①②③④
19. Evito di parlare di sessualità con i miei utenti perché li imbarazza.	⓪①②③④
20. Mi scuso con un utente se mi rendo conto di aver sbagliato con lui.	⓪①②③④

21. Gli utenti mi contattano al di fuori dell'orario di lavoro.	⓪①②③④
22. Riesco a integrare i protocolli o i manuali di intervento con il mio modo di lavorare.	⓪①②③④
23. Comunico tramite internet con gli utenti.	⓪①②③④
24. Tengo conto del parere degli operatori degli altri servizi (di Salute Mentale o Sociali) con cui è in contatto l'utente anche quando hanno visioni differenti dalla mia.	⓪①②③④
25. Ogni mese dedico una parte del mio tempo per mantenere i contatti con gli operatori di altri servizi che seguono i miei mie utenti.	⓪①②③④
26. Insisto per far rispettare agli utenti regole e limiti.	⓪①②③④
27. Mi infastidisco quando un collega si arrabbia con un utente.	⓪①②③④
28. Gli atti aggressivi dei miei utenti sono la conseguenza di stati di malessere intenso che non riescono a controllare. *(Se gli utenti non hanno comportamenti aggressivi segni "0 = mai")*	⓪①②③④
29. Mi sento a disagio quando un utente mi tratta come se fossi un suo amico.	⓪①②③④
30. Concordo insieme agli utenti le regole che entrambi dobbiamo rispettare.	⓪①②③④
31. Nel mio lavoro riesco ad essere efficace solo se definisco degli obiettivi chiari e concreti.	⓪①②③④
32. Chiedo ai miei utenti di parlare della loro sessualità.	⓪①②③④
33. Faccio fatica a comprendere il linguaggio professionale usato da altri professionisti che si occupano dei miei utenti	⓪①②③④
34. Mi aggiorno sulle tecniche ritenute più efficaci dalla comunità scientifica.	⓪①②③④
35. Evito atteggiamenti amichevoli verso gli utenti.	⓪①②③④
36. Evito di stare da solo con utenti con un disturbo mentale grave. *(Se gli utenti con i quali lavora non soffrono di disturbi mentali gravi, segni "0 = mai")*	⓪①②③④
37. Mi è capitato d'osservare che essere credente influenza positivamente la salute mentale di un utente.	⓪①②③④
38. Il lavoro a contatto con gli utenti mi provoca sovraccarico ed esaurimento emotivo.	⓪①②③④
39. Quando parlo di un utente con i miei colleghi, parlo anche della sua sessualità.	⓪①②③④
40. Nel mio lavoro ho contatti con amici, vicini o colleghi degli utenti.	⓪①②③④
41. Sono infastidito dalle richieste di attenzione degli utenti.	⓪①②③④
42. I colleghi mi chiedono dei pareri sugli utenti in virtù delle mie specifiche competenze professionali.	⓪①②③④
43. Il parere degli altri clinici che hanno seguito l'utente in passato mi è d'aiuto per impostare gli interventi terapeutici o le attività riabilitative.	⓪①②③④
44. Quando parlo di un utente con i miei colleghi, parlo anche della sua vita spirituale.	⓪①②③④
45. Riesco a migliorare davvero la qualità della vita di un utente soltanto quando intervengo sul suo contesto familiare e sociale.	⓪①②③④
46. Utilizzo scale, questionari o test per valutare il cambiamento degli utenti.	⓪①②③④
47. Il comportamento degli utenti mi fa perdere la pazienza.	⓪①②③④
48 Ciò che dico ad un utente viene smentito da un collega.	⓪①②③④
49. Parlo con i miei utenti di argomenti quali la masturbazione, il rapporto sessuale e l'uso di contraccettivi.	⓪①②③④

Appendix 3. Bicocca Mental Health Professional Culture Inventory (French-Canadian Version)

Pour **chacune des phrases** ci-dessous, veuillez **indiquer quelle est votre expérience** professionnelle, en encerclant le numéro qui correspond le mieux à votre choix tout en considérant l'échelle suivante :

0 = jamais, **1** = rarement, **2** = parfois, **3** = souvent, **4** = toujours

En répondant **tenez compte que** :

- ce **questionnaire** a été **conçu pour être administré** auprès d'intervenants provenant de **différents types de services** de santé mentale (services résidentiels, services de soins ambulatoires, centres de jour, services hospitaliers, etc.) et **dans différents contextes culturels**;
- l'appellation du vocable «**usagers**» renvoie aux personnes utilisatrices de services dans lesquels vous pourriez travailler;
- **quelques phrases pourraient ne pas être pertinentes** dans votre situation professionnelle. Si c'est le cas, veuillez **répondre** « 0 = **jamais** »;
- dans le cas d'une **erreur de compilation**, tirez un trait sur la mauvaise réponse et encerclez le numéro qui correspond à la bonne réponse.

01. Je donne le plus de renseignements possibles aux usagers concernant leur diagnostic.	⓪①②③④
02. Je garde un contact régulier avec la famille des usagers.	⓪①②③④
03 J'ai l'impression que mes réflexions à propos des usagers ne sont pas comprises par d'autres collègues.	⓪①②③④
04. Je me contrôle pour ne pas montrer mes sentiments négatifs à l'égard des usagers.	⓪①②③④
05. Je peux compter sur les proches des usagers.	⓪①②③④
06. Je suis objet de menaces ou d'actes agressifs par des usagers.	⓪①②③④
07. Je parle avec les usagers de sujets concernant la spiritualité et la religion.	⓪①②③④
08. J'aide les usagers à accepter leur homosexualité comme un aspect important et positif de leur identité. *(Si aucun usager n'est d'orientation homosexuelle, répondez "0 = jamais")*	⓪①②③④
09. J'implique activement les proches des usagers dans mes interventions.	⓪①②③④
10 Mon travail avec les usagers est basé sur des modèles théoriques clairs et bien documentés.	⓪①②③④
11. Je suis toujours sur le qui-vive, afin de ne pas être pris au dépourvu par des actes agressifs imprévisibles de la part des usagers.	⓪①②③④
12. J'ai de la difficulté à intervenir efficacement quand les usagers ont des croyances religieuses.	⓪①②③④
13. Je donne mon numéro de téléphone (personnel) à mes usagers pour me rejoindre au besoin.	⓪①②③④
14. Je gère facilement les comportements agressifs des usagers. *(Si les usagers n'ont pas de comportements agressifs, répondez "0 = jamais")*	⓪①②③④
15. Je parle avec les usagers de mes pensées, de mes sentiments et de mes expériences.	⓪①②③④
16. Il me semble que d'autres collègues qui n'ont pas la même formation ou profession que moi, font pourtant le même travail que moi.	⓪①②③④
17. Je m'implique dans les aspects légaux et judiciaires de mes usagers.	⓪①②③④
18. J'utilise avec les usagers un système d'apprentissage basé sur les récompenses et les punitions.	⓪①②③④
19. J'évite de parler du thème de la sexualité avec les usagers, car cela les gêne.	⓪①②③④

20. Je m'excuse auprès de l'usager si je me rends compte de m'être trompé.	⓪①②③④
21. Les usagers me contactent en dehors des heures de travail.	⓪①②③④
22. Je réussis à intégrer les protocoles ou les manuels d'intervention avec ma façon de travailler.	⓪①②③④

23. Je communique par Internet avec les usagers.	⓪①②③④
24. Je tiens compte de l'opinion des intervenants provenant d'autres services (de santé mentale ou des services sociaux) qui sont en contact avec les usagers que je rencontre, quelle que soit leur opinion.	⓪①②③④
25. Je dédie une partie de mon temps pour garder le contact avec les intervenants d'autres services qui suivent mes usagers.	⓪①②③④
26. J'insiste pour que les usagers respectent les règles et les limites.	⓪①②③④
27. Je suis contrarié si un collègue se fâche avec un usager.	⓪①②③④
28. Je pense que les actes agressifs des usagers sont le résultat d'états de détresse intense qu'ils n'arrivent pas à contrôler. *(Si les usagers n'ont pas de comportements agressifs, répondez "0 = jamais")*	⓪①②③④
29. Je me sens mal à l'aise quand un usager me traite comme si j'étais son ami/e	⓪①②③④
30. J'établis avec les usagers les règles sur lesquelles nous nous entendons de respecter.	⓪①②③④
31. Dans mon travail, je peux être efficace seulement si je définis des objectifs clairs et concrets.	⓪①②③④
32. J'accepte d'entendre les usagers parler de leur sexualité.	⓪①②③④
33. Je trouve difficile de comprendre le langage professionnel utilisé par d'autres professionnels qui suivent mes usagers	⓪①②③④
34. J'essaie d'être au courant des techniques jugées les plus efficaces par la communauté scientifique.	⓪①②③④
35. J'évite d'avoir une approche amicale avec les usagers.	⓪①②③④
36. J'évite de rester seul/seule avec des usagers atteints d'un trouble mental grave. *(Si les usagers ne sont pas atteints d'un trouble mental grave, répondez "0 = jamais")*	⓪①②③④
37. J'ai remarqué que le fait que l'usager croit en une religion influence positivement son état de santé mentale.	⓪①②③④
38. Le travail avec les usagers me crée une surcharge et de l'épuisement émotionnel.	⓪①②③④
39. Quand je discute d'un usager avec mes collègues, je parle aussi de leur vie sexuelle	⓪①②③④
40. Dans mon travail, je prends contact avec les amis, les voisins ou les collègues des usagers.	⓪①②③④
41. Je suis contrarié par les demandes d'attention des usagers.	⓪①②③④
42. Mes collègues me demandent mon avis concernant les usagers, faisant appel aux compétences spécifiques de ma profession.	⓪①②③④
43. L'avis d'autres cliniciens qui ont suivi l'usager dans le passé, m`aide à établir les interventions thérapeutiques ou les activités de réadaptation.	⓪①②③④
44. Quand je discute d'un usager avec mes collègues, je parle aussi de sa vie spirituelle.	⓪①②③④
45. Je peux vraiment améliorer la qualité de vie d'un usager si je tiens compte de son contexte familial et social.	⓪①②③④
46. J'utilise des échelles, des questionnaires ou des tests pour évaluer le changement chez les usagers.	⓪①②③④
47. Le comportement des usagers me fait perdre patience.	⓪①②③④
48 Ce que je dis à un usager est démenti par un collègue.	⓪①②③④
49. Il m'arrive de parler aux usagers de sujets tels que la masturbation, les rapports sexuels et l'utilisation de contraceptifs.	⓪①②③④