“We’re in this together:” Exploring how mental health professionals experience resilience and the role of social identity processes

by

Colm Hayes, BA, HDipPsych, MA
19202559

Thesis submitted to the National University of Ireland in fulfilment of the requirements for the degree of D Psych Sc (Clinical Psychology)

School of Psychology, College of Social Sciences and Law, University College Dublin, Belfield, Dublin 4,
2022

Head of School: Professor Suzanne Guerin

Course Directors: Professor Gary O’Reilly, Professor Alan Carr

Supervisors: Assistant Professor Clíodhna O’ Connor
Professor Jessica Bramham

Submitted April 2022

Table of Contents

List of Tables

List of Figures

List of Appendices

Declaration

I declare that the work presented within this thesis is my own. Where the work of others has been used to support my work it has been appropriately referenced.

Signed:

Date: 08/04/2022

Acknowledgements

Thank you to Clióhna for your patience and guidance throughout this journey, and for helping me to navigate the many plot-twists along the way.

Thank you to Jessica for being a calm, supportive presence throughout and for helping me cross the finish line.

Thank you to Tom for making yourself available for crucial brainstorming sessions and pep-talks at key moments during the recruitment phase.

Thank you to all of my incredible clinical supervisors whom I had the pleasure of working with on placement during my training; all of whom were so generous with their support, wisdom, and time.

Thank you to the entire course team for your continued support, and to my class for the chats, the craic, and the direction over the past three years.

Thank you to my beautiful wife, Kristine, the wisest person I know and whose patience knows no bounds.

Thank you to my wonderful little girl, Saoirse, for illuminating my life with a joy that is beyond comprehension.

Thank you to my long-suffering parents for their eternal support, to my aunties Siobhan and Mairead, all of my family and friends, near and far, many of whom are still unsure as to what I've been up to over these last three years.

Thank you to Freya and Archie, my feline family. As the old saying goes, every good home deserves a pair of quirky cats…

Finally, thank you to all of the participants who contributed to this thesis for your honesty and openness. Thank you for sharing your experiences with me.

Abstract

Mental health professionals are known to work in challenging and often stressful environments. Prior to the added complication of Covid-19 to service provision, burnout had been identified as an emergent critical issue in this context. This thesis sought to address a gap in the literature by clarifying the conceptual underpinnings of resilience in mental health service provision by investigating mental health professionals' experience of resilience in their practice, and exploring the role of social identity processes therein. To address the aims of this thesis, a two-study approach was taken. Study 1 is a systematic review of qualitative empirical literature on mental health professionals' experiences of resilience in their practice. Twenty-six papers were included in the final review. Resilience was conceptualised as a dynamic, interactive phenomenon that is heavily influenced by social connection. Study 2 is a qualitative study exploring the influence of social identity processes on staff working in Irish regional approved centres during the Covid-19 crisis. Seventeen participants were interviewed in this study. Findings support conceptualisations of resilience as flexible and multidimensional in the context of mental health service provision, contingent on the dynamic interplay between multiple interconnected factors. Practitioners describe resilience as a shared process that occurs in relationship within a social ecological context. This thesis proposes that social identity can offer a useful theoretical framework for understanding the group dimension of resilience processes in mental health settings, wherein the application of social identity theory can provide an underlying explanation of how group identification can both strengthen and undermine collective resilience in a crisis. This thesis highlights the conceptual compatibility of resilience and social identity theory as both may represent complementary pathways to practitioner wellbeing that can help foster positive outcomes for staff, service users, and mental healthcare systems.

Chapter One

Introduction to the Thesis

1.1 Thesis Outline

This chapter outlines some of the longstanding challenges associated with mental health service provision globally and nationally. Following an overview of the theoretical underpinnings of resilience and social identity, social identity theory is proposed as a useful theoretical framework for conceptualising resilience as a dynamic process that occurs within a context. It further examines the resilience and social identity literature in the context of mental health, while exploring the immediate and residual impact of Covid-19 on global and national mental health services. This chapter concludes with an overview of thesis objectives and proposed research questions.

1.2 Background

Mental Health (MH) is considered by many an inherently challenging area in which to work (Rössler, 2012; Zarea et al., 2013). Historically, global MH systems have not been adequately funded, organised, or implemented given the extensive burden of MH issues worldwide (WHO, 2018). The impact of burnout on global healthcare systems has been identified as an emergent critical issue with no area more adversely impacted than MH as indicated by reported burnout prevalence rates ranging from 21-67% among service providers (Morse et al., 2012). Moreover, research examining burnout prevalence rates suggests that over 50% of MH professionals (MHPs) endure high levels of burnout early on in their careers (Volpe et al., 2014).

These findings are perhaps unsurprising when one considers the dynamic nature of the work environments inhabited by MHPs, who contend with a unique array of emotional and systemic demands (Maslach & Leiter, 2016). Among the stressors frequently encountered in mental healthcare provision include the intense emotional involvement of MHPs with service

users (SUs) over a prolonged period of time (Edwards & Burnard, 2003; Mann & Cowburn, 2005), stigma associated with working in MH (Rössler, 2012), an increased risk of experiencing physical assault and aggression in the workplace (Jovanović et al., 2016; NHS, 2010; Renwick et al., 2016; Shiao et al., 2010), the management of complex risk and suicidality (Rössler, 2012), exposure to secondary traumatic stress (Sjølie et al., 2017), and working long hours (Imai et al., 2004; Rupert & Morgan, 2005). Not only are MHPs at an increased risk of experiencing burnout, vicarious traumatisation, and compassion fatigue from the cumulative effect of bearing witness to trauma, suffering, and loss over time (Edward et al., 2017; Råbu et al., 2016), they must concurrently withstand the filter down effects of the well documented systemic shortcomings associated with mental healthcare provision. These shortcomings can include pervasive organisational uncertainty, inadequate resourcing and funding, chronic staff shortages, excessive workload pressures, and the lack of opportunities for professional development (Aiken et al., 2002; Bressi et al., 2009; Bride & Figley, 2007; Cleary et al., 2010; Graber et al., 2008; Honberg et al., 2011; Huxley et al., 2005; Kindy et al., 2005; McGeorge et al., 2000; Pinikahana & Happell, 2004; Sørgaard et al., 2007; Willard-Grace et al., 2014; Yadav & Fealy, 2012). Additional factors that can add to the burden of responsibility on MHPs include long waiting lists and high levels of chronicity in the context of SU presentations, the latter limiting responsiveness to short-term therapeutic interventions and thereby restricting capacity to manage the former (Knekt et al., 2016; Leichsenring et al., 2013; Leichsenring & Rabung, 2011).

Not only do these factors jeopardise MHP wellbeing (Braun, Schönfeldt-Lecuona et al., 2010; Rössler, 2012), they also risk compromising the quality of care provided to SUs (Barnett et al., 2007; Hall, Johnson, Watt, et al., 2016; Happell & Koehn, 2011; Laschinger & Leiter, 2006). Burnout, for example, has been implicated in a plethora of adverse outcomes for MHPs,

SUs, and organisations alike (Morse et al., 2012; Salyers et al., 2015). MHPs who report high levels of burnout can experience challenges to their physical and MH (Acker, 2010; Peterson et al., 2008), lower levels of role engagement, poor morale, significant reductions in job satisfaction (Maslach et al., 2001; Paris & Hoge, 2010), and higher rates of absenteeism (Borritz et al., 2006). Consequently, burnout risks compromising quality of care (Barnett & Hillard, 2001; Happell & Koehn, 2011; Laschinger & Leiter, 2006; Maslach, 2003; Morse et al., 2012), where a correlation exists between high levels of burnout and lower self-reported quality of care among MHPs (Salyers et al., 2015; Shanafelt et al., 2002; Van Bogaert, Kowalski et al., 2013). At an organisational level, the resulting staff absenteeism and retention difficulties can have financial repercussions (Smoot & Gonzales, 1995; Waldman et al., 2010), further straining the finite financial resources at the disposal of this sector (Druss, 2006; Honberg et al., 2011).

1.3 Resilience

1.3.1 Theoretical Review of Resilience

Originating from the Latin verb, resilire, meaning to rebound or "leap back," the construct of resilience has been studied empirically since the early 1970s (Fletcher & Sarkar, 2013). Although there is no agreed conceptualisation of resilience at present (Vella & Pai, 2019), existing definitions appear to centre around the pairing of positive outcomes with some form of adversity or risk (Fletcher & Sarkar, 2013; Rutter, 2006). That said, resilience has been subjected to numerous conceptual iterations over the years, such that the concept of resilience can be characterised nowadays as *"reduced vulnerability to environmental risk experiences, the overcoming of a stress or adversity, or a relatively good outcome despite risk experiences"* (Rutter, 2012, p. 336).

Some have conceptualised resilience as an inherent personal characteristic or quality that promotes adaptive coping and adjustment in the face of adversity (e.g., Ahern et al., 2008; Connor & Davidson, 2003; Hu et al., 2015). Others have extended the focus beyond an apparent overreliance on individual attributes in recognition of resilience as a dynamic process that unfolds within a context, thus having the capacity to operate and interact across multiple levels (e.g., Curtis & Cicchetti, 2007; Hill et al., 2018; Luthar et al., 2000). The conceptual evolution of process-based theories present resilience as an interactive construct that involves the interplay between the following four factors: person, adversity, outcome, and environment (Rutter, 2006). In doing so, there is an acknowledgement that resilience cannot exist in isolation and is best viewed in terms of occurring on a continuum rather than in binary terms (Southwick et al., 2014).

The three waves of resilience research completed to date (see Vella & Pai, 2019) give some insight into the journey of its conceptual evolution. The first wave of research commenced in the seventies and was primarily concerned with the attributes of the individual and their environment, generating detailed descriptors of resilience phenomena following exposure to adversity (Luthar & Cicchetti, 2000; Mizuno et al., 2016; Wright et al., 2013). Next, the second wave sought to ascertain how to promote resilience through the application of knowledge acquired during the previous wave (Mizuno et al., 2016; Wright et al., 2013), facilitating the emergence of research models. One prominent metatheory of resilience proposed at this time by Richardson and colleagues suggests that individuals endeavour to achieve biopsychospiritual homeostasis in three distinct movements: the first involves the successful implementation of protective factors that allow for a positive reaction to adversity; the second refers to adaptive coping when confronted with change; and the third requires a motivation to achieve self-actualisation (Richardson, 2002; Richardson et al., 1990). As

resilience research entered its third wave, the aim was to determine how resilience could be fostered in instances where it did not occur naturally (Wright et al., 2013), again building upon the findings of previous waves to develop preventative strategies and sophisticated interventions for the purpose of bolstering resilience (Masten, 2007; Wright et al., 2013). Resilience research is currently undergoing its fourth wave; many predict that the pace of technological advancement will enable researchers to develop a more comprehensive understanding of resilience as a multidimensional phenomenon; one that is contingent upon the dynamic interaction between multiple complex systems of interconnectivity (Masten, 2007; Masten & Obradović, 2006).

1.3.2 Resilience in the context of mental health service provision

In recent years, there has been renewed interest in the concept of resilience with attempts to better understand its applicability in various areas (Bonanno et al., 2015; Everly & Lating, 2013; Pipe et al., 2012; Thomas et al., 2016; Wagnild & Young, 1993). This has coincided with a shift in the focus of MH research, moving from a traditional deficits model to a more strengths-based approach (Kleinman, 2012; Lapsley et al., 2002; Priebe et al., 2014; Rashid & Ostermann, 2009); a shift that is reflected in global MH policy and practice (Priebe et al., 2014). The resultant proliferation of resilience in MH literature has brought with it similar reservations to those that dominate the wider resilience literature; namely concerns pertaining to its conceptual clarity (Luthar et al., 2000; Windle, 2011). As a result, resilience has lacked conceptual consistency in its application to MH research (Friborg et al., 2009; Hoge et al., 2007; Larm et al., 2010; Lawn et al., 2011; Zamirinejad et al., 2014), where some empirical investigations utilise process-based conceptualisations of resilience (Crowe et al., 2016; Geanellos, 2005) and others advocate for its use as a trait (Kalathil et al., 2011).

Resilience and its promotion in SUs represent a core feature of national and global MH policy documents (Mental Health Commission, 2005; Mental Health Commission of Canada, 2015). With regards to MHPs, McCann et al. (2013) posit that resilience relates to their capacity to maintain personal and professional wellbeing in highly demanding work environments; a complex process that involves dynamic interactions between personal and external resources (King & Rothstein, 2010). It has previously been suggested that prior exposure to manageable stressors, meaningful social relationships, experiential learning, and an individual's capacity for self-reflection and planning all play a role in fostering resilience when working in this area (Rutter, 2013). The majority of existent research on resilience and MHPs consults staff working in psychiatric services and trauma counsellors, and burnout, secondary traumatic stress, and compassion fatigue are often the primary focus (Bride & Figley, 2007). Over time, there has been an increased acknowledgement of MHP resilience as a relational, interactive phenomenon that is influenced to a large extent by support systems and relationships (e.g., Adamson et al., 2014); a process that has also benefited from the development of a more comprehensive understanding of newer concepts like vicarious resilience and compassion satisfaction through qualitative empirical endeavour (Álvarez & Hurley, 2010; Hernández et al., 2010; Radey & Figley, 2007). Although there is growing empirical interest in the efficacy of resilience training programmes in healthcare settings generally – a trend facilitated by the third wave of resilience research - relatively little attention has historically been afforded to the promotion of health and wellbeing among MHPs (Morse et al., 2012). Recently, several systematic reviews have been published examining existent literature on resilience among specific professional cohorts in MH (e.g., Foster et al., 2019; Howard et al., 2019). However, none thus far have sought to systematically synthesise MHP experiences of resilience, either with respect to distinct staff cohorts or among MH workers generally.

Rössler (2012) notes that as the incidence of MH difficulties increase in the community, so too does the pressure on those providing the care; an observation of resonance considering the emergence of burnout as a critical global phenomenon among those working in MH (Morse et al., 2012). This, coupled with the conceptual inconsistencies that dominate the resilience and MH literature, suggest the merits of reconsolidating empirical efforts to better understand resilience in this context. The welcome expansion of the recovery model worldwide has brought with it an increased recognition of the lived SU experience of mental illness and service provision, with an emphasis on ideals of empowerment and self-determination (Farkas et al., 2005; Slade et al., 2014). The move towards the prioritisation of SU perspectives, particularly in the formation of MH policy and practice guidelines, is a key avenue through which the responsiveness of global MH systems can be enhanced. Perhaps the similar application of recovery model ideals to those at the frontline of service provision would prove equally beneficial, allowing for a more comprehensive understanding of how MHPs experience resilience processes. Moreover, with the fourth wave of resilience research currently unfolding, it is perhaps timely to broaden our understanding of resilience as a multidimensional construct in the context of MH service provision, where practitioner resilience is similarly contingent on the dynamic interaction between a complex array of interwoven multisystemic phenomena; a qualitative perspective would help move us closer to this outcome.

1.4 Social Identity Theory

Tajfel et al.'s social identity theory (1979) provides a new lens through which modern conceptualisations of resilience can be understood; social identity theory (SIT) proposes a rich theoretical framework that integrates group psychology with the psychology of the individual

and centres upon identity processes that involve intergroup and intragroup dynamics (Abrams & Hogg, 2004, 2006; Hogg, 2018; Hogg & Ridgeway, 2003; Turner et al., 1987).

1.4.1 Theoretical Review of Social Identity Theory

SIT asserts that a person's self-concept is closely intertwined with the type of group they identify with, and the perceived value of this in-group compared to the affiliated out-group. Thus, a person's social identity represents *"that part of an individual's self-concept which derives from knowledge of membership in a social group (or groups) together with the value or emotional significance attached to that membership"* (Tajfel, 1978, p. 63). SIT is based upon the minimal group paradigm (Tajfel et al., 1979), which posits that the categorisation of people into basic groups at a *"purely cognitive"* level (Tajfel et al., 1979, p. 39) can facilitate the emergence of in-group favouritism (Tajfel, 1970). These findings conflicted with the dominant perspective on intergroup relations of that era, Realistic Conflict Theory (Sherif & Sherif, 1969), which espouses the position that conflict over scarce material resources represents a fundamental pre-requisite to intergroup conflict. In interpreting this phenomenon, Tajfel suggested that not only do individuals aim to achieve a positive personal identity or relative "uniqueness" as individuals, so too do they covet a positive social identity (Scheepers & Ellemers, 2019). Thus, since participants in the minimal group experiments lacked additional information pertaining to the group's value, in-group favouritism was the only strategy through which they could positively differentiate "us" from "them."

At its core, SIT presupposes that social categorisation is of fundamental relevance to the individual. It posits that the tendency for individuals to engage in self-categorisation alongside the aforementioned desire for a positive social identity encourages a process of social comparison, whereby the individual seeks to positively differentiate the in-group from

associated out-groups (Tajfel et al., 1979). When this process is successful, it can benefit one's self-esteem while also facilitating a meaningful sense of purpose and belonging (Abrams & Hogg, 1988; Scheepers et al., 2006). So while cognitive processes play a formative role in SIT, alongside the motivation to attain a positive social identity, SIT also elicits important affective processes. As SIT has developed as a concept, so too have researchers begun to acknowledge its multidimensional nature that incorporates the following components: the cognitive (self-categorisation), the affective (self-esteem or satisfaction) and the behavioural (solidarity or group commitment) (Leach et al., 2007; Ouwerkerk et al., 1999).

SIT can also be viewed from a socio-structural perspective in describing how people respond when they come to possess a negative social identity (Scheepers & Ellemers, 2019). Given that natural groups differ to minimal groups in terms of having evaluative connotations in the social world, a clear demarcation emerges between high status and low status groups. The human desire for positive social identity indicates that whereas low status group members should harbour a motivation to advance their group's social standing, those who occupy the ranks of high status groups are more likely to prioritise defending theirs (Scheepers, 2009; Turner & Brown, 1978). So, while a positive social identity brings with it considerable benefits to self-esteem, its negative counterpart tends to encourage one of the following options: individual mobility, collective action to achieve higher status, or the use of cognitive strategies or social creativity to enhance the image of the out-group (Scheepers & Ellemers, 2019; Trepte & Loy, 2017). Moreover, factors that determine which strategy is likely to be employed include the permeability of group differences as well as the legitimacy and stability of status divergence (Ellemers, 1993; Tajfel et al., 1979), where permeability is necessary for individual mobility. Status discrepancies that are considered illegitimate and unstable are more likely to encourage

collective action, while those seen as legitimate and stable may require more social creativity in one's response.

This illustrates how social identity threat plays a key role in determining whether an individual opts to flee from the marginalised group or instead favours taking on the status quo as a collective (Ellemers, 1993; Tajfel et al., 1979). Similarly, different framings of threat can elicit different consequences. While intergroup threat tends to foster collective level solidarity and cooperation, often by strengthening people's commitment to their in-group (e.g., Castano et al., 2002; Ellemers et al., 1997), intragroup threat tends to undermine group ties (Greenaway & Cruwys, 2019). Importantly, however, the strengthening of people's commitment to their in-group in the face of intergroup threat can result in more intolerance and prejudice towards out-group members (McCann, 2008). Recently, social identity has been implicated in *catastrophe compassion* (Zaki, 2020); a term referring to the positive social behaviours that can occur following complex disasters. Although an emergent concept, its historic prevalence is notable as are its pro-social and beneficial effects on helpers by way of increasing happiness and reducing stress and loneliness (Jordan et al., 2021). Similarly, studies suggest that positive collective outcomes such as solidarity, social connection, and shared resilience can be elicited by mutual aid programmes established in the wake of disasters (Drury et al., 2019; Steffen & Fothergill, 2009). Interestingly, this concept bears some similarity to Williams and Drury's (2009) *collective psychosocial resilience*; a term proposed to describe the resilience processes of groups in emergency situations, the assumption being that *"collective reactions to emergencies and disasters are more typically resilient"* (p. 294) and involve cohesion, solidarity, and social support (Drury et al., 2019).

1.4.2 Social Identity and Mental Health

Given that social identities exert considerable influence on an individual's psychology and behaviour, SIT has profound implications for health and wellbeing (Haslam et al., 2009, 2018). Research has shown social identity to demonstrate a range of large and robust effects on health. Positive social identities have been found to represent a reliable predictor of better recovery from depression (Cruwys et al., 2013). Moreover, a study conducted by Greenaway et al. (2016) found a link between increases in social identification over time and lower levels of depression, to the point where the psychological needs of the individual were satisfied, resulting in an increased sense of meaning, control, and self-esteem. Positive social identities have been found to predict better quality of life for individuals post-brain injury (Jones et al., 2011), while social isolation has been implicated in more frequent visits to primary care centres (Cruwys et al., 2018). A lack of social connection has also been shown to have negative implications on MH outcomes (McKenzie et al., 2002) and quality of life (Yanos et al., 2001). Meta-analyses indicate that interventions that succeed in increasing social identification engender physical and MH benefits (Steffens et al., 2021), indicating that social relationships may provide more protection against dying prematurely than exercise or smoking cessation (Holt-Lunstad et al., 2010). Current evidence suggests that these powerful health benefits are attributable to the psychological resources that social identities provide; namely, resources in the form of meaning, a sense of purpose, and support, which have a protective effect on the health of the individual (Greenaway et al., 2016; Jetten et al., 2015; Junker et al., 2019). The capacity for psychological resources to benefit health and wellbeing has been referred to as *"the social cure"* (Jetten, Haslam, & Alexander, 2012); a product of establishing a shared social identity with like-minded others.

A recent study by Cruwys, Stewart, et al. (2020) suggests that, as a theoretical framework, SIT is of particular relevance when it comes to the recovery model, given that identity and social inclusion represent central tenets of recovery. In recent years, the majority of Anglophone countries have placed a growing emphasis on rehabilitation and recovery orientation in MH policy formation (Leamy et al., 2011). Tew et al. (2012) have posited that a primary mechanism through which the recovery model elicits positive outcomes pertains to its capacity to encourage individuals to band together in collectively challenging stigma and other societal barriers to wellbeing. Previous research has also highlighted the capacity for group identification to fill an important need in counteracting the negative outcomes associated with stigma; the social support experienced safeguarding against prejudice or discriminatory behaviours (Crabtree et al., 2010; Turner et al., 1994). Moreover, a large body of social activism literature indicates that collective efficacy is a fundamental precursor to the collective action required to achieve positive social change (McNamara et al., 2013; Muldoon et al., 2017). It makes sense then to propose collective efficacy as an important mediator when it comes to MH, as outlined by Van Zomeren et al. (2008). Recently, Cruwys, Stewart, et al. (2020) added credence to this proposal; they found that identification with community-based recovery-oriented support groups elicits positive MH outcomes by fostering that same sense of collective efficacy among group members – a sense that by working together, they have the capacity to accomplish shared goals.

Research exploring SIT processes in MH settings is reasonably sparse and few studies have adopted a SIT approach to explore relational functioning in inpatient MH facilities. Previous studies have tended to focus exclusively on SU experiences in this context (e.g., Jackson et al., 2009; Kessing, 2020), examining patterns of interaction on the ward (Dunn et al., 1990; Harries et al., 1984) to better understand SU experiences of supporting one another

(Bouchard et al., 2010; Galloway & Pistrang, 2019; Wood et al., 2013). A study conducted by Jackson et al. (2009) examined social identity processes among inpatient SUs and found that while salient in-groups and out-groups were largely context specific, they were to some degree influenced by factors external to inpatient MH group membership. Recent research by Kessing (2020) set forth to further elucidate the nature of the social relations that occur between inpatient psychiatric SUs. They describe how inpatients can construct a collective illness identity through shared experience and use shared experiential knowledge as a means of supporting one another and challenging the status quo.

Alongside the proposed expansion of recovery model ideals to incorporate those at the frontlines of service provision, broadening the focus of SIT in MH research to encompass MHP perspectives may also be worthwhile. Although at present there is a dearth of research exploring social identity processes among MHPs, previous research has illustrated the applicability of SIT in better understanding interdisciplinary teamwork in the context of healthcare provision (Burford, 2012). A recent study demonstrated, for example, that paediatric residents and nurses are more likely to value professional feedback given by members of their own profession more than interdisciplinary feedback (van Schaik et al., 2016). Moreover, a meta-analysis conducted by Kreindler et al. (2012) concludes that social identity exerts considerable influence over how healthcare systems function, proposing SIT as a useful framework for understanding the group dimension of organisational issues; one that can assist in identifying mechanisms for positive systemic change. The need for authentic integration and interdisciplinary collaboration between disparate healthcare providers has long been regarded as a key challenge, where overcoming professional, sectoral, and institutional *"silos"* represents a common theme in healthcare service provision research (e.g., Clancy, 2006; McDonald et al., 2007).

1.5 Integration of Resilience and Social Identity Theory

Since its emergence as construct, resilience has been excessively individualised in its framing as an inherent property or trait of the individual. As the current fourth wave of resilience research unfolds, however, there is a growing recognition of resilience as a dynamic, multidimensional phenomenon that is reliant upon the interaction between multiple interrelated systems. In the last decade alone, researchers have increasingly acknowledged that focusing solely on resilience at the individual level ignores the processes and factors implicated in group resilience following exposure to adversity, thus pre-empting a move towards the prioritisation of collective levels of resilience in the resilience literature (see Drury et al., 2009; Lyons et al., 2016; Norris et al., 2008). Whilst social identity has not yet been thoroughly corroborated as a collective resilience factor, social identification has been shown to benefit the physical and psychological wellbeing of the in-group and its individual members (Detrie & Lease, 2007; Haslam et al., 2018; Jetten, Haslam, & Haslam, 2012; Verkuyten & Lay, 1998), and has been associated with mechanisms involved in group maintenance (Molenaar et al., 2022). Moreover, research has identified the collective resilience factors of social support and collective efficacy as important mechanisms through which social identification can foster positive health outcomes (Avanzi et al., 2015, 2018a, 2018b; Junker et al., 2019). Research similarly has demonstrated that supportive relationships can increase a person's capacity to demonstrate resilience in the face of adversity, thus serving as a protective factor against the subsequent development of adverse MH outcomes (Ozbay et al., 2007).

Social identity research offers an underpinning explanation of community or collective resilience and public responder behaviours. It has previously been proposed that SIT can act as a merger in resilience processes through its capacity to shape collective cognition and action

(Turner, 2010), and recent research has sought to explore social identity as a collective resilience factor and the role it plays in counteracting the ill-effects of environmental stress on individuals and groups (e.g., Erfurth et al., 2021). Van Dick et al. (2017) highlight the need to regard resilience and social identity as complementary pathways or two sides of the same coin in their ability to facilitate positive health outcomes; they note that while the former reduces the negative effects of stress through promoting positive coping, the latter can be actively drawn upon to foster positive outcomes through the capacity for social identification to enhance wellbeing. Indeed a core premise of the social identity approach is that shared identity can equip individuals with strengths and abilities that they alone are unable to access. Since resilience cannot exist in isolation from the social environment, and the relationships that unfold therein, social identity can thus serve as a helpful theoretical framework for conceptualising resilience as a dynamic process that occurs within a context.

1.6 Current State of MH Services in Ireland

At present, Irish MH services are chronically under-resourced across the board; the staffing and funding recommendations previously laid out in *A Vision for Change* (O' Connor, 2006) - a national policy that outlines a framework for the provision of accessible, community-based, specialist MH services for SUs - have not materialised, with many suggesting that urgent action is needed to bring Irish MH services back from the brink of an all-out collapse (O' Connor et al., 2021). Staffing data provided by Ireland's Health Service Executive in December 2019 confirmed that staffing levels in CAMHS, Psychiatry of Old Age, and Psychiatry for People with Intellectual Disability were substantially less than the recommendations outlined in *A Vision for Change*, with staffing levels coming in at 57%, 61%, and 33% lower respectively (see O' Connor et al., 2021). Funding for MH services in Ireland has remained consistently low at

approximately 6% of the country's total budgetary healthcare allocation in comparison to 10-13% in the UK, France, Germany, the Netherlands, Sweden, and New Zealand (College of Psychiatrists of Ireland, 2018; Cullen et al., 2017). This funding shortfall persists despite the recommendation outlined in *A Vision for Change* for government spending on MH in Ireland to represent 8% of overall healthcare expenditure by 2016; with the recently published *Sláintecare Implementation and Action Plan 2021 to 2023* (Department of Health, 2021) setting a target of 10% to be reached by 2025. Mental Health Reform have expressed concerns regarding this recently established 10% target, suggesting that it does not go far enough and is reflective of the low priority given to MH in the overall *Sláintecare* strategy (2021).

Ireland's resource-scarce MH service has recently been described as an outlier in the context of psychiatric care when compared to other European countries; chronic service inefficiencies mean that there are 22 adult acute MH beds per 100,000 population in contrast to the EU mean of 70 per 100,000 (Irish Hospital Consultants Association, 2021). These figures mean that Ireland currently has the third lowest number of psychiatric beds in all of Europe (Eurostat, 2017). Moreover, nearly 2000 children and young people currently populate waiting lists for CAMHS and, as of January 2020, there were more than 10,000 people on Primary Care Psychology waiting lists, with a third already waiting for over a year (Mental Health Reform, 2021). Today, there are fewer staff working in MH services in Ireland than in 2008, with only 78% of MHPs required in post as per *A Vision for Change* recommendations (Mental Health Reform, 2021).

1.7 Implications of Covid-19 on Mental Health Systems

As societies the world over contend with the unprecedented collective challenge posed by the Covid-19 pandemic, it has been suggested that its psychosocial repercussions will outlive

the acute medical crisis by a considerable margin (Kumar & Nayar, 2021; Wang et al., 2020). Some posit that the secondary effects of the pandemic such as increased unemployment, poverty, and social inequality will extend outward into the future (Banks et al., 2021).

Although the evidence concerning the impact of Covid-19 on MH is in its infancy and ever evolving, preliminary research suggests that the acute MH burden of Covid-19 is substantial, irrespective of whether people had been exposed to the pathogen or not. Following infection with Covid-19, some have cited a prevalence of depression, anxiety, psychosis, delirium, cognitive impairment, insomnia, and post-traumatic stress disorder (Kotfis et al., 2020; Romanò, 2020; Salins et al., 2020; Zambrelli et al., 2020). A recent review of high-quality MH studies commissioned by the Lancet's Covid-19 Commission Mental Health Task Force confirms that average levels of anxiety and depression, as well as a broader sense of psychological distress increased dramatically during the early stages of the pandemic, as did the number of clinically significant presentations of these conditions (Aknin et al., 2021). The review illustrates that reported rates of depression in the US and Norway during March and April of 2020 saw three-fold increases compared to averages from previous years (Ebrahimi et al., 2021; Ettman et al., 2020). Moreover, a longitudinal probability survey by Pierce et al. (2020) consulted more than 50,000 individuals across the UK and found that 27% exhibited clinically significant levels of psychological distress during the early stages of the pandemic in comparison to 19% prior to the onset of Covid-19.

Alongside the general public, the pandemic also poses psychosocial risks to those at the frontlines of service provision at a time of unprecedented upheaval. When one considers the strain placed on global healthcare systems as a consequence of Covid-19, it is unsurprising that healthcare workers as a societal grouping have been disproportionately impacted by the virus when it comes to rate of infection and mortality (Bandyopadhyay et al., 2020; Erdem &

Lucey, 2021). The Covid-19 pandemic placed a unique challenge on the health and social care workforce that disrupted both their usual workplace duties and their social context (Markwell et al., 2020), leaving them more vulnerable to experiencing significant psychological distress as a direct consequence of the public health crisis (De Kock et al., 2021). MH service provision has been similarly disrupted due to Covid-19, and increased levels of stress and burnout have been reported among an already vulnerable professional cohort; a process informed to a large extent by abrupt work-related changes, fear of contagion, and problems maintaining acceptable standards of care when caring for people with severe or enduring MH issues (Johnson et al., 2021).

Whilst the more long-term MH consequences of the pandemic remain to a large extent unknown, research in this area continues to evolve at a rapid pace. The previously mentioned Lancet Covid-19 review does offer a glimmer of hope, however, in its observation that with the onset of summer in 2020, levels of depression, anxiety, and psychological distress began to stabilise (Robinson et al., 2021), with some figures suggestive of overall distress returning to pre-Covid-19 levels (Daly & Robinson, 2021). Aknin et al.'s (2021) review indicates that many individuals demonstrated a capacity to withstand the psychological challenges that accompanied the early stages of the pandemic, paying tribute to humanity's apparently durable psychological immune system. While the Lancet review suggests the negative MH implications might be less than previously expected, the authors strike a cautious tone in their acknowledgement of a global picture that continues to unfold. Moreover, they also make the point that most of the evidence reviewed was collected early in the pandemic (Aknin et al., 2021).

Certainly, for some, the MH consequences of Covid-19 are likely to be significant and long-lasting (Jeong et al., 2016; Liu et al., 2012). Thus, it is vital that MH service provision is not

ignored; a temptation may exist from a governance standpoint to do so given the extent to which public health expenditure has been redirected towards tackling the acute medical crisis arising from Covid-19. From an Irish standpoint, Burke et al. (2020) posit that the Irish public require increased access to localised MH services to meet an increase in levels of psychological distress associated with the pandemic, suggestive of a need for increased investment in MH systems. Mental Health Reform (2021) report that the pandemic has had a significant impact on Irish people's MH and demand for services and supports has increased significantly, noting that this has only served to highlight the longstanding deficits that permeate Ireland's MH service. The IHCA (2021) similarly confirm that Covid-19 has impacted the timely delivery of psychiatric care; an outcome that is likely to pre-empt longer hospital stays for SUs with severe mental illnesses. They also cite the potential for longer waiting lists for diagnostics and treatment in other areas of medicine to have a cascading effect on psychiatric care due to the increased likelihood for SUs to develop secondary MH symptoms. Given that knowledge of the psychosocial consequences of Covid-19 continues to evolve, notwithstanding the longstanding challenges endemic to MH service provision, MHP resilience represents a timely area of investigation; one that may help in the amelioration of occupational stress, and its negative consequences, among this professional cohort as the post Covid-19 era comes into view.

1.8 Thesis Objectives and Research Questions

This thesis is composed of two studies that contribute to an overall understanding of the factors that influence MHP resilience processes. This introductory chapter highlights the many challenges encountered by this professional cohort in fulfilling their professional obligations, while also exploring the application of resilience and social identity processes in MH. Furthermore, the implications of Covid-19 for MH service provision are explored in depth.

This thesis therefore considers factors of relevance across all these levels, to develop a comprehensive understanding of the experience of MHPs working in approved centres in Ireland during the Covid-19 pandemic. Furthermore, it recognises that there is a need to broaden our understanding of resilience as a dynamic and multidimensional construct in the context of MH service provision through a systematic investigation of qualitative empirical literature exploring MHP experiences of resilience in their work. A qualitative perspective would help shift the focus away from an overreliance on preconceived variables that conceptualise resilience in terms of an innate psychological construct; the use of which are of questionable merit given the ongoing conceptual evolution of resilience as a construct. Instead, an in-depth exploration of how MHPs come to understand and experience resilience in the fulfilment of their professional obligations may help further elucidate the conceptual underpinnings of resilience when applied to MH.

It also identifies social identity as an important consideration as societies band together to overcome the collective threat posed by Covid-19; social identity theory represents an overlooked area of research in the context of approved centres to date and a MHP perspective has been lacking. Moreover, this thesis recognises the importance of exploring the experiences of frontline MHPs working in Irish approved centres during Covid-19 to better understanding how an unprecedented, novel public health crisis of this scale impacts on service providers. In doing so, this thesis explores whether Covid-19 has inadvertently stimulated intra or intergroup social identity processes in these settings.

The two studies included are as follows: (1) A systematic review of qualitative research exploring MHP experiences of resilience in their delivery of MH services; (2) A qualitative study exploring the experiences of MHPs working in regional approved centres during Covid-19 using a SIT approach. Chapters Two and Three of this thesis details each of these two studies. In

Chapter Four, overall findings from the two studies are discussed in the context of an integration of theories relating to resilience and social identity.

1.9 Positioning of the Thesis

It is important that I acknowledge some unexpected developments that informed my doctoral journey and the trajectory of my thesis. Initially, I had hoped to base my thesis on the recovery model, a subject of particular interest to me as I had previously undertaken research on Open Dialogue, a recovery-oriented model of mental healthcare originating in Western Lapland. Thus, my proposed research project was to be a qualitative empirical study entitled, *An exploration of perceptions of the core principles of the recovery model, and their implementation, in regional Irish inpatient psychiatric hospitals*, and my signed research feasibility statement was duly submitted to the course team in January of 2020.

In the months that followed, I set about drafting a comprehensive systematic review protocol entitled, *Perspectives on Mental Health Recovery: A systematic Review of Qualitative Research*, confident that I now had the skeleton for what would become Chapters 2 and 3 of my doctoral thesis. My confidence would have been well founded were it not for the onset of a novel coronavirus pandemic; an unprecedented global event that understandably rendered my proposed research topic untenable, as was communicated to me by onsite collaborators. Although disappointing on a personal level, this development paled in comparison to the macro level existential threat posed by Covid-19 and its societal implications. And so it was back to the drawing board to draft a revised research proposal or thesis version 2.0; a process that required much soul searching if truth be told. As Theodore Roosevelt once posited, *"nothing worth having comes easy;"* an astute observation that perfectly sums up this process. A new research proposal was indeed drafted soon thereafter in July of 2020, and its feasibility

subsequently confirmed. I owe a debt of gratitude to my primary academic supervisor, COC, for being a steadying influence at this time.

As I set about working on the lengthy National Research Ethics Committee for Covid-19-related Research (NREC Covid-19) application form, I was buoyed by the new exciting direction that my thesis had taken. Prior to completing the application, however, I was unexpectedly requested to complete a full Data Protection Impact Assessment (see Appendix G), which delayed my ethics submission to the NREC Covid-19. As this was a temporary Covid-19 related ethics pathway that was to be dismantled soon thereafter in early September, I accepted that this ship had sailed. Nevertheless, after DPIA approval was granted in October, 2020, ethical approval was then sourced via a conventional Research Ethics Committee and granted in November, 2020. While this was a most welcome development, the celebration was short-lived as structural developments at a local organisational level had implications on site access. The future of my thesis was once again draped in a fog of uncertainty. As more delays followed, I began to question whether this revised enterprise too was destined not to take flight. To my eternal relief, data collection commenced in earnest in May of 2021. As chance would have it, my first interview coincided almost to the day with the now infamous HSE ransomware attack, the most significant cybercrime attack on an Irish state agency to date. Granted that this temporarily impeded my recruitment of a sample entirely made up of HSE professionals, my increased tolerance for the unexpected stood me in good stead; an outcome perhaps reflective of a valuable meta-skill acquired from living during a global pandemic.

Chapter Two

Resilience and mental health professionals: A systematic review of qualitative empirical literature on practitioner experiences of resilience in their work

Abstract

Mental health professionals work in challenging settings that can elicit high levels of stress. Burnout has been identified as an emergent critical issue that is said to affect this professional cohort more than most. Recently, there has been a growing acknowledgement of resilience as a multidimensional phenomenon; one that involves the dynamic interaction between multiple complex systems in promoting positive adaptation to hardship. This systematic review collates, evaluates and synthesises the qualitative research that has explored mental health professionals' experiences of resilience in their work. Thematic synthesis of their findings outline the multifaceted ways that a diverse sample of mental health professionals experience resilience in the context of their practice, identifying the following themes: resilience in relationship, resilience in equilibrium, resilience in bloom, and resilience in meaning. Resilience is described in terms of an interactive process that is heavily influenced by interpersonal relationships, personal meaning-making processes, and experiential learning; the latter facilitated to a large extent by reflective practice. Commonalities between interdisciplinary experiences of resilience are discussed, as are the implications on mental healthcare service delivery. In systematically illustrating the multiple systems that positively interact with practitioner resilience from the perspective of those at the frontlines of service provision, this review provides an accessible roadmap for researchers, practitioners, and mental healthcare service providers interested in how to promote and sustain resilient practice among frontline mental health workers.

KEY WORDS: mental health, mental health practitioner, resilience, wellbeing, qualitative, systematic review, mental health systems

2.1 Introduction

In recent years, there has been renewed interest in the concept of resilience and its applicability across a range of settings (Everly & Lating, 2013; Fullagar & Kelloway, 2009; Pipe et al., 2012; Wagnild & Young, 1993). Although definitions of resilience can vary, most can be placed in either of the following two categories: those conceptualising resilience as an innate personal characteristic that promotes adaptive coping in the face or hardship or adversity (e.g., Ahern et al., 2008; Connor & Davidson, 2003; Hu et al., 2015) and those that recognise resilience as a dynamic process that involves positive adaptation to adversity (Luthar et al., 2000), operating interactively across multiple dimensions (e.g., Curtis & Cicchetti, 2007; Hill et al., 2018).

Mental health (MH) has long been considered an inherently challenging area in which to work (Rössler, 2012; Zarea et al., 2013). Recently, the impact of burnout on global healthcare systems has been identified as an emergent critical issue, with no area more adversely impacted than MH (Morse et al., 2012). Alongside burnout, issues like secondary traumatic stress, compassion fatigue, organisation uncertainties, resource shortages, excessive workloads, and prolonged exposure to workplace stressors are routinely associated with the MH workplace (Aiken et al., 2002; Braun et al., 2010; Bride & Figley, 2007; Cleary et al., 2010; Huxley et al., 2005; Kindy et al., 2005; McGeorge et al., 2000; Rössler, 2012; Yadav & Fealy, 2012) and risk compromising the provision of high standards of care (Barnett et al., 2007; Hall et al., 2016).

McCann et al. (2013) posit that resilience relates to a mental health professional's (MHP) capacity to maintain personal and professional wellbeing in highly demanding work environments; a process that involves dynamic interactions between personal and external resources (King & Rothstein, 2010). Rössler (2012) notes that as the incidence of MH difficulties

increases in the community, so too does the pressure on those providing the care; an important observation today as societies the world over contend with the psychosocial repercussions of the Covid-19 pandemic. Some have suggested that ramifications of this nature will outlive the acute medical crisis by a considerable margin (Kumar & Nayar, 2021; Wang et al., 2020). On this basis, improving our understanding of resilience factors in MHPs represents a crucial and timely area of empirical investigation; one that can help counteract stress, and its negative consequences, among this cohort as the post Covid-19 era comes into view.

Although there is growing empirical interest in the efficacy of resilience training programmes in healthcare settings generally, relatively little attention has historically been given to the promotion of health and wellbeing among MHPs (Morse et al., 2012). Recently, systematic reviews have been published on resilience in specific MH professions such as MH nursing (e.g., Foster et al., 2019) and psychiatry (e.g., Howard et al., 2019). The former review describes resilience as a developing concept in MH nursing; the authors note that existing literature has primarily focused on MH nurse resilience as an individual trait or attribute rather than exploring environmental factors that influence their resilience. Howard et al.'s (2019) review illustrates that a combination of workplace, personal, and non-workplace factors influence psychiatrists' resilience, implying that resilience-building interventions solely targeting the individual would likely fall short of the mark without concurrently taking into consideration contextual factors.

To date there is no review that focuses exclusively on qualitative research in systematically synthesising perspectives on resilience among MHPs as a single cohort. A qualitative perspective is important as it facilitates an in-depth exploration of how MHPs come to understand resilience in the context of their day-to-day professional obligations. Research examining first-hand practitioner experiences of resilience offers insight into how resilience is

promoted among staff working in MH settings. Understanding MHP accounts of factors that impact on their experience of resilience is relevant to the successful future implementation of resilience-building programmes and strategies targeted at this cohort, given their potential to misfire without acknowledging the experiences of those at the coalface of service provision. Moreover, understanding factors that influence MHP resilience in the workplace, and the contexts that are most likely to build and sustain resilient practice, is relevant for a number of interest groups: frontline MHPs, MH service-users (SU) and their families, MH researchers, MH service providers seeking to uphold high standards of care through promoting staff wellbeing and career longevity, and policymakers invested in maximising positive outcomes for MHPs and SUs alike.

2.1.1 Current Research

The current review aims to collate, evaluate, and synthesise published research that utilises qualitative designs to explore MHP accounts of resilience in their work and to develop a comprehensive understanding of factors that influence practitioner resilience according to those on the frontlines of service provision. In doing so, it is anticipated that the review will shed further light on the conceptual underpinnings of resilience. This review sets out to explore the following questions:

1) What is the experience and understanding of resilience among frontline mental health professionals in the context of their daily work?
2) What does current qualitative empirical research tell us about mental health worker resilience processes?
3) What are the commonalities and differences among subjective accounts of resilience?

2.2 Method

Relevant literature was located via a systematic search process that involved searching four key databases utilising a predetermined search strategy (see table 2.1). Previously utilised search terms in published systematic reviews (ex: Foster et al., 2019; Howard et al., 2019) were incorporated into this search strategy where applicable. In searching databases, sensitivity was prioritised over specificity; a decision was made not to restrict searches to Title/Abstract across databases in an effort to broaden the search scope in a manner consistent with previous reviews of qualitative empirical studies (e.g., O' Connor et al., 2018).

A narrative evidence synthesis method was employed by this review to address the aims of this study as per the guidelines established by Briner and Denyer (2012). In doing so, the following five steps were strictly adhered to: 1) planning; 2) structured searching; 3) evaluating the relevance of material against established eligibility criteria; 4) analysis involving thematic coding; and 5) reporting on findings. Narrative synthesis was employed as it is regarded as an effective way to identify the story that underpins a distinct body of evidence; it achieves this by affording reviewers sufficient flexibility to identify and develop themes that bring coherence to qualitative data (Briner & Denyer, 2012; Popay et al., 2006).

2.2.1 Data sources

MEDLINE Complete, CINAHL Complete, PsycINFO, and Academic Search Complete databases were searched for titles and abstracts using the search strategy outlined in table 2.1. The following database parameters were incorporated into the search: English Language, Peer Reviewed. While the majority of titles and abstracts were identified through electronic database searching, an additional 77 articles were located by hand-searching the reference lists of included articles, including relevant review articles, and by conducting informal Google

Scholar searches. Data relevant to the study aims were extracted and subjected to rigorous analysis and synthesis.

Table 2.1

Search Strategy

Resilien*	Psychiatr*	Nurs*	Qualitativ*	Knowledge
	Psycholog*	Worker*	Focus group*	Attitude*
	Mental health	Staff	Interview*	Understanding*
		Clinician*		Expectation*
		Team*		Impression*
		Care coordinator*		Perception*
		Personnel*		Perspective*
		Employee*		Experience*
		Leader*		Thought*
		Manager*		Belief*
		Occupational therap*		View*
		Speech and language therap*		Account*
				Conceptuali*
		Social work*		Opinion*
		Psycholog*		Viewpoint*
		Psychiatr*		Insight*
				Discourse*
				rhetoric

2.2.2 Study characteristics

The below table (Table 2.2) utilises the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) search strategy tool for qualitative and mixed methods research as outlined by Cooke et al. (2012) to summarise key aspects of the research question. Importantly, for the purpose of this review, 'Mental Health Professional' was defined by setting (conventional vs. specialist) rather than by discipline. See exclusion criteria in 2.2.3 for additional details.

Table 2.2

SPIDER search string strategy

Sample	Previous and current mental health professionals (working in primary, secondary, or tertiary care, students in professional training)
Phenomenon of **I**nterest	Descriptive conceptualizations of resilience in the context of their work
Design	Interviews, focus groups, diary studies, analysis of consultation or meeting transcripts
Evaluation	Expressed knowledge, attitudes, beliefs, perceptions, or self-reported experiences of resilience
Research Type	Qualitative

2.2.3 Inclusion and Exclusion Criteria

Inclusion criteria for studies were determined in advance and included the following: Peer reviewed original empirical qualitative research, including mixed method studies, published in the English language that explored MHP's descriptive conceptualisations of resilience in the context of carrying out their work. Empirical qualitative research that consulted MHPs as part of a wider sample population, for example, where SU perspectives were concurrently investigated, were eligible for inclusion. Student only studies that consulted students in professional training were included.

Articles not in English, non-peer-reviewed articles, literature reviews, dissertations, book chapters, conference proceedings, and other grey literature were excluded. Other exclusion criteria included the following: studies where MHPs did not make up a portion of the participant sample; studies that included MHPs and other healthcare workers, but didn't

discriminate between them in their findings; studies that assessed the effectiveness of workplace resilience training programmes, apps, or interventions from the perspective of MHPs; studies that explored MHP perspectives on factors that influence SU resilience; studies where the participant sample consisted of MHPs working in specialist settings or for specialist services (for example, psycho-oncology, palliative care, forensic or correctional facilities, specialist services for asylum seekers and/or refugees, trauma settings, domestic violence, aged care settings, Intellectual Disability services, war veteran support); studies where the participant sample was made up of a broad category of emotional workers (for example, school counsellors, call-centre workers, first responders, guidance counsellors) that did not work within a MH service framework; systematic review studies; studies that performed a synthesis of existing systematic reviews; doctoral theses; and commentary or opinion pieces.

2.2.4 Screening

The initial screening of abstracts and titles was conducted using Covidence, an electronic application for systematic reviews and meta-analyses that facilitates the independent review of articles for inclusion (Covidence, n.d.). A total of 7160 studies identified via electronic searches were initially imported into Covidence and 1780 duplicates were subsequently removed. 77 additional records were identified through other sources. Titles and abstracts of 5457 papers were independently inspected by one researcher, CH, to establish relevance to the research question. This involved identifying articles that satisfied the inclusion criteria and excluding clearly irrelevant articles. A second researcher, COC, independently crosschecked a random subsample (15%) of identified titles and abstracts to ensure reliability. Similarly, a third researcher, EH, independently crosschecked a further random subsample (10%) of identified titles and abstracts; this meant that 25% of identified titles and abstracts

were independently crosschecked by additional researchers. Reviewers agreed on 99% of articles (Cohen's κ = 0.9). Any articles on which there was disagreement were automatically included for full-text screening. The full text of all retained articles was subsequently obtained and inspected for eligibility, according to the inclusion and exclusion criteria. All 168 full-text articles were independently inspected by one researcher, CH, and any ambiguous cases were reviewed by COC for a second opinion. Reasons for exclusion were noted on a customised eligibility checklist and a total of 26 articles were included for review.

2.2.5 Analysis and quality appraisal

Data were extracted from each article and included the following: study characteristics (year of publication; country of data collection; setting of data collection; availability of data; ethical considerations); methods (study design); participant information (participant professions; sample size); outcome of interest (self-reported experiences of resilience); and study findings relevant to the review questions (i.e. results and author interpretations).

Since the review focused exclusively on qualitative empirical research, studies were evaluated using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) prior to inclusion in the review. This quality framework considers the various stages and processes that inform qualitative empirical enquiry to determine the contribution, rigour, and credibility of individual studies.

Narrative synthesis was used to analyse extracted data (Popay et al., 2006). Tabulation was employed to present study characteristics including country, healthcare setting, participant group, design, sample size, and bibliographic information. The complete set of results across studies and relevant segments of text from the discussion sections pertaining to participant self-reported descriptions of resilience were extracted and subjected to an

inductive thematic analysis (Frith & Gleeson, 2004) in accordance with the procedure outlined by Braun and Clarke (2006). This process involved identifying meaningful text segments relevant to the research questions, subsequent systematic code generation and grouping of related text segments into analytic categories or themes with provisional definitions. Themes were coded at a descriptive level with little attempt to infer meaning. Given the researcher's background in the area of clinical psychology, any pre-existing biases regarding resilience processes in MHPs were considered via a reflective process. A critical realist epistemological stance was taken by the researcher in the interpretation of extracted data. In doing so, the possibility of alternate accounts of phenomena was accepted (Maxwell, 2012) and the influence of the social context over how individuals meaningfully interpret their lived experience acknowledged (Braun and Clarke, 2006).

The second researcher (COC) provided credibility checks through regular independent examination of the coding and thematic mapping generated by the principal analyst (CH). This was supplemented with the regular comparison of individual analysis of pre-selected fragments of text throughout the data analytic phase to promote consensus and resolve discrepancies through in-depth discussion. Analysis was undertaken using NVivo QSR qualitative analysis software, Version 12.

2.3 Results

2.3.1 Results of Literature Search

Following screening, a total of 26 articles were included in this review. Figure 2.1's PRISMA Flow Diagram (Moher et al., 2009) presents the number of articles excluded at each stage. Table 2.3 lists the studies included.

Figure 2.1

Results of the systematic search and screening of citations based on PRISMA guidelines (Moher et al., 2009)

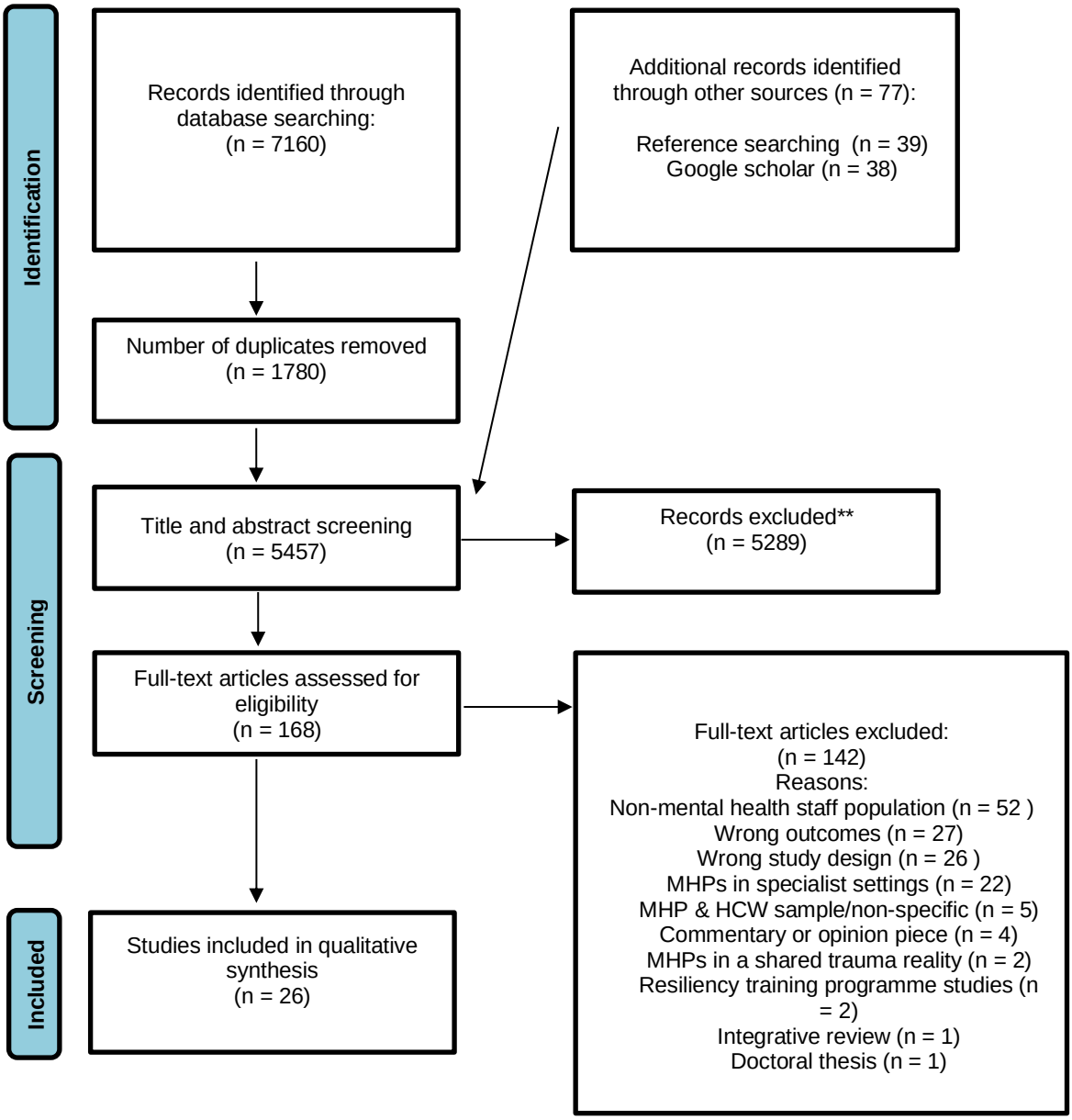


Table 2.3

Summary of papers included in the review

Paper No.	Authors	Region	Sample Make-Up	Sample Size	Clinical Experience	Data Source	Analysis	JBI Quality Rating
1	McMahon (2018)	Ireland	Clinical Psychologists	N = 4	5 - 10 years post-qualification clinical experience	Unstructured and exploratory in-person interviews	Interpretative Phenomenological Analysis (IPA)	20 (High Quality)
2	Carmichael et al. (2020)	UK	Clinical Psychologists	N = 7	28.6% = 5 – 10 years since qualified 28.6% = 2 – 5 years since qualified 42.8% ≤ 2 years	Demographics questionnaire; reflective diary on specific clinical events over a three-week period; semi-structured interviews	IPA	18 (High Quality)
3	Adamson et al. (2014)	New Zealand	Social Workers; health social workers, mental health social workers & social work student supervisors	N = 21; MHSW (N ≥ 9)	Practitioners with ≥ 3 years' experience; Student Supervisors = qualified social workers with 5 – 30 years of post-qualification practice experience (note: only mental health social worker data was included in this review)	Semi-structured interviews	Thematic Analysis (TA)	16 (Moderate Quality)
4	Wampole and Bressi (2020)	Pennsylvania, USA	Registered nurses employed at the inpatient psychiatric unit working in direct care, non-managerial roles	N = 5	Mean = 13 years; Range of 5 - 30 years	written survey of open-ended questions	Content Analysis	11 (Low Quality)
5	Foster et al. (2018)	Australia	Registered nurses working in mental health subdivided into two participant groups: 1) those who participated in a mental health service-initiated resilience programme (Promoting Adult Resilience) & 2) those who delivered the programme	N = 29	≤5 - ≥20 years in current role/years in a mental health setting	Semi-structured telephone interviews, focus groups, open-ended written data	TA	18 (High Quality)

Paper No.	Authors	Region	Sample Make-Up	Sample Size	Clinical Experience	Data Source	Analysis	JBI Quality Rating
6	Gevaux and Petty (2018)	UK	Focus group N = 7 (not otherwise specified, clinical team members who later participated in card sorting tasks); card sorting tasks N = 25 - 14 support workers, 6 mental health nurses, 2 clinical managers, 1 assistant psychologist, 1 occupational therapist and 1 activities coordinator	Focus group (N = 7); Card-sorting tasks (N = 25)	N/A not disclosed	Preliminary focus group (supplemented by brief scoping review of current literature), two card sorting tasks	Content Analysis	18 (High Quality)
7	Wharne (2020)	UK	1 X social Worker employed in community mental health services; 1 X senior counselor in a primary mental health service; 1 X counselor employed in primary care counseling services/completing a doctorate in counseling psychology; 1 X team leader for a community mental health team/registered mental health nurse	N = 4	N/A not disclosed	Semi-structured interviews	An interpretive hermeneutic analysis & a descriptive phenomenological account	18 (High Quality)
8	Brolese et al. (2017)	Brazil	psychiatric hospital staff sample: Qualitative = 27 X nurse technicians, 5 X physicians, 4 X nurses, 1 X pharmacist, 1 X social worker, 1 X psychologist, 1 X physical educator; Quantitative = 3 X nurse, 14 x Nurse technicians, 5 X physicians, 1 X pharmacist, 1 X social worker, 1 X psychologist, 1 X physical educator.	Quant (N = 40); Qual (N = 26)	Mean/SD = not disclosed; ≤ 1 year (40%), 1 - 5 years (10%), 6 - 10 years (20%), ≥ 10 years (30%).	Quantitative (cross-sectional design); Qualitative interviews	Grounded Theory	16 (Moderate Quality)
9	Hurley and O' Reilly (2017)	Canada	front-line Assertive Community Treatment (ACT) clinicians that included 4 X social workers (SW), 3 X registered nurses (RN), and 3 X occupational therapists (OT)	N = 10	Mean = 12 years, range 3 - 30 years (working in mental health); Mean = 8 years, range 1 - 16 years (working on an ACT team)	Interviews	IPA	17 (Moderate Quality)
10	De Lange and Chigeza (2015)	South Africa	psychotherapists: clinical (four), counselling (two) or educational psychologists (one participant)	N = 7	13 - 20 years full-time private practice	Interviews	Narrative Analysis	14 (Moderate Quality)

Paper No.	Authors	Region	Sample Make-Up	Sample Size	Clinical Experience	Data Source	Analysis	JBI Quality Rating
11	Barton (2020)	UK	female counsellors who were qualified to at least BA Level currently participating in an MA Counselling training programme	N = 5	at least 8 years' experience in practice	Exploratory, semi-structured interviews	IPA	14 (Moderate Quality)
12	Bowden et al. (2015)	UK	Mental health link-workers from a variety of professional backgrounds - They were 'front line' staff in that they were usually the first point of contact for people with mental health difficulties. They also worked at the interface between primary care and secondary mental health services providing mental health assessments and brief interventions for individuals and signposting to other services when indicated. Link-workers also offered specialist guidance to primary care staff on how to manage mental health difficulties in primary care. They were frequently the only mental health professional in a primary care setting.	N = 9	N/A not disclosed	Interviews, focus groups	Grounded Theory	18 (High Quality)
13	Lamb and Cogan (2016)	UK	focus group 1 = Samaritans volunteers; focus group 2 = four clinical psychologists, two trainee clinical psychologists, one counsellor, and two clinical associates in applied psychology.	N = 17; focus group 1 (N = 8), focus group 2 (N = 9)	Focus group 1: work related experience range = 6 months - 25 years (Mean = 8.88 years); Focus group 2: work-related experience range of 3–17 years (mean = 7.11 years)	Focus groups x 2	IPA	17 (Moderate Quality)
14	Ashby et al. (2013)	Australia	Occupational therapists with more than two years' experience in mental health and who had worked in more than one workplace	N = 9	mean number of years worked in mental health practice = 14.3 years; range = 5–35 years	Interviews	Narrative Thematic Analysis	14 (Moderate Quality)

Paper No.	Authors	Region	Sample Make-Up	Sample Size	Clinical Experience	Data Source	Analysis	JBI Quality Rating
15	Hou and Skovholt (2020)	USA	practicing therapists: 7 x licensed psychologists (PhD/PsyD), 2 x licensed marriage and family therapists (MS/MSE), and 1 x licensed social worker (MSW)	N = 10	Mean/SD = not disclosed; 6 participants > 20 years post degree clinical experience; 4 participants > 10 years' experience.	Semi-structured interviews; demographics questionnaire	Grounded Theory	20/20 (High Quality)
16	Fischer et al. (2007)	New Zealand	practicing psychiatrists in New Zealand	N = 12	N/A not disclosed	Semi-structured interviews	Grounded Theory	17/20 (Moderate Quality)
17	Huxley et al. (2005)	UK	mental health social workers	N = 237	Mean = 11.9 years' experience; SD = 8.7 years' experience (since social work qualification); Age Range = not disclosed	Postal questionnaire (free text responses); diary relating to the working week; Questionnaire and Diary content informed by 2 focus groups involving MHSWs from a South London mental health trust	TA	14/20 (Moderate Quality)
18	Deborah et al. (2020)	Ghana	registered psychiatric nurses	N = 24	Mean = not disclosed, SD = not disclosed; Range of experience = 5/10 participants had 6 - 8 years' working experience	Semi-structured interviews	IPA	16/20 (Moderate Quality)
19	Davison et al. (2019)	New Zealand	psychiatry registrars	focus group 1 (N = 5); focus group 2 (N = 4); Meeting minutes = 12 sets of minutes between 2014 and 2016; independently produced researcher vignettes (N = 5)	Mean/SD = not disclosed; all participants psychiatric registrars	Three data sources: 1) 'stress' vignettes written by Stage 3 trainees; 2) minutes of regular registrar meetings; 3) focus groups	Grounded Theory (abbreviated)	19/20 (High Quality)

Paper No.	Authors	Region	Sample Make-Up	Sample Size	Clinical Experience	Data Source	Analysis	JBI Quality Rating
20	Prosser et al. (2017)	Canada	acute psychiatric nurses	N = 4	M/SD = not disclosed; range of experience in an acute psychiatric hospital setting = 2 - 16 years, while practice as a registered nurse ranged from 2 - 21 years	Semi-structured interviews	IPA	19/20 (High Quality)
21	Edward, 2005	Australia	All participants were mental health clinicians currently working in the area of mental health crisis care; participants were recruited from the disciplines of nursing [4Ps], allied health [1P] and medicine [1P]	N = 6	N/A not disclosed	Interviews	IPA	17/20 (Moderate Quality)
22	Roebuck and Reid, 2020	UK	trainees in the latter halves of psychotherapy, counselling and counselling psychology postgraduate degrees and had been seeing clients for at least 6 months	N = 4	M/SD = not disclosed; all participants had been client facing for at least 6 months	Semi-structured interviews	IPA	20/20 (High Quality)
23	Marie et al. (2017)	Palestine	nurses working in community mental health centers in Palestine	N = 15	N/A not disclosed	32 hours of observations in two community mental health centers. Multiple local workplace and operational documents; Interviews	TA	18/20 (High Quality)
24	Ragusa and Crowther (2012)	Australia	mental health nurses from geographical areas classified as rural and remote using the ARIA index	N = 32	N/A not disclosed	Focus Groups	Grounded Theory	14/20 (Moderate Quality)
25	Hurley and Kirwan (2020)	Ireland and Canada	practicing social workers on community mental health (CMH) teams	Irish CMH social workers (N = 10); Canadian social workers on Assertive Community Treatment teams (N = 10)	N/A not disclosed	Semi-structured interviews	IPA	20/20 (High Quality)
26	Ramalisa et al. (2018)	South Africa	professional nurses working in a psychiatric ward for a period longer than three months	N = 24	working in a psychiatric ward for a period longer than three months	Demographic info; written narratives to open-ended questions	TA (deductive)	16/20 (Moderate Quality)

2.3.2 Quality assessment scores

Total JBI Critical Appraisal Checklist scores for each article were averaged; scores of 12 or below were interpreted as low-quality, scores of 13-17 were interpreted as moderate-quality, and scores of 18-20 were interpreted as high-quality. Table 2.4 illustrates the aggregate assessment scores across relevant domains of the JBI Critical Appraisal Checklist rather than study level assessment. Twelve articles (46%; n = 12) were evaluated as high-quality, thirteen articles moderate-quality (50%; n = 13) and one low-quality (4%; n = 1). None met the predetermined threshold for unacceptably low quality meriting exclusion from the review (total score < 10).

Table 2.4

Quality Appraisal using the JBI Critical Appraisal Checklist

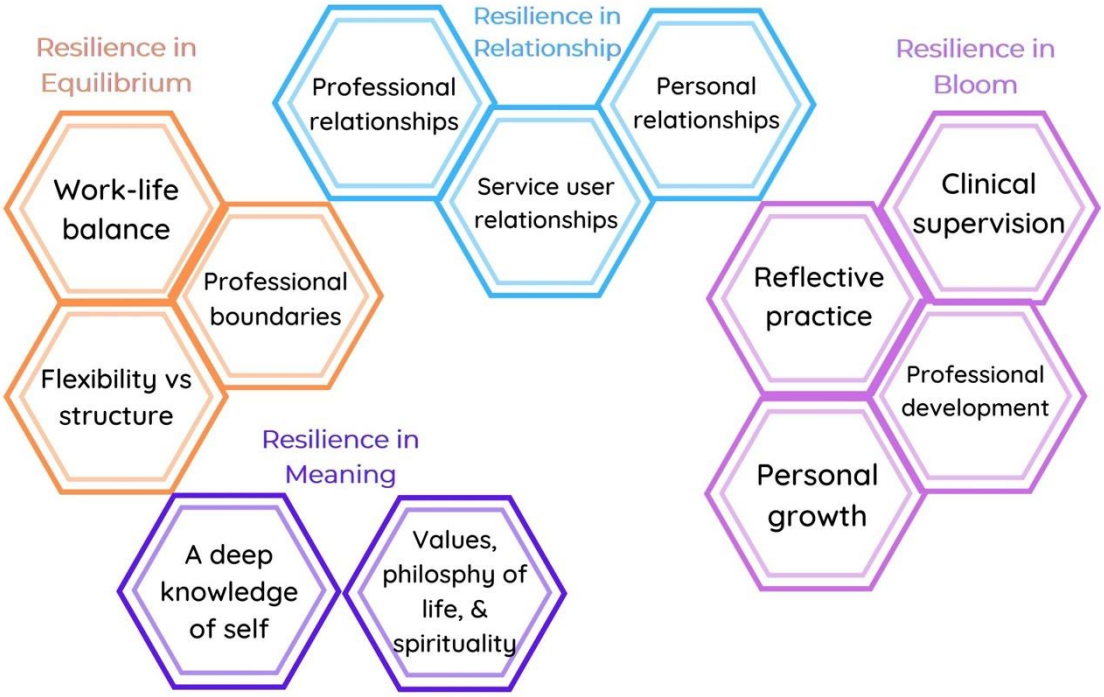
Quality Appraisal criterion	Yes	No	Unclear
1. Is there congruity between the stated philosophical perspective and the research methodology?	24 (92%)	2 (8%)	
2. Is there congruity between the research methodology and the research question or objectives?	25 (96%)		1 (4%)
3. Is there congruity between the research methodology and the methods used to collect data?	22 (84%)	2 (8%)	2 (8%)
4. Is there congruity between the research methodology and the representation and analysis of data?	22 (84%)		4 (16%)
5. Is there congruity between the research methodology and the interpretation of results?	25 (96%)		1 (4%)
6. Is there a statement locating the researcher culturally or theoretically?	11 (42%)	13 (50%)	2 (8%)
7. Is the influence of the researcher on the research, and vice- versa, addressed?	12 (46%)	10 (38%)	4 (16%)
8. Are participants, and their voices, adequately represented?	22 (84%)	2 (8%)	2 (8%)
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	18 (68%)	4 (16%)	4 (16%)
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	25 (96%)		1 (4%)

2.3.3 Thematic synthesis

Thematic synthesis identified 12 analytic themes. These were organised into four overarching 'super-themes': resilience in relationship, resilience in equilibrium, resilience in bloom, and resilience in meaning. It should be noted that these thematic categories are deployed for parsimonious presentation of the results and do not imply that the data presented therein represent mutually exclusive phenomena. Themes are visually represented in Figure 2.2 and are described below along with illustrative quotes from participants.

Figure 2.2

Themes and sub-themes representing mental health professional experiences of resilience



2.3.4 Resilience in Relationship

This theme relates to the notion of resilience as a relational construct; a shared process that emerges from the interplay between self and other. It emphasises the strong connection between relationship and resilience as perceived by MHPs, where colleagues, SUs, family, friends, and the wider community all feature in this process.

2.3.4.1 Professional Relationships

The capacity for a positive team culture characterised by supportive professional relationships to strengthen practitioner resilience was identified by MHPs in 17 articles (Adamson et al., 2014; Ashby et al., 2013; Bowden et al., 2015; Brolese et al., 2017; Davison et al., 2019; Edward, 2005; Fischer et al., 2007; Gevaux & Petty, 2018; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; Lamb & Cogan, 2016; Marie et al., 2017; Ragusa & Crowther, 2012; Ramalisa et al., 2018; Roebuck & Reid, 2020). Numerous MHPs describe how a positive team culture can facilitate a sense of shared experience among colleagues where no one practitioner shoulders the responsibility alone (Bowden et al., 2015; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017):

> *"Sharing the responsibility is the key thing for me, I'm not alone in working with this person."* (Hurley & Kirwan, 2020, p. 6)

Many MHPs attest to the sense of social cohesion engendered by shared experience among colleagues (Marie, et al., 2017; Ragusa & Crowther, 2012; Roebuck & Reid, 2020). Through having to overcome workplace challenges together as a team, a strong sense of kinship, camaraderie, and solidarity is forged among colleagues:

> *"Nobody understands this job except your colleagues. You can't share it with somebody who doesn't know what it's about."* (Ragusa & Crowther, 2012, p. 49)

MHPs also highlight the role of shared values among colleagues in promoting resilient practice (Fischer et al., 2007; Lamb & Cogan, 2016) and the collective sense of pride that can manifest when practitioners feel personally invested in a team and the service it provides:

> *"… on a personal level there's some ownership as well, there's some ownership of the service we're very proud of it, we've worked very hard, amazingly hard and we've worked within our team, whatever we've achieved we've achieved within our team."* (Bowden et al. , 2015, p. 495)

MHPs highlight the importance of being open to the support of colleagues in safeguarding resilience (Adamson et al., 2014; Brolese et al., 2017; Hou & Skovholt, 2020; Roebuck & Reid, 2020):

> *". . . To stay oriented in this field, I guess it's not a good idea to be a lone wolf. It's a hard job and it's isolating enough as it is. It's important to stay connected."* (Hou & Skovholt, 2020, p. 391-392)

A number of MHPs intimate that the collective resilience demonstrated by a cohesive and supportive MH team can directly influence the resilience of individual practitioners. Numerous MHPs report having learned to become more resilient by observing their colleagues' modelling resilient practice (Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Ragusa & Crowther, 2012). Conversely, the collective resilience exuded by a positive team culture can also serve to strengthen resilient practice among individual practitioners (Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Ragusa & Crowther, 2012); a process seemingly demonstrative of an interdependence:

> *"Having a strong working relationship with colleagues allows … you to feed off their resilience, … from a professional stand point … . kind of collective resilience."* (Hurley & Kirwan, 2020, p. 6)

Many MHPs suggest that a positive team culture that nurtures practitioner resilience has a dual purpose in safeguarding the welfare of both the clinician and SU, thus ensuring that quality of care is not compromised (Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Ramalisa et al., 2018):

> *"You have to have a team that nurtures you and helps you to heal so at the end of the day you don't go home hating every day, so tomorrow you can go forth and bring something healthy to your clients."* (Hurley & O' Reilly, 2017, p. 12)

Alongside the potential to benefit from the support of team members, many MHPs also identify a supportive managerial structure as having the potential to strengthen practitioner resilience (Gevaux & Petty, 2018; Marie et al., 2017; Ramalisa et al., 2018). Others highlight the value of peer support in promoting adaptive coping, where developing formal and informal professional support networks can help maintain professional resilience through regular professional socialisation (Ashby et al., 2013; Bowden et al., 2015; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Ramalisa et al., 2018; Roebuck & Reid, 2020):

> *"I'm allowed to actually meet up on a Monday and go with all my colleagues and have a moan and then a laugh. It sort of sets you up for the week really, yeah that's a real strength of the team I think ..."* (Bowden et al., 2015, p. 494)

2.3.4.2 Service User Relationships

SU relationships were identified by MHPs as a valuable source of practitioner resilience in 11 articles (Deborah et al., 2020; De Lange & Chigeza, 2015; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley, Evans et al., 2005; Lamb & Cogan, 2016;

Ragusa & Crowther, 2012; Ramalisa et al., 2018; Roebuck & Reid, 2020; Wampole & Bressi, 2020):

> *"So it's sort of like for me my resilience is my relationship with these people, and the enjoyment that I get from the time that I get to spend with them and that they're all unique."* (Hurley & O' Reilly, 2017, p. 13)

Numerous MHPs allude to the bidirectional nature of resilience in MH work, describing resilience in terms of a shared process that can facilitate mutually beneficial outcomes for both SUs and MHPs (Deborah et al., 2020; De Lange & Chigeza, 2015; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; Lamb & Cogan, 2016; Ragusa & Crowther, 2012; Ramalisa et al., 2018; Wampole & Bressi, 2020):

> *"if that person can get through that, that people bounce back from diversity or hardships you know, then what's to say I can't get through something that I'm going through? I think it definitely has that knock-on effect."* (Hurley & Kirwan, 2020, p. 9)

Many MHPs attribute the vicarious resilience experienced in their therapeutic work to the strong sense of compassion satisfaction that often comes with helping SUs meet their recovery needs (Deborah et al., 2020; De Lange & Chigeza, 2015; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Lamb & Cogan, 2016; Ragusa & Crowther, 2012):

> *"I love to see people starting to live their life again and knowing that my support has helped."* (Hurley & Kirwan, 2020, p. 8)

Numerous practitioners attest to experiencing high levels of personal accomplishment and satisfaction in facilitating positive SU outcomes and bearing witness to the recovery process (Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; Ragusa & Crowther, 2012; Wampole & Bressi, 2020):

> *"I just love watching people make that recovery, achieving a level of self-awareness feeling 'I can cope with this' it's a lovely feeling to see this, the fact that I've been able to do my job with a level of wellness that impacts on them, even on the bad days I couldn't imagine myself doing anything else."* (Hurley & Kirwan, 2020, p. 9)

A number of MHPs indicate that their regular therapeutic work with SUs enables them to develop greater insight into the mechanisms governing their own wellbeing, which can strengthen resilience (Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017):

> *"Every day I learn something new about life from working with my clients, I feel I have a much deeper understanding of my own mental health which makes me more resilient."* (Hurley & Kirwan, 2020, p. 9)

Although some MHPs suggest that it may be safer for practitioners to engage with SUs at a *"head"* level to bypass the messiness that often comes with *"the heart stuff"* (Foster et al., 2018; McMahon, 2018, p. 222; Wharne, 2020), most report that upholding a sense of emotional authenticity in SU interactions can help sustain resilience (Deborah et al., 2020; Hou & Skovholt, 2020; Huxley et al., 2005; Ragusa & Crowther, 2012; Roebuck & Reid, 2020; Wampole & Bressi, 2020). Many note that such an orientation can strengthen the therapeutic connection by evoking a sense of shared humanity (Hou & Skovholt, 2020; Ragusa & Crowther,

2012; Roebuck & Reid, 2020; Wampole & Bressi, 2020), leading to a greater sense of efficacy as a practitioner, thus promoting resilient practice:

> *"we're all humans with emotions and everyone at one time or another has had that moment of being out of control . . . they just want to feel better somehow."* (Wampole & Bressi, 2020, p. 624)

Some note that adopting a compassionate stance in their work with SUs enables them to remain fully present when working therapeutically and maintain a capacity for empathic engagement over time (Deborah et al., 2020; Hou & Skovholt, 2020):

> *"I think I am really touched and moved when people make progress, and usually I let that show. I think people know I care"* (Hou & Skovholt, 2020, p. 392)

2.3.4.3 Personal Relationships

Numerous MHPs describe how supportive personal relationships outside of work can positively influence their resilience, as identified in 9 articles (Adamson et al., 2014; Barton, 2020; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Lamb & Cogan, 2016; Marie et al., 2017; Ramalisa et al., 2018; Wharne, 2020). Numerous MHPs discuss the importance of weaving a *"web of connectedness"* (Hou & Skovholt, 2020, p. 395) with close family and friends to counteract work-related stresses (Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Marie et al., 2017; Wharne, 2020):

> *"If I ever feel that I need to self-care around client work I will make sure I can go and have a hug from my youngest grandchild. There's something about just holding him—or just being with a five year old—that can really be grounding."* (Barton, 2020, p. 5-6)

MHPs report that close personal relationships can have a replenishing effect on their resilience, representing an important juxtaposition to the inherent complexities often characteristic of relationships cultivated in their professional roles (Barton, 2020; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Lamb & Cogan, 2016; Ramalisa et al., 2018). This allows practitioners to access *"a different thing"* (Hou & Skovholt, 2020, p. 391); it is as though connecting to *"ordinary people with ordinary lives"* (Barton, 2020, p. 6) can support MHPs in maintaining a healthy work-life balance, thereby promoting resilient practice and reducing the risk of boundaries blurring:

> *"I live a [professional] life where I really leave that in large part at the door and come home and be a different person. I connect with my family and get a different thing through that connection."* (Hou & Skovholt, 2020, p. 391)

Several MHPs highlight the protective role of local community support in safeguarding practitioner resilience (Fischer et al., 2007; Marie et al., 2017). As one psychiatrist notes, *"[psychiatrists] who don't have a lot of people in the community are ... more likely to find themselves burnt out."* (Fischer et al., 2007, p. 419)

2.3.5 Resilience in Equilibrium

This theme reflects the importance of achieving balance, equilibrium, or homeostasis in the context of MH work, allowing clinicians to better maintain resilient practice over time. In doing so, it outlines different areas that MHPs believe can help counteract the many stressors associated with their work; areas that should co-exist in harmony with their professional obligations as a means of prioritising wellbeing and avoiding burnout.

2.3.5.1 Work-Life Balance

MHPs emphasised the need for balance between their personal and professional lives in upholding resilient practice in 15 articles (Adamson et al., 2014; Barton, 2020; Bowden et al., 2015; Brolese et al., 2017; Carmichael et al., 2020; Deborah et al., 2020; Edward, 2005; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Lamb & Cogan, 2016; McMahon, 2018; Prosser et al., 2017; Ragusa & Crowther, 2012). Maintaining a healthy work-life balance is strongly associated with resilience as perceived by MHPs, where engagement with personal interests, hobbies, and relationships can protect against MHP burnout:

> *"I have my own life. I have my own friends. I have lots of things outside of work. It's not the be-all end-all. I come here for those eight hours and it ends there, even if I come back or I stay for a double… then it does."* (Prosser et al., 2017, p. 3)

Many MHPs articulate the importance of being assertive in maintaining a healthy work-life balance, emphasising the need for intentionality in this regard (Barton, 2020; Deborah et al., 2020; Edward, 2005; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Prosser et al., 2017). Knowing when to disengage from the professional sphere is identified as a crucial component of this process (Hou & Skovholt, 2020; Lamb & Cogan, 2016) alongside the need for proactivity in creating the space required to accommodate role transitions from the professional to the personal (Barton, 2020; Edward, 2005; Hurley & Kirwan, 2020):

> *"When I get home in the evening the first thing I do is change my clothes, it's sort of a boundary I've created between work and home."* (Hurley & Kirwan, 2020, p. 5)

The importance of separating personal from professional is highlighted in numerous studies as a means of preventing unwanted spill-over of difficult emotions (Adamson et al., 2014; Barton, 2020; Brolese et al., 2017; Hurley & O' Reilly, 2017; Ragusa & Crowther, 2012), with some suggesting that success in accomplishing this demarcation can vary according to work context (Barton, 2020; Ragusa & Crowther, 2012). For example, MHPs living and working rural areas and those working from home appear to face additional challenges in this regard:

> *"I always have access to my work … never ending admin is always on my desk. I've got my study separate from my counselling room, I'm very lucky, but nevertheless it's so easy to have stuff in my living room and all of that, you know, and I think it's challenging to keep personal life separate particularly when you work from your own home."* (Barton, 2020, p. 3)

In 10 articles, MHPs identify self-care as central to the maintenance of a healthy work-life balance (Adamson et al., 2014; Barton, 2020; Bowden et al., 2015; Edward, 2005; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Lamb & Cogan, 2016; Prosser et al., 2017; Ramalisa et al., 2018). Numerous MHPs emphasise the importance of self-care or *"conservation mode"* (Hou & Skovholt, 2020, p. 393) in safeguarding resilience and facilitating ongoing engagement with practice (Adamson et al., 2014; Edward, 2005; Lamb & Cogan, 2016; Prosser et al., 2017; Ramalisa et al., 2018). In order for the caregivers to be in a position to provide high quality care to SUs, they must first ensure that their own self-care needs have been met:

> *"I'm taking care of my own mental health before I'm going to take care of someone else's mental health. So, ensuring that I'm eating right, sleeping right, that if I have any concerns, that I express them at work."* (Prosser et al., 2017, p. 3)

MHPs similarly emphasise the need for proactivity when it comes to enacting self-care strategies (Barton, 2020; Hou & Skovholt, 2020; Lamb & Cogan, 2016) and allowing themselves permission to do so, in moving beyond preconceived notions of self-care as selfish or self-indulgent:

> *"Being kind to yourself … giving yourself permission to put in the time you know every now and then. I think, now I'm allowed to do this. I'm allowed to take an hour out in the garden centre, or you know spend a few hours in the garden, or giving myself permission to do that."* (Barton, 2020, p. 5)

Some MHPs highlight a tendency for management to pay mere lip-service to self-care (Hurley & Kirwan, 2020; Lamb & Cogan, 2016), while others raise concerns about having to develop an understanding of self-care through first-hand experience in the absence of any formalised guidance on the subject (Barton, 2020); a process fraught with hard-earned wisdom following experiences of stress-induced ill-health:

> *"Just the type of people we are as counsellors means that there should be more teaching around self-care. An elastic band can get stretched and stretched and if it gets stretched too much it breaks eventually."* (Barton, 2020, p. 4)

2.3.5.2 Professional Boundaries

MHPs in 12 articles described a boundaried approach to service provision as critical to building and sustaining resilience over time. (Adamson et al., 2014; Barton, 2020; Bowden et al., 2015; Brolese et al., 2017; Gevaux & Petty, 2018; Hou & Skovholt, 2020; Hurley & Kirwan,

2020; Huxley et al., 2005; Lamb & Cogan, 2016; Prosser et al., 2017; Ragusa & Crowther, 2012; Wharne, 2020):

> *"I do have clear boundaries about professional work, about what I do at work, about who I talk about it with and the relationships I have with clients. You must keep those boundaries clear and delineated."* (Adamson et al., 2014, p. 535)

For many, this involves setting reasonable limits and drawing upon internalised strategies to manage high demands (Adamson et al., 2014; Bowden et al., 2015; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Huxley et al., 2005; Prosser et al., 2017):

> *"You regulate yourself and I say sometimes I'm not answering the phone, I'll take a message (…) I just need some time and you can't really control if five people want to speak to you."* (Bowden et al., 2015, p. 495)

Numerous MHPs discuss the importance of respecting boundaries when working therapeutically with SUs (Barton, 2020; Gevaux & Petty, 2018; Prosser et al., 2017; Wharne, 2020). When MHPs *"haven't dealt with [their] own stuff"* (Adamson et al., 2014, p. 535), it can pre-empt the unwelcome intrusion of unresolved personal issues into the clinical realm (Adamson et al., 2014; Brolese et al., 2017; Prosser et al., 2017). Others describe having to strike a balance in cultivating a therapeutic orientation characterised by a sense of boundaried generosity; one that embodies authentic and empathic SU engagement while avoiding enmeshment or overattachment (Hou & Skovholt, 2020). Moreover, setting reasonable boundaries from the outset can help manage expectations about SU agency and recovery:

> *"… people expect someone to fix up all their problems for them whether it's … relationship, drugs and alcohol, whatever. So, rather than having to depend on their own resources, they can go here, there or everywhere because someone is going to help them out."* (Ragusa & Crowther, 2012, p. 52)

In this way, appropriate boundary setting can allow MHPs to avoid the pitfalls of adherence to unrealistic standards of care and facilitate the recognition that it is not always possible or preferable to go above and beyond these boundaries – be they organisational or discipline-specific (Bowden et al., 2015; Prosser et al., 2017):

> *"I think recognizing your limitations is one because that's quite difficult you know it's really quite hard to say to someone there's absolutely nothing I can offer you."* (Bowden et al., 2015, p. 496)

Some MHPs describe the process of having to reconcile their ethos of inclusivity when it comes to alleviating human suffering with the necessity for boundary setting in MH work as challenging:

> *"Whether it's a case of being a bit stricter with our boundaries. Which I think we are going to have to, I mean I think the boundaries to make it manageable is going to have to happen but that's a shame because then I think that's going to lose the ethos of what we do which is to see, I see it as seeing anyone with distress."* (Bowden et al., 2015, p. 497)

2.3.5.3 Flexibility vs Structure

The importance of achieving an optimal balance between flexibility and structure was identified by numerous MHPs as a core contributor to resilient practice, where flexibility

affords practitioners a sense of choice and autonomy in their work (Adamson et al., 2014; Bowden et al., 2015; Davison et al., 2019; Fischer et al., 2007; Hurley & Kirwan, 2020; Huxley et al., 2005; Lamb & Cogan, 2016; Ragusa & Crowther, 2012; Wharne, 2020). Many MHPs describe how choice and autonomy in their roles can have an empowering effect (Adamson et al., 2014; Bowden et al., 2015; Hurley & Kirwan, 2020; Huxley et al., 2005; Wharne, 2020):

> *"It is interesting and varied. I spend most of my time working with clients directly. I like my colleagues. I have a great deal of autonomy and responsibility and am appreciated by my social services team manager and my colleagues. It seems less involved with bureaucracy than many jobs in social services."* (Huxley et al., 2005, p. 1072)

MHPs assert that the perceived lack of control and autonomy that can surface in the absence of flexibility can jeopardise resilience (Davison et al., 2019; Fischer et al., 2007; Lamb & Cogan, 2016; Ragusa & Crowther, 2012). Psychiatrists and psychiatry registrars describe an underlying sense of powerlessness that can emerge when responsibility is retained in the absence of control, which can drain resilience (Davison et al., 2019; Fischer et al., 2007). Several MHPs also highlight the need for flexibility in managing expectations when it comes to SU outcomes to sustain resilient practice (Bowden et al., 2015; Hurley & Kirwan, 2020):

> *"You need to change your mindset of what success is, success could be that they got out of bed or they took out their own garbage, that's a huge success, be happy and grateful and celebrate that."* (Hurley & Kirwan, 2020, p. 6)

Many MHPs identify career mobility as potential means of sustaining resilience and promoting career longevity (Adamson et al., 2014; Ashby et al., 2013; Hou & Skovholt, 2020), where a willingness to remove oneself from sub-optimal working arrangements that jeopardise

resilience can preserve practitioner wellbeing and promote goodness-of-fit between practitioner and role:

> *"If I'm working at systems that do not feel good to me, or if I'm working with people that do not feel good to me, and I'm not able to have some equanimity around that, I'm willing to move."* (Hou & Skovholt, 2020, p. 393)

Importantly, MHPs allude to the need for adequate levels of organisational support to co-exist with flexibility in their roles, where the structure and containment provided at an organisation level can positively contribute to practitioner resilience (Adamson et al., 2014; Davison et al., 2019; Huxley et al., 2005; Marie et al., 2017; Ragusa & Crowther, 2012):

> *"To feel valued by your employers. For them to recognise our job is extremely stressful and that we need protective factors put in place to enable us to work effectively..."* (Huxley et al., 2005, p. 1075)

Moreover, many MHPs allude to the dangers of absolute autonomy in the absence of adequate organisational support, which in their view only serves to drain clinician resilience, leaving individual practitioners feeling as though they bear the sole responsibility for all aspects of care provision. This can instil in MHPs a sense that they are fully accountable in the event of a negative SU outcome (Bowden et al., 2015; Ragusa & Crowther, 2012):

> *"I think that's hard, sometimes you think oh god have I made the right decision, particularly sometimes when you're positive risk taking when you're thinking gosh if this goes horribly wrong then it's on my shoulders."* (Bowden et al., 2015, p. 493)

On the other hand, when the structure imposed on practitioners from an organisational standpoint is perceived as oppressive and overbearing, practitioners are likely to feel disempowered (Bowden et al., 2015; Huxley et al., 2005); this renders them more vulnerable to experiencing feelings of apathy and an overarching sense of futility in their individual roles:

> *"I'm increasingly wondering what the point of my role is—less enthusiastic overall. I feel I'm becoming hardened to clients' needs. Not as empathic as I once was which worries me."* (Huxley et al., 2005, p. 1072-1073)

2.3.6 Resilience in Bloom

This theme describes resilience as a flexible, dynamic process highlighting the enduring role of experiential learning, professional development, and growth in promoting resilient practice, job satisfaction, and career longevity as perceived by MHPs.

2.3.6.1 Clinical Supervision

Clinical Supervision may represent a critical contributor to sustaining resilient practice over time for MHPs. In eight articles, MHPs describe the protective impact of effective clinical supervision on their resilience (Adamson et al., 2014; Ashby et al., 2013; Bowden et al., 2015; Davison et al., 2019; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; McMahon, 2018). Interestingly, this viewpoint is predominantly articulated by participants representing disciplines other than MH nursing. Numerous MHPs describe the availability of effective supervisory support as playing a critical role in preserving their resilience and facilitating career longevity (Davison et al., 2019; Hurley & O' Reilly, 2017; Huxley et al., 2005; McMahon, 2018):

> *"I couldn't survive without good supervision … I'd say the quality of the therapeutic work I'd be doing would slowly start deteriorating … I can't really see how you would do the work we do without having that somewhere."* (McMahon, 2018, p. 223)

For many MHPs, effective clinical supervision provides a secure base and represents a key source of emotional containment (Adamson et al., 2014; Bowden et al., 2015; McMahon, 2018), while concurrently facilitating ongoing professional development throughout one's career (Ashby et al., 2013; Davison et al., 2019; McMahon, 2018). Many MHPs highlight the capacity for clinical supervision to facilitate reflective practice in MH work, an outcome that can positively impact personal and collective resilience (Ashby et al., 2013; Hurley & Kirwan, 2020; McMahon, 2018). While some benefit from an opportunity to formally reflect on clinical decision-making, others report that clinical supervision facilitates an increased awareness of idiosyncratic personal processes that can manifest in clinical work (McMahon, 2018):

> *"Clinical supervision … has been good at [looking] at what's going on inside of you …"* (McMahon, 2018, p. 221)

Numerous MHPs describe the importance of parallel processes in supervision, where the nature of the supervisory relationship is mirrored to a large extent in their relationships with SUs (Bowden et al., 2015; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; McMahon, 2018). In this way, the benefits of effective clinical supervision can extend beyond the practitioner and vicariously encourage the emergence of resilience processes in MHP interactions with SUs. An awareness of this process is reflected in this MH social worker's frustration at the lack of adequate supervisory support: *"How can you support the resilience of the client if your supervisor is not supporting the resilience of the worker?"* (Hurley & O' Reilly, 2017, p. 12). This

MHP similarly explains how the validation they experience in supervision increases their ability to reflect these attributes outwards in their work with SUs (Bowden et al., 2015):

> *"I really feel so valued and I feel that sort of nurtured feeling that you get when you feel that people actually understand and listen and I often feel that the job that I do outside is reflected by what I feel when I get supervision, that sort of supervision and that attentiveness that people give me that I can then give to other people ..."* (Bowden et al., 2015, p. 495)

Several MHPs allude to the capacity for clinical supervision to promote a positive team culture within an organisation, suggesting that this occurs through actively nurturing MHP resilience by conveying a sense that their professional expertise is of value (Hurley & O' Reilly, 2017; Huxley et al., 2005). On the other hand, ineffective supervision can result in a swathe of negative outcomes that jeopardise MHP resilience (Davison et al., 2019; Hurley & Kirwan, 2020; McMahon, 2018), which can lead to ambivalence towards using clinical supervision as a vehicle for support; an approach that is also not without its risks (McMahon, 2018):

> *"… I think that that's a dangerous way to work because it's easy to lose sight of whether you're managing yourself or not … that's where the external supervision provides a safety net in doing that …"* (McMahon, 2018, p. 223)

2.3.6.2 Reflective Practice

MHPs identified reflective practice as a contributor to resilience in seven articles (Carmichael et al., 2020; De Lange & Chigeza; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Lamb & Cogan, 2016; Prosser et al., 2017; Wharne, 2020):

> *"My resilience is reflecting on my own practice with my team."* (Hurley & Kirwan, 2020, p. 6)

MHPs describe how reflective practice can facilitate emotional containment and encourage meaning-making when confronted with difficult and painful emotions in their work (Carmichael et al., 2020; Prosser et al., 2017). This supports MHPs to maintain clear professional boundaries when working with SUs and reduces the likelihood that raw and unprocessed emotions will contaminate their personal lives:

> *"I self-reflect to know what I can handle and not handle. I think that's a big thing. I could be going through something and I might start bawling talking to somebody about their problems. If we're both crying… it's not good."* (Prosser et al., 2017, p. 3)

Several articles allude to the importance of MHPs engaging in meaningful reflective practice in-between therapeutic sessions with SUs (Lamb & Cogan, 2016; Wharne, 2020). Without this opportunity to reflect on emotions elicited in-session, it can be challenging for MHPs to achieve a healthy separation of their own feelings from those of SUs:

> *"Just sort of go from one to the next and the next without kind of really reflecting and feeling able to, um, put one to bed and then move on to the next one, you know that sense of you just kind of, processing straight away, without actually thinking, is that healthy?"* (Wharne, 2020, p. 11)

Some psychotherapists allude to a higher level of understanding that can be attained via continuous self-reflection, which encourages them to often consider their position as therapists in relation to SUs. These MHPs describe how this can foster a sense of appreciation

and a cumulative recognition of the SUs they have assisted in their careers (De Lange & Chigeza, 2015):

> *"Throughout my past experience as a psychotherapist when I reflect back I always believe that, everything that you are, everything that you have forms part of what you have to offer."* (De Lange & Chigeza, 2015, p. 58)

This idea that reflective practice can enable practitioner growth and a more expansive perspective is echoed in other articles (Carmichael et al., 2020; Hou & Skovholt, 2020; Hurley & Kirwan, 2020). Some MHPs describe how the growth attained through engaging in deliberate reflective practice can facilitate a process whereby MHPs can experience resilience vicariously through reflecting on SU resilience (Hurley & Kirwan, 2020):

> *"These clients are still moving forward despite everything and it really humbles me! Feeding off resiliency gives me the energy to continue to do my work and also provides opportunities to reflect on what is and what is not important in life!"* (Hurley & Kirwan, 2020, p. 9)

The capacity for reflective practice to sustain role satisfaction in MH work is identified by several MHPs (Carmichael et al., 2020; De Lange & Chigeza, 2015), an outcome that is achieved by promoting practitioner competence and increased confidence in one's own abilities:

> *"I think being able to reflect on when things are going positively and recognizing that . . . and appreciating that makes it more sustainable . . . I think whether it's positive or negative. So, like, when – in this case, when it was positive, it's good for self-care for my ability to carry on doing the work, erm have confidence in myself."* (Carmichael et al., 2020, p. 9)

2.3.6.3 Professional Development

In thirteen articles, MHPs identify continued professional development (CPD) as an important mechanism through which MHP resilience can be strengthened (Adamson et al., 2014; Barton, 2020; Brolese et al., 2017; Edward, 2005; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Huxley et al., 2005; Lamb & Cogan, 2016; Marie et al., 2017; Ragusa & Crowther, 2012; Ramalisa et al., 2018; Roebuck & Reid, 2020). MHPs describe an apparent correlation between resilience and professional competence, where the continued development of clinical knowledge and skillsets via accessing in-service training and educational opportunities can pre-empt gains in practitioner resilience through facilitating better coping with professional challenges:

> *"Skills and experience that I have acquired make me cope easily …"* (Ramalisa et al., 2018, p. 4)

As well as extolling the benefits of formalised training and educational opportunities, many MHPs suggest that practitioner resilience can strengthen over time due to an accumulation of clinical expertise or practice wisdom acquired via experiential learning on the job (Adamson et al., 2014; Barton, 2020; Marie et al., 2017; Ragusa & Crowther, 2012; Roebuck & Reid, 2020):

> *"I think a lot of that just comes from experience just you know hundreds of client hours on you see more and you learn how to work. I think training, whether it's doing more sort of formal training or just CPD days, increases your capability, and that increases your sense of confidence, and that builds inner strength. So yeah I'm definitely more resilient ten years on than when I first started."* (Barton, 2020, p. 5)

Many MHPs indicate that an important element of this practice wisdom involves moving from a position of self-sacrifice to one of self-preservation, which can encourage more self-advocacy in their professional roles (Barton, 2020; Hurley & Kirwan, 2020; Roebuck & Reid, 2020). Several MHPs attest to how this shift can likewise empower SUs:

> *"I think I've moved again from being more self-sacrificial when I started but I think part of that's to do with wanting to do your best - you're quite concerned about getting things right - you'll put yourself out there for clients and now I'm more, I don't know, I'm more self-preserving than sacrificial. That sounds a bit selfish, but I don't believe it is. I think looking after ourselves - that actually equals better therapy for our clients."* (Barton, 2020, p. 4)

Other MHPs describe benefiting from their application of personal resilience strategies that draw from their own professional expertise to promote adaptive coping (Lamb & Cogan, 2016; Ramalisa et al., 2018):

> *"I do probably intuitively try and use ideas, cognitive behavioural skills or sometimes just being able to tolerate the stress and be ok to feel these emotions and the kind of mindfulness in particular I've found a really useful personal strategy to manage some of the stresses of the job."* (Lamb & Cogan, 2016, p. 8)

A number of MHPs suggest that remaining committed to CPD keeps them enthusiastic in their work, which some suggest may be protective against burnout (Hou & Skovholt, 2020). One psychiatrist suggests that dedication to their profession can be nurtured through experiencing new and interesting challenges: *"Doing new things keeps you interested, keeps you stimulated"* (Fischer et al., 2007, p. 419). Some MHPs suggest that CPD should be viewed in terms of an

ethical responsibility rather than a choice (Hurley & Kirwan, 2020), as the potential for growth never disappears:

> *"I think that I have a tenacious desire to learn, and that is a core force for me to stay vibrant and connected; it's a feeling that is humbling because you can never know enough. You're never quite enough."* (Hou & Skovholt, 2020, p. 394)

A number of MHPs suggest that the benefits of CPD are not solely confined to the workplace (Barton, 2020; Brolese et al., 2017), alluding to the transformative effect that working in MH has had on their personal lives. MHPs report extensive personal growth as a consequence of their professional development, experiencing considerable gains in maturity, perspective-taking, and self-assuredness:

> *"I think I've grown quite a lot as a person through doing the training. I'm more comfortable in my own skin and probably more assured in who I am as a person … I am quite different—more confident and more assured …"* (Barton, 2020, p. 4)

2.3.6.4 Personal Growth

Ten articles allude to the role of personal growth in promoting resilient practice among MHPs (Adamson et al., 2014; Barton, 2020; Carmichael et al., 2020; Fischer et al., 2007; Foster et al., 2018; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; McMahon, 2018; Roebuck & Reid, 2020; Wharne, 2020). Many MHPs describe how overcoming adversity in their own lives can facilitate significant personal growth (Foster et al., 2018; Hurley & Kirwan, 2020; Roebuck & Reid, 2020):

> *"It's kinda like you know your body building up resistance to antibiotics or whatever it might be? I think that people that are constantly exposed to hardship will build up resilience to combat that or to lessen the impact it has on them."* (Hurley & Kirwan, 2020, p. 10)

Numerous MHPs describe how personal growth from overcoming adverse experiences has also facilitated considerable professional development (Adamson et al., 2014; Foster et al., 2018; Hou & Skovholt, 2020; Roebuck & Reid, 2020; Wharne, 2020). As this MHP notes, *"... through these kinds of adverse events; [we have] the opportunity to learn more skills"* (Adamson et al., 2014, p. 534):

> *"…you grow and you learn and excel through hardship. That doesn't mean that you can't be affected by something but that in time you use that positively, or to improve yourself, or improve your practice in some way as you go on."* (Foster et al., 2018, p. 5)

Several MHPs, for example, describe how their own personal journeys have contributed to the development of a more compassionate, expansive therapeutic presence; one that cultivates a deeper recognition of the hardships of the other, thus facilitating a higher level of empathic understanding when engaging SUs therapeutically (Hou & Skovholt, 2020; Wharne, 2020):

> *"You could call it insider knowledge of things, but you know I've actually experienced some things that actually gives me a bit of empathy that I can think actually that I do sort of understand how powerless this person may feel or how difficult it is for this person to actually move on."* (Wharne, 2020, p. 12)

A number of MHPs attest to the value of personal therapy as a means of facilitating personal growth (Carmichael et al., 2020; Fischer et al., 2007; Hou & Skovholt, 2020; McMahon, 2018).

MHPs describe how personal therapy can encourage a deeper understanding of internal processes that can facilitate personal growth and protect against burnout (Fischer et al., 2007):

> *"I think that the ongoing process of understanding and knowing, seeing, understanding yourself, your reactions to things, how you are changing over time, your own process of change and growth... that commitment, I feel really strongly that therapists would benefit from being in therapy to some degree."* (Hou & Skovholt, 2020, p. 394)

Personal therapy can help instil confidence in therapeutically-oriented MHPs, resulting in a sense of heightened credibility in the context of their therapeutic practice (McMahon, 2018). As one clinical psychologist notes, *"… how could you work that through with other people if you haven't done it for yourself?"* (McMahon, 2018, p. 221). That said, other MHPs in the same article describe having misgivings about attending personal therapy, with one psychologist expressing concerns around the potential messiness of the process, equating it to opening a *"Pandora's Box"* (McMahon, 2018, p. 223). Others cite stigma as a barrier to attending personal therapy when working in MH:

> *"I just think there's probably a bit of a prejudice and I'd say there's probably a stigma … I think that people think that maybe if you're doing your own personal work, maybe you're not a good therapist … Something wrong with you, maybe you're not coping."* (McMahon, 2018, p. 224)

2.3.7 Resilience in Meaning

This theme refers to the strong connection between personal meaning-making processes and resilience, as outlined by MHPs. It describes how self-knowledge, professional

identity, values, and overarching systems of belief can help engender a deep sense of purpose that promotes and safeguards resilient practice among those working in MH.

2.3.7.1 A Deep Knowledge of Self

Nine articles allude to the importance of self-knowledge as a means of promoting resilient practice in MH work (Adamson et al., 2014; Barton, 2020; Bowden et al., 2015; Edward, 2005; Hou & Skovholt, 2020; Huxley et al., 2005; Prosser et al., 2017; Roebuck & Reid, 2020; Wharne, 2020). An authentic sense of self is described by some MHPs as a prerequisite to resilient practice (Hou & Skovholt, 2020; Prosser et al., 2017; Wharne, 2020). As one acute psychiatric nurse explains:

> *"Be clear about what your life is about and what you see yourself as being about and what you hold in the highest values."* (Prosser et al., 2017, p. 4)

Numerous MHPs assert that cultivating a deep connectedness with the self allows for *"a vast vision of who you are and what you are and where you're going"* (Prosser et al., 2017, p. 3), even if this sometimes requires one to accept *"painful realities"* (Hou & Skovholt, 2020, p. 393). Some discuss how a high degree of self-understanding can promote more effective practice, particularly in instances of high emotionality:

> *"I think it's more about understanding yourself and how you manage yourself really and I think if you can understand your own emotions, and how things will make you feel, and you're able to express that. It's potentially, is quite a valuable thing to, to have isn't it, to be able to sort of read your emotions, being able to, you know try and say the right thing at the right time."* (Wharne, 2020, p. 10)

The process of developing self-attunement is conceptualised as dynamic and interactive; one that promotes a clear understanding of own's own strengths and limitations (Adamson et al., 2014; Hou & Skovholt, 2020; Prosser et al., 2017; Roebuck & Reid, 2020). Some MHPs posit that in order to fully benefit from this knowledge, an ongoing commitment to its application is crucial, even when one's underlying motivations may be misconstrued by others:

> *"Being quite firm about what I know I can do and what I can't do has got increasingly important to me. I don't really mind if somebody thinks I'm slacking. I know - ten years on—I know what my limits are and that's fine."* (Barton, 2020, p. 4)

Several articles highlight the potential for increased knowledge of one's own limitations to follow exposure to adversity in the form of personal ill-health, family bereavement, or challenging therapeutic work (Adamson et al., 2014; Barton, 2020). Developing more attunement to one's personal needs through experiencing hardship can foster a deeper understanding of personal resilience among MHPs, resulting in an increased vigilance in their application of this self-knowledge going forward:

> *"I've become quite conscious that if my client stuff is becoming quite heavy or there's a lot of stuff going on personally, then I try to increase my self-care a little bit, and I think for me it is about being intentional as far as self-care is concerned."* (Barton, 2020, p. 4)

To know 'thyself' in this way is described by some MHPs in terms of a journey without a final destination, where flexibility is necessary when interacting with dynamic work environments characterised by uncertainty and variability in terms of SU outcomes. Numerous MHPs

emphasise the importance of self-compassion in enabling them to remain steadfast in the pursuit of self-knowledge against this backdrop (Barton, 2020; Hou & Skovholt, 2020):

> *"I think that I have worked personally on being more compassionate with myself, and I think that has reaped a lot of good things in terms of ebb and flow. Things go well and they do not go well.... It's just being able to be solid even when it doesn't feel solid, to just be flexible with okay."* (Hou & Skovholt, 2020, p. 393)

In numerous articles, a strong professional identity or commitment to the vocational self is described by MHPs as an important contributor to coping (Adamson et al., 2014; Ashby et al., 2013; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Huxley et al., 2005; Marie et al., 2017; Ragusa & Crowther, 2012). MHPs in several studies express the view that a commitment to the goals and values of their profession is key to maintaining resilience over time (Adamson et al., 2014; Huxley et al., 2005; Marie et al., 2017):

> *"I am motivated to remain in my current job because I have the opportunity within the CMHT to work in some depth with people who have a variety of mental health problems. This can be challenging and enables me to increase my knowledge & skills, e.g. working with women who have been sexually abused in their childhood."* (Huxley et al., 2005, p. 1073)

While some MHPs report that the application of discipline-based theories or concepts to their work enriches their sense of professional identity, which, in turn, promotes resilience practice (Adamson et al., 2014; Ashby et al., 2013; Hou & Skovholt, 2020), others allude to the benefits of developing a shared professional identity among colleagues of the same discipline (Hurley & Kirwan, 2020; Ragusa & Crowther, 2012); a process that can engender a sense of

camaraderie even when *"we don't work together on a daily basis …"* (Ragusa & Crowther, 2012, p. 49).

2.3.7.2 Values, Philosophy of Life & Spirituality

Numerous articles describe how a deep connectedness with something that transcends the self can help promote personal resilience among MHPs through encouraging a "vast" perspective. More specifically, MHPs discuss how overarching values-based systems of belief that influence personal meaning-making processes can promote resilient practice in 20 articles (Adamson et al., 2014; Barton, 2020; Bowden et al., 2015; Brolese et al., 2017; Deborah et al., 2020; De Lange & Chigeza, 2015; Edward, 2005; Fischer et al., 2007; Gevaux & Petty, 2018; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; Lamb & Cogan, 2016; Marie et al., 2017; Prosser et al., 2017; Ragusa & Crowther, 2012; Ramalisa et al., 2018; Roebuck & Reid, 2020; Wampole & Bressi, 2020).

Numerous articles describe how experiencing passion, enthusiasm, and appreciation for MH work can foster meaning, commitment, and a sense of purpose among MHPs; an outcome viewed by many as instrumental to promoting sustained resilient practice and career longevity (Deborah et al., 2020; De Lange & Chigeza, 2015; Fischer et al., 2007; Hou & Skovholt, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; Lamb & Cogan, 2016; Marie et al., 2017; Ragusa & Crowther, 2012; Roebuck & Reid, 2020):

> *"I have a passion for this... I often say to people, I am really fortunate that I can do a job that I love like a hobby I enjoy being able to assist my clients."* (De Lange & Chigeza, 2015, p. 57)

Described in one article as *"a complete feeling that I am in the right place"* (Roebuck & Reid, 2020, p. 7), the job satisfaction achieved when personal values align with professional obligations can lead to MHPs deriving maximal meaning from their work. The feeling that one is making a valuable contribution can strengthen practitioner resolve to overcome professional challenges as they arise (Deborah et al., 2020; Edward, 2005; Fischer et al., 2007; Huxley et al., 2005; Marie et al., 2017; Ragusa & Crowther, 2012; Roebuck & Reid, 2020). As this psychiatrist notes, *''If I am driven and have a passion for what I am doing I can tolerate a lot''* (Fischer et al., 2007, p. 419).

> *"Am lucky I have a career am passionate about. When you wake up every day doing something you love, it boosts your morale. That passion fuels me, and I am able to streamline my thoughts towards the task at hand. I find a reason and strength to complete a task, even when it's challenging."* (Deborah et al., 2020, p. 5)

In seven articles, participants suggest that acceptance of the limits of what is achievable in their professional role can act as a buffer against occupational stress and help alleviate fears around SU outcomes, thus representing an important characteristic of a resilient practitioner (Deborah et al., 2020; De Lange & Chigeza, 2015; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Lamb & Cogan, 2016; Prosser et al., 2017; Roebuck & Reid, 2020). This enables MHPs to better recognise *"what things here are beyond [their] control"* (Lamb & Cogan, 2016, p. 8), which can help counteract occupational stress:

> *"Letting things go is very important … you're not in control, they're in control of their lives … you can only do what you can do and you just try and put your best foot forward and you know that sometimes you can't change certain things, you can just change how you chose to react."* (Hurley & Kirwan, 2020, p. 6)

This can have a liberating effect as MHPs are less burdened by unrealistic demands and are more at ease in their roles, thus allowing them to focus their energies on the provision of high quality care to SUs:

> *"Accepting that I am a therapist who may not be the best therapist for some clients, and that is okay....I think one of the keys to how I can be a resilient therapist is be okay with that fact that I'm probably not the best therapist for everybody. Just accepting that is really pretty freeing and puts me at ease. I do not have to be the best therapist for absolutely everybody."* (Hou & Skovholt, 2020, p. 393)

Other articles suggest that acceptance of the present moment can aid in the development of resilience in MHPs (Hou & Skovholt, 2020; Prosser et al., 2017; Roebuck & Reid, 2020), both in terms of anchoring oneself in the here and now and mindful engagement with sensory experience:

> *"When you're at work, you're focusing on your work. When you leave work, you're in the present moment again. You're focusing on what's happening right now. You're not bringing the past."* (Prosser et al., 2017, p. 4)

MHPs also reference other features of what they consider to make-up a resilient mindset or philosophy of life. Many articles discuss the importance of holding on to the positives as a means of cultivating an enduring sense of hope in MH work (Adamson et al., 2014; Edward, 2005; Hurley & Kirwan, 2020; Huxley et al., 2005; Lamb & Cogan, 2016):

> *"You need a mindset that is eternally optimistic, sort of never losing hope for what our clients are capable of..."* (Hurley & Kirwan, 2020, p. 6)

Numerous articles suggest that incorporating elements of an overarching values structure or philosophy of life into their work can enable MHPs to grow spiritually whilst meeting role obligations (De Lange & Chigeza, 2015; Edward, 2005; Hou & Skovholt, 2020; Hurley & Kirwan, 2020; Marie et al., 2017; Prosser et al., 2017; Roebuck & Reid, 2020). Connecting with something deeper that transcends the self offers access to *"a much wider field of resilience, of inherent wellness, that is not just [their] own"* (Roebuck & Reid, 2020, p. 6):

> *"It is just reconnecting to what's much bigger. It's what's much bigger than myself. I'm not religious, but I borrow from many traditions.... gardening helps me see attachment or nonattachment... whatever is going on in life comes up on your yoga mat. It's a way I can actually connect with myself in a renewing way.... Reconnected to the nature cycle of life and that helps you to reconnect to yourself."* (Hou & Skovholt, 2020, p. 395)

Moreover, the experience of spiritual growth encourages an expanded perspective that can have a grounding effect on MHPs (De Lange & Chigeza, 2015; Hou & Skovholt, 2020; Marie et al., 2017; Prosser et al., 2017; Roebuck & Reid, 2020):

> *"This is the most humbling job that you can ever have and I think the more you look at the universe and grow spiritually, in actual fact you become more humble…There is something positive happening and we must look into it. Don't go for the negative."* (De Lange & Chigeza, 2015, p. 58)

Religiosity, spiritual belief, and associated systems of morality are also identified by numerous MHPs as a vital source of resilience in their work (Adamson et al., 2014; Barton, 2020; De Lange

& Chigeza, 2015; Edward, 2005; Hou & Skovholt, 2020; Marie et al., 2017; Prosser et al., 2017; Ramalisa et al., 2018):

> *"[T]his is my belief, and it comes from Buddhism. If we can open to our own pain fully, our heart is open, and we can connect very deeply with the pain and suffering in other people."* (Hou & Skovholt, 2020, p. 394)

2. 4 Discussion

This systematic review has revealed the existence of a significant body of qualitative research that illuminates MHPs' experience of resilience in their delivery of MH; its systematic literature search identified twenty-six peer reviewed empirical articles, the majority of which represent good quality research. This literature notably consults a diverse sample of MHPs, exploring their understanding of resilience in the context of their practice. These MHPs represent the following disciplines: MH nursing, psychiatry, psychology, social work, occupational therapy, counselling, psychotherapy, and MH support workers. For a more comprehensive breakdown of the participant samples of studies included in this review, see Table 2.3. One key contribution of this review is to collate and synthesise multidisciplinary MHP understandings of factors that promote resilient practice. In doing so, this review provides an accessible roadmap for researchers, practitioners, and MH service providers interested in how to promote and sustain resilient practice among frontline MH workers.

What is the experience and understanding of resilience among frontline MHPs in their daily work?

The thematic synthesis illuminated the multifaceted nature of resilience as experienced by MHPs and is in line with evolving conceptualisations of resilience as a flexible, interactive process (Aburn et al., 2016; Masten, 2007). Contrary to trait-based conceptualisations that describe resilience as something innate to the individual that exists in isolation from others (e.g., Ahern et al., 2008; Connor & Davidson, 2003; Hu et al., 2015), existent qualitative empirical research indicates that MHPs view resilience as a shared process that exists in relationship; one that emerges from the dynamic interaction between multiple complex systems of interconnectivity (e.g., Aburn et al., 2016; Curtis & Cicchetti, 2007; Hill et al., 2018;

Luthar et al., 2000; Masten, 2007; Masten & Obradović, 2006). These findings also support the application of a social-ecological model of resilience (e.g., Panter-Brick, 2014, p. 441) in MH settings, where MHP resilience may more accurately be interpreted through the lens of the environment within which they operate. Importantly, the findings of this review align with the notion of resilience as something that can be nurtured and developed through intervention in the environment rather than in the individual.

What does existent qualitative empirical research tell us about MHP resilience processes?

Existent qualitative empirical research indicates that MHP resilience processes occur across three different levels: relationship with self, others, and something greater. Findings suggest that MHPs consider a willingness to connect deeply with the self as an important means of promoting resilience in their work. This recognition among MHP cohorts of the value of personal meaning-making processes in promoting resilience fits neatly into the resilient reintegration stage of Richardson's (2002) meta-theory of resilience, which posits that individuals can acquire meaning from adverse events, thus enabling growth and the strengthening of resilience. MHPs describe a positive association between the attainment of self-knowledge and resilience, where the former is described as a journey without a final destination – one that is heavily influenced by experiential learning through overcoming personal and professional challenges. Practitioners highlight a considerable overlap between personal growth and professional development, whereby one has the potential to encourage the other. For MHPs, the process of self-attunement is dynamic and interactive, requiring authenticity, flexibility, self-compassion, and an understanding of one's strengths and limitations. This supports recent hypotheses describing MHP resilience as the preservation of wellbeing in the context of a highly demanding professional environment, which is facilitated

via myriad dynamic interactions that occur between internal and external resources (King & Rothstein, 2010; McCann et al., 2013).

Reflective practice is highlighted by practitioners as an important mechanism through which professional growth can occur; with clinical supervision often serving as the conduit through which reflective practice takes place. Findings indicate that engaging in reflective practice can help MHPs maintain clear professional boundaries and can facilitate recovery following challenging SU interactions. These findings are in line with Rutter's (2013) assertion that resilience may be encouraged through exposure to manageable adversity, experiential learning, and a capacity for self-reflection and planning. Reflective practice has been formalised to a considerable degree in allied MH disciplines like clinical psychology, counselling psychology, and social work to facilitate professional inquiry, problem-solving, and ongoing training (Anderson et al., 2004; Fisher et al., 2015; Lavender, 2003). Alongside its scientist-practitioner identity, clinical psychology also incorporates the idea of the reflective practitioner into its core ethos (Schön, 1987), the latter accepting the need for some interplay between personal and professional knowledge bases in the development of practitioner competence. While reflective practice, or the capacity to *"think critically, reflectively and evaluatively"* (Stedmon et al., 2003, p. 30), is regarded as a laudable aspiration for MHPs generally, academics in nursing and medicine have raised some concerns around its conceptual validity and evidence-base (Mackintosh, 1998; Newell, 1992; Ng et al., 2015).

Findings also highlight the need for MHPs to move from a position of self-sacrifice to one of self-preservation to promote resilient practice, which involves the prioritisation of self-care and a healthy work-life balance. This finding is consistent with Foster et al.'s (2019) recent review of resilience and MH nursing, and the wider literature. This observation is important since MHPs may be more vulnerable to experiencing negative outcomes like stress, burnout,

and professional impairment than other professional cohorts (El-Ghoroury et al., 2012; Harrison & Westwood, 2009; Wityk, 2003). Moreover, some suggest that this cohort can often neglect their own needs in the fulfilment of their role obligations (Barnett et al., 2007). It has been suggested that MHPs occupy a *"powerful but vulnerable"* position (Sansó et al., 2015, p. 204); this implies that self-directed care and nurturance is a prerequisite to preventing negative consequences among MHPs (Butler et al., 2017) and those in receipt of their care (Stebnicki, 2007). In this light, practitioner self-care can be more accurately framed as an ethical imperative rather than a dispositional preference (Norcross & Guy, 2007). While the lack of self-care is associated with a plethora of negative outcomes for MHPs, engagement in self-care is synonymous with greater wellbeing (Colman et al., 2016), compassion satisfaction (Butler et al., 2017), improved clinical performance (Zahniser et al., 2017), and a higher quality of life (Goncher et al., 2013). Self-care has also been associated with a greater sense of personal accomplishment among MHPs and a reduced likelihood to depersonalise SUs (Rupert & Kent, 2007). Similarly, the ability to maintain a healthy work-life balance has been identified as an effective resilience building strategy among MHPs (Skovholt & Trotter-Mathison, 2014) and nursing and midwifery cohorts (Hart et al., 2014), whereas its counterpart has been implicated in occupational stress, compassion fatigue, and exhaustion among MHPs (Killian, 2008; Scanlan et al., 2013).

Alongside establishing a healthy boundary between the personal and the professional, MHPs also describe the need to remain professionally boundaried to sustain resilience; a finding consistent with previous research involving psychotherapists (Harrison & Westwood, 2009). Many discuss the need to set reasonable limits in managing workload and SU expectations, while others highlight the importance of respecting SU autonomy through

positioning them as co-collaborators in their recovery. Findings support continued efforts to transition from a paternalistic model of care to the application of recovery model ideals across MH settings, given the likelihood for such a shift to jointly empower MHPs and SUs.

Making meaningful connections with others is highlighted as an integral component of MHP resilience processes in this review. In the context of professional relationships with colleagues, for example, there is cross-disciplinary consensus regarding the capacity of a positive team culture to strengthen practitioner resilience, wherein practitioners feel supported and valued by one another. These findings are consistent with existent MH nursing resilience literature (Cleary et al., 2014; Edward, 2005) and a growing body of nursing literature (Benadé et al., 2017; Cameron & Brownie, 2010; Gillespie et al., 2007; McDonald et al., 2013; Zander et al., 2010) demonstrating how cohesive and collaborative working teams that engender a sense of camaraderie can build resilience. MHPs similarly attest to the resilience-related benefits associated with cultivating a deep sense of connectedness to one's own professional identity; a process that is influenced by myriad relational factors not least of which pertain to inter and intradisciplinary social dynamics in the workplace. These findings are in line with existing Social Identity Theory (SIT; Tajfel et al., 1979) research and a related phenomenon known as "*the social cure,"* the latter referring to the capacity for shared social identities to engender considerable psychological rewards that can pre-empt a plethora of individual health and wellbeing benefits (Haslam et al., 2009, 2018). This review's findings indicate that SIT and related concepts like the social cure may play an important role in facilitating MHP resilience processes, as MHPs identify social relationships, both personal and professional, as an important source of resilience that promotes longevity in their roles.

This review supports the bidirectional nature of resilience in the context of MH work. In doing so, it builds upon previous research in describing an interactive process of synergic interdependence that can unfold between the individual practitioner and collective practitioner groupings, where the resilience of one has the capacity to positively influence that of the other. Importantly, findings suggest that this process appears to transcend disciplines; an important consideration given the longstanding challenges associated with overcoming professional "silos" in the pursuit of authentic interdisciplinary collaboration in healthcare settings (e.g., Clancy, 2006; McDonald et al., 2007). MHPs describe how individual resilience can complement that of the collective and vice versa, where the sum is greater than its individual parts. Findings attest to the bidirectional benefits of formal and informal peer support on practitioner resilience, where effective clinical supervision is identified by MHPs as a key contributor to sustaining resilient practice over time, due to its capacity to facilitate emotional containment, reflective practice, and CPD. Moreover, participants describe how clinical supervision can contribute to a positive team culture, bolster collective resilience, and encourage positive outcomes in the context of SU interactions.

Despite working within what has been described as a unidirectional culture of caring (Guy, 2000), MHPs attest to the bidirectional quality of resilience in their interactions with SUs; resilience is similarly depicted as a shared process that can facilitate mutually beneficial outcomes. This is in line with an extensive body of qualitative empirical studies documenting vicarious resilience (Hernández et al., 2007) in MHPs working with trauma survivors and families of political violence (Acevedo & Hernández -Wolfe, 2014; Edelkott et al., 2016; Engstrom et al., 2008; Hernández et al., 2007; Silveira & Boyer, 2015). In reference to the capacity for SUs to influence practitioners in ways that promote practitioner growth, vicarious resilience denotes a profound reciprocity that can occur in the context of the therapeutic

alliance that allows for the mutual construction of meaning that can pre-empt positive change (Anderson, 2007). This sits well with the findings of this review, which denotes the capacity for therapeutic engagement with SUs to increase practitioner insight and self-awareness. A number of MHPs reference the importance of authenticity in their relationship with SUs, enabling them to maintain a capacity for empathic engagement over time. MHPs also describe how an abundance of compassion satisfaction and personal accomplishment can manifest in accompanying SUs on their recovery journeys, which can promote resilient practice and a renewed commitment to their roles. The concept of compassion satisfaction is difficult to disentangle from resilience in the context of MH service delivery, especially when one considers its role in enabling practitioners to better cope with adversity, which some suggest is achieved through eliciting feelings of hope, optimism, and a sense of commitment to one's caregiving role (Radey & Figley, 2007). Interestingly, recent research on compassion satisfaction is consistent with the findings of this review in suggesting that healthcare workers are more likely to experience compassion satisfaction when they are performing well in their role, when they see their work as having social value, or when they are satisfied with the nature of their relationships with colleagues (Roney & Acri, 2018).

MHPs describe how connecting with something greater than the self in the form of systems of belief, values, and/or morality that transcend the individual can function as an effective resilience resource; one that can positively influence personal meaning-making processes, allowing for a more expansive perspective. This process can enable MHPs to expand their window of tolerance, enabling access to a wider field of resilience; findings indicate that this may have a grounding effect in the context of adverse occupational situations, thereby facilitating sense-making and a meaningful reframing of adversity. MHPs describe how an acceptance of the present moment and the limits of what is achievable in their roles can

strengthen resilience; a philosophy reflective of the Buddhist underpinnings of mindfulness, defined by Kabat-Zinn (2003, p. 145) as *"the awareness that arises through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment."* Shapiro et al. (2006) posit that a mindfulness-based philosophy of life can facilitate a *"fundamental shift in perspective"* (p. 377) through a process of reperceiving or decentering (Baer, 2003; Brown et al., 2007), which encourages positive adaptation to adversity. Moreover, the practical application of these values derived primarily from Eastern philosophical traditions into the development of programmes (e.g., Mindfulness-Based Stress Reduction) has been shown to consistently engender positive mental and physical health outcomes in various SU and healthcare professional populations (Gockel, 2010; Krasner et al., 2009; Shapiro et al., 2005), alongside lower levels of burnout among MHPs (Crowder & Sears, 2017; Irving et al., 2009). Although previous research has found the relationship between religion and spirituality to be complex and dynamic (Tuck & Anderson, 2014), spirituality can provide a framework that supports individuals to overcome life challenges (Ardelt et al., 2008). Previous qualitative research has described spirituality as a pathway to resilience, suggesting that both constructs were *"instrumentally linked"* to individual wellbeing (Manning, 2013, p. 6). Moreover, research has shown that spirituality can reinforce resilience through promoting meaning in life and supporting the reframing of loss narratives (Ramsey & Blieszner, 2016). Other studies have found that religiousness, systems of belief, and spirituality are associated with increased happiness, wellbeing, and overall life satisfaction (Faigin & Pargament, 2011; Pargament & Cummings, 2010; Pickard & King, 2011).

What are the commonalities and differences among subjective accounts of resilience?

While there is a high degree of commonality among subjective accounts of resilience across the various MH professions, there are some instances where perspectives may represent a discipline-specific divergence. One such example centres around clinical supervision and its capacity to positively influence MHP resilience; a perspective that was primarily articulated by non-mental health nursing cohorts (e.g., Adamson et al., 2014; Ashby et al., 2013; Bowden et al., 2015; Davison et al., 2019; Hurley & Kirwan, 2020; Hurley & O' Reilly, 2017; Huxley et al., 2005; McMahon, 2018). This finding supports those of previous studies demonstrating that organisational context can have a considerable impact on both the implementation and sustainability of clinical supervision (Lynch & Happell, 2008; Sloan & Grant, 2012). In contrast to other disciplines, clinical supervision is not compulsory for nursing cohorts, including MH nurses. This is in part due to the resource implications that come with allocating one hour of weekly supervision to every nurse on the roster (Gray, 2001). Furthermore, practitioners working in medical and allied health professions often exhibit higher levels of autonomy in their work, whereas nursing culture tends to place a strong emphasis on intra-professional support and guidance; some suggest that this minimises the need for formalised clinical supervision arrangements among nursing cohorts (Cleary & Freeman, 2005). It has been noted that clinical supervision in MH nursing is still to a large extent aspirational (Faugier, 1994; Grant, 2001; Townend, 2005), and high levels of confusion and suspicion persist around its function, both from a clinical and managerial standpoint (Kelly et al., 2001; Sloan, 1999; Walsh et al., 2003). That said, clinical supervision in this context is often perceived in a positive light (Mullarkey et al., 2001), in spite of the limited empirical evidence in support of its efficacy (Buus & Gonge, 2009).

While findings highlight the need for models of service delivery to achieve an optimal balance between flexibility and structure in imbuing MHPs with a sense of control and autonomy in their work alongside the provision of adequate levels of organisational support, psychiatrists and psychiatric registrars in particular attest to strong feelings of powerlessness that can emerge when one is required to shoulder a high degree of responsibility in the absence of control. This is in line with previous research illustrating a correlation between increased job control and increased job satisfaction among psychiatrists (Heponiemi et al., 2014). Given that psychiatry has traditionally carried much of the responsibility when it comes to risk in MH, it is perhaps unsurprising that psychiatrists have been shown to report higher levels of SU-related stress than physicians belonging to other medical specialities (Martini et al., 2004). The findings of this review support previous research illustrating that the considerable meaning and purpose derived by psychiatrists in their work plays a significant role in counteracting the significant occupational stresses associated with their role (Fothergill et al., 2004; Howard et al., 2019; Kumar et al., 2006). Moreover, the importance of a flexible yet structured work environment has been echoed in MH nursing literature highlighting the accountability of management and organisations in providing this balance as a means of promoting practitioner resilience (Cleary et al., 2014).

This review's findings suggest that MH social workers (e.g., Hurley & Kirwan, 2020; Huxley et al., 2005) are especially attuned to the importance of healthy relationships within an MDT for promoting resilience, where practitioner input is valued by fellow colleagues. This is perhaps reflective of a previously identified legacy issue stemming from the relatively recent integration of health and social services in the establishment of community MH teams. Research suggests that social workers have had longstanding concerns about their role with CMHTs (Onyett et al., 1997; Peck & Norman, 1999), with some attributing this to the

discrepancy between medical and social models of care (Barnes et al., 2000). Reid et al. (1999) found that MH social workers demonstrated a higher degree of role conflict and role ambiguity in comparison to other professions. Moreover, the heterogenous nature of social work is often misunderstood by other disciplines, which can significantly restrict the capacity for social workers to practice dynamically on integrated healthcare teams (Zerden et al., 2019).

2.4.1 Strengths and Limitations

This review has several methodological limitations that should be acknowledged in the interpretation of its results. Firstly, resource restrictions meant that the search did not incorporate any grey literature or content published in books. Given that the publication of qualitative research is not exclusive to peer-reviewed journals (Grant, 2004), some relevant studies may not have been included. Moreover, the scope of this review was limited to English-language publications and formalised searches relied on a predetermined, purposively-selected search string of keywords (see Table 2.2) due to a lack of standardised terms for the purpose of indexing qualitative research via electronic databases. Another limitation centres upon the inclusion of exclusively qualitative studies, alongside qualitative components of mixed methods studies where appropriate. In light of the previous discussion (see Chapter One) around the conceptual evolution of resilience and the implications of this on its application to MH service provision, the prioritisation of a qualitative perspective allows for a departure from a traditional overreliance on preconceived variables that conceptualise resilience in terms of an innate psychological construct. Thus, a systematic exploration of MHP experiences of resilience can further develop our understanding of resilience and its application in the delivery of MH services. Additionally, practitioners featured in this review for

the most part worked with general population service users across a diverse range of practice settings, whilst those working exclusively in specialist settings were excluded.

These limitations notwithstanding, this review is the first to systematically collate, evaluate, and synthesise qualitative empirical studies exploring MHP experiences of resilience in their practice and has important implications for governance in the context of MH service provision. It systemically presents qualitative empirical evidence from a diverse range of countries and provides data from numerous studies. Moreover, this review contributes to an ongoing debate in the resilience literature regarding its conceptual underpinnings. The findings of this review contribute to the unfolding fourth wave of resilience research through further developing our understanding of resilience as a dynamic and multidimensional construct in the context of MH service provision. Resilience in the delivery of MH services is not something that occurs in a vacuum, whether or not one conceptualises it as a personal characteristic or an outcome-based process. On the contrary, those at the frontline of service delivery describe resilience in terms of a process that occurs in relationship; one that involves complex multisystem interactions. In promoting and safeguarding MHP resilience, it is incumbent upon those who preside over clinical governance and determine MH policy to acknowledge resilience as a dynamic, relational process.

2.4.2 Clinical Implications and Future Directions

This review's findings add cross-discipline validity to the notion that resilience-based interventions exclusively targeting individual MHPs are likely to prove insufficient and cost ineffective, building upon the findings of Howard et al.'s (2019) recent discipline-specific review. The findings of this review support the multi-layered, holistic application of resilience in MH settings; although conceptualisations of resilience have undergone considerable

evolution in recent years, there is limited evidence of the application of these theoretical developments on the frontlines of service delivery.

This review's findings support the meaningful expansion of the recovery model framework to facilitate the dual application of its most fundamental ideals so that practitioner perspectives are given equal standing to the experiences of SUs in order to maximise occupational wellbeing, career longevity, and the quality of care provided. In the same way that prioritising SU perspectives in the formation of MH policy and best practice guidelines enhances the overall responsiveness and efficacy of global healthcare systems, the joint prioritisation of practitioner perspectives on how organisational structures can encourage resilient practice is likely to yield similar gains. Crucially, the bidirectional nature of resilience as outlined in this review suggests that SUs stand to benefit enormously from an extension of the recovery model ethos to those providing the care, particularly when one considers the secondary wellbeing benefits (e.g., compassion satisfaction, vicarious resilience etc.) reported by practitioners in their adoption of a recovery orientation when interacting with SUs as the majority of Anglophone countries continue to move towards the implementation of recovery model ideals in MH delivery. Overall, the findings of this review suggest that an organisational ethos that values and actively promotes practitioner self-care practices and other pro-resilience strategies can be viewed in terms of an ethical imperative, given the stark implications of neglecting to do so, not least of which when it comes to quality of care. From an empirical perspective, findings indicate that future research involving MHPs would likely benefit from incorporating process-based rather than trait-based measures of resilience into its empirical design; scales like the *Workplace Resilience Inventory* (McLarnon & Rothstein, 2013) acknowledge that resilience processes are heavily influenced by the interaction between individual and environmental factors. Finally, a key conceptual advance of this review relates

to the integration of SIT and resilience, whereby social identity may provide a novel lens through which to better understand MHP resilience processes. This warrants further investigation in future empirical research.

2.4.3 Conclusion

MHPs are known to work in challenging settings that are often underpinned by high levels of stress. The aim of this systematic review was to synthesise existent qualitative research exploring MHPs' experiences of resilience in the context of service provision to better understand how to promote resilient practice in their work. The thematic synthesis illuminated the multifaceted nature of resilience as experienced by MHPs in the context of their practice and is in line with evolving conceptualisations of resilience as a flexible, interactive process; one that is largely contingent upon the dynamic interplay between multiple interconnected factors that co-exist in relationship (Aburn et al., 2016; Masten, 2007). Existent qualitative empirical research indicates that practitioners view resilience as a shared, relational process that emerges from the dynamic interaction between multiple complex systems of interconnectivity. Importantly, the findings of this review align with the notion of resilience as something that does not exclusively reside within individuals but instead is open to the influence of culture and context. Findings imply that resilience can be nurtured and developed; MHPs identify a willingness to develop meaningful connections with others, the self, and something greater than the self as integral components of MHP resilience processes. This review describes resilience in terms of a bidirectional construct in the context of MH work, where MHP resilience processes can influence or be influenced by the wider team and SUs.

It is hoped that this review can contribute to the unfolding fourth wave of resilience research through further developing our understanding of resilience as a dynamic and

multidimensional construct in the context of MH service provision. This review has important implications for governance in the context of MH service provision and supports the multi-level and holistic application of resilience in MH settings, where the application of resilience-based interventions that exclusively target individual MHPs are likely to prove insufficient and cost ineffective. These findings also support the application of a social-ecological model of resilience in MH settings, where practitioner resilience may more accurately be interpreted through the lens of the work environment rather than an innate capacity to overcome adversity.

Chapter Three

Exploring staff experiences of social identity processes in Irish regional approved centres during Covid-19 – A qualitative study

Abstract

Social Identity Theory is an important consideration during Covid-19 since group identification can increase in times of crisis and instability. Inpatient mental health settings are regarded as challenging environments wherein complex group dynamics can manifest. However, minimal research has examined how social identity processes are subjectively experienced by staff in these settings. The current study explores the experiences of staff working in Irish regional approved centres during Covid-19 to examine the role of social identity processes. Seventeen practitioners from diverse disciplines working in three identified regional approved centres during Covid-19 opted into this qualitative study, where sites included acute psychiatry, rehabilitation and recovery, and psychiatry of later life units. Semi-structured interview transcripts were analysed using inductive thematic analysis to generate an in-depth understanding. Findings indicate that the pandemic influenced intergroup and intragroup social dynamics in these settings, which could both strengthen and undermine group ties. While results illustrate the emergence of positive collective outcomes like solidarity and social cohesion, they also suggest that the crisis exacerbated intergroup divisions early on. It was found that differences in Covid-19 threat appraisal and vaccination status could undermine intragroup ties and facilitate the establishment of pronounced self-other dichotomies. Findings illustrate the protective role of informal channels of intradisciplinary peer support in approved centres and suggest an association between social identity and resilience processes, where group-level identification may influence health outcomes and help to mitigate against occupational stress and burnout. This study contributes to the development of robust Covid-19 mental healthcare research and supports the application of social identity theory to inpatient mental health settings to better understand group processes and to promote positive systemic change.

3.1 Introduction

Officially declared a global pandemic on March 11th, 2020, by the World Health Organisation (Cookson, 2020), the outbreak of the novel coronavirus disease, Covid-19, and its implications, have impacted the healthcare systems the world over on an unprecedent scale (Sachs et al., 2020). Global healthcare systems quickly became the frontline in the battle against the virus, and healthcare workers as a cohort are considered to have been disproportionately affected by Covid-19, both in terms infection and mortality rates (Bandyopadhyay et al., 2020; Erdem & Lucey, 2021). Mental health service provision has similarly experienced considerable upheaval because of the pandemic, and increased stress and burnout has been reported among mental health professionals (MHPs), where abrupt work-related changes, fear of contagion, and problems ensuring that acceptable standards of care are maintained in caring for people with severe or enduring mental health difficulties were implicated in this process (Johnson et al., 2021).

The challenges faced by MHPs working in regional approved centres, defined as hospitals or other inpatient facilities *"for the care and treatment of persons suffering from mental illness or mental disorder"* (Mental Health Act, 2001), were significant. In these settings, adherence to public health measures like social distancing poses challenges given their normative layout, the vulnerabilities of the populations being cared for, and highly publicised issues with overcrowding. Generally, MHPs working in inpatient settings must also contend with organizational uncertainties and accompanying resource shortages, regular exposure to acute psychological distress, disproportionately high rates of staff burnout, complex intergroup dynamics, and difficulties embedding change in these settings (Aiken et al., 2002; Cleary et al., 2010; Kindy et al., 2005; Laker et al., 2019; McGeorge et al., 2000; Thompson et al., 2008; Yadav & Fealy, 2012). Covid-19 risks exacerbating these issues as it mounts myriad additional

demands on staff in the context of service provision. Moreover, the threat posed by the virus is significant in many of these settings due to the inordinate degree of risk should an outbreak occur on-site.

Social identity is an important consideration in the context of Covid-19 as societies call for unity in their efforts to overcome the crisis. Tajfel et al.'s (1979) social identity theory (SIT) notes that a person's self-concept is closely intertwined with the type of group they identify with, and the perceived value of this in-group compared to the associated out-group. Although people tend to exhibit more pro-sociality towards members of their own groups (Levine et al., 2005), social identity is malleable; its potency variable and dependent on contextual factors (Balliet et al., 2014; Tajfel, 1974; Tajfel et al., 1971). One thing that can influence our sense of connection to groups relates to how we respond to threat. Specifically, different framings of threat can elicit different consequences. Intergroup threat tends to foster collective level solidarity and cooperation, often by strengthening people's commitment to their in-group (e.g., Castano et al., 2002; Ellemers et al., 1997). However, this process can result in more intolerance and prejudice towards out-group members (McCann, 2008; Skitka et al., 2006). Intragroup threat tends to undermine group ties (Greenaway & Cruwys, 2019). Recently, social identity has been implicated in *catastrophe compassion* (Zaki, 2020) - a term referring to the positive social behaviours that can occur following complex disasters. Although an emergent concept, its historic prevalence is notable as are its pro-social benefits on helpers by way of increasing happiness and reducing stress and loneliness (Jordan et al., 2021). Similarly, studies have shown that positive collective outcomes such as solidarity, social connection, and shared resilience can be elicited by mutual aid programmes established in the wake of complex disasters (Drury et al., 2019; Steffen & Fothergill, 2009).

Developing a better understanding of how SIT manifests in inpatient mental health settings would be beneficial, particularly since a clear demarcation exists in these environments between MHPs and service users (SUs) in terms of their respective roles and associated status. Furthermore, the clinician-SU dynamic is often complex in inpatient mental health settings, where the onus on rapid stabilisation and symptom control can be at odds with the perceived recovery needs of SUs (Aston & Coffey, 2012; Compton et al., 2014). To date, qualitative research exploring staff perspectives of social identity processes in inpatient mental health settings is limited, with most studies focusing exclusively on SU experiences (e.g., Jackson et al., 2009). The Covid-19 pandemic presents a unique opportunity to consult with frontline MHPs to explore their experience of working in inpatient settings during a global public health crisis and to explore whether intragroup or intergroup social identity processes were inadvertently stimulated from the perspective of frontline staff working in these services.

This study adopts a social identity perspective to explore the subjective experience of a sample of MHPs working in regional approved centres in Ireland during an unprecedented public health crisis. It is hoped that this study can contribute to the development of robust mental healthcare research in the context of Covid-19 and serve as a useful resource for policymakers should a crisis of this magnitude re-occur. More specifically, this study's aims are as follows:

- To examine the experiences of frontline MHPs working in approved centres during Covid-19
- To explore whether the Covid-19 crisis inadvertently stimulated intra or intergroup social identity processes from the perspective of frontline staff working in these services

3.2 Method

3.2.1.Research Design and Epistemology

To gain a deeper insight into the experience of MHPs working in approved centres during Covid-19 and the emergence of social identity processes therein, a qualitative research design was employed. This methodological approach is considered appropriate for research that aims to develop a comprehensive understanding of the lived experience of individuals operating within a given context (Elliott et al., 1999; Stake, 1995). In doing so, the participant is positioned as the expert to facilitate depth of understanding (Auerbach & Silverstein, 2003).

This study adopted a critical realist approach; a philosophical orientation that draws tenets from both positivism and interpretivism in providing a useful framework for critical and exploratory social science (Fletcher, 2020). Critical realism is known to have clearly defined ontological and epistemological underpinnings (Brown et al., 2003). Ontologically, critical realism aligns with positivism in its assertion that reality is fundamentally knowable. However, it deviates from the positivistic perspective in its acknowledgement that reality extends beyond the parameters of what is immediately observable or identifiable through data (Fletcher, 2020). In drawing upon interpretivism at an epistemological level, critical realism posits that this deep reality cannot be wholly disentangled from human knowledge, language, and experience (Bhaskar, 2014; Sayer, 1992). The critical realist perspective therefore claims to identify the driving force behind social phenomena at the deepest possible level. Critical realism aligns well with a qualitative research design in its acceptance that there are multiple and at times conflicting explanations of reality (Hu, 2018). Moreover, critical realism acknowledges that social science concerns itself with the social world and the complex multifactorial interplay of factors that can occur therein to the extent that statistical data alone may lack the depth required to facilitate causal explanations of social phenomena (Lennox &

Jurdi-Hage, 2017). Finally, the fact that this study adopts a social identity perspective in its analysis sits well with the critical realist emphasis on explicit and intentional engagement with existent theory in setting out to explain structural causes.

3.2.2 Participants

Participants (n = 17, 76.47% female) were comprised of MHPs including mental health nurses, psychologists, and occupational therapists, working in three identified regional approved centres in Ireland during the Covid-19 pandemic. These sites included an acute psychiatric inpatient setting (n = 9), a rehabilitation and recovery unit (n = 4), and a psychiatry of later life facility (n = 4). A relatively even sample distribution across participating sites was sought and multi-discipline participation was encouraged to the greatest extent possible. See Table 3.1 for additional information on the demographic characteristics of participants. for Participants were eligible for inclusion if they worked at any of the three identified approved centres on a full-time or part-time basis during the Covid-19 pandemic in Ireland. Participants were excluded from the study if they had less than six months clinical experience as a MHP.

3.2.3 Procedure

Ethical approval was obtained from Health Service Executive (HSE) Research Ethics Committee (see Appendix H). Once gatekeepers had granted approval for the researcher to approach participants, information leaflets and poster adverts were circulated at identified sites (see Appendix F). Of note, issues pertaining to access, availability, and interest inevitably influenced the selection process; the ongoing Covid-19 pandemic and the HSE ransomware attack in May 2021 represented two salient factors in this regard. Prospective participants were asked to contact the researcher by email or phone if they were interested in taking part.

The study was explained in detail to individuals who expressed an interest in partaking. Following verbal or informal written consent, interviews were scheduled. Formalised written consent was obtained at the point of interview. Interviews were conducted in-person either on-site or at a neutral venue at an agreed time as per the preference of the interviewee. Prior to commencement of the interview, a brief demographics questionnaire was completed by each participant. All interviews were conducted by CH and ranged between 30 and 75 minutes in duration. Participants were advised that they could withdraw from the research at any point until the transcript had been generated and anonymised. Data collection took place between May 2021 and August 2021.

Table 3.1

Demographic characteristics of participants

Participant	Gender	Mental Health Profession	Approved Centre Setting	Clinical Experience
1	m	Allied Health	Psychiatry of Later Life	3 – 5 years
2	f	Nursing	Psychiatry of Later Life	> 20 years
3	f	Allied Health	Acute Psychiatry	5 – 10 years
4	m	Nursing	Rehab and Recovery	> 20 years
5	f	Nursing	Psychiatry of Later Life	10 – 20 years
6	f	Nursing	Rehab and Recovery	5 – 10 years
7	f	Nursing	Rehab and Recovery	10 – 20 years
8	m	Nursing	Acute Psychiatry	< 1 year
9	f	Nursing	Acute Psychiatry	10 – 20 years
10	f	Allied Health	Psychiatry of Later Life	1 – 3 years
11	f	Nursing	Rehab and Recovery	< 1 year
12	m	Nursing	Acute Psychiatry	> 20 years
13	f	Allied Health	Acute Psychiatry	3 – 5 years
14	f	Nursing	Acute Psychiatry	> 20 years
15	f	Allied Health	Acute Psychiatry	5 – 10 years
16	f	Nursing	Acute Psychiatry	> 20 years
17	f	Nursing	Acute Psychiatry	3 – 5 years

3.2.4 Semi-structured interviews

Semi-structured interviews were selected to facilitate in-depth discussions between the researcher (CH) and interviewees through constructing a non-intrusive, interactive environment within which active participation can occur. Widely used in flexible designs, a semi-structured approach to interviewing involves the use of selection of predetermined questions, at the same time allowing for a degree of improvisation or modification on the part of the interviewer depending on how the interview progresses (Robson, 2002). So, while semi-structured interviews have an overall purpose prompted by the research agenda, they are strongly guided by the individual interviewee's thoughts, perceptions, and experiences (Jarvinen & Mik-Meyer, 2020). The interviewer adopted an inductive approach so as not to rigidly adhere to an interview schedule. The interview schedule was developed by CH in consultation with the second researcher and following a comprehensive review of the SIT literature. Previous qualitative SIT interview templates were used as a guide. All participants were asked the same key questions; the interview process providing flexibility to follow up on points raised where appropriate. The interview schedule was piloted with one Senior Clinical Psychologist and one Healthcare Assistant, which indicated revisions based on suggestions made prior to commencing data collection. The interview schedule is provided in Appendix B.

All semi-structured interviews were conducted in person in strict adherence to government public health guidelines and commenced with brief demographic questions considered relevant to the proposed research aims/objectives. Participants were given the option to participate in interviews remotely via a secure platform approved by the HSE (e.g., Microsoft Teams). The questionnaire requested information on participant subjective health status (i.e., if they viewed themselves as having an underlying condition rendering them more vulnerable to Covid-19), participant profession and occupational status, gender, age range, and

breadth of professional experience. All in-person interviews were recorded on a Dictaphone, which was both encrypted and password protected. Interviews were transferred to a password protected HSE laptop assigned to CH and subsequently transcribed verbatim.

3.2.5 Data Analysis

Following transcription of recorded interviews, collected data were analysed using inductive thematic analysis (TA), as outlined by Braun and Clarke (2006). TA was chosen primarily due to its theoretical flexibility and its empirical utility; the core strength of TA relates to its capacity to generate a rich and detailed understanding of the lived experience of various participant groupings (Nowell et al., 2017). TA has also been used extensively in previous SIT studies (e.g., Cooper et al., 2021).

TA involves *"systematically identifying, organising and offering insight into patterns of meaning and experiences across a data set"* (Braun & Clarke, 2006, p. 57). In doing so, TA attempts to differentiate between common themes versus meaningful themes by facilitating the identification of themes that best answer the specific research questions asked. Data analysis was conducted by CH, who had completed each interview, transcribing and reading each interview transcript carefully in advance. The six-phase process outlined by Braun and Clarke (2006) was adhered to in completing the analysis as follows: 1) Familiarising yourself with the data; 2) Generating initial codes; 3) Searching for themes; 4) Reviewing potential themes; 5) Defining and naming themes; 6) Producing the report.

The analytic process commences with the researcher getting to know the collected data by listening to interviews, transcribing interviews, reading interview transcripts, and taking notes. Next, the researcher engages in a process of identifying meaningful text segments from transcribed interviews relevant to the research question and objectives; these are

provisionally labelled with a brief synopsis and grouped for future analysis. Following the generation of systematic codes, phase three involves the grouping together of codes based on their pattern; patterns are subsequently examined to identify an overarching theme. Phase four facilitates the performance of quality checks to assess whether identified codes and extrapolated themes represent a good fit for the data set as a whole, where themes are assessed in terms of usefulness and coherence. In phase five, themes are defined and named. According to Braun and Clarke (2006), good themes are singular in their focus, related but do not overlap to avoid repetition, and directly address the research question. The final phase involves organising the research into a cohesive report. Data saturation is considered met when additional interviews no longer result in the emergence of new themes (Francis et al., 2010).

The concept of data saturation refers to the point during data collection at which no new information or additional depth to the overall data set can be achieved (Braun and Clarke, 2021), thus representing an important consideration in the context of time-limited qualitative empirical endeavour. For this study, a level of thematic cohesion was established as data collection progressed in late July of 2021, at which point it was felt that the research aims could be sufficiently addressed. A further two semi-structured interviews were subsequently conducted following expressions of interest, which confirmed that saturation had been reached from the standpoint of the researcher.

While many researchers have criticised TA as a method of data analysis that is prone to interpretive bias (Nowell et al., 2017), this study has aimed to deliver a clear and transparent outline of the analytic procedure undertaken and the results subsequently generated to support the trustworthiness of the analysis. To this end, a coding frame was inductively developed by the primary researcher to capture recurring thematic features and was

subsequently applied systematically to transcripts (see Appendix A). The principal supervisor of this work (COC) provided credibility checks through regular independent examination of the coding generated by the principal analyst (CH). This was supplemented by the comparison of individual analysis of pre-selected fragments of interview transcript during the data analytic phase to promote consensus and resolve discrepancies through in-depth discussion. This involved a second coder (CS) independently crosschecking 10% of transcribed interview data; a process that yielded a moderate level of inter-coder agreement (Cohen's $\kappa = 0.7$) that is considered acceptable (McHugh, 2012).

3.2.6 Materials

Interviews were audio recorded, transcribed using Microsoft Word, and inputted into version 12 of NVivo (2015) (QSR International Pty Ltd.) to aid data coding and analysis.

3.2.7 Reflexive Statement on behalf of the researcher

I am a 37-year-old Irish male who is currently completing his Doctorate in Clinical Psychology. As a psychologist in clinical training, I work primarily within the public health service. It is important to declare from the outset that as part of the requirements of my clinical training, I have co-facilitated weekly psychological groups in one of the approved centre sites featured in this study between May and July, 2021. My therapeutic work with service users is typically integrative in nature and I favour the cultivation of a deep understanding of the experience of the individual within a context over a reductionist orientation that conceptualises psychological distress through a medicalised, disorder-focused lens. As a therapist, I would position myself within a phenomenological epistemological position, as I prioritise "lived experience" and how people make sense of their personal and social worlds. I

am thus inclined to pay close attention to the complex meanings that particular experiences, events, and states hold for people; my approach to clinical work is to a large extent reflective of a core aim of phenomenological empirical enquiry in seeking to capture *"the richness, poignancy, resonance and ambiguity of lived experience, allowing readers to see the worlds of others in new and deeper ways"* (Finlay, 2009, p. 474). In this sense, I believe that my professional identity and my approach to my clinical work are important considerations in the positioning of this research.

Whilst endeavouring to navigate this research in a manner that minimises bias through the explicit prioritisation of developing an accurate sense of participants' experiences, it is important that I acknowledge that my ability as a researcher to suspend my inner world entirely is compromised. Consequently, it was important that I reflect regularly on my own role within this research to carefully monitor my own biases. Furthermore, since this study involved interviewing an array of practitioners from disparate backgrounds and disciplines, I was acutely aware of the need to reflect on my own position throughout to minimise my careless imposition of these assumptions on the data.

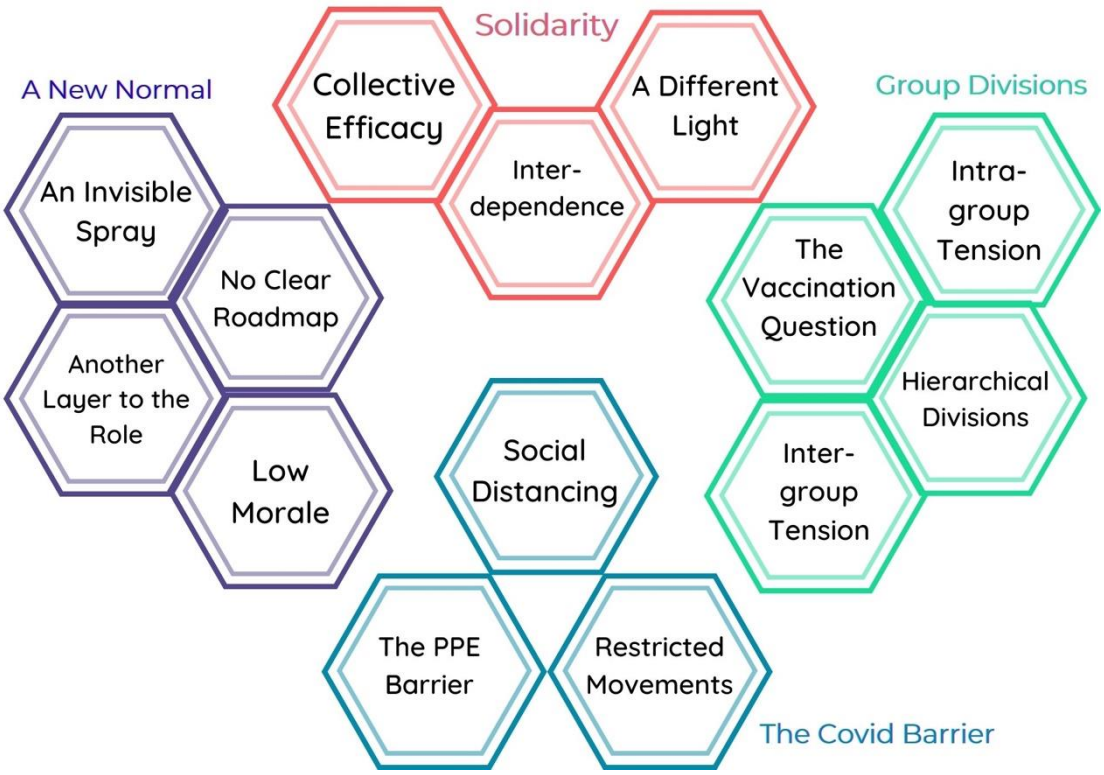
As such, I am aware that I bring my own experiences and beliefs around group organisational dynamics to this piece of research. Whilst I believe this to be largely beneficial, having played an important role in guiding the development of this research, this will inevitably be reflected in my approach to data collection, analysis, and interpretation. This, of course, represents an intrinsic element of all qualitative empirical endeavour and although it facilitates the development of depth and meaning, it also increases the potential for bias. A personal reflective journal was therefore necessary to manage this process. I also sought insight from my academic supervisor, COC, who does not have a clinical background and was therefore uniquely poised to counteract possible sources of personal bias when necessary.

3.3 Results

Thematic analysis identified 30 systematic codes. These were organised into fourteen analytic categories or 'sub-themes,' which were then organised into four 'super-themes:' *A New Normal*, *Group Divisions*, *The Covid Barrier,* and *Solidarity*. See Figure 3.1 for a visual representation of the results and the coding frame in Appendix A for a detailed description of the relationship between themes, sub-themes, and analytic categories. Themes are described below with illustrative quotes from participants.

Figure 3.1

Themes and sub-themes representing staff experiences during Covid-19



3.3.1 A New Normal

As the world was thrust into the unknown with the initial onset of the Covid-19 pandemic, staff working in Irish approved centres had to adjust to a new normal almost overnight. This involved learning to work alongside the significant threat posed by the virus,

taking on additional role demands, and making unprecedented adaptations to their clinical practice. This extensive adjustment informed staff attitudes and influenced the nature of workplace interactions.

3.3.1.1 An Invisible Spray

With the onset of the pandemic, staff in approved centres became hyper-alert to the threat posed by a virus that infiltrated the air like *"an invisible cloud that is a killer"* (P14, Mental Health Nurse):

> *"I mean, it was weighing, you know, you're suddenly dealing with something, but it's not tangible you can't see it."* (P2, MHN)

Confronted by a growing sense of unease, many MHPs felt like *"sitting ducks"* (P14, MHN) as they grappled with the various scenarios that might unfold were an outbreak to occur onsite:

> *"What if? What if you get an outbreak? What if we lose all our staff? How are we going to staff the place? Have we going to manage our patients? How are we going to risk assess? All those things coming through ... all the 'what ifs'"* (P9, MHN)

Participants describe having to reconcile their professional obligations with the safety of their families, where the fear of inadvertently carrying the virus home was considerable:

> *"Funnily enough, I was balancing my work commitments, the safety, of the service users and colleagues, with my home situation and young children, and whether I was going to be carrying Covid on clothing on you know on surfaces or whatever I was breathing in eh this aerosol and carrying that home, so I suppose I was trying to strike the balance between my home life and my work life, and what that entails, you know?"* (P12, MHN)

MHPs became hyper-alert to the threat posed by SUs in the context of Covid-19 risk. As one practitioner notes, *"I saw them as a threat"* (P14, MHN). Initially, the fact that staff *"didn't know who was coming through the door, whether they had Covid or not …"* (P16, MHN) could negatively impact on the staff-SU dynamic:

> *"I think it caused almost a bit of tension because service users with mental health challenges don't really take into account on occasions social distancing and … once you kind of come within that distance, you're more alert to the fact that there's aerosol being produced because the bulk of people here don't wear masks or face coverings, you know? So that was on your mind that you were ... getting a kind of an invisible spray."* (P12, MHN)

In certain instances, the positioning of SUs as a threat facilitated the emergence of discriminatory and prejudicial attitudes. Many MHPs found themselves becoming increasingly judgemental towards SUs, questioning their capacity to adhere to public health guidance:

> *"So, I suppose from that perspective, we were a little bit nervous of oh, my god, you know, from some of the clientele that would come in, I suppose some of the service users, you know, they could be outside socializing with everyone and anyone and wouldn't realise the risk they would be bringing onto ourselves here …"* (P17, MHN)

Participants allude to a prevailing sense of distrust and cynicism towards SUs for a period in the acute unit, where MHPs became increasingly dismissive of voluntary admissions:

> *"Em, I think there was a bit of distrust there. Em I could see it sometimes. I'd think does this person actually need to be here? Do they not realize the threat they are to us as staff? Because they may have Covid. So, a bit of distrust em (.) which kind of, I think was a little bit (.) led to staff being a bit cynical of patients, dare I say."* (P14, MHN)

Conversely, others were acutely aware of the threat that they posed to SUs to extent that they felt a strong sense of responsibility for SU welfare. This was especially evident, albeit not exclusively, in care of older adults:

> *"I suppose the sheer responsibility you feel for your residents and ... you know, at the end of the day, we were coming into work to protect those and keep them safe and well and do our best for them, and that was constantly in the back of your mind, you know, and every decision you made throughout was always you were thinking of work and the knock-on effects for work really, especially initially ...."* (P5, MHN)

Participants describe an overarching fear that they would be solely responsible for carrying the virus onto the unit and exposing vulnerable SU cohorts to it, which was a source of considerable stress:

> *"God I ... I don't know, it definitely was stressful worrying about, are you going to bring something on to the ward yourself and are you going to pass anything you know, like, would you be the cause of something like, that was definitely stressful."* (P10, Allied Health Professional)

For many, this heightened sense of responsibility had significant personal ramifications:

> *"So, our activities of daily living and our family life changed from that day to this day still, that has changed that had a huge strain on our own marital homes and private lives as well, because the stress of being in here."* (P6, MHN)

This MHN perfectly captures this personal toll in describing how strong feelings of paranoia, guilt, and shame could surface when performing basic activities of daily living:

"But then I had this fear as well that oh if anybody knew that I met up and went with my sister for a walk now like outdoors, if anyone says anything, you know, I don't know, I just had this paranoid (laughs), like, if anyone rats me out, and I'm supposed to be a nurse, I shouldn't be here." (P5, MHN)

3.3.1.2 No Clear Roadmap

Participants describe how an absence of clear guidance on infection control due to the rapidly evolving situation contributed to an atmosphere of uncertainty in approved centres early on. Feelings of confusion and bewilderment were common among staff as they set forth into the unknown without any clear roadmap. For some, this process resembled *"mad panic"* as *"everyone was giving different answers"* (P14, MHN):

"There was a pan pandemonium, perhaps a bit strong, you know, but definitely a sense of confusion leading to bewilderment, you know what I mean, amongst the people because, it was like eh ... the blind leading the blind, nobody knew exactly what they were doing." (P1, AHP)

During this initial phase of the pandemic, participants describe a growing sense of exasperation due to guidelines constantly changing, with the demands placed on staff increasing daily:

"… you were unclear, the guidance was unclear, because it was all evolving so quickly, em that the initial measures we were taking seemed to be changing and the what, what was expected of you seemed to be growing each day." (P12, MHN)

Participants outline their frustration at being inundated with a high volume of policy documents in a short space of time due to rapidly evolving infection control guidance in the

absence of clear, tangible guidelines that could be applied to their own clinical practice or setting:

> *"… I can get quite annoyed with not having good clear guidelines … and guidelines were coming in hard and fast, you know, emails twice a day or whatever, but none of them were tangible and none of them applied to where we were, like, you know, it was really hard to get any kind of actual factual, like direction out of them."* (P15, AHP)

The resulting information overload exacerbated the prevailing sense of uncertainty, further overwhelming staff to the point where requests were made to scale things back:

> *"… we were just being bombarded then with guidance and procedure and, you know, it was very overwhelming to the point where I had to actually email one of the ADONs and say, can we ask whoever's sending these emails to please stop because we're being bombarded daily with all of these emails about Covid regulations, Covid protocols, Covid, you know what I mean, it was just an information overload."* (P16, MHN)

Those in frontline managerial positions describe the challenge of having to hold this uncertainty in front of staff, while continuing to appear competent in fulfilling their role obligations. Not having the answers was a difficult space to inhabit and could pre-empt a degree of self-doubt, role inadequacy, and a sense of ill-preparedness:

> *"I suppose I felt I wasn't doing enough because em like … I felt like I didn't have the information to give because I wasn't provided with information. It was practical things like em gloves, masks ..."* (P14, MHN)

For some, it was important to model a veneer of calm and certainty to younger, less experienced staff members; a process that involves close monitoring of their own reactions and behaviour:

> *"And it's so hard and even my job … you feel like you have to role model in some way of how you're reacting and how you behave and that so you're seeing your junior colleagues looking up to you, so you don't want to let yourself down either, you know, saying it will it be okay, but you don't know if it will be okay or not, you know?"* (P9, MHN)

3.3.1.3 Another Layer to the Role

MHPs working in approved centres had to rapidly adjust their clinical practice and assume additional role demands. Participants describe how having to adopt a more flexible approach in supporting SUs and their families was juxtaposed with the rigid oversight of SU adherence to public health guidance; a process that could influence the nature of staff interactions with SUs and their families.

For many practitioners, it felt as though their professional roles had suddenly become less defined, as *"[their] actual role or function in the workplace could be different on any given day"* (P12, MHN). Practitioners highlight how the added layer of risk assessment in the context of infection prevention and control brought with it an entirely new professional lexicon. It is as though they had to embody multiple professional identities at once when supporting SUs:

> *"… it's added another layer on to what I do in the workplace like okay, my responsibilities and the rest, I think ... vocabulary has had to change you know, how you dance around explaining things, you find yourself almost em ... you could be almost like a security officer one day where you're explaining that someone can't enter a space because x y z*

or, or you know, you're eh almost doing a hand hygiene audit. Have you washed your hands? have you checked in?" (P12, MHN)

With Covid-19 restrictions an obstacle to therapeutic engagement, MHPs had to come up with novel and innovative ways of supporting SUs. This AHP gives an account of this process in the context of dementia care:

"I had to devise strategies and ways by which I could engage with individuals so … I kind of I set up a production line, em in one of the rooms that we use for therapeutic interventions, and I took fish nets … and I got, you know, we got our needles and threads, you know, for repairing the nets and things like that. And I I'd wake him up and tell them we're gonna (sic) go off, we're gonna (sic) head into the factory and he will follow with me you know what I mean and I said, show me how to repair them nets …" (P1, AHP)

MHNs also describe making significant adjustments to their practice to compensate for SUs being sealed to the space and unable to receive visitors. Communication with SU families quickly became paramount to answer queries, provide reassurance, and relay messages back and forth between SUs and their families:

"The biggest challenge for the staff … the staff came in and did their work [and] that was a challenge in itself. But then they had to support the residents' families. And that was a huge body of work. There was (sic) daily phone calls to some people constant keeping in touch, answering the phone, dealing with queries, making sure that family members were aware of how their loved ones were, and you know, constant reassurance for families because they couldn't get in to see the relatives." (P2, MHN)

The role of the inpatient MHN became more all-encompassing, expanding outwards beyond the walls of the unit and into the wider community.:

> *"… we just took on everything from like cutting their hair to buying them new clothes, when we had to, you know, if they needed something, it was kind of back to us to do those extra duties again. But again, we just, it was like, oh look they have to they need haircuts and we've no access to a barber there's nobody coming in, we're going to have to do it."* (P5, MHN)

Clinicians also moonlighted as entertainment officers now that SUs were solely dependent on onsite recreational activities since *"people couldn't go out anymore, couldn't go for spins in the van, they'd get frustrated, our activities, therapy was closed off, you know?"* (P4, MHN):

> *"… you can't go bowling with everyone, that's cancelled, this is cancelled, no you can't go to the shops because there's no shops open, and here I think … there was an increased effort on [the] part of management and em the occupational therapists, to provide recreational activities here, safely."* (P14, MHN)

This MHP describes how staff working in the rehab unit went the extra mile to safeguard SU wellbeing when their established routines were dismantled overnight:

> *"… we had one or two other residents here and we kind of got them jobs to do around to kind of keep them occupied. These clients would have been used to coming and going all day, gone on the bus and going off spinning and doing different things, really independent, you know, but then to try and entertain them. And then we're trying to keep them on the on the on on the level playing field."* (P6, MHN)

Despite the extent to which staff had to be more flexible in how they supported SUs and families, many attest to an increased rigidity when it came to other aspects their roles:

> *"So everything is just kind of more extreme I don't know, it's just you've to be a lot more vigilant em, even when it comes to the clinical side of, you know, taking obs like that's done twice a day was so extreme that any little sniffle, it's like, take another set of obs, just to be sure."* (P5, MHN)

Others lament the added layer of bureaucracy that has accompanied Covid-19, suggesting that it detracts from the quality of staff-SU interactions and removes any potential for spontaneity now that *"everything has to be so planned and prepped and organized, whereas before we could kind of change things to suit ... the cohort of people that were here …"* (P12, MHN):

> *"I think there's more paperwork involved, which takes away from the patient. There's more checks and policies and stuff that you have to do, which takes away from the patient. And I think it's got more legal as well."* (P7, MHN)

Many report that the nature of interactions with SUs shifted with the onset of Covid-19 due to the continuous reassurances that SU's sought from staff about their safety onsite:

> *"So there's a lot of reassurance that had to be doled out on a daily basis, often, every minute you were talking to someone individually and saying that you're safe in this space. And even though there's an element of doubt in your own head that, yeah, it could, Covid could come in via whatever pathway into the ward and someone would be exposed."* (P12, MHN)

3.3.1.4 Low Morale

Initially, the fear and uncertainty accompanying the pandemic adversely affected the atmosphere at work, causing a dip in morale. Participants describe how a dull, heavier atmosphere took hold as they collectively shouldered the pressure of the unknown. MHPs were quieter; their heads held low as though *"there was something missing"* (P10, AHP):

> *"… definitely the atmosphere at work, the morale staff morale had really dipped, you know, because everyone was carrying that pressure of the unknown, there wasn't the same what would you call it fun aspect. But there wasn't any any humorous side to work, it was all quite serious for so, so long, that em ... that people didn't have that kind of eh a light atmosphere. It was all it was kind of dull, heavy, and morale was dipped and, you kind of felt, God we were just trudging around, does that make sense?"* (P12, MHN)

Alongside the pressure of the unknown, staff had to carry the burden of an increased workload due high levels of staff turnover and chronic staff shortages:

> *"… I think most people barely got through their days to get to their days off, to try and have a bit of recovery, to kind of set themselves up to come back in again."* (P2, MHN)

Participants allude to a deep sense of loneliness that manifested at the height of the pandemic. Some felt as though they were *"grieving nearly for the loss of the life that [they] had before"* (P7, MHN). Travelling to work bordered on the surreal, where the knowledge that others were secure in their protective bubbles at home compounded this lonely feeling:

> *"Like so em, was just driving into work and the roads were completely empty. And I remember thinking like it was again surreal is the word I would've used, but like being*

like a zombie apocalypse, it was just completely empty. And that sort of feeling of em nearly a bit of a loneliness I suppose, because you were just driving in the road and like you know everyone else was safely tucked away in their homes." (P16, MHN)

Participants report that there were less opportunities for social connection with colleagues; the necessity for staff to have split and staggered breaks to facilitate social distancing limited positive social interactions, negatively impacting on camaraderie:

"… we'll say, people would previously have tended to go em ... go off-site for their breaks or sit together in a larger group and have that bit of camaraderie. Now, when you're limited to a certain number in any room em ... people are split for breaks, things are staggered, there's not the same meet-up time or check-in time with each other during the day, we're all focused on the job we're doing." (P12, MHN)

Avenues for accessing collegial support were closed off as *"staff were spread out all over the place, you know at break times and things like that"* (P16, MHN), which had an isolating effect:

"Now you're isolated. You are a little bit more physically isolated. It's when they're the guidelines that have come in, social distancing, em staff breaks (.) you're a little bit more isolated, two at a time were in a different tearoom. Initially the tearoom was where most of the decisions were made, there could be eight in the the tearoom or ten maybe and put in more chairs (.) whereas now, it's lonelier." (P14, MHN)

Many attest to how their personal wellbeing suffered as a result:

"Em ... I definitely found myself stressing a little bit more than I would, I would not consider myself a stress person to to ruminate on really anything ... em kind of it would kind of wear you down a little bit at night you'd be thinking about things." (P8, MHN)

Participants report how this led to a shift in workplace dynamics as *"you didn't have that same kind of cohesiveness"* (P16, MHN). Some would find a quiet space to have lunch by themselves, while others resorted to *"sitting in their cars, having their lunch on their own, so they were missing that interaction and myself included, you know?"* (P9, MHN):

> *"So, a lot of times I think I was on my own having my lunch I'd go to an office space on my own, or I'd go to my car into my car and have my lunch and that and, you do miss the connections there. So there has been a lot of ... time missed out on, spending time with people that just get you through the day …"* (P9, MHN)

Protocol around handovers became more regimented out of necessity, leaving less scope for informally debriefing or unwinding with colleagues, further straining morale:

> *"Yeah, it was very … strange and it would go against the grain of, you know, normally we at our hand overs, you know, we'd be all together or you know in the tea room, break time, like you go in and you could just unwind you know with your colleagues and have a bit of fun, have a laugh, you know, where it was like, again, isolating …"* (P16, MHN)

Numerous MHNs discuss how the curtailment on collegial socialising outside of working hours further exacerbated feelings of isolation, and many express regret at being unable to mark significant events on the staff social calendar:

> *"I just generally think, honestly see, for colleagues as well, we would've had Christmas nights out and summer nights out and all those, so we weren't able to have any of those. So, em, you know, that that would have been, you know, a big thing that you'd miss out on as where colleagues would be, you know, socializing outside of work."* (P17, MHN)

3.3.2 Group Divisions

This theme examines how the Covid-19 pandemic threatened group solidarity among MHPs working in approved centres. Divergent voices emerged within staff cohorts, where individual colleagues held different attitudes towards the public health crisis, and how best to respond at any given time. This led to the formation of new group divisions and an upsurge in intragroup tension, which left some more vulnerable to marginalisation and intolerance. Staff also report an escalation of intergroup conflict, where pre-existing interdisciplinary tensions were magnified, and hierarchical divisions became more entrenched for a period.

3.3.2.1 Intragroup Tension

Participants describe how the pressure of the unknown could create tension in approved centres early on, as staff *"… got to know each other's strengths and weaknesses fairly fast"* (P2, MHN):

> *"When a person's environment changes and uncertainty is brought to the fore, especially when you're working in a dangerous or frontline environment, people's insecurities, and their doubts and their own, you know, their their (sic) own personal issues, I believe came to the fore. People were more snappy, they were more agitated, and things like that …"* (P1, AHP)

MHPs responded differently to the threat posed by Covid-19, where some were more threat-focused than others. This was often a source of tension and could irritate those who did not share the same level of concern:

> *"Other people also at the start, some people individual staff members were more … hyper alert than others we'll say, for their own personal reasons, you know? And that irritated some people."* (P4, MHN)

Some found it more challenging than others to reconcile professional responsibilities with personal safety concerns, which caused *"... conflict, and you know they were trying 'should I go into work at all?'"* (P2, MHN). This culminated in staff refusing to come on-site during an outbreak, which *"kind of disgruntled the shift and caused a little divide"* (P5, MHN):

> *"Groups formed. That's what happened, do you know what I mean? There were those who, well I was one of the ones that came in on a 15-hour shift. Or if asked to stay 18 hours I'd done so when you wouldn't come in, or you took your holidays, you know what I mean? Things like that. So, and that still exists ... that kind of em I suppose, dislike of groups."* (P1, AHP)

Diverse attitudes towards the application of Covid-19 protocols could similarly cause conflict between staff. Several participants recount experiencing stress when others failed to exhibit what they consider an acceptable level of caution in their work:

> *"I suppose, so you have your different kind of staff attitudes, which can be quite stressful, especially as a junior staff member. So, say if people were taking, you know, what I deem as necessary precautions to deal with this, if they weren't taking them precautions, that can be quite stressful."* (P11, MHN)

Participants describe how several *"us"* vs. *"them"* group divisions formed early on. In the rehab unit, a division emerged between those who supported the reintroduction of tunic uniforms for hygiene purposes and those who did not, where the latter cohort were *"… throwing shade at the people all of a sudden wearing in the tunic"* (P8, MHN). On the acute unit, night duty staff report a temporary split with their daytime counterparts as they felt excluded from the

decision-making process. Others describe an increase in role envy, where staff would scrutinise each other's roles based on risk and the extent that people had to adapt:

> *"… people look at other people's roles with a little bit of envy, I know that sounds strange but if someone's work hours are 9 to 5, and people are leaving work at a certain point in the day, I think there's people who'll do a long shift, like a 13-hour plus shift, and feel they're here exposed to that extent, within the workplace, a long day, I think that that's quite taxing for some, so I think, yeah, people view each other's role they scrutinise each other's roles, and as to what level people have had to adapt."* (P12, MHN)

As the pandemic continued, diverse beliefs developed among staff about Covid-19. This divergence of experience threatened intragroup cohesiveness, creating disharmony in the ranks. One participant describes this as *"a sad secondary effect of Covid,"* adding that *"[they] would have never probably argued with these people or had any form of ... annoyance with them were it not for Covid"* (P8, MHN):

> *"It was a very difficult environment in regards to differences of opinions. And, again, from someone who stood back a lot of the time and observed what was going on, I would be a person who by [their] very nature would be a mediator, do you know what I mean? But there was no mediating a lot of, I suppose the heightened opinions and anxiety that people felt …."* (P1, AHP)

Many MHPs report feeling judged more by colleagues during the pandemic. Some describe experiencing resentment and anger towards colleagues due to a perceived unwillingness on their part to tolerate divergent voices:

> *"I think when it comes to Covid people have such a fear around it, that if you in any way have a different opinion, they automatically ... dislike you almost, they can't just see it as an opinion. It's reckless or it's because you're young and you don't understand, the threat isn't towards you."* (P11, MHN)

When this MHN contracted Covid-19, they felt that *"everyone's looking at me they think I didn't wash my hands enough"* (P14). Others describe *"being almost judged on how you're reacting or responding around clients:"*

> *"… there's like a couple of the residents on the ward and every evening at the same time they come to look to hold your hand and they just want to go for a walk with you that's all they want is company and if say someone if they were going for your hand you'd have other staff members kind of looking going (sic) you can't do it, you know?"* (P10, AHP)

Some MHPs report losing respect for colleagues because of their response to the crisis:

> *"I suppose I've lost lost a lot of respect for people for, you know, the way that they've acted towards patients and relatives and their work, you know what I mean?"* (P7, MHN)

3.3.2.2 The Vaccination Question

One of the most divisive topics raised by the Covid-19 pandemic pertains to the issue of vaccination. This was mirrored in approved centres, where different views on vaccination could represent a significant source of tension between staff. For many MHPs, vaccination was like a *"…light at the end of the tunnel*" (P2, MHN), whereas others were more wary at the prospect, concerned about potential risks and long-term impacts:

> *"I lost a bit of sleep em ... a little bit of sleep around the whole the vaccination. I'd be very, I've gotten all my vaccines, I've gotten the flu vaccine, but taking an untested vaccine, I was a bit worried about that. And I still am very worried about that, you know, potential long-term effects, and being branded like an anti-vaxxer, or when everybody was blindly taking it."* (P8, MHN)

This MHN expresses concern at the lack of sensitivity around the topic, as vaccination status became common knowledge without due consideration for people's privacy. They describe their unease at having to decline the vaccine in front of colleagues, which led to the formation of opposing groups based on vaccination status:

> *"Even how it was integrated, like when were offered the vaccine, we were offered it in work while we're working as a nurse, in front of all your colleagues, in front of patients. Em, do you want to come down here now and or it is your time now for your vaccine. And it's a big thing to have to turn around, like nobody knows what my reasons are for for not getting the vaccine and to put someone in that position ... is not, it's not right, you know?"* (P11, MHN)

The decision of some MHPs to decline the vaccine was viewed negatively by others who espoused the view that all staff should be obliged to accept the vaccination to not compromise the wellbeing of colleagues or SUs:

> *"I must say I find it irritating that some ... staff didn't get vaccinated ... by choice. I'm against that big time, you should be obliged to get vaccinated or else move away from the frontline."* (P4, MHN)

In some instances, the unvaccinated minority were dismissed as *"young people"* with *"little experience of life,"* who were *"too precious"* and *"full of their own importance"* (P4, MHN). This MHP felt betrayed at what they consider a lack of solidarity shown by their unvaccinated colleagues to the wider group, noting that *"we're in this thing together, we should be all accepting the vaccine …"* (P4, MHN):

> *"Like young people are ... full of themselves, and they really think they're great, you know? They know everything. And that irritates me an awful lot, you know, they've little experience of life and they kind of second guess you, "no, I don't believe it's true. It's just a hoax." It's hard to believe. I find it hard to understand that, you know?"* (P4, MHN)

Others struck a more conciliatory tone in highlighting the need *"to be mindful that, you know, we all don't think the same"* (P17, MHN), that people have diverse views and are entitled to make their own decisions as autonomous individuals:

> *"I suppose different people are individuals, and they have the right to their own view and their own decision-making skills (.) you know, you just have to as I said, continue to look after yourself … the majority of the world is compliant with the vaccine and stuff so look, you know, personally, I don't get upset over things like that."* (P17, MHN)

Unvaccinated MHPs describe having to withstand considerable pressure from colleagues to reconsider their decision, to the extent that they felt as though they were being coerced, albeit subtly, into taking the vaccination:

> *"And you're only being peer pressured and bullied into taking something like that from your work colleagues. I found that to be probably the most stressful part of it all to be*

honest. It really would stick in your head. Am I gonna (sic) have to be forced to take this? And it won't be forced because I'll be pressured, you know, but it's forced, it's coercion in a way, you know, as indirect as it is." (P8, MHN)

These participants describe how they were regularly singled out by their colleagues and were openly discriminated against for their stance on vaccination, where *"… people would have said openly, I refuse to work with anyone here who's not vaccinated"* (P11, MHN):

"So em ... there's no real way out, you know, like, to be honest, you're in the minority, and you're quite singled out by people, you know, for being in that minority. Which is mad, you know? You'd never think it." (P8, MHN)

Unvaccinated MHPs describe feeling stigmatised and pejoratively labelled as selfish and reckless by others. This took a significant emotional toll on this cohort, who felt that they would be held accountable if an outbreak occurred onsite, which is *"a big thing to carry"* (P11, MHN):

"I was so anxious, you know, and a part of me said, 'God you're just gonna (sic) have to go now and get this, okay?' You know, this is your role as a nurse and everyone else's opinions, you know, start to come into your head and you believe that they're your own then, if that makes sense? So, you begin to think … like what if I'm putting everyone here at risk?" (P11, MHN)

For this MHP, the topic of vaccination has caused near irreparable damage to collegial relationships, limiting the extent to which they can seek support from colleagues going forward, which could have implications on quality of care and career progression:

"The hours that you work with them, the stuff that you have to deal with, you need to be able to talk to your ... colleagues about stuff. And if you can't, if that relationship is broken I suppose? It would be difficult if something happened in the future, you're not going to go to them for advice, you're not going to go to them for support, because it's been damaged, because of something so big, I suppose." (P11, MHN)

3.3.2.3 Hierarchical Divisions

Participants report that the pandemic exacerbated existing hierarchical divisions in approved centres. Numerous MHPs allude to an escalation in tensions between frontline staff and senior management caused by the Covid-19 crisis. Several MHPs describe feeling undervalued and unsupported in their roles when the pandemic first hit, citing a lack of recognition from senior management of the increased risk they were required to manage in their roles. This AHP recalls how it felt as though management had *"no appreciation for what it was like for staff members to come in to work every day"* (P3, AHP). Their use of the word *"dehumanised"* paints a picture of subjugation and expendability at the hands of an oppressive hierarchical structure. Their sense of being unjustly treated in this way stirred feelings of resentment, leading them to contemplate a move elsewhere:

"… in many ways, you're just, you're dehumanized, or something or ... yeah, you don't matter. It's like, you need to come into work, you need to make sure the patients get the care … but I just think if there had been a softer, more appreciative approach, it would have made all the difference. Because I wouldn't have not come to work. I wouldn't have not gone to a meeting, I wouldn't have not done my one-to-one and I wouldn't have not done a group, because I could see the value. So, it just made me consider... if I want to work for the organization." (P3, AHP)

Many attest to a general disregard on the part of senior management for staff wellbeing during the pandemic, where tokenistic offerings of support were par for the course:

> *"… like nobody has been ever given the opportunity to de-stress or debrief. Like they'll come in and they'll say, 'Oh, we've employee assistance or debriefing if you want anything,' and then they run out before you can say, 'yeah actually yeah, let's do this.' No support at all. Nothing of how can we help you? It's all have you done this? Have you done that? Why haven't you done it? Then giving out that you haven't done it."* (P7, MHN)

Several MHPs feel that senior management could do more to support staff burdened by increased workloads during the pandemic who are now on the cusp of burnout:

> *"I think we've been slipping a lot of staff have been slipping through the net and [management] have they've been kind of seeing that things weren't great with them, but they haven't really done anything."* (P6, MHN)

This AHP's experience of working in an approved centre during Covid-19 has led them to conclude they are not truly supported in their work. With an air of resignation, they reflect on coming to the realisation that in their darkest hour, nobody has their back:

> *"I would have been sure that this was my job for life, but it has made me see that I'm not minded in this job and nobody really cares about my wellness, or my mental health or my, you know, resilience, except me and it has made me have a change of mind going, 'Is there something else that isn't this job?' because em (.) you're never going to be minded and really difficult things can happen and there will be absolutely no flexibility. So, in your darkest hour or your hour of need, nobody has your back."* (P15, AHP)

Participants describe a growing sense of disconnect between decision-makers and frontline staff since the onset of Covid-19. Many voice frustration at not having the requisite resources to meet the needs of SUs during the pandemic: *"… we're refused by individuals who have spent no time with dementia patients or their families and they don't see the requirements"* (P1, AHP):

> *"… the support I've gotten from staff has been phenomenal at the we'll say the ground level. But I think it was was it Paulo Ferriera who said, 'the eyes see where the feet stand.' You know what I mean? And in order to, you know, you have to be on the battlefield to understand what's going on and if you're shouting orders from the top without seeing as much as a musket being fired, it's very difficult to talk about the experience of the battlefield."* (P1, AHP)

Some junior staff report experiencing hierarchical tension when working with senior colleagues, where the prospect of speaking truth to power could be a source of stress. This participant expresses their discomfort when faced with the dilemma of whether to reprimand a senior colleague in breach of public health advice when caring for SUs:

> *"So I'm going in with my mask on and doing all that's being asked of me. And if you have a colleague who isn't doing that but you're a junior staff member, that can be quite stressful. You know, having to bring that up and if you're brave enough to bring it up, or if it's the right thing to bring it up and you start asking all these questions."* (P11, MHN)

Conversely, managers on the ground report that it could be challenging to deal with *"hysterical"* staff, engaging in *"dramatics"* (P7, MHN). This participant expresses resentment at having to pander to staff at a time of crisis when workplace demands had increased ten-fold:

> *"What was going through my head is how can people not come in, do a day's work and go home without bringing so much drama in their personal life into work. Now, I know that sounds really, really callous, but like, we are so busy in mental health, we have so much to do, that we don't have time to be pandering to people."* (P7, MHN)

Some senior practitioners in frontline managerial roles recount scenarios wherein they felt there was a mismatch between their role obligations and staff expectations:

> *"… and the staff, you know, one or two people would say, 'oh we never see her she's never around, we never see her she's never around,' I had that once or twice. So at the end you just have to say, 'Look, I'm here like, I'm in my office, I'm across the corridor, or when I'm in there I wear my PPE, and I do, you know, and I'm very much hands on but what I'm doing is to support you to be in here looking after the residents …"* (P2, MHN)

Participants suggest that divisions between staff in frontline managerial positions and senior management also became more pronounced because of the pandemic, where some on the frontlines felt let down by those in higher positions:

> *"… the support we have from the managers here is absolutely shocking. Like then with Covid we did not see any managers, you know what I mean? They rang us on the phone, or we didn't see them, that was it, and they were it was ... unbelievable, it was it was actually disgusting …"* (P7, MHN)

Others were wary of litigation in the event of a Covid-related fatality onsite, concerned that they would be left shouldering the responsibility:

"You have to cover your back as well. I'm expecting a lot of cases. We've been ok here thank God, nobody has died, nobody's got sick even, none of our people here ... If it had happened, you see what would happen then? Was your practice poor, you didn't adhere to the visitors' policy, you weren't donning and doffing PPE properly, they'd find some link and say, well there you are, you brought it in ... they could easily try and pinpoint it." (P4, MHN).

Several participants refer to a local culture that typically favours *"a hierarchical way of dealing with things"* rather than actively involving staff in the discussion; an inclination that became more entrenched during Covid-19:

"(.) like I was never brought into a meeting to say this is the plan on forward, either, if you know I mean? It seemed to be above, above were making decisions and stuff was filtering down, em which was kind of people were saying shur (sic) you can't put a door you can't block off there, and I was saying, where is this coming from?" (P14, MHN)

This MHN reflects on what they view as a double standard in terms of what was expected from them versus those occupying senior management positions:

"… there was a lot of people that would not step into the unit because you're afraid, and like so you're talking about audits weren't done, cleaning audits, em looking after the students weren't done properly. But yet the people that are on the ground looking after the patients, they still had to go in to do everything." (P7, MHN)

3.3.2.4 Intergroup Tension

During the initial phase of the pandemic, existing interdisciplinary tensions between professions were magnified, deepening the medical-social divide. AHPs working in approved

centres report experiencing a sharp escalation in tensions between them and their nursing counterparts, which took a significant toll on their wellbeing:

> *"… when you're talking about the social environment and the atmosphere, it was really heavy back then, like so, and it just exacerbated tensions that were probably underlying anyway, or almost addressed anyway. But … it really affected us negatively."* (P15, AHP)

Several participants report that the onset of Covid-19 fanned the flames of historic interdisciplinary tensions around the sourcing of therapeutic spaces onsite, culminating in *"a big face-off"* (P15, AHP) in one centre.

> *"… in the beginning, there was a territorial thing I felt, and I, I was upset about that. Because I felt we're in a pandemic, this is a once in a lifetime, I hope. And I really felt all staff should be supporting each other."* (P3, AHP)

This rise in intergroup tension led to the forging of strong intradisciplinary bonds among AHPs, where *"direct colleagues"* became *"… really tight because of it"* (P15, AHP). This practitioner reflects on how advocating for their colleagues helped cement intragroup bonds:

> *"And it really affected my colleagues … and I suppose there was a power in that, in that sometimes you can advocate for others more than yourselves and sometimes it really helped tighten us as a unit. So, there was only three of us in there at the time and we really strengthened from it like we still have a really good bond …"* (P15, AHP)

This participant reports that *"… once it nearly got to the bullying stage … we got some more backup from other professions,"* (P15, AHP), citing this development as a turning point in

interdisciplinary relations *"because up until then I felt like people just saw us as, you know, just disrespected our profession outwardly, everyone did …"* (P15, AHP), which led to greater intergroup cooperation:

> *"… I think relations got a lot better after that, so … like I do think I feel like the trajectory of staffing and relations between staffing is probably on the up."* (P15, AHP)

AHPs in other centres also report a rise in interdisciplinary tension. This participant describes how nursing colleagues cast aspersions on the value of their role during the pandemic, implying that they were not doing enough to engage SUs therapeutically:

> *"… like I'm doing the best I can like and it was like, I suppose that came down to Covid and the fact people didn't see what you were doing because you were doing kind of less groups, less kind of obvious stuff, more individual work, it was kind of almost an attitude that, what are you, you know, we need someone to entertain them ..."* (P10, AHP)

This AHP depicts a scenario wherein they felt openly disrespected by a medical colleague when endeavouring to mitigate against Covid-19 risk during a departmental meeting:

> *"… when I go into the rooms, I would always open a window. Because the meetings wouldn't last for one hour, they could last two to three hours. And I felt we had to have the windows open. And one time when the consultant wouldn't allow that. He said, I'd catch a cold. And I said there's a pandemic on, we have to open the window and he just closed it. So those types of things were were hurtful, and it felt disrespectful."* (P3, AHP)

Collectively, AHPs attest to a deepening of the medical and social cultural divide because of Covid-19, with some arguing that the medical model has reasserted its dominance in the prioritisation of physical health over psychological wellbeing:

> *"... I saw a noticeable kind of a ... a disparity arise between the different disciplines, you know, between different professions. And the medical model automatically took centre stage, you know?"* (P1, AHP)

For some, the escalation in interdisciplinary conflict during the pandemic is a personification of a deeper disparity between different models of care; an underlying philosophical tension that causes people to *"feel negative about you for nothing to do with you"* (P15, AHP). Several AHPs describe how a culture of disrespect towards the social model of care and its proponents casts a long shadow, even when strong alliances with individual nursing colleagues exist. Having their voices silenced by the dominant medical culture can engender within them a deep sense of powerlessness:

> *"I can have like really good relationships with individuals in there, really good working relationships but if there's kind of an atmosphere of undermining you or disrespecting you, that all goes back when you're not there. So like, you're powerless to change it really. No matter how good your relationships with people are in there, you still can feel it."* (P15, AHP)

Participants also allude to an emboldening of the general healthcare vs. mental healthcare divide because of the pandemic. Many articulate the view that mental health took a backseat during Covid-19, cementing an attitude among staff that they represent the bottom rung on the ladder of the healthcare agenda and are *"the last to get everything"* (P7, MHN):

"All the rest of the staff in the General Hospital were provided with PPE and everything very swiftly, scrubs the whole lot and we weren't, you know, so I think that was one thing that was very noticeable the difference between the General Hospital and with us. It took a little bit of time for you know PPE and things like that to come on board. And I suppose yeah because mental health weren't seen as a priority, you know?" (P16, MHN)

3.3.3 The Covid Barrier

This theme refers to how the Covid-19 pandemic created barriers in approved centres. Social distancing created a spatial barrier between staff and SUs, while PPE could represent a barrier to effective communication. Covid-19 also placed a barrier between SUs, their families, and the wider community, and could obstruct SU access to meaningful therapeutic supports.

3.3.3.1 Social Distancing

With the onset of Covid-19, MHPs were forced to take a step back from SUs to maintain a safe distance. This placed a spatial barrier between MHPs and SUs that influenced the nature of their social interactions, as staff focused on promoting SU wellbeing from a distance:

"It became less about the intimate connection, and therapeutic engagement to sort of … enhance their psychological wellbeing, and more about how do we distance ourselves from that individual, but still, you know what I mean, enhance a sense of wellbeing, and that was quite difficult, you know?" (P1, AHP)

MHPs in approved centres reflect on having to become *"quite conscious of kind of keeping the space"* (P12, MHN) and *"not getting too close"* (P17, MHN) to SUs, which for many goes against normal human inclinations:

> *"… it feels really strange still … having to tell a client, can you move away, we need to keep the distance, we need to keep two metres between us and explaining to them. But it just felt a bit invalidating, or it felt a bit for them to be to say, you're too close to me."* (P3, AHP)

Participants describe experiencing a sense of apprehension when approaching SUs that didn't exist previously, as though an invisible barrier now stood between them:

> *"You would be a little afraid ... kind of say approaching people. There's like a wall that would have never been there before, you know?"* (P8, MHN)

Numerous MHPs attest to what they consider to be the far-reaching consequences of social distancing on the quality of staff-SU interactions:

> *"Everything is impeded, your your ability to have a therapeutic relationship with somebody, sometimes people just em, you know, they want just a shoulder and just say just a patient that comes in, look, we're here with you, you know, you can't do that."* (P14, MHN)

Practitioners describe social distancing as a barrier to connecting with SUs on a human level, restricting their capacity to evoke a sense of shared humanity in SU interactions. As one MHP notes, *"we're all human, we all want the same things, we all have the same wants and needs"* (P17, MHN). Many participants struggle with being unable to reassure or comfort distressed SUs or families with physical touch:

> *"I'm quite a tactile person, and there's nothing like the human touch, you know, there isn't em to touch someone's hand or I tend to give hugs out, you know, because the patients in here have never had that kind of physical ... someone to put their arms around you to know that we are with you on this one, we're all the same. So you're kind of stepping back and you're nearly becoming OCD when it comes to things …"* (P6, MHN)

Several MHPs allude to the inherent challenge of socially distancing from familiar SUs, which can be a source of distress and lead some SUs to believe that they have done something wrong and are being purposely punished:

> *"... you know, a lot of patients would know us as well, very well, from previous admissions, and especially if they're elated they come in and they want they might want to give you a hug, you know, and you're like, 'no no, I can't do it,' and why aren't you giving me a hug and what did I do to you and, the paranoid ideas come out from the patient, that you're not their friend anymore, or, you know, if they are unwell, and those things are hard to come by."* (P9, MHN)

In lamenting that the *"personal touch is gone"* (P14, MHN), some posit that social distancing serves as an impediment to rapport building and promoting equality in interactions with SUs:

> *"I think it's something you automatically do, you throw your hand out to someone, and it would have been received as something comforting before, or drops that barrier of like, you're a mental health professional, you're a service user, we're all on the same level here, like, you know but, if you can't do that with someone ... and you're standing back a pace, and you're trying to build a rapport with someone, it's very difficult, you know?"* (P12, MHN)

For many MHPs, social distancing is a balancing act; one that requires practitioners to conduct a cost-benefit analysis and weigh-up the merits versus the risks of breaking the two-meter rule when supporting SUs in the moment:

> *"… if someone is unsteady you have to walk beside them you have to do what you have to like to protect ... you have to weigh up like what's safe for the resident and what they need and then weigh up the risks of Covid and you passing something on or vice versa like, you just ... you just do what you have to do I think. Like if someone goes falling and they or if someone is at a risk of kind of ... wandering or falling like you're going to go with them, like you're going to hold their hand if you have to, you know?"* (P10, AHP)

Staff in approved centres had to cap group numbers to facilitate social distancing, which represented a barrier to SU recovery as it restricted access to meaningful group-based therapeutic supports. This was particularly challenging for AHPs, who describe the prospect of refusing SUs in crisis as *"devastating"* (P15, AHP) as it runs contrary to their professional values:

> *"… limiting group numbers is a huge one as well, because I hate saying 'no' to people, I don't run closed groups, that's me, you know, but I don't think they work in there anyway because you'll have someone who's unwell who wants to come in who (.) just saying 'no' to someone at that point (laughs) is really (.) difficult. So, like, we had to limit group numbers a good bit and I definitely found that difficult."* (P15, AHP)

AHPs experienced guilt at not being able to meet the needs of SUs, and some allocated time to work individually with SUs who could not attend groups. This guilt was magnified for AHPs who were not permitted to run any therapeutic groups and could only engage SUs one-to-one, as SUs could lack access to therapeutic input for extended periods as a result:

"… there was that kind of guilt that like, there are some people who wouldn't have been seen for weeks, and there was just nothing I could do about it because you'd have people who were really agitated when you'd come on to the ward and you had to prioritize. Whereas if you were able to do a group, you could have a large number of people in the room …" (P10, AHP)

On the acute unit, AHPs describe how denying people in crisis access to previously all-inclusive therapeutic groups could negatively impact on SU wellbeing and sometimes cause confusion and upset, leading to challenging staff-SU encounters:

"I feel one of the things that was the hardest … telling people that they can't come to the group because of social distancing, and that we don't have enough room … I think in mental health that can lead to people becoming more paranoid and delusional as well. Em and it can have a negative effect on people as well that don't, you know, understand or they're not well enough to, to understand what's going on." (P13, AHP)

3.3.3.2 The PPE Barrier

For MHPs working in approved during the Covid-19 pandemic, the wearing of PPE could represent a significant barrier when interacting with SUs. Practitioners describe how the wearing of PPE had an unsettling effect on some SU cohorts early on and could compromise staff efforts to create a therapeutic environment:

"… we had would have elderly patients coming in as well, and they weren't used to seeing people in masks. So, everything was a little bit compromised and contradictory. We were there to do em the best we could under the therapeutic umbrella, and yet here we were presenting, and I know I did notice, possibly with some elderly patients or even say psychotic patients, the masks added to the paranoia because people weren't used to them." (P14, MHN)

Others report that this initial sense of unease among SUs in response to staff wearing PPE was mirrored in long-stay facilities:

> *"I'd be thinking like, we're coming in here, we're all wearing masks, we're dressed up to the nines in all this em PPE, and it's not reassuring, you know, to see. And I remember thinking, God, they must be so worried because they're not out there seeing what's going on, you know, they're not listening to the news so, all we say to them is what they realize, you know, and with people with dementia I don't know how much of that they would retain."* (P11, MHN)

Many MHPs discuss how approaching SUs while wearing PPE could in some instances encroach upon a SU's sense of safety and security, serving as an obstacle to building trust and rapport:

> *"I suppose as well as that, where when patients were coming in first, and you know you had to swab them for Covid and you're wearing your full PPE, it can be a bit nerve racking for the patient because they can't see you properly em, so they might find it hard to, to trust you or feel comfortable with you."* (P17, MHN)

These sentiments are echoed by others who highlight that the PPE barrier is especially pronounced when caring for SUs with dementia, serving as a considerable impediment to therapeutic engagement:

> *"You're a representation of comfort to them if you approach them correctly. But when you come in, you know, you're dressed like Dustin Hoffman, in that film, you know what I mean outbreak or whatever, you're all gowned up and the whole lot, they're looking at you like, 'what's going on here?'"* (P1, AHP)

Others note that the wearing of PPE could be disconcerting for staff too when first introduced, as their workspace more closely resembled a laboratory than a mental health facility:

> *"I think then the PPE advice came in and all that and next thing, people were donning full PPE to bring admissions in. Again, that's frightening. And I suppose the directive was there at the time to wear PPE, and again, it was probably misconstrued as regards how far you go, but people were erring on the side of caution because nobody really knew. Em, again that's like frightening for people. It's like they're coming into a laboratory."* (P14, MHN)

On a practical level, numerous MHPs describe the wearing of PPE as a significant barrier to clear communication with SUs, which for them represents a fundamental aspect of their role:

> *"It's a bit strange now with the mask, I find a lot of people can't understand you, and you'd find yourself pulling down the mask to say something, to repeat it, it's kind of a barrier to communication because the whole nursing mental health role is communication it's kind of a foundation, you know?"* (P8, MHN)

Participants depict how the muffled effect of face-coverings can inadvertently trigger negative interactions with SUs, who can sometimes get frustrated at having to constantly repeat themselves to staff or vice versa, which some feel has been detrimental to staff-SU relations:

> *"... we have to say everything twice, you know? Em, there's that muffled voice we're coming out with the whole time, when before we could get our message across quite clearly, then someone is someone is frustrated by the fact that they have to repeat*

themselves, or we have to repeat ourselves. There's ... so yeah there's like the PPE barrier we'll call it." (P12, MHN)

Participants portray how mask-wearing can further complicate the nature of social interactions with SUs who can no longer pick-up on important non-verbal cues like facial expressions:

"I suppose, I think a huge barrier is wearing a mask, you know, so you can't they can't kind of gauge your facial expressions and things and that that that is a huge, that's a kind of a barrier …" (P6, MHN)

Participants stipulate that this can be a particular hindrance when trying to communicate with older SUs, or those who are hearing or visually impaired, given their increased reliance on non-verbal cues, making it harder to arrive at a shared understanding without temporarily forgoing the face-covering:

"I remember particularly how difficult the mask wearing was because you're dealing with a lot of elderly clients and you realize how much they rely on your, your verbal cues, I suppose, and your facial expression, and you know, a lot of them will be hard of hearing and I don't know what you're saying to me, and really difficult to communicate with that group of people em not understanding, you know, people with dementia, I remember that being very, very difficult, sometimes so much so you'd be tempted to have to step back and take down your mask and give them a simple cue, and how much they relied on that. And that that barrier was a big thing in care of the elderly." (P11, MHN)

Some describe making a conscious effort to surmount the PPE barrier by compensating for that which remains hidden under the face-covering by engaging verbally with SUs more, to reassure them they are not being ignored:

"... you know, instead of walking down the corridor, you see someone like ... you're smiling at them, but they don't know you're smiling at them. So, you're trying to verbalize to people more. 'Hello, how are you?' rather than giving a nod like you might have done before, like, you know? So, you're just trying to make a conscious effort, with the mask on to make people know that you're aware that they're there …" (P9, MHN)

3.3.3.3 Restricted Movements

In approved centres, restrictions on visitations to slow the spread of Covid-19 placed a spatial barrier between SUs and their families. Covid-19 restrictions placed additional barrier between SUs and the wider community, limiting opportunities for community inclusion. Participants report that visiting restrictions represented a significant adjustment for SUs:

"…it's impacted most on the service users. They're on site here, sealed to a space, with no visitors, unless there's ... special measures put in place and that's only a brief 15-minute visit that, you think God that was huge just for people that would expect up to two visits a day, you know?" (P12, MHN)

SUs *"… suffered hugely because the outside inputs weren't coming in"* (P2, MHN). This *"detachment from the community"* (P12, MHN) removed access to social outlets and opportunities for positive community engagement. MHPs were cognisant of this when engaging SUs therapeutically:

"I think what was really hard for them is before Covid, they'd be able to get visitors, they'd be able to go upstairs for a coffee, they'd be able to go out for a walk, they'd be able to go on day release, you know, so I would bring that into the work as well and say,' I know it's hard at the moment,' which I wouldn't have done before." (P3, AHP)

Practitioners describe finding it hard to witness the adverse impact of visiting restrictions on the wellbeing of SUs, many of whom *"were becoming upset because they didn't have loved ones visiting"* (P1, AHP):

> *"… that's the thing that's going to impact on people's mental health the most, like, having no visitors means you have no advocate at the toughest time of your life, it means you have no support at the toughest time of your life, it means you haven't got, you know, it's (.) that was very difficult for me to see."* (P15, AHP)

Visiting restrictions were particularly challenging for families early on and participants describe how at times this distress could spill over into tense exchanges with staff. In these instances, MHPs had to enforce restrictions whilst simultaneously trying to provide reassurance:

> *"… some visitors turned up at the front demanding to be left in. Now they had to be treated with kid gloves like because they were all very upset and ... so there was a lot of challenges like that around the visiting that was a big challenge for the for the staff, because we couldn't have visitors, you know?"* (P2, MHN)

This MHP conveys the devastation experienced by a family member when visiting restrictions were first imposed amidst a flurry of chaos and uncertainty. They depict a glass partition separating an older adult SU from his distraught wife, preventing them from consoling one another as their lives were suddenly split in two:

> *"He was sitting up and he was looking out through the glass, and she was looking up at him through the glass and she was bawling her eyes out and she put her hand up and it*

was like something from the Midnight Express, do you mean? And she wanted that contact, she wanted to be able to embrace her husband and touch him and ... that went on for six or seven months before she could physically sit in the same room with him …" (P1, AHP)

Participants describe how staff would make a concerted effort to lift the spirits of SUs who were separated from their families on special occasions. This showing of solidarity with SUs fulfilled a very human need that was would otherwise not have been met:

" … we would make more of an effort because they couldn't see anybody else so, you know, you have to think of the personal factor there as well, not just profess[ionals], you know, we're all human at the end of the day so we have to … factor in that they'd like to have a bit of a deal made out of them at their birthday (sic) and at Christmas. So, we definitely went above and beyond, in particular, in the last year and a half than maybe at other times when they would've seen friends or family on special occasions." (P17, MHN)

It was difficult for MHPs to explain to SUs why they could not see their families, and many experienced considerable guilt as a result. This MHP describes how staff felt as though they had to apologise to SUs as if they were personally culpable for imposing these restrictions:

"I don't know will it get back to being the same as it was pre Covid … and em didn't feel like we had to apologize to the service users the whole time for the restrictions that we weren't responsible for imposing, does that make sense? So, the likes of visiting restrictions and all that we were constantly explaining to people, well it's not our fault, it's, its guidance that's out there the whole time." (P12, MHN)

Others report that restricting SU movements could cause frustration. MHNs outline how having to constantly promote compliance in this regard could strain the nurse-SU relationship, citing a tendency for SUs to blame staff when denied access to preferred community pursuits:

> *'I suppose, with the relationship between the nurse and a patient is, all of the information that they get about Covid is through us, so when they come to us and ask, em 'nurse, can I I go to the cinema?' It's me telling them, no, you can't go to the cinema and it's because of Covid things are closed. Therefore, it's, I suppose at a certain point, they look and they say, 'oh it's your fault that I can't go to the cinema.' So, I think a lot of them might belief that it's us reinforcing it, and not really the bigger idea that it's out there, you know, and the more you're reinforcing guidelines, that does damage the relationship, like every second thing they come and ask us for is no, because of Covid. Like that has to damage your relationship with people, you know?"* (P11, MHN)

One practitioner discusses having to explain to bereaved SUs that they could not attend the funeral of a fellow resident when limits had been placed on attendees. They describe how this had a profound effect on the unit and impeded the extent to which SUs could process what had happened and grieve the loss of their friend:

> *"…like their funerals as well, they were smaller, so it wouldn't have been a celebration like it was before. So that had a huge ripple effect across our service, you know, and then trying to explain to the residents then that they couldn't attend. So that was very, very difficult then he was there one day and then he wasn't there and then trying to explain to them as well what was going on?"* (P6, MHN)

3.3.4 Solidarity

A strong sense of solidarity emerged between MHPs working in approved centres during the Covid-19 pandemic, a process that was mirrored to a large extent in staff-SU relations. MHPs attest to a strong fellowship developing among colleagues as they shared the novel experience of working in an approved centre during a public health crisis on a scale hitherto unseen. A strong sense of collective efficacy developed among colleagues – a sense that by working together, they had the capacity to accomplished shared goals. Staff to a large extent became interdependent; they could lean on one another and access mutual support within their group. Collegial relationships became an invaluable source of social connection for MHPs, and the resulting camaraderie inspired a higher degree of mutual trust and friendship among colleagues, a sense that they were in this together. Moreover, MHPs report coming to view colleagues, and SUs, in a different light because of the pandemic.

3.3.4.1 Collective Efficacy

Participants shared the novel experience of working in an approved centre during the Covid-19 pandemic with each other. For many, there was solace in the sense that everyone was in it together, and *"… were all kind of trudging blindly into it"* as a collective (P12, MHN):

> *"… I felt everyone's going through it at the same time, like, it was almost like a collective herd of staff coming to work experiencing the same thing. And I think that's what kept people going, knowing that you're not on your own doing it you weren't expected to go into the coalface solo."* (P12, MHN)

Participants report that a strong sense of collective efficacy developed among colleagues, who felt as though they could accomplish shared goals by working together as a cohesive unit. Staff describe how colleagues put their differences aside to work towards overcoming the crisis:

> *"I saw a number of colleagues … there was (sic) areas that had broken down, you know what I mean, due to the toxicity of working together and have a differences of opinions, and then all of a sudden, they saw there was a kind of em ... there was a, there was a kind of a primary focus, a primary goal, that we have to work together to get this thing. And you know, that was nice to see I saw people formed alliances because of that … there were very positive alliances that were formed and friendships that were made, you know?"* (P1, AHP)

Numerous participants depict how staff in approved centres banded together in solidarity and *"… put their shoulders to the wheel"* (P4, MHN) to keep Covid-19 out and ensure that vulnerable populations under their care were protected. As a strong sense of group cohesion came to the fore, many MHPs were buoyed by a sense that *"… we're all doing it together"* (P14, MHN), despite having their own personal fears and concerns:

> *"… we just all worked so well together, and looked out for each other and like we had to we had to be strong and pull together, otherwise, we wouldn't have gotten through it, you know? And everybody, like everybody had their own personal lives and their own background and their own concerns living with elderly parents, you know, small babies at home, everybody had something going on but to be fair, like, we just we just didn't bring it to the shift we just came in, we were ready to go and get through the day and that was it."* (P5, MHN)

Many attest to how duty of care and the shared belief that their work was of value encouraged adaptive coping in the face of adversity, allowing them to overcome their anxieties and ensure that the service could still function when staffing challenges arose:

"Like people are doing this as a group, and everyone just seemed to just manage even with your own anxiety around it, knowing that people still had to be cared for 24/7 here. And em and as colleagues got sick or took leave off, people managed and backfill that cover, you know?" (P12, MHN)

Several participants allude to experiencing a collective sense of pride and satisfaction as a group at having achieved so much in a short space of time under difficult circumstances:

"I suppose for me, the overwhelming thing was satisfaction, which sounds kind of weird. But it was the satisfaction in achieving what we achieved within a very short space of time. And the value of being down here and seeing the staff embracing the whole thing and just basically gettin' on with it." (P2, MHN)

Participants report that this *"sense of pulling together"* (P15, AHP) in the pursuit of shared objectives could also extend to those in frontline managerial positions, where management were on hand *"if ever there was anything to firefight"* (P2, MHN):

"But, generally, you know, like, my line manager was excellent, she was there all the time. She was in to offer support ... when needed, you know?" (P 5, MHN)

Others attest to how management were supportive towards staff who for different reasons during the Covid-19 journey felt vulnerable. This helped maintain group cohesion among staff who might have otherwise felt marginalised or isolated:

"I suppose some of our colleagues that would have had some type of medical conditions or might have been pregnant and might have been concerned about themselves or … other family members who were severely compromised or whatever. The management

here would have accommodated them, which was which was good to see, you know, people didn't need to be afraid to come in to work …" (P17, MHN)

Some describe how this collaborative ethos could strengthen lines of communication between staff and management, empowering the voice of the practitioner:

"… I had more contact with direct management and that was beneficial because, you have a voice, and I'd never had a voice in that job before. So I definitely had relationships with management that I'd never had before and I could be involved in decision making in a way that I hadn't had before." (P15, AHP)

This sense of collectively efficacy also extended to the Mental Health Commission, who "*were ringing us once a week to see how we were getting on and you know, if we'd any problems, which I have to say, they were fantastic, and they were so supportive"* (P7, MHN). The *"constant communication between the Mental Health Commission and the service"* (P2, MHN) ensured that staff felt as though they weren't abandoned and that everyone was doing their bit:

"…we had a weekly call from the Mental Health Commission eh usually on Monday can't remember the lady's name, lovely lady used to ring on Monday to check and see how we were, had we PPE, what was our staffing like, and, you know, was there anything they could do to be of assistance, and you know ... so there was, they didn't just forget about us, you know?" (P2, MHN)

Participants also allude to the emergence of collective efficacy between staff and SUs during Covid-19, arising from a shared acknowledgement of the need to work together to neutralise the threat posed by the virus:

> *"…there was a little feeling of that, that look it we all have to get through this and we will get through it together and, like supporting each other and as I say now the older people like the wisdom that they had do you know about life or … difficult times that they've been through before, you know, so there was that kind of a … sense of togetherness I suppose and camaraderie, I think."* (P16, MHN)

Despite what some regard as a prevailing undercurrent of *"not thinking that clients could be responsible in that way"* (P15, AHP), participants report that most SUs have *"taken it in their stride"* and *"anything we've asked here in relation to Covid protocols, like the masks and the sanitizer, people have adhered to"* (P13, AHP):

> *"We never had someone in a group program em not socially distance. And if they did, we could, you know, if they were very say, you know, energetic or whatever, we could say, oh, we can't do that in here because of social distancing and they'd happily leave. Like, we never had problems with that. We never had problems with getting people to sanitize or explaining why we couldn't do something because of Covid. Even like the group numbers, whatever, that was really people can take that kind of responsibility, which it just strengthened that I think."* (P15, AHP)

Participants convey a sense of staff and SUs coming together in solidarity for the greater good, where the collective welfare of the unit took precedence over that of single individuals:

> *"… like even people that were acutely unwell, you know, that if we asked them, you know, that they needed to stay in the room because of their Covid pathway, they were very responsive now, even as I said even when they were very very unwell (.) so people were really, were em very responsive and so respectful of the sort of what needed to happen like you know what I mean, em and I suppose it's that greater, the greater good*

isn't it? Like this has happened for the whole unit it's not just you about one person so, yeah." (P16, MHN)

3.3.4.2 Interdependence

An interdependence developed between MHPs working in approved centres during the pandemic, where colleagues depended on one another for support. Participants depict an environment of mutual support, wherein colleagues looked out for one another:

> *"We looked out for each other and you know, say if somebody didn't get their lunch break or like we were all just hyper aware and hyper alert of everybody's you know, how the day was rolling out and if somebody was extra busy we'd like look, you got no tea break, go home a half an hour early or you know, if we could if things had quietened down, we were just able to look out and make sure that ... everybody looked out for each other and offered support."* (P5, MHN)

As a consequence, MHPs felt as though they could lean on each other for support when it was necessary to do so. For many participants, this camaraderie helped them to remain steadfast during a tumultuous time of great personal and professional upheaval:

> *"And as I said like from day one there's absolutely no way I think that myself included, would have gotten through this whole 16 months without my work colleagues. No way. Absolutely no way. They were just outstanding like now, and I'm getting emotional now talking about that so … no they were just brilliant like. I was saying that one the one colleague in particular was just fab like, and we really helped each other like you know?"* (P16, MHN)

Staff had each other to confide in when they needed to vent. Being *"able to kind of bounce things off each other"* meant that they were *"… not left on [their] own with [their] own thoughts thinking, you know, I'm isolated here"* (P8, MHN):

> *"I think eh definitely, people checked in with each other, like, you know, people were conscious that someone might be stressed about it. And in the space, again, where I work here, people tend to come and have check-in with each other here, you know, this is an office where a lot of things are discussed. But it's, I suppose, an ancillary tearoom if that makes sense. So, I think the tea breaks where people shared a bit of space and chat was that was almost a kind of where the valve would be opened, you could release the pressure."* (P12, MHN)

Participants depict a prevailing sense of loyalty among colleagues in approved centres during the Covid-19 crisis, where individual practitioners were deeply cognisant of the extent to which their colleagues depended on them and vice versa:

> *"… I'm relying on those people to keep me alive. They're relying on me to keep them alive. And thankfully that I have very good structure and support within my colleagues. And I have to be there as well for those. So I tend to be there for my colleagues."* (P6, MHN)

As a result, MHPs went to considerable lengths to avoid leaving their colleagues on the lurch:

> *"… I just knew that I couldn't take any risk of chances of contracting Covid myself, because the knock-on effect that would have on my colleagues, if I was out for the two weeks, you know?"* (P5, MHN)

As well as support, practitioners also depended on one another to *"put the bright side out for everybody"* (P17, MHN) during darker days. Participants depict how humour helped keep spirits high, offering a necessary counterweight to the more sombre aspects of the pandemic:

> *"… we did have a good laugh as well because if you didn't laugh, you'd cry, you know? And it's kind of, you know, we had to make light of the situation by putting on all the gear and the whole lot, you know, you have to kind of see the humour in some of this traumatic event, you know, we've very dark humour now in psychiatric nursing, but that's just part of our job."* (P6, MHN)

Whilst approved centres were dependent on an ongoing commitment from staff to fulfil their professional obligations during the Covid-19 crisis, staff were equally dependent on their roles, and the outlet provided therein. For many, coming to work each day had a grounding influence, bringing with it a sense of normality and structure:

> *"… ironically then as things moved on, the lockdowns and things like that, the routine of work actually sort of maintained you because other people weren't having that. Like say my sister, for example, was at home all day, every day, you know, working from home and just no out like, whereas at least, to have that freedom to even come into work and see other people … like was very helpful. You know, as time went on it was actually a sort of saving grace nearly, you know?"* (P16, MHN)

Participants felt lucky and privileged to have benefitted from the routine of work and being able to access an environment beyond their own four walls at a time when others could not:

> *"… I think the main saver was having the job to go to and having a routine to your week and a routine to your day is definitely a positive, when you compare it to a lot of other people, you know?"* (P8, MHN)

Numerous practitioners posit that having work as an outlet better equipped them to maintain their psychological wellbeing when others struggled to do so:

> *"I'd say all together throughout the pandemic, I haven't been depressed, I haven't been overly anxious. It's been okay. It hasn't been a horrendous experience for me. And I actually think coming to work every day has helped to steady that, you know, cause (sic) I know that some of my friends that haven't had work, have struggled."* (P3, AHP)

Additionally, numerous MHPs became highly dependent on the social connection provided by their roles at a time when self-isolation and social distancing were the norm:

> *"… your own personal circumstances are changing, because you're not seeing the people you want to be seeing, you know, you're in your own little bubble at home, you're not going anywhere bar your two kilometres and that, you know, and it's, it's the social outlet at times coming to work and that?"* (P9, MHN)

> *"... like colleagues at work, we've kind of carried each other through and we've had that social contact with each other, that others haven't had. And I think to see how damaging that was towards the elderly and towards other people that you'd know ... but I've had that social contact with people, even at difficult times or if the conversations weren't too, too uplifting …"* (P12, MHN)

3.3.4.3 A Different Light

Many MHPs describe viewing their colleagues in a different light as a result of the public health crisis. Some felt privileged to have witnessed first-hand the heroics of others at the height of the pandemic:

> *"I think that em coming into work for me was a privilege and it was something that ... to be able to witness the colleagues of mine, you know, the nursing staff in particular. And, you know ... eh what they had put themselves through, I mean, you know, people put up images of people with masks and, you know, dry faces, and, you know, bloodshot eyes and things like that but I saw that in real time."* (P1, AHP)

As things settled, *"there was a newfound respect for people who wouldn't have typically had gotten on beforehand"* (P1, AHP). Many describe a greater mutual understanding among colleagues and a strengthening of group ties that *"has brought people closer"* (P17, MHN):

> *"I think once it's settled down, you know, and then I suppose I mean, it's been over a year as well. So, you know, but I would certainly feel I'm more, I've got a better connection, or I've got more positive relationships with some staff, you know, with, with, like, nursing staff, you know, with staff members that I wouldn't have had - that wouldn't have been there before Covid."* (P3, AHP)

Others similarly portray how the resolve and determination shown by colleagues in meeting the considerable demands that accompanied the pandemic have engendered a strong sentiment of goodwill among staff working in approved centres:

> *"I think they stuck at it really and they are genuine, you know, and they have done it. And they all they have families at home, and they have mortgages and kids and all that as well, you know, under pressure. But they kept it going."* (P4, MHN)

Some suggest that the crisis has led to a shift in the group identity of staff, where the collective experience of working together during Covid-19 has instilled in them a sense that, as a unit, they are more resilient than they had previously thought:

> *"I suppose this is something none of us could foresee em happening and I ... I think we've all learned a lot from it. And I think one of the things we've all learned is how resilient we are, you know, there's massive resilience amongst the staff em to, to deal with it, to manage it, to come out the other side of it relatively intact, and be able to smile about it, you know?"* (P2, MHN)

Others reflect on the need for staff to move beyond preconceived notions of invulnerability. For this practitioner, their experience of working through Covid-19 has reminded them that no single practitioner is infallible. As a result, they are more cognisant of the importance of a working environment that prioritises mutual support among colleagues, since *"Covid has taught us that it's connections really are most important and our relationships"* (P13, AHP):

> *"I think it would just make you more aware of looking after each other in this environment, you know, like whereas I think we have probably taken for granted that us as professionals that we're resilient and we can deal with anything and, but I think that em throughout the last 16 months like there's been definitely days and weeks where somebody has not being managing well, you know, for whatever reason, em be it in work or out of work. And I think probably practice-wise I think it just makes you even more aware, to look out for each other."* (P16, MHN)

Numerous MHPs report that the pandemic has prompted them to see SUs in a different light – *"I think once it calmed down, I think ... there was a much stronger connection ... between staff and patients"* (P3, AHP). MHPs in approved centres shared this novel experience with SUs as it unfolded. For many, this commonality of experience enabled them to empathise with SUs on a more genuine level, thus facilitating a stronger sense of connection between staff and SUs:

> *"That was the one thing for me, I think, maybe slightly more connected to clients because we all have a shared experience of the pandemic. So, you know, so it impacts you, and it impacts me. We're sharing. Am I making sense? So, there's something going on in the world that affects us both. So, if anything, maybe being a bit closer, yeah, because … we're both impacted by the same thing. There's a commonality."* (P3, AHP)

Other participants similarly reflect on having more empathy for SUs following their own personal experiences of isolation during the pandemic. These personal experiences of adversity allowed them to walk a mile in the shoes of a SU with enduring mental health issues and adopt a more compassionate stance:

> *"… Covid has actually shown us how it feels to be isolated, you know? Cause (sic) I suppose myself I would have never been cut off from people before, where I think it's given us an appreciation of how kind of we need others and how some people can live their lives totally isolated, you know, em without family or friends normally, you know, without any Covid. So, I think it's given us a taster of what life could be like living with enduring mental health issues."* (P13, AHP)

For many MHPs, the extent to which the pandemic adversely affected SUs was *"an eye-opener,"* causing them *"to be more empathetic towards patients, you know, be more mindful to their needs, be more mindful how the pandemic has affected [them]"* (P17, MHN):

> *"I'm definitely very empathetic towards them, as in from the perspective that how much they rely on certain things to get through their day, how much routine is important to them, and I suppose ... how much more difficult it is for them to go through something like Covid compared to someone I suppose like myself or, you know, whoever so that how easy they can be knocked because they're predisposed, I suppose with a mental illness em and that that something like this can be really hard on them."* (P11, MHN)

This has prompted some practitioners to modify their practice in favour of a more holistic approach to caregiving:

> *"Em … I would like to think since Covid that I'm more holistic, I suppose, in my approach to the service user. And I suppose more more empathetic as well, I think?"* (P13, AHP)

Some describe returning to the essence of what it means to work in a caring profession, stepping back from psychiatric diagnosis and clinical theory and instead engaging with SUs on a human level:

> *"I think it … has shown me that generally it's bringing it back to the basics of like being in a caring profession. It's like, it's just stripped away a lot of, say, this sort of theory that you've learned, you know, about certain psychiatric illnesses and even, but I think it definitely has stripped it back, right back to the basics of just has is the person have are they sleeping well, are they eating well, you know, are they able to brush their teeth, you know, just just paired it right back to the basics of looking after another human being I think, you know?"* (P16, MHN)

3.4 Discussion

SIT is an important consideration in the era of Covid-19 as group identification tends to come to the fore in times of crisis and instability. Social identity theory (SIT) is a widely acknowledged phenomenon and a range of studies have shown that subjective identification with a particular group membership impacts on thoughts, perception, attitudes, and behaviour (see Haslam, 2014). However, minimal research has explored how SIT processes are subjectively experienced by MHPs working in approved centres. The current study represents the first to examine the experiences of MHPs working in regional approved centres during a global pandemic to investigate whether the public health crisis inadvertently stimulated intra or intergroup social identity processes in these contexts. Findings indicate that Covid-19 influenced intergroup and intragroup social dynamics in Irish regional approved centres according to the subjective experience of MHPs working in these environments, which had the effect of both strengthening and undermining group ties.

3.4.1 Main Findings

3.4.1.1 Intergroup Social Identity Processes

Findings indicate that the Covid-19 pandemic contributed to the occurrence of positive collective outcomes and pro-social behaviours among staff and SU cohorts. MHPs describe carrying a strong collective responsibility for safeguarding the welfare of SUs during the pandemic, which influenced their behaviour outside of work in their efforts to mitigate against the risk of acquiring Covid-19. The notion that one might be solely responsible for causing an outbreak on the unit and exposing SUs to the virus weighed heavily on the shoulders of many MHPs, particularly albeit not exclusively among those working in long-stay units (e.g., rehabilitative and psychiatry of later life). Results illustrate that the pandemic triggered

numerous examples of collective solidarity between MHPs and SUs. MHPs describe going to considerable lengths to counteract any potential ill-effects of Covid-19 restrictions on SUs, whether that be through devising innovative Covid-19 compliant therapeutic strategies, the provision of onsite recreational activities, making efforts to engage individual SUs unable to attend therapeutic groups, or coming together to lift SU spirits on special occasions when visitations were prohibited. Findings similarly suggest that a sense of collective efficacy developed among MHPs and SUs to neutralise the risk of an outbreak onsite, with both groups working together to safeguard the collective welfare of the unit. It was found that the shared experience of Covid-19 prompted many MHPs to alter their perception of SUs, enabling them to empathise with them on a more genuine level and encouraging a stronger social connection, with some adjusting the nature of their clinical practice as a result.

These findings are in line with previous research on the collective experience of adversity, which suggests that when people are confronted with a shared global trauma and co-ordinated responses are required to neutralise a common threat, this can promote social cohesion and the perception that everybody is *"in it together,"* regardless of any pre-existing intergroup divisions (Drury et al., 2016; Flade et al., 2019; Gilligan et al., 2014; Muldoon, 2020). There is also evidence to suggest that under these circumstances, groups often demonstrate more cooperation (Bauer et al., 2016; Bowles & Gintis, 2004; Gneezy & Fessler, 2012). In this regard, the shared experience of Covid-19 appears to have improved intergroup relations between staff and SUs in approved centres and facilitated the forging of closer bonds, due to the necessity of having to put forth a united front when faced with a shared challenge (e.g., Gaertner & Dovidio, 2009). The solidarity demonstrated by MHPs towards SUs as described above adds preliminary support to the validity of Jamil Zaki's emergent theory of *catastrophe compassion* (Zaki, 2020), and its applicability to the Covid-19 pandemic. Moreover, findings

echo those of previous studies suggesting that the instability caused by complex disasters may pre-empt gains in altruistic behaviours, a stronger sense of community (Glynn et al., 2003), and the broadening of social connections (Testard et al., 2021).

Conversely, findings suggest the prevalence of group-based 'othering' of risk in approved centres at the onset of the pandemic, where a weighted self-other dichotomy developed resulting in the categorisation of SUs as a threat. Social representations (e.g., Joffe, 1996; Wagner et al., 2002) may have been inadvertently employed by MHPs working in approved centres as a mechanism of symbolic coping with the Covid-19 threat, when fear and uncertainty reigned supreme. Importantly, this was most evident among MHPs working in the acute setting where there was a regular flow of new admissions. These findings draw comparisons to Helen Joffe's (1999) work on *Risk and the 'Other,'* which posits that in times of potential threat or crisis, the distinction between self and other representations intensifies, causing a powerful division to emerge between a righteous *"us"* and a disruptive, transgressive *"them"* (Douglas, 2003; Joffe, 2007). Prior research suggests that the self-other dichotomy is of central importance in the conceptualisation of contemporary risk issues including emergent infectious diseases, illustrating that a pattern of attribution can emerge that blames marginalised groups for 'leaking' the disease into the rest of the population (Joffe, 1999; Joffe & Bettega, 2003; Smith et al., 2015). These findings also align with prior research suggesting that our perception of safety and vulnerability are inextricably linked to shared group membership and group processes (Blois & Ryan, 2013; Cruwys, Stevens, et al., 2020), where social identities influence our cognitive and emotional responses to others in shaping our own self-perception (Cruwys, Stevens, et al., 2020). These findings support the hypothesis that people tend to more readily recognize the risk posed by out-group members (Cruwys, Stevens, et al., 2020), leading them to take appropriate precautions or, in certain instances, engage in

discriminatory behaviours (e.g., Greenaway & Cruwys, 2019; Zhai & Du, 2020). Consequently, potential threats arising from in-group members, in this case MHPs, with a shared social identity were perceived in some instances as less risky.

Results also illustrate that the Covid-19 restrictions and the wearing of PPE in approved centres could present a significant obstacle to building rapport with SUs and promoting social cohesion in staff-SU interactions. Moreover, promoting Covid-19 compliance among SUs in approved centres could threaten social cohesion and facilitate the emergence of prejudicial and discriminatory attitudes towards SUs. This is in line with decades of SIT research illustrating that human beings are motivated to enhance the relative status of their group (Tajfel, 1981) and to justify existing social hierarchies (Jost et al., 2004).

It emerged that the onset of the Covid-19 pandemic exacerbated existing interdisciplinary tensions in approved centres across medical-social lines, where AHPs felt increasingly disrespected by their medical counterparts. With interdisciplinary ties further undermined, intradisciplinary ties strengthened between out-group members and closer bonds were forged. This is in line with prior research indicating that threat tends to ratchet up in-group identification to maintain a sense of safety and control in the face of uncertainty (Fritsche et al., 2010, 2013; Hogg, 2007), where the strengthening of people's commitment to their in-group can sometimes lead to more intolerance and prejudice being directed towards out-group members (McCann, 2008). Previous studies have also demonstrated a positive association between in-group identification and in-group favouritism (Hewstone et al., 2002). This escalation in interdisciplinary tensions may reflect a dissonance between values espoused by social and medical models of care in an era when the latter has arguably re-asserted its dominance in approved centres with the prioritisation of infection prevention and control; the

ensuing sense of powerlessness experienced by out-group members arising from a perceived inability to enhance group status in a largely medicalised environment.

Findings also illustrate that hierarchical divisions in approved centres became more pronounced because of the public health crisis amidst a growing sense of underappreciation and isolation from upper management. SIT suggests that this may in part be attributable to the tendency for threat to prompt people to support their in-groups and derogate out-groups under certain conditions due to the propensity for group membership to serve as a buffer to threat (Castano & Dechesne, 2005; Giannakakis & Fritsche, 2011). This sense of a growing disconnect between staff and management echoes recent qualitative research exploring healthcare worker experiences of caring for Covid-19 patients in the NHS (Bennett et al., 2020). Importantly, current research on burnout in healthcare worker populations during Covd-19 suggests that perceived support or feeling valued by those in leadership positions is associated with lower levels of adverse outcomes such as stress, burnout, anxiety, depression, and post-traumatic stress disorder (Feingold et al., 2021; Linzer et al., 2021; Prasad et al., 2021).

3.4.1.2 Intragroup Social Identity Processes

Results indicate that the Covid-19 pandemic saw MHPs working in approved centres band together more as a collective in solidarity; this phenomenon was very much evident among MHNs, who relied heavily on each other for mutual support. The fact that these processes were most evident in, albeit not exclusive to, an intradisciplinary context echoes previous SIT research suggesting that people are more likely to offer and receive support from in-group members rather than out-group members (Haslam et al., 2009; Levine et al., 2005). A strong sense of collective efficacy came to the fore as MHNs pulled together to accomplish shared goals. Prior research suggests that gains in solidarity of this nature may arise from

identity fusion, which refers to a feeling of *"oneness"* with the in-group, where the alignment of the personal and social self (Segal et al., 2018) can increase collective action taken to protect the community (Paredes et al., 2020), or in this context, the unit. Findings illustrate that MHPs benefitted from the social outlet provided by their roles at a time of social distancing, offering a necessary counterweight to the reduction of social contacts in their personal lives. The increased distance that Covid-19 restrictions placed between MHPs represented a considerable adjustment for MHNs, threatening morale early on as opportunities for social support and camaraderie among colleagues were few and far between. That said, results suggest that collegial relationships helped to promote a sense of shared resilience among MHPs. Collegial relationships were described as an invaluable source of social connection and social support, often serving as a necessary pressure release valve for MHPs, thus helping them preserve a sense of personal wellbeing during a tumultuous time.

This is in line with recent *'social cure'* research, which illustrates how group-based processes of social support contribute to a range of positive health outcomes (e.g., Haslam et al., 2018; Holt-Lunstad et al., 2010; Jetten, Haslam, & Haslam, 2012). Previous studies have demonstrated an equivalence between social variables and behavioural risk factors in terms of predicting mortality (Holt-Lunstad et al., 2010; Putnam, 2000; Steffens et al., 2016). A recent meta-analysis by Steffens et al. (2017) has similarly demonstrated that social identification in organisational contexts is linked to health outcomes. It also emerged that the shared experience of Covid-19 strengthened collegial bonds through encouraging a deeper level of mutual understanding and respect. This draws parallels to prior research indicating that solidarity and social cohesion within groups can often manifest in the wake of mass tragedies or natural disasters (e.g., Hawdon & Ryan, 2011). Finally, findings suggest that the collective experience of working through a global pandemic may have positively altered the group

identity of MHPs working in approved centres, instilling in them a sense that, as a collective, they are more resilient than they had previously thought. Findings indicate that while intragroup hierarchical tensions could manifest among staff based on rank and status, a degree of collective efficacy was evident between staff and management on the ground.

Conversely, it was found that individual differences among MHPs in the context of Covid-19 threat appraisal led to novel divisions forming within staff groups, which had the effect of establishing pronounced *"us"* vs. *"them"* dichotomies that undermined group ties, as one might expect (e.g., Greenaway & Cruwys, 2019). Numerous studies have illustrated how people can become more prejudiced and intolerant towards others who they perceive as different when they feel threatened (Burke et al., 2010; Duckitt et al., 2002; Fein et al., 2003; Greenberg et al., 1997). As the pandemic continued, different beliefs about Covid-19, particularly regarding vaccination, posed a significant threat to intragroup cohesion. Findings indicate that a weighted self-other dichotomy (e.g., Joffe, 1999) emerged within mental health nurses between the majority vaccinated group and the minority unvaccinated group, whereby members of the latter came to possess a negative social identity. They describe being subjected to considerable pressure to conform to the status quo as they were viewed by many as a threat to the safety of others. Consequently, seeds of discontent were sown, and the minority group were more susceptible to discrimination, stigmatisation, and condemnation by majority group members.

A recent study by Maher et al. (2022) highlights an association between Covid-19 threat and authoritarian tendencies, building on previous research in indicating that authoritarianism is rooted in threat and group-related concerns (e.g., Jugert & Duckitt, 2009; Kreindler, 2005). Authoritarianism as a psychological construct is said to involve three key elements: a deep respect for authority, a desire to uphold order, and a fear of outsiders (Altemeyer & Altemeyer,

1996; Funke, 2005). In this instance, the predetermined apportioning of blame to the unvaccinated minority for hypothetical future outbreaks in advance of any objective wrongdoing reinforces the sense that disease is carried by transgressive, feared others, who in this context are the unvaccinated minority. It could thus be argued that efforts to marginalise the insubordinate group in this way represent an effort to restore or uphold order in response to perceived threat, particularly since perceived threat can encourage authoritarian responses (Jugert & Duckitt, 2009). This is interesting given the association between greater group identification and increased conformity to group norms (e.g., see Neighbors et al., 2010; Stevens et al., 2019). Results indicate that this conflict has damaged social cohesion; it has led to a heightened sense of distrust, leaving some hesitant to seek support from colleagues and more inclined to avoid opportunities for social connection in the workplace.

3.4.2 Strengths, Limitations, and Future Directions

To the best of the researcher's knowledge, this study is the first to explore MHP experiences of SIT processes in a diverse selection of inpatient mental health settings; previous studies have tended to focus exclusively on SU experiences in this context (e.g., Bouchard et al., 2010; Dunn et al., 1990; Galloway & Pistrang, 2019; Harries et al., 1984; Jackson et al., 2009; Kessing, 2020; Wood et al., 2013). Moreover, this study is the first to empirically explore social identity processes among a sample of MHPs working in Irish regional approved centres during an unprecedented and novel public health crisis. As such, this study contributes to the development of robust mental healthcare research in the context of both Covid-19 and the application of SIT in healthcare settings (e.g., Burford, 2012; van Schaik et al., 2016), serving as a useful resource for policymakers in times of crisis. This study's findings converge with previous research in highlighting SIT's considerable influence over healthcare systems and

their functionality (e.g., Kreindler et al., 2012). Furthermore, they support SIT as a useful framework for understanding group processes in inpatient mental health settings with a view to promoting positive systemic change and further dismantling professional, sectoral, and institutional *"silos."*

This study further elucidates the link between SIT and resilience in organisational contexts, suggesting that group-level identification may exert an influence on health outcomes among MHPs, potentially having a mitigating effect against occupational stress and burnout. Future research might benefit from employing mixed methods to further explore this possibility where a process-based measure of resilience like the *Workplace Resilience Inventory* (McLarnon & Rothstein, 2013) and a trait-based measure of burnout (e.g., MBI: Maslach Burnout Inventory; Maslach et al., 1996) could be used in tandem with a qualitative examination of MHPs accounts of group processes in approved centres. In line with previous research exploring human behaviour in the wake of significant crises (e.g., Bauer et al., 2016; Drury et al., 2016; Hawdon & Ryan, 2011), this study highlights the potential for solidarity and social cohesion to manifest within and between groups during a global pandemic, which can inspire higher levels of cooperation. At the same time, it highlights how the strengthening of in-group commitment in response to threat can further marginalise out-group members, and the role of threat perception in undermining intra and intergroup ties (e.g., Burke et al., 2010; Duckitt et al., 2002). Perhaps future research could use a social identity approach to build on Maher et al.'s (2022) recent research investigating the association between Covid-19 threat and authoritarian tendencies in exploring pandemic-related societal divisions (e.g., vaccination) and the role of government messaging therein.

This study collected in-depth data from a cross-section of MHPs working in diverse regional approved centres, representing a respectable sample size for a qualitative study

(Vasileiou et al., 2018). Whilst data saturation was deemed to have been achieved, recruitment of participants in healthcare settings during a pandemic was not without its challenges and this likely had the effect of curtailing the sample size. In as much as was possible, diversity in terms of staff characteristics was encouraged with participants from a variety of nursing and allied health professional backgrounds taking part. However, due to protection of confidentiality, it was not possible to make comparisons between single allied health professions or refer directly to a participant's profession in this context. A larger sample size or a higher representation of AHPs in the sample may have allowed for comparisons and references of this nature to be made. That said, the aim of qualitative research is not to achieve statistical representativeness (Braun & Clarke, 2019), which is why the inclusion of a diverse a range of MHPs working in a selection of regional approved centres was prioritised.

Since the sole focus of the present study was to explore the experience of MHPs in approved centres during Covid-19 with a view to elucidating group processes within this organisational context, SUs were not consulted. This means, however, that many of these findings rely solely on MHP accounts of intergroup processes involving SUs and lack a corresponding SU perspective. Despite deciding to focus exclusively on subjective MHP accounts due to this being a historically under-represented area of study, the exclusion of SUs is anathema to recovery model ideals and may represent a missed opportunity to jointly consult with SUs regarding their experiences in approved centres during a global pandemic. While this critical realist analysis did not consider the factual accuracy of participants' accounts, deeming this immaterial to understanding their subjective implications, future research could also compare MHP narratives with SU perspectives on intergroup social identity processes in approved centres. For instance, it would have been interesting to know whether SUs in long-stay facilities share MHP perceptions of solidarity and less pro-social intergroup processes.

Given that inductive thematic analysis was employed for an exploratory examination of findings with a view to summarising key features of the data, the study is limited by the overly descriptive nature of the analysis. However, given the exploratory nature of the study and its objective to describe the experiences of MHPs working in regional approved centres during a pandemic, thematic analysis was considered the most appropriate approach to data analysis. Importantly, the current qualitative analysis sought to map the range of experiences present in this MHP sample from approved centres in one healthcare region of Ireland rather than generalizing findings beyond this dataset. Therefore, the experiences of participants are not fully representative of the experiences of MHPs in other Irish approved centres and should not be regarded as such. Future quantitative research could systematically investigate whether diverse inpatient MHP interpretations of group processes reliably correlate with particular antecedents and consequences.

The lack of respondent validation as a means of exploring credibility of results represents another limitation of this study. Given that trustworthiness of results is a cornerstone of qualitative research, employing this well-established validation technique would have enabled participants to provide feedback on data both during and following completion of the research process (Slettebø, 2021). Although the utility of respondent validation is contested by some who note the inherent challenges associated with participants having to accurately vouch for the interpretations of the researcher (e.g., Hammersley and Atkinson, 1996), its inclusion in the design of this study may have offered participants an opportunity to construct new meanings and experience empowerment through a re-examination of validity in dialogue with the researcher (Stoner et al., 2005).

Finally, the use of Cohen's Kappa in this study for inter-coder reliability purposes can be viewed as a limitation considering the ongoing controversy surrounding its applicability to

qualitative research. Although popular, the use of Cohen's Kappa among qualitative researchers has long been controversial (see Friese, 2020). While it has been noted that this measure was created for a very different purpose without the qualitative researcher in mind (e.g., Cicchetti & Feinstein, 1990; Feinstein & Cicchetti, 1990), others regard it as a viable instrument for quality assurance in qualitative analysis (Burla et al., 2008). Importantly, the critical realist epistemological approach employed by this study acknowledges the subjectivity of the researcher's own analysis, and the possibility of alternative accounts (Martin, 2020).

3.4.3 Clinical Implications

Findings raise implications for clinical practice. The results of this study suggest that MHPs in regional approved centres relied heavily on each other for social support and connection during the Covid-19 pandemic, highlighting the protective role of informal channels of intradisciplinary peer support in these settings. As a post-Covid-19 world comes into view, and exhausted global healthcare systems attempt to regroup and assess the damage incurred, frontline MHPs in approved centres may benefit from an organisational commitment to the provision of localised formal peer support to help facilitate this transition and re-build intra-organisational trust. Proactive strategies of this nature should go further than what could be perceived by staff as tokenistic offers of support or basic signposting to counteract the perceived undervaluation of staff working in these settings by senior management and help reverse the growing sense of disconnect between decision-makers and frontline staff. Results suggest that bridging this gap is paramount to the wellbeing of MHPs and their ability to continue providing high quality of care to SUs, particularly when one considers how the current literature on burnout identifies the lack of perceived support from those in leadership positions as a significant contributor to adverse outcomes among healthcare worker populations

(Feingold et al., 2021; Linzer et al., 2021; Prasad et al., 2021). Whilst some recent studies highlight this trend of disconnectedness from senior management among healthcare workers caring for Covid-19 patients (e.g., Bennett et al., 2020), findings suggest that this sentiment may be prevalent among other healthcare cohorts, more specifically, those working in inpatient mental health settings.

Whilst SUs were not consulted in this study, practitioner accounts suggest that the necessary imposition of Covid-19 restrictions on SUs in approved centres could at times frustrate SUs and serve as an obstacle to rapport building and equality in the context of MHP-SU relations. This is understandable when one considers that such restrictions are more aligned to paternalistic models of care, oftentimes representing the antithesis of the core ideals of the recovery model, where social inclusion, empowerment, self-determination, and hope represent central tenets of recovery (HSE, 2018). Findings similarly imply that client-centred practice that upholds recovery model ideals has been further challenged in approved centre settings due to the added layer of Covid-19 compliance, where some practitioners highlight a tendency for the increased bureaucracy associated with overseeing infection prevention and control to detract from the quality of SU care. With these factors in mind, it is vital that efforts are made to bridge this gap going forward from a clinical governance standpoint to ensure that barriers to recovery and vital therapeutic engagement are not upheld when it is no longer necessary to do so from a public health perspective. There may be a role for an external body in overseeing this transition (e.g., the Mental Health Commission, HIQA), to promote the prioritisation of a client-centred approach where applicable.

Results indicate an ongoing medical-allied health cultural division in Irish approved centres; one that risks becoming more entrenched in times of increased stress and can leave some practitioners feeling powerless. This highlights a need to reprioritise efforts to dismantle

professional silos in regional approved centres, where team-building interventions on the ground could play a key role in facilitating this process through opening lines of dialogue between professions and promoting understanding. The results also shed light on the capacity for societal divisions that have emerged because of the pandemic, namely regarding Covid-19 vaccination, to permeate clinical settings and pose a threat to group cohesion. This suggests a need for increased sensitivity around the provision of vaccination onsite in approved centres so that the choices of individual colleagues are not inadvertently disclosed to others, as the sharing of vaccination status may invite peer pressure and marginalisation.

Finally, it is important to consider the clinical implications of this study's findings in light of an evolving public health crisis that continues to impact on global healthcare services. It is thus useful to interpret thematic patterns longitudinally as many of the intragroup and intergroup social identity processes outlined in this study came to prominence at different timepoints during the Covid-19 journey in approved centre sites. For example, the positive social identity processes outlined between staff and service users were prominent in non-acute settings for the entirety of Covid-19 journey documented in this study, whereas a weighted self-other dichotomy superseded the cultivation of a collective efficacy in the acute setting at the onset of the pandemic. Moreover, the early phase of the Covid-19 pandemic saw a general dip in staff morale coincide with a flashpoint in interdisciplinary conflict across settings; an exacerbation in what many considered to represent pre-existing tensions that for the most part resolved over time and in some instances led to more cohesive interdisciplinary working relationships. In line with existent SIT literature, positive intragroup identity processes were more pronounced at times of heightened instability where intradisciplinary colleagues tended to rely on each other for mutual support, though these processes were evident throughout and across settings. Importantly, the evolution of the pandemic saw an added layer of

complexity emerge with the advent of vaccination and its implications threatened intragroup cohesion.

3.4.4 Conclusion

SIT is a widely acknowledged phenomenon and is an important consideration in times of crisis and instability. Considerable research has demonstrated that subjective group identification can influence a person's thoughts, perception, attitudes, and behaviour. While inpatient mental health settings have long been regarded as challenging places to work, wherein complex intergroup dynamics can manifest (Cleary et al., 2010), minimal research has explored how SIT processes are subjectively experienced by MHPs working in approved centres. The Covid-19 pandemic provided a unique opportunity to explore group social identity processes in Irish regional approved centres, from the perspective of those at the frontlines of service delivery. Findings indicate that the pandemic influenced intergroup and intragroup social dynamics at these centres, which both strengthened and undermined group ties.

On the one hand, findings illustrate that the shared experience of Covid-19 led to positive collective outcomes and pro-social behaviours like solidarity and collective efficacy, both within staff groupings and between staff and SUs, which encouraged social cohesion and increased cooperation. It also emerged that the threat posed by the pandemic led to instances of group-based 'othering' in approved centres, where SUs were categorised as a threat. Results indicated a sharp escalation in interdisciplinary tensions at the onset of the pandemic as intragroup identification strengthened, which for a period deepened the medical-social divide. Pre-existing hierarchical divisions similarly grew more pronounced, with staff reporting a greater sense of disconnect from senior management. Results also indicate that a divergence within certain MHP cohorts in the context of both Covid-19 threat appraisal and vaccination

led to novel divisions forming within staff groups, which had the effect of establishing pronounced *"self"* versus *"other"* dichotomies, which could pre-empt out-group marginalisation and discriminatory attitudes.

This study contributes to the development of robust mental healthcare research in the context of Covid-19, and the application of SIT to inpatient mental health settings to better understand group processes therein, with a view to promoting positive systemic change. Moreover, findings are suggestive of an association between SIT and resilience in organisational contexts, where group-level identification may influence health outcomes in this context and help to mitigate against occupational stress and burnout. This represents a fertile area for future exploratory research. Results highlight the protective role of informal channels of intradisciplinary peer support in approved centres and the importance of an organisational commitment to enacting proactive formalised strategies to build organisational trust going forward. Form a clinical governance perspective, findings illustrate the importance of ensuring that potential barriers to SU recovery and client-centred care in approved centres are removed in accordance with public health guidance. Future research should endeavour to compare the subjective experiences of MHPs and SUs in approved centres of intergroup social identity processes.

Chapter Four

Discussion

4.1 Chapter Overview

As the final chapter of the thesis, this chapter aims to place the independent studies of Chapters 2 and 3 within the broader context of the wider thesis aims. In doing so, this chapter will revisit the aims and rationale of the thesis that were introduced in Chapter 1, and will discuss the contribution of the two studies to these wider thesis aims, and existing theory and knowledge. Since the thesis forms part of a Doctorate in Clinical Psychology, a key element of this chapter will centre upon the clinical implications of the findings. Following a discussion of the strengths and limitations of the current research, this chapter will include a commentary on areas for future research. This chapter seeks to synthesise the findings of the two featured studies to broaden our understanding of the concept of resilience in mental health service provision and the role of social identity processes. Finally, it is hoped that this chapter will leave the reader with an in-depth understanding of the degree to which the goals of this thesis were met and the implications for clinical practice and future research.

4.2 Revisiting Thesis Aims and Rationale

The aim of this thesis was to address a gap in the literature by examining mental health practitioner (MHP) experiences of resilience in the context of service delivery and to explore the application of social identity theory (SIT) to inpatient clinical settings and its role in facilitating MHP resilience processes therein. Given that evidence points to the relevance of group identification in times of instability and its robust effects on health and wellbeing, this thesis posits that group-level processes influence MHP resilience. In doing so, it proposes SIT as a useful theoretical framework for understanding resilience processes in the context of inpatient mental health (MH) service provision, particularly in times of crisis.

To address the aims of this thesis, a two-study approach was taken. These studies contribute to an overall understanding of the factors that influence MHP resilience outcomes according to those at the frontlines of service delivery. The two studies include: (1) A systematic review of qualitative literature on MHP experiences of resilience in their practice, and (2) A qualitative study exploring staff experiences of social identity processes in Irish regional approved centres during Covid-19. The rationale for completing these studies within this thesis was to facilitate a more comprehensive understanding of the conceptual underpinnings of resilience in the context of MH service provision in line with the unfolding fourth wave of resilience research that supports the growing recognition of resilience as a dynamic, multidimensional construct. This was identified as a timely area of empirical investigation given the emergence of burnout as a critical issue in global mental healthcare systems, well documented chronic resourcing issues in Irish MH services, and the impact of Covid-19 on service provision. Factors of relevance at the level of group identification were considered, with the aim of establishing an in-depth understanding of the experiences of MHPs working in Irish regional approved centres during the Covid-19 pandemic to explore whether group social identity processes were inadvertently stimulated by the crisis.

4.3 Key Findings

Findings support conceptualisations of resilience as flexible and multifaceted in MH service provision, contingent on the dynamic interplay between multiple interconnected factors. Rather than an intrinsic quality that exists in isolation, resilience is described by MHPs as a shared process that exists in relationship. Findings illustrate the key role of meaningful social connections in facilitating resilience processes among MHPs. Results recognise the bidirectional nature of resilience in MH work, where the resilience of the collective can

influence that of the individual practitioner, and vice versa. Findings suggest that resilience and social identity may represent complementary pathways to MHP wellbeing in inpatient MH service provision, wherein SIT can provide an underlying explanation of how group-level identification can both strengthen and undermine collective resilience in times of crisis. This thesis' findings suggest that SIT represents a helpful theoretical framework for conceptualising resilience as a dynamic process that occurs within a social context, and support the integration of resilience and SIT in efforts to promote staff wellbeing in clinical settings. Results across studies demonstrate a significant degree of convergence between subjective MHP experiences of factors that facilitate resilient practice and the considerable influence exerted by social identity processes over MHPs in regional approved centres during Covid-19. Finally, findings indicate that SIT may provide a constructive lens through which to better understand inpatient MHP resilience processes and promote resilient practice by reducing stress and enhancing wellbeing among staff in inpatient settings. Alongside the applicability of SIT in MH settings, results more generally support previous assertions that SIT exerts a substantial influence on how healthcare systems function and thus propose SIT as a useful framework for understanding the group dimension of organisational issues.

4.4 Contribution to theory

The key conceptual advance of this thesis relates to the integration of SIT and resilience, whereby social identity can provide a useful theoretical framework for understanding the group dimension of resilience processes. More specifically, the findings of this thesis suggest that SIT may represent a crucial interface between personal and collective resilience processes and support Turner's (2010) proposal that SIT can act as a merger in resilience processes through its influence over collective cognition and action. This thesis builds upon Southwick et

al.'s (2014) hypothesis that resilience cannot exist in isolation and should be viewed as occurring on a continuum rather than in binary terms, where findings suggest that the theoretical coupling of resilience and social identity may help further elucidate the adjacent elements that make up this continuum, and the role of group processes therein.

This thesis contributes to an ongoing debate in the resilience literature regarding its conceptual underpinnings, as reflected in its application to MH research to date (Friborg et al., 2009; Hoge et al., 2007; Larm et al., 2010; Lawn et al., 2011; Zamirinejad et al., 2014). In doing so, it contributes to the unfolding fourth wave of resilience research and supports conceptualisations of resilience as a dynamic, interactive process that draws from multiple complex systems of interconnectivity (e.g., Aburn et al., 2016; Curtis & Cicchetti, 2007; Hill et al., 2018). Results support the growing consensus in the literature that conceptualising resilience solely at the level of the individual excludes fundamental processes implicated in group resilience following exposure to adversity and support the ongoing prioritisation of collective levels of resilience in this context (see Drury et al., 2009; Lyons et al., 2016; Norris et al., 2008), where social identification may represent one such process.

In highlighting the value of meaning-making processes in promoting resilience, the findings of this thesis are consistent with the resilient integration stage of Richardson's meta-theory of resilience (2002), which posits that the capacity for individuals to derive meaning from adversity can enable growth and the strengthening of resilience (see Chapter 1). Results across studies suggest that MHPs can experience gains in resilience as a product of overcoming personal or professional adversity; a process that can prompt significant professional development and growth. In Chapter 3, for example, MHPs describe how overcoming adversity in their own lives during the pandemic facilitated significant personal growth and enabled them to empathise with SUs on a more genuine level, with some adopting a more compassionate,

holistic therapeutic presence due to a deeper recognition of the hardships of the other. Moreover, there may be further scope for extending Richardson's meta-theory beyond the level of the individual to capture collective meaning-making and growth in this context. MHPs working in approved centres, for example, allude to a shift in their collective identity having overcome the significant challenges posed by the pandemic, after which they saw themselves as more resilient as a group, as outlined in Chapter 3.

By further demonstrating the link between SIT and resilience processes, this thesis contributes to a lengthening chain of theoretical development concerned with conceptualising collective responses to complex emergencies that are often pro-social by nature. While findings to a large extent support Williams and Drury's (2009) theory of *collective psychosocial resilience* and Zaki's (2020) emergent concept of *catastrophe compassion*, they also shed light on how group-level processes in this context can also undermine group ties and threaten resilience; a process for which SIT provides a helpful underlying explanation.

4.5 Synthesis of findings across studies and contribution to knowledge

Findings across studies build upon recent research suggesting that resilience and social identity can be viewed as complementary pathways to enhancing wellbeing and facilitating positive health outcomes (e.g., Van Dick et al., 2017), and extend this premise to encompass inpatient MHPs in an Irish context for the first time. Results suggest that social support and cohesion among MHPs play a key role in facilitating resilience processes and support the application of the *social cure* perspective to MH settings. As discussed in Chapter 1, this perspective is deeply rooted in SIT and sheds light on the link between social groups and wellbeing. Moreover, this perspective comes with a substantial evidence base across healthcare, employment, community life, and sporting domains, where identification with

meaningful social groups is associated with a vast array of physical and psychological health outcomes (Haslam et al., 2012, 2018).

Findings across studies suggest that the psychological resources derived through the cultivation of a shared social identity with colleagues can benefit the wellbeing of MHPs by facilitating a strong sense of solidarity and social cohesion. As evidenced in Chapter 2, MHPs conceptualise resilience as a relational construct, describing it in terms of a shared process that emerges from the interplay between self and other. This study also draws attention to the pro-resilience benefits that can accompany the cultivation of a shared professional identity with intradisciplinary colleagues; a process that can engender a strong sense of camaraderie. Findings from Chapter 3 similarly demonstrate how MHPs in approved centres were highly dependent on the social connection provided by their roles during the pandemic, which had a protective effect on their personal resilience when access routes to other sources of meaningful social connection, as evidenced in Chapter 2, were compromised on the grounds of public health. Furthermore, while approved centres were dependent on staff to fulfil their role obligations during the pandemic, staff were also dependent on their roles to achieve something approximating a healthy work-life balance, at a time when the majority of the public were confined to their homes (see Chapter 3); the latter having been identified in Chapter 2 as important protective factor in the context of MHP resilience. Since social identity serves as a basis for group-based social identification, so too can the lack or loss of social identity bring forth social disconnection and loneliness (Haslam et al., 2022). This is reflected among the findings of Chapter 3, when an overarching sense of social disconnection among MHPs lowered morale for a time, challenging group cohesion and collective resilience. These findings are consistent with studies that illustrate the adverse impact of a lack of social connection on

psychological wellbeing (Cruwys et al., 2018; McKenzie et al., 2002; Yanos et al., 2001), and physical health (Holt-Lunstad et al., 2010).

The findings of this thesis align with contemporary research that proposes social identity as a collective resilience factor. Recent studies indicate that the cultivation of a shared social identity can help counteract the adverse impact of environmental stress on individuals and groups (e.g., Drury, 2018; Erfurth et al., 2021; Ntontis et al., 2018, 2021); a process that can serve as a basis for collective self-organisation across a range of emergency situations. Under such circumstances, an ethos of cooperation, social support, and collective efficacy can develop against a backdrop of shared problems and shared goals. This, in turn, can facilitate the disintegration of previous group boundaries and positively affect wellbeing (Ntontis et al., 2018, 2021). Results from Chapter 3 illustrate how a strong sense of collective efficacy developed among MHPs and SUs in approved centres, where the shared experience of the pandemic required intergroup cooperation to overcome a shared challenge, allowing for the dissolving of pre-existing divisions and facilitating the forging of closer intergroup bonds; an outcome that is consistent with existing research on the collective experience of adversity (e.g., Drury et al., 2016; Flade et al., 2019; Gilligan et al., 2014; Muldoon, 2020). Importantly, MHPs had to recognise SUs as co-collaborators in the process of neutralising the Covid-19 threat for this collective efficacy to develop, echoing findings outlined in Chapter 2 that highlight the need for practitioners to respect SU agency to sustain resilience. This required MHPs in approved centres to move beyond categorising SUs as transgressive saboteurs who represent an existential threat; in-group divisions can intensify in times of crisis and pre-empt the manifestation of social representations of this nature as discussed in Chapter 3 (e.g., Joffe, 1999).

Collective efficacy has previously been proposed as an important mediator when it comes to MH (Cruwys, Stewart, et al., 2020; Van Zomeren et al., 2008), and it has been proposed as the core mechanism through which the recovery model inspires positive outcomes among SUs (Tew et al., 2012). This thesis similarly proposes collective efficacy as an important mediator when it comes to MHP wellbeing, suggesting that it plays a key role in facilitating collective resilience in inpatient MH settings. This sits well with a core premise of SIT which posits that shared identity can produce a synergy whereby individuals are equipped with strengths and abilities that they would not come to possess in isolation; a process that was very much evident in Chapter 3, when a collective sense of duty of care and a shared belief that their roles were of value encouraged adaptive coping in the face of adversity, enabling individual MHPs to overcome their own personal anxieties and keep approved centres functional. This mirrors findings outlined in Chapter 2 that identify a strong professional identity and commitment to the vocational self as important contributors to coping, where the sense that one is making a valuable contribution can foster meaning, commitment, and a deep sense of purpose; a place where personal identity merges with that of collective. This brings to mind the concept of identity fusion (Segal et al., 2018) or a feeling of *"oneness"* with the in-group as discussed in Chapter 3, where the convergence of the personal and social self can encourage collective action to protect the community (Paredes et al., 2020). This alignment of the personal with the collective is also evidenced in Chapter 2 and is positively implicated in MHP resilience processes, encouraging a goodness-of-fit between practitioners' personal and professional values.

Conversely, a divergence in social identities can threaten wellbeing; a process referred to by some as the *social curse* (Kellezi et al., 2019; Kellezi & Reicher, 2012; Muldoon et al., 2019; Schury et al., 2020; Wakefield et al., 2019). This can give rise to social processes like

stigma, discrimination, and inequality, which have been implicated in poor health outcomes (e.g., Major & O' Brien, 2005). Chapter 3 outlines an escalation in existing interdisciplinary tensions during the pandemic, where professional identities were split across a medical-social cultural divide. Allied health professionals report that this conflict took a significant toll on their personal wellbeing, a process well documented in the SIT literature where the strengthening of people's commitment to their in-group can sometimes lead to more intolerance and prejudice being directed towards outgroup members (see McCann, 2008). The injustice experienced by the marginalised out-group facilitated an increase in collective self-advocacy, where practitioners moved from a position of self-sacrifice to one of self-preservation; an important element of resilient practice as outlined in Chapter 2. This conflict led to a strengthening of intragroup bonds (e.g., Fritsche et al., 2010, 2013; Hogg, 2007), as allied health professionals could reflect and make sense of things together whilst supporting each other emotionally. This similarly converges with results from Chapter 2 that identify reflective practice as a key contributor to resilience due to its capacity to facilitate emotional containment and encourage meaning-making in the face of work-related challenges.

When social groups splinter and divide in response to intragroup threat, this darker side of the *social cure* again comes to the fore, as is evidenced in Chapter 3 when a range of 'self-other' dichotomies formed within groups, none more pronounced than that originating from the contentious issue of vaccination. The unvaccinated minority staff off-shoot came to possess a negative social identity and were more susceptible to discrimination by majority group members; a process illustrated by a range of studies (see Chapter 3). Given that MHPs conceptualise resilience as a relational construct on which workplace relationships and culture exert considerable influence as evidenced in Chapter 2, it is understandable that such a scenario would threaten the resilience of the unvaccinated minority. Moreover, these MHPs

were more inclined to distance themselves from their colleagues, limiting their capacity to access collegial support. Research suggests that not only do former group members lose in-group support but that support is often actively denied to them (e.g., Kellezi & Reicher, 2012), where norm-violating in-group members receive harsher treatment than their out-group equivalents (Marques et al., 1988; see Wakefield et al., 2019). Whilst stigma increases exclusion, undermining trust and cooperation, as is reflected in the experience of unvaccinated MHPs in Chapter 3, research suggests that this conflict can be overcome by reinforcing intergroup commonalities and evoking a sense of shared humanity, thereby paving the way for *social cure* processes (Bowe et al., 2019); an outcome perhaps evident in MHPs coming to view SUs with more empathy as a consequence of the pandemic as evidenced in Chapter 3.

An important area of convergence across both studies relates to the role of management in encouraging MHP resilience processes. Firstly, the two studies cite a tendency for management to pay lip service to the notion of self-care in MH work in the absence of sincere efforts to promote practitioner resilience. Chapter 2 suggests that practitioner resilience is to a large degree reliant upon adequate levels of organisational support, where flexibility, autonomy, and feeling valued in their roles can have an empowering effect on MHPs. This is in stark contrast to the growing sense of disconnect from senior management as reported by MHPs in Chapter 3, where findings depict a prevailing sense of underappreciation and MHPs feeling inadequately supported in their work. These findings are consistent with current research on healthcare populations that demonstrate an association between perceived support or feeling valued by management and lower levels of burnout and other adverse outcomes (Feingold et al., 2021; Linzer et al., 2021; Prasad et al., 2021). Moreover, MHPs in approved centres report an increased rigidness in their roles due to the added layer of Covid-19 compliance, which can reduce opportunities for spontaneity and inhibit their

capacity to meaningfully engage with SUs. This converges with findings in Chapter 2 indicating that having a sense of choice and autonomy in their roles can empower MHPs. Additionally, the results of the systematic review suggest that when organisations impose structure on MHPs that is perceived as oppressive or overbearing, this can have a disempowering effect and leave MHPs more vulnerable to experiencing feelings of apathy and powerlessness. This also evokes the sentiment of allied health professionals in Chapter 3, who describe how feeling oppressed by the dominant medical culture in approved centres can give rise to a similar sense of powerlessness.

4.6 Limitations and Strengths

The thesis was constructed with a funnel-type design whereby the aim was to first develop a broad understanding of factors that influence practitioner resilience based on the subjective experience of MHPs in Chapter 2. Considering the findings therein and recent trends in the resilience literature, it was then decided to move to a more focused examination of practitioner accounts of social identity processes in regional approved centres during Covid-19 in Chapter 3. This structure was designed to address the overarching aim of developing greater conceptual clarity of the construct of MHP resilience in the context of service delivery, and to further elucidate the role of social identification in this process. However, this methodology also encompassed practical considerations. The preferred thesis structure as defined by the doctoral programme was that of a systematic review in conjunction with an empirical study, which meant that certain elements of the design were prescriptive. Furthermore, as a thesis undertaken within a clinical programme it was important to prioritise clinical applicability. In implementing this funnel-type design it was possible to address key thesis aims whilst balancing the prescribed parameters of the doctoral programme. Within these parameters, an

aim was to work towards developing a greater awareness of MHP experiences of resilience and factors that impact on same with a view to broadening understandings of resilience and how it might be promoted among staff working in notoriously challenging clinical environments.

While satisfied that this choice of methods succeeded in contributing to this aim, particularly since this represents an under-represented area of empirical investigation, it is important to note that there are relevant clinical experiences that were not captured by this thesis methodology. With both studies focusing on practitioner experiences, it is likely that the inclusion of SU experiences in this thesis could have provided a worthwhile alternate methodology. This is particularly relevant in Chapter 3, where findings relating to intergroup processes between staff and SUs rely solely on MHP interpretations, lacking a corresponding SU perspective. Although a decision was made to solely focus on MHP experiences of resilience and social identity processes, with a view towards encouraging positive outcomes both for MHPs and SUs alike, excluding SU viewpoints represents a salient limitation of this thesis. Moreover, the exclusion of SUs from MH research runs contrary to recovery model ideals and perhaps can be viewed as a missed opportunity to consult the lived experience of SUs in approved centres during an unprecedented time of crisis and upheaval.

Another limitation to the thesis centres upon the possibility that a sample selection bias may have occurred during data collection for the empirical study. Approved centre staff who volunteered to participate in the study outlined in Chapter 3 may have had a greater interest in the topic or may have felt more compelled than others to use the research project as an opportunity to express their dissatisfaction with the nature of clinical governance at these centres, and the workplace culture therein. Despite having achieved data saturation, participant recruitment in inpatient hospital settings during the Covid-19 pandemic had its challenges, and consequently, the sample size was likely curtailed. This curtailment of the

sample size, coupled with the traditional under-representation of allied health professionals in approved centres, meant that comparisons could not be made between single allied health professions in this context to protect confidentiality. Comparisons of this nature were, however, possible in the systematic review.

The fact that this thesis solely employed a qualitative design in its methodology represents another limitation, where the absence of a quantitative approach may have limited the breadth and depth of understanding achieved, removing opportunities for corroboration of findings by employing a mixed method approach, particularly in the systematic review where studies that employed process-based measures of resilience were excluded. Moreover, an exclusively qualitative design arguably magnifies the risk of interpretative bias in this thesis. That said, the lack of a review that systematically collates, evaluates, and synthesises qualitative empirical studies exploring MHP experiences of the reality of what resilience means in their practice was problematic, particularly as such a document may have important implications for governance in the context of MH service provision. Furthermore, my experiences as a clinician inspired a desire to develop a wider understanding of the construct of resilience as experienced by MHPs as I felt it merited further attention given its relevance to practitioner wellbeing and quality of care. The prioritisation of a qualitative perspective also made sense given the ongoing conceptual evolution of resilience as a dynamic, interactive construct as outlined in Chapter 1, as it facilitated a departure from a traditional overreliance in MH literature on preconceived variables conceptualising resilience as an innate psychological construct, encouraging further development of how resilience is understood in this context. Moreover, the ongoing issues around the conceptual clarity of resilience and its application to MH research are reflected in quantitative empirical investigations, with some

utilising process-based measures of resilience (e.g., Crowe et al., 2016) and the majority relying on trait-based measures (e.g., Kalathil et al., 2011).

These limitations notwithstanding, this thesis has many strengths. Firstly, an important conceptual advance of this thesis involves the integration of SIT and resilience in the context of MH service provision. Therefore, this thesis contributes to an unfolding fourth wave of resilience research in developing an understanding of resilience as a dynamic and multidimensional construct in MH service delivery and the role of social identity processes therein. Secondly, this thesis covers new ground in investigating social identity processes among a sample of MHPs working in Irish regional approved centres during a global pandemic. It thus contributes to the development of both a robust body of Covid-19 mental healthcare research and the application of SIT to healthcare service provision research (e.g., Burford, 2012; van Schaik et al., 2016). As the findings of this thesis can shed further light on the multiple systems of interconnectivity that influence MHP resilience, and the role of social identity processes, it is hoped that it may serve as a helpful resource for researchers, practitioners, and policymakers going forward.

4.7 Implications for Practice and Policy

The findings of this thesis raise implications for clinical practice and policy. Since resilience and social identity may represent complementary pathways to MHP wellbeing, findings support a reconsolidation of organisational efforts to promote social cohesion among staff in Irish regional approved centres as services re-group post-pandemic. Given the central importance of relationships in influencing practitioner resilience, it is crucial that efforts to build MHP resilience are sufficiently multifaceted and extend beyond the level of the individual. Findings support the application of a social ecological model of resilience (e.g., Ungar, 2015) in

approved centres; one that accepts practitioner resilience as something that cannot exist in isolation from the organisational culture, and the group dimensions therein.

An organisational commitment to the provision of incentivised group-based peer support could represent a resource efficient means of simultaneously encouraging personal reflection, strengthening social identification, and hence collective resilience. There is some evidence to suggest that group-based trainings can be more effective than individual trainings (e.g., Mantzios & Giannou, 2014), where collective efficacy has been proposed as an important mediator. Moreover, some posit that the positive wellbeing outcomes elicited by community-based, recovery-oriented support groups are similarly mediated by collective efficacy (e.g., Cruwys, Stewart, et al., 2020). Consequently, evidence-based resilience workshops, like the Stress Management and Resiliency Training (SMART; Sood et al., 2014) programme, that incorporate a group format may simultaneously foster resilience and SIT processes among MHP cohorts. Similarly, group-level interventions like Mindfulness-Based Stress Reduction that have been shown to reduce burnout among healthcare professional samples (Luken & Sammons, 2016) may jointly stimulate individual and collective resilience processes in this way, since opportunities for reflection are incorporated into this model.

An important area of convergence across both studies relates to the relationship between the hierarchical organisational structure and MHP resilience processes. Indeed authentic leadership has been shown to increase staff wellbeing in organisational contexts, with some implicating increased social identification in this outcome (e.g., Hystad et al., 2014). Moreover, findings from Chapter 2 suggest that practitioner resilience is highly reliant on perceived organisational support, where flexibility, autonomy, and feeling valued in their role can have an empowering effect. A growing sense of disconnect between staff and senior management is highlighted in Chapter 3, and findings illustrate that MHPs in approved centres

feel increasingly underappreciated and unsupported. Importantly, current research on healthcare populations demonstrates an association between perceived support or feeling valued by management and lower levels of burnout and other adverse outcomes (Feingold et al., 2021; Linzer et al., 2021; Prasad et al., 2021). With burnout identified as a critical issue in MH service provision prior to the disruption caused by Covid-19, MHPs in approved centres should be encouraged to abandon preconceived notions of invulnerability at a policy level. An organisational culture that values practitioner wellbeing and proactively promotes self-care practices and other pro-resilience strategies should be viewed as an ethical imperative, given the plethora of adverse outcomes associated with the alternative (see Chapter 1).

Findings are suggestive of the enduring presence of professional silos in Irish regional approved centres, and imply that relations between disciplines may become more inflamed in a time of crisis. This risks compromising effective interdisciplinary collaboration and, consequently, quality of care in these settings. Moreover, it draws attention to the need to further dismantle professional silos in MH, a longstanding challenge and a common feature of research on healthcare service provision (e.g., Clancy, 2006; McDonald et al., 2007). Findings in Chapter 2 attest to how MHPs can feel disempowered when they perceive an organisational structure to be oppressive or overbearing, limiting their sense of autonomy in their roles. This can leave practitioners more vulnerable to experiencing feelings of apathy and powerlessness; a sentiment expressed by allied health professionals in Chapter 3 in response to their perceived subservience to the dominant medical culture in approved centres. The findings of this thesis are consistent with previous research in proposing SIT as a useful framework for understanding the dynamics of interdisciplinary teamwork in healthcare settings (Burford, 2012; van Schaik et al., 2016) and suggest that interdisciplinary team-building interventions could help

encourage a more egalitarian culture of care. It is only through facilitating an open dialogue between the disciplines that commonalities can emerge.

Findings have implications for policy and recovery-oriented care in highlighting the importance of positioning SUs as co-collaborators in the clinical sphere. Results outlined in Chapter 3 suggest that paternalistic and prejudiced attitudes towards SUs persist in approved centres, where the added dimension of promoting adherence to public health measures could run contrary to the core tenets of the recovery model, namely social inclusion, empowerment, self-determination, and hope (HSE, 2018). Practitioners also suggest that the increased bureaucracy accompanying Covid-19 compliance in their roles could compromise client-centred care. This thesis highlights the benefits of adopting a recovery-orientation for both SUs and practitioners. It is important to note, however, that organisational factors play a key role in influencing staff receptiveness to making recovery-oriented changes (Gee et al., 2017), whereby an organisational commitment to steer away from a culture of blame towards one that encourages positive risk-taking can incentivise staff to move beyond traditional role boundaries. From a clinical governance perspective, it is critical that barriers to SU recovery are removed in tandem with public health guidance where an impartial external body could oversee this transition (e.g., the Mental Health Commission, HIQA). This is of particular salience given the longstanding challenges associated with embedding a recovery-oriented ethos into inpatient MH settings.

This thesis identifies social inclusion and identity as core contributors to MHP resilience. This is interesting when one considers that these represent central tenets of recovery and is further suggestive of a link between social identity processes and the recovery model. From a service development perspective, a meaningful extension of fundamental recovery model ideals to MHPs may help promote occupational wellbeing, career longevity, quality of care and

positive SU outcomes, and a host of organisational benefits. In the same way that prioritising SU perspectives in the formation of MH policy and best practice guidelines enhances the overall responsiveness and efficacy of global healthcare systems, an organisational culture of co-collaboration that empowers practitioner voices is likely to yield similar gains. Furthermore, findings from Chapter 3 can inform a broader ethical conversation about the processing of Covid-19 vaccination data in organisational contexts, and the right of individual practitioners to privacy. Findings suggest that failing to handle the issue of vaccination with due sensitivity within an healthcare service provision framework may threaten collective resilience, which in turn risks compromising individual practitioner wellbeing and quality of care. On a national level, results indicate a widening of the healthcare/mental healthcare schism from the perspective of MHPs working in Irish approved centres, where staff attitudes on the ground are reflective of the low priority given to MH in the overall *Sláintecare* strategy, as critiqued by Mental Health Reform (2021) and outlined in Chapter 1.

4.8 Implications for Research

This thesis offers significant scope for future research. Since the thesis supports the application of the *social cure* perspective to staff in MH settings and an extension of recovery model ideals to MHPs to promote resilient practice, future research could examine the potential application of Haslam et al.'s (2016) *"groups 4 health"* to inpatient MH settings. This manualised 5-module psychological intervention has already been shown to be an effective means of developing social group relationships in SU populations (Cruwys et al., 2021; Haslam et al., 2019) and has prompted gains in mental health, wellbeing, and social connectedness. Moreover, recent Covid-19 related research suggests that this intervention may offer protection against unanticipated environmental and contextual threats to wellbeing, and may

be effective as an intervention to 'inoculate' people against changes associated with major life events (Cruwys et al., 2021).

Findings support efforts to move beyond the use of trait-based resilience measures in resilience research to reflect its current state of conceptual evolution. For example, future resilience research in healthcare settings may benefit from incorporating process-based resilience measures like the *Workplace Resilience Inventory* (McLarnon & Rothstein, 2013) into the empirical design. Similarly, this thesis supports the application of psychometric instruments that acknowledge the group dimension of resilience processes to inpatient mental health settings. For example, the *Fletcher-Lyons Collective Resilience Scale* (FLCRS; Lyons et al., 2016) has shown promise in its capacity to assess the wellbeing benefits associated with belonging to resilient groups or communities. Results suggest that explorative efforts to validate this instrument for use among MHP cohorts may represent a fertile avenue for future research.

A key conceptual advance of this thesis relates to the integration of SIT and resilience in the context of MH service provision, whereby social identity may provide a constructive lens through which to better understand MHP resilience processes. This warrants further investigation in future empirical research as efforts to combine the two fields of resilience and social identity research show promise. Future research should build on the exploratory findings of this thesis and further examine social identity as a resilience factor in MH service provision both globally and nationally, to develop an understanding of how it operates in reducing the adverse impact of environmental stress on individuals and groups in this context. Given that this thesis sought to address a gap in the literature by establishing a deeper understanding of MHP experiences of resilience in the context of service delivery, and the role of social identity processes, SUs were not consulted in this research. In keeping with recovery model ideals and the social identity approach, it is imperative that future qualitative research in this area

dissolves this intergroup boundary in prioritising SU inclusion, where future studies could compare MHP and SU perspectives on how intergroup social identity processes in approved centres impact on resilience. Future exploratory research could also seek to further develop the emergent concept of *catastrophe compassion* (Zaki, 2020) by examining its applicability to acute inpatient MH settings. Finally, given that SIT and polyvagal theory (Porges, 1997, 2003) overlap in their concern with human responses to threat and how a perceived lack of safety can influence social functioning, research combining these disparate fields of research may represent a timely area of empirical endeavour, both from a theoretical and a clinical standpoint, as the world recovers from a collective trauma in the form of a global pandemic.

4.9 Conclusion

This thesis sought to explore the concept of resilience in MH service provision to better understand processes that influence practitioner resilience in this context and investigate the role of social identification therein. The findings of the thesis as a whole suggest that resilience represents a flexible, multidimensional construct in the area of MH delivery that is largely contingent upon the dynamic interplay between multiple factors of interconnectivity; a process wherein social identification and group-level processes play a key role. This thesis highlights the conceptual compatibility of resilience and SIT, where both may represent complementary pathways to MHP wellbeing that can be harnessed to engender positive outcomes for individual practitioners, SUs, and mental healthcare systems.

This thesis raises important clinical implications. Findings posit that SIT exerts a considerable influence over the functionality of inpatient mental healthcare systems and propose it as a useful framework for understanding the group dimension of organisational conflicts in this context. This thesis also offers significant scope for future research and

supports the integration of resilience and social identity in MH research, to further develop an understanding of how to mitigate against the adverse impact of environmental stress on individuals and groups in this context. The unfolding fourth wave of resilience research is an area in which there is a great deal of scope to develop a deeper understanding of dynamic, relational processes that may yield long lasting benefits for mental healthcare staff populations and perhaps wider society.

References

Abrams, D., & Hogg, M. A. (1988). Comments on the motivational status of self-esteem in social identity and intergroup discrimination. European journal of social psychology, 18(4), 317-334.

Abrams, D., & Hogg, M. A. (2004). Metatheory: Lessons from social identity research. Personality and social psychology review, 8(2), 98-106.

Abrams, D., & Hogg, M. A. (2006). Social identifications: A social psychology of intergroup relations and group processes. Routledge.

Aburn, G., Gott, M., & Hoare, K. (2016). What is resilience? An integrative review of the empirical literature. Journal of advanced nursing, 72(5), 980-1000.

Acevedo, V. E., & Hernández -Wolfe, P. (2014). Vicarious resilience: An exploration of teachers and children's resilience in highly challenging social contexts. Journal of Aggression, Maltreatment & Trauma, 23(5), 473-493.

Acker, G. M. (2010). The challenges in providing services to clients with mental illness: Managed care, burnout and somatic symptoms among social workers. Community Mental Health Journal, 46(6), 591-600.

Adamson, C., Beddoe, L., & Davys, A. (2014). Building resilient practitioners: Definitions and practitioner understandings. British Journal of Social Work, 44(3), 522-541.

Ahern, N. R., Ark, P., & Byers, J. (2008). Resilience and coping strategies in adolescents–additional content. Nursing Children and Young People, 20(10).

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. Jama, 288(16), 1987-1993.

Aknin, L. B., De Neve, J. E., Dunn, E. W., Fancourt, D. E., Goldberg, E., Helliwell, J. F., Jones, S. P., Karam, E., Layard, R., Lyubomirsky, S., & Rzepa, A. (2021). Mental health during the first year of the COVID-19 pandemic: a review and recommendations for moving forward. Perspectives on Psychological Science.

Altemeyer, R. A., & Altemeyer, B. (1996). The authoritarian specter. Harvard University Press.

Álvarez, L. H., & Hurley, D. J. (2010). Desde la zona de riesgo a la zona de resiliencia.

Anderson, A. G., Knowles, Z., & Gilbourne, D. (2004). Reflective practice for sport psychologists: Concepts, models, practical implications, and thoughts on dissemination. The Sport Psychologist, 18(2), 188-203.

Anderson, H. (2007). The heart and spirit of collaborative therapy: The philosophical stance–"A way of being" in relationship and conversation. Collaborative therapy: Relationships and conversations that make a difference, 43-59.

Ardelt, M., Ai, A. L., & Eichenberger, S. E. (2008). In search for meaning: The differential role of religion for middle-aged and older persons diagnosed with a life-threatening illness. Journal of Religion, Spirituality & Aging, 20(4), 288-312.

Ashby, S. E., Ryan, S., Gray, M., & James, C. (2013). Factors that influence the professional resilience of occupational therapists in mental health practice. Australian occupational therapy journal, 60(2), 110-119.

Aston, V., & Coffey, M. (2012). Recovery: what mental health nurses and service users say about the concept of recovery. Journal of Psychiatric and Mental Health Nursing, 19(3), 257-263.

Auerbach, C., & Silverstein, L. B. (2003). Qualitative data: An introduction to coding and analysis (Vol. 21). NYU press.

Avanzi, L., Albertini, S., Fraccaroli, F., Sarchielli, G., De Plato, G., & van Dick, R. (2018a). Exploring identity dynamics from a combined social exchange and social identity perspective. International Public Management Journal, 21(4), 677-702.

Avanzi, L., Fraccaroli, F., Castelli, L., Marcionetti, J., Crescentini, A., Balducci, C., & van Dick, R. (2018b). How to mobilize social support against workload and burnout: The role of organizational identification. Teaching and Teacher Education, 69, 154-167.

Avanzi, L., Schuh, S. C., Fraccaroli, F., & van Dick, R. (2015). Why does organizational identification relate to reduced employee burnout? The mediating influence of social support and collective efficacy. Work & Stress, 29(1), 1-10.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. Clinical psychology: Science and practice, 10(2), 125.

Balliet, D., Wu, J., & De Dreu, C. K. (2014). Ingroup favoritism in cooperation: a meta-analysis. Psychological bulletin, 140(6), 1556.

Bandyopadhyay, S., Baticulon, R. E., Kadhum, M., Alser, M., Ojuka, D. K., Badereddin, Y., Kamath, A., Parepalli, S. A., Brown, G., Iharchane, S., & Gandino, S. (2020). Infection and mortality of healthcare workers worldwide from COVID-19: a systematic review. BMJ global health, 5(12), e003097.

Banks, J., Fancourt, D., & Xu, X. (2021). Mental health and the COVID-19 pandemic. Helliwell J, Layard R, Sachs JD, JE. DN, editors. World Happiness Report. New York: Sustainable Development Solutions Network, 109-30.

Barnes, D., Carpenter, J., & Dickinson, C. (2000). Interprofessional education for community mental health: attitudes to community care and professional stereotypes. Social work education, 19(6), 565-583.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. Professional Psychology: Research and Practice, 38(6), 603a.

Barnett, J. E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. Professional Psychology: Research and Practice, 32(2), 205.

Barton, H. (2020). An exploration of the experiences that counsellors have of taking care of their own mental, emotional and spiritual well-being. Counselling and Psychotherapy Research, 20(3), 516-524.

Bauer, M., Blattman, C., Chytilová, J., Henrich, J., Miguel, E., & Mitts, T. (2016). Can war foster cooperation?. Journal of Economic Perspectives, 30(3), 249-74.

Benadé, P., Du Plessis, E., & Koen, M. P. (2017). Exploring resilience in nurses caring for older persons. health sa gesondheid, 22, 138-149.

Bennett, P., Noble, S., Johnston, S., Jones, D., & Hunter, R. (2020). COVID-19 confessions: a qualitative exploration of healthcare workers experiences of working with COVID-19. BMJ open, 10(12), e043949.

Bhaskar, R. (2014). The possibility of naturalism: A philosophical critique of the contemporary human sciences. Routledge.

Blois, K., & Ryan, A. (2013). Affinity fraud and trust within financial markets. Journal of Financial Crime.

Bonanno, G. A., Romero, S. A., & Klein, S. I. (2015). The temporal elements of psychological resilience: An integrative framework for the study of individuals, families, and communities. Psychological Inquiry, 26(2), 139-169.

Borritz, M., Rugulies, R., Christensen, K. B., Villadsen, E., & Kristensen, T. S. (2006). Burnout as a predictor of self-reported sickness absence among human service workers:

prospective findings from three year follow up of the PUMA study. Occupational and environmental medicine, 63(2), 98-106.

Bouchard, L., Montreuil, M., & Gros, C. (2010). Peer support among inpatients in an adult mental health setting. Issues in Mental Health Nursing, 31(9), 589-598.

Bowden, G. E., Smith, J. C. E., Parker, P. A., & Boxall, M. J. C. (2015). Working on the edge: Stresses and rewards of work in a front-line mental health service. Clinical psychology & psychotherapy, 22(6), 488-501.

Bowe, M., Wakefield, J. R., Kellezi, B., McNamara, N., Harkin, L., & Jobling, R. (2019). 'Sometimes, it's not just about the food': The social identity dynamics of foodbank helping transactions. European Journal of Social Psychology, 49(6), 1128-1143.

Bowles, S., & Gintis, H. (2004). The evolution of strong reciprocity: cooperation in heterogeneous populations. Theoretical population biology, 65(1), 17-28.

Braun, M., Schönfeldt-Lecuona, C., Freudenmann, R. W., Mehta, T., Hay, B., Kächele, H., & Beschoner, P. (2010). Depression, burnout and effort-reward imbalance among psychiatrists. Psychotherapy and psychosomatics, 79(5), 326.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101.

Braun, V., & Clarke, V. (2019). Novel insights into patients' life-worlds: the value of qualitative research. The Lancet Psychiatry, 6(9), 720-721.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. Qualitative research in sport, exercise and health, 13(2), 201-216.

Bressi, C., Porcellana, M., Gambini, O., Madia, L., Muffatti, R., Peirone, A., Zanini, S., Erlicher, A., Scarone, S., & Altamura, A. C. (2009). Burnout among psychiatrists in Milan: a multicenter survey. Psychiatric services, 60(7), 985-988.

Bride, B. E., & Figley, C. R. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. Clinical Social Work Journal, 35(3), 151-153.

Briner, R. B., & Denyer, D. (2012). Systematic review and evidence synthesis as a practice and scholarship tool. Handbook of evidence-based management: Companies, classrooms and research, 112-129.

Brolese, D. F., Lessa, G., Santos, J. L. G. D., Mendes, J. D. S., Cunha, K. S. D., & Rodrigues, J. (2017). Resilience of the health team in caring for people with mental disorders in a psychiatric hospital. Revista da Escola de Enfermagem da USP, 51.

Brown, A., Fleetwood, S., & Roberts, J. M. (2003). The marriage of critical realism and Marxism: happy, unhappy or on the rocks?. In Critical realism and Marxism (pp. 1-22). Routledge.

Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. Psychological inquiry, 18(4), 211-237.

Burford, B. (2012). Group processes in medical education: learning from social identity theory. Medical education, 46(2), 143-152.

Burke, B. L., Martens, A., & Faucher, E. H. (2010). Two decades of terror management theory: A meta-analysis of mortality salience research. Personality and Social Psychology Review, 14(2), 155-195.

Burke, T., Berry, A., Taylor, L. K., Stafford, O., Murphy, E., Shevlin, M., McHugh, L., & Carr, A. (2020). Increased psychological distress during COVID-19 and quarantine in Ireland: a national survey. Journal of clinical medicine, 9(11), 3481.

Burla, L., Knierim, B., Barth, J., Liewald, K., Duetz, M., & Abel, T. (2008). From text to codings: intercoder reliability assessment in qualitative content analysis. Nursing research, 57(2), 113-117.

Butler, L. D., Carello, J., & Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. Psychological Trauma: Theory, Research, Practice, and Policy, 9(4), 416.

Buus, N., & Gonge, H. (2009). Empirical studies of clinical supervision in psychiatric nursing: A systematic literature review and methodological critique. International journal of mental health nursing, 18(4), 250-264.

Cameron, F., & Brownie, S. (2010). Enhancing resilience in registered aged care nurses. Australasian journal on ageing, 29(2), 66-71.

Carmichael, K., Rushworth, I., & Fisher, P. (2020). 'You're opening yourself up to new and different ideas': Clinical psychologists' understandings and experiences of using reflective practice in clinical work: an interpretative phenomenological analysis. Reflective Practice, 21(4), 520-533.

Castano, E., & Dechesne, M. (2005). On defeating death: Group reification and social identification as immortality strategies. European review of social psychology, 16(1), 221-255.

Castano, E., Yzerbyt, V., Paladino, M. P., & Sacchi, S. (2002). I belong, therefore, I exist: Ingroup identification, ingroup entitativity, and ingroup bias. Personality and Social Psychology Bulletin, 28(2), 135-143.

Cicchetti, D. V., & Feinstein, A. R. (1990). High agreement but low kappa: II. Resolving the paradoxes. Journal of clinical epidemiology, 43(6), 551-558.

Clancy, C. M. (2006). Care transitions: a threat and an opportunity for patient safety. American Journal of Medical Quality, 21(6), 415-417.

Cleary, M., & Freeman, A. (2005). The cultural realities of clinical supervision in an acute inpatient mental health setting. Issues in Mental Health Nursing, 26(5), 489-505.

Cleary, M., Horsfall, J., & Happell, B. (2010). Developing practice in mental health settings. International Journal of Mental Health Nursing, 19(1), 45-52.

Cleary, M., Jackson, D., & Hungerford, C. L. (2014). Mental health nursing in Australia: Resilience as a means of sustaining the specialty. Issues in Mental Health Nursing, 35(1), 33-40.

College of Psychiatrists of Ireland. (2018). Pre Budget Submission 2018 (https://www.irishpsychiatry.ie/external-affairs-policy/college-paperssubmissionspublications/positions-policies-perspective-papers/prebudget-submission-2020/) Accessed 10 August 2020.

Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., & Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. Training and Education in Professional Psychology, 10(4), 188.

Compton, M. T., Reed, T., Broussard, B., Powell, I., Thomas, G. V., Moore, A., Cito, K., & Haynes, N. (2014). Development, implementation, and preliminary evaluation of a recovery-based curriculum for community navigation specialists working with individuals with serious mental illnesses and repeated hospitalizations. Community mental health journal, 50(4), 383-387.

Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). Depression and anxiety, 18(2), 76-82.

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qualitative health research, 22(10), 1435-1443.

Cookson, C. (2020, March 11). WHO labels coronavirus a pandemic. The Financial Times. https://www.ft.com/content/5946a17c-63bb-11ea-a6cd-df28cc3c6a68

Cooper, R., Cooper, K., Russell, A. J., & Smith, L. G. (2021). "I'm proud to be a little bit different": The effects of autistic individuals' perceptions of autism and autism social identity on their collective self-esteem. Journal of Autism and Developmental Disorders, 51(2), 704-714.

Crabtree, J. W., Haslam, S. A., Postmes, T., & Haslam, C. (2010). Mental health support groups, stigma, and self-esteem: Positive and negative implications of group identification. Journal of Social Issues, 66(3), 553.

Crowder, R., & Sears, A. (2017). Building resilience in social workers: An exploratory study on the impacts of a mindfulness-based intervention. Australian Social Work, 70(1), 17-29.

Crowe, A., Averett, P., & Glass, J. S. (2016). Mental illness stigma, psychological resilience, and help seeking: What are the relationships?. Mental Health & Prevention, 4(2), 63-68.

Cruwys, T., Dingle, G. A., Haslam, C., Haslam, S. A., Jetten, J., & Morton, T. A. (2013). Social group memberships protect against future depression, alleviate depression symptoms and prevent depression relapse. Social science & medicine, 98, 179-186.

Cruwys, T., Haslam, C., Rathbone, J. A., Williams, E., & Haslam, S. A. (2021). Groups 4 Health protects against unanticipated threats to mental health: Evaluating two interventions during COVID-19 lockdown among young people with a history of depression and loneliness. Journal of Affective Disorders, 295, 316-322.

Cruwys, T., Stevens, M., & Greenaway, K. H. (2020). A social identity perspective on COVID-19: Health risk is affected by shared group membership. British Journal of Social Psychology, 59(3), 584-593.

Cruwys, T., Stewart, B., Buckley, L., Gumley, J., & Scholz, B. (2020). The recovery model in chronic mental health: A community-based investigation of social identity processes. Psychiatry Research, 291, 113241.

Cruwys, T., Wakefield, J. R., Sani, F., Dingle, G. A., & Jetten, J. (2018). Social isolation predicts frequent attendance in primary care. Annals of Behavioral Medicine, 52(10), 817-829.

Cullen, K., McDaid, D., Wynne, R., Matosevic, T., & Park, A. L. (2017). A wide-angle international review of evidence and developments in mental health policy and practice. Evidence review to inform the parameters for a refresh of A Vision for Change (AVFC).

Curtis, W. J., & Cicchetti, D. (2007). Emotion and resilience: A multilevel investigation of hemispheric electroencephalogram asymmetry and emotion regulation in maltreated and nonmaltreated children. Development and psychopathology, 19(3), 811-840.

Daly, M., & Robinson, E. (2021). Psychological distress and adaptation to the COVID-19 crisis in the United States. Journal of psychiatric research, 136, 603-609.

Davison, L., Amer, H., Krishnan, J., Seale, E., Young, K., & Romans, S. (2019). Trainee welfare: a New Zealand perspective. Australasian Psychiatry, 27(3), 215-218.

Deborah, T. D., Anthony, E. K., Badu, E., Amy, B. A., Gyamfi, N., Josephine, A. N., & Opoku, M. P. (2020). The burden of caregiving among mental health nurses providing services to consumers with depression in Ghana. Perspectives in psychiatric care, 56(1), 72-80.

De Kock, J. H., Latham, H. A., Leslie, S. J., Grindle, M., Munoz, S. A., Ellis, L., Polson, R., & O'Malley, C. M. (2021). A rapid review of the impact of COVID-19 on the mental health

of healthcare workers: implications for supporting psychological well-being. BMC public health, 21(1), 1-18.

De Lange, E. F., & Chigeza, S. (2015). Fortigenic qualities of psychotherapists in practice. Journal of Psychology in Africa, 25(1), 56-59.

Department of Health. (2021). Title: Sláintecare Implementation and Action Plan 2021 to 2023. Retrieved from: https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/

Detrie, P. M., & Lease, S. H. (2007). The relation of social support, connectedness, and collective self-esteem to the psychological well-being of lesbian, gay, and bisexual youth. Journal of Homosexuality, 53(4), 173-199.

Douglas, M. (2003). Purity and danger: An analysis of concepts of pollution and taboo. Routledge.

Drury, J. (2018). The role of social identity processes in mass emergency behaviour: An integrative review. European review of social psychology, 29(1), 38-81.

Drury, J., Brown, R., González, R., & Miranda, D. (2016). Emergent social identity and observing social support predict social support provided by survivors in a disaster: Solidarity in the 2010 Chile earthquake. European Journal of Social Psychology, 46(2), 209-223.

Drury, J., Carter, H., Cocking, C., Ntontis, E., Tekin Guven, S., & Amlôt, R. (2019). Facilitating collective psychosocial resilience in the public in emergencies: Twelve recommendations based on the social identity approach. Frontiers in public health, 7, 141.

Drury, J., Cocking, C., & Reicher, S. (2009). The nature of collective resilience: Survivor reactions to the 2005 London bombings. International Journal of Mass Emergencies and Disasters, 27(1), 66-95.

Druss, B. G. (2006). Rising mental health costs: what are we getting for our money?. Health Affairs, 25(3), 614-622.

Duckitt, J., Wagner, C., Du Plessis, I., & Birum, I. (2002). The psychological bases of ideology and prejudice: testing a dual process model. Journal of personality and social psychology, 83(1), 75.

Dunn, M., O'Driscoll, C., Dayson, D., Wills, W., & Leff, J. (1990). The TAPS Project. 4: An observational study of the social life of long-stay patients. The British Journal of Psychiatry, 157(6), 842-848.

Ebrahimi, O. V., Hoffart, A., & Johnson, S. U. (2021). Physical distancing and mental health during the COVID-19 pandemic: Factors associated with psychological symptoms and adherence to pandemic mitigation strategies. Clinical Psychological Science, 9(3), 489-506.

Edelkott, N., Engstrom, D. W., Hernández -Wolfe, P., & Gangsei, D. (2016). Vicarious resilience: Complexities and variations. American Journal of Orthopsychiatry, 86(6), 713.

Edward, K. L. (2005). The phenomenon of resilience in crisis care mental health clinicians. International Journal of Mental Health Nursing, 14(2), 142-148.

Edward, K. L., Hercelinskyj, G., & Giandinoto, J. A. (2017). Emotional labour in mental health nursing: An integrative systematic review. International Journal of Mental Health Nursing, 26(3), 215-225.

Edwards, D., & Burnard, P. (2003). A systematic review of stress and stress management interventions for mental health nurses. Journal of advanced nursing, 42(2), 169-200.

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. Training and education in professional psychology, 6(2), 122.

Ellemers, N. (1993). The influence of socio-structural variables on identity management strategies. European review of social psychology, 4(1), 27-57.

Ellemers, N., Spears, R., & Doosje, B. (1997). Sticking together or falling apart: In-group identification as a psychological determinant of group commitment versus individual mobility. Journal of personality and social psychology, 72(3), 617.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British journal of clinical psychology, 38(3), 215-229.

Engstrom, D., Hernández, P., & Gangsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. Traumatology, 14(3), 13-21.

Erdem, H., & Lucey, D. R. (2021). Healthcare worker infections and deaths due to COVID-19: a survey from 37 nations and a call for WHO to post national data on their website. International Journal of Infectious Diseases, 102, 239-241.

Erfurth, L. M., Hernandez Bark, A. S., Molenaar, C., Aydin, A. L., & van Dick, R. (2021). "If worse comes to worst, my neighbors come first": social identity as a collective resilience factor in areas threatened by sea floods. SN Social Sciences, 1(11), 1-24.

Ettman, C. K., Abdalla, S. M., Cohen, G. H., Sampson, L., Vivier, P. M., & Galea, S. (2020). Prevalence of depression symptoms in US adults before and during the COVID-19 pandemic. JAMA network open, 3(9), e2019686-e2019686.

Eurostat. (2017). (https://ec.europa.eu/eurostat/web/products-datasets/-/tps00047) Accessed 4 May 2020.

Everly, G. S., & Lating, J. M. (2013). Stress-Related Disease: A Review. A Clinical Guide to the Treatment of the Human Stress Response, 67-102.

Faigin, C. A., & Pargament, K. I. (2011). Strengthened by the spirit: Religion, spirituality, and resilience through adulthood and aging. In Resilience in aging (pp. 163-180). Springer, New York, NY.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. Community mental health journal, 41(2), 141-158.

Faugier, J. (1994). Mental health. Thin on the ground. Nursing Times, 90(20), 64-65.

Fein, S., Hoshino-Browne, E., Davies, P. G., & Spencer, S. J. (2003, January). Self-image maintenance goals and sociocultural norms in motivated social perception. In Motivated social perception: The Ontario symposium (Vol. 9, pp. 21-44). Mahwah, NJ: Erlbaum.

Feingold, J. H., Peccoralo, L., Chan, C. C., Kaplan, C. A., Kaye-Kauderer, H., Charney, D., Verity, J., Hurtado, A., Burka, L., Syed, S. A., & Murrough, J. W. (2021). Psychological impact of the COVID-19 pandemic on frontline health care workers during the pandemic surge in New York City. Chronic Stress, 5, 2470547020977891.

Feinstein, A. R., & Cicchetti, D. V. (1990). High agreement but low kappa: I. The problems of two paradoxes. Journal of clinical epidemiology, 43(6), 543-549.

Finlay, L. (2009). Exploring lived experience: Principles and practice of phenomenological research. International Journal of Therapy and Rehabilitation, 16(9), 474-481.

Fischer, J., Kumar, S., & Hatcher, S. (2007). What makes psychiatry such a stressful profession? A qualitative study. Australasian Psychiatry, 15(5), 417-421.

Fisher, P., Chew, K., & Leow, Y. J. (2015). Clinical psychologists' use of reflection and reflective practice within clinical work. Reflective Practice, 16(6), 731-743.

Flade, F., Klar, Y., & Imhoff, R. (2019). Unite against: A common threat invokes spontaneous decategorization between social categories. Journal of Experimental Social Psychology, 85, 103890.

Fletcher, A. (2020). Critical realism: philosophical and methodological considerations. In Qualitative analysis: eight approaches for the social sciences (p. 173-194). Sage.

Fletcher, D., & Sarkar, M. (2013). Psychological resilience. European psychologist.

Foster, K., Cuzzillo, C., & Furness, T. (2018). Strengthening mental health nurses' resilience through a workplace resilience programme: A qualitative inquiry. Journal of psychiatric and mental health nursing, 25(5-6), 338-348.

Foster, K., Roche, M., Delgado, C., Cuzzillo, C., Giandinoto, J. A., & Furness, T. (2019). Resilience and mental health nursing: An integrative review of international literature. International journal of mental health nursing, 28(1), 71-85.

Fothergill, A., Edwards, D., & Burnard, P. (2004). Stress, burnout, coping and stress management in psychiatrists: findings from a systematic review. International journal of social psychiatry, 50(1), 54-65.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. Psychology and health, 25(10), 1229-1245.

Friborg, O., Hjemdal, O., Martinussen, M., & Rosenvinge, J. H. (2009). Empirical support for resilience as more than the counterpart and absence of vulnerability and symptoms of mental disorder. Journal of Individual Differences, 30(3), 138-151.

Friese, S. (2020). Measuring inter-coder agreement—Why Cohen's Kappa is not a good choice.

Frith, H., & Gleeson, K. (2004). Clothing and embodiment: Men managing body image and appearance. Psychology of men & masculinity, 5(1), 40.

Fritsche, I., Jonas, E., Ablasser, C., Beyer, M., Kuban, J., Manger, A. M., & Schultz, M. (2013). The power of we: Evidence for group-based control. Journal of Experimental Social Psychology, 49(1), 19-32.

Fritsche, I., Jonas, E., Kayser, D. N., & Koranyi, N. (2010). Existential threat and compliance with pro-environmental norms. Journal of Environmental Psychology, 30(1), 67-79.

Fullagar, C. J., & Kelloway, E. K. (2009). Flow at work: An experience sampling approach. Journal of occupational and organizational psychology, 82(3), 595-615.

Funke, F. (2005). The dimensionality of right-wing authoritarianism: Lessons from the dilemma between theory and measurement. Political Psychology, 26(2), 195-218.

Gaertner, S. L., & Dovidio, J. F. (2009). A common ingroup identity: A categorization-based approach for reducing intergroup bias.

Galloway, A., & Pistrang, N. (2019). "We're stronger if we work together": experiences of naturally occurring peer support in an inpatient setting. Journal of Mental Health, 28(4), 419-426.

Geanellos, R. (2005). Adversity as opportunity: Living with schizophrenia and developing a resilient self. International Journal of Mental Health Nursing, 14(1), 7-15.

Gee, M., Bhanbhro, S., Cook, S., & Killaspy, H. (2017). Rapid realist review of the evidence: achieving lasting change when mental health rehabilitation staff undertake recovery-oriented training. Journal of advanced nursing, 73(8), 1775-1791.

Gevaux, N. S., & Petty, S. (2018). Maximising resilience resources for mental healthcare staff. Mental health review journal.

Giannakakis, A. E., & Fritsche, I. (2011). Social identities, group norms, and threat: On the malleability of ingroup bias. Personality and Social Psychology Bulletin, 37(1), 82-93.

Gillespie, B. M., Chaboyer, W., Wallis, M., & Grimbeek, P. (2007). Resilience in the operating room: Developing and testing of a resilience model. Journal of advanced nursing, 59(4), 427-438.

Gilligan, M. J., Pasquale, B. J., & Samii, C. (2014). Civil war and social cohesion: Lab-in-the-field evidence from Nepal. American Journal of Political Science, 58(3), 604-619.

Glynn, S. A., Busch, M. P., Schreiber, G. B., Murphy, E. L., Wright, D. J., Tu, Y., & Kleinman, S. H., NHLBI REDS Study Group & NHLBI REDS Study Group. (2003). Effect of a national disaster on blood supply and safety: the September 11 experience. Jama, 289(17), 2246-2253.

Gneezy, A., & Fessler, D. M. (2012). Conflict, sticks and carrots: war increases prosocial punishments and rewards. Proceedings of the Royal Society B: Biological Sciences, 279(1727), 219-223.

Gockel, A. (2010). The promise of mindfulness for clinical practice education. Smith College Studies in Social Work, 80(2-3), 248-268.

Goncher, I. D., Sherman, M. F., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of self-care utilization. Training and Education in Professional Psychology, 7(1), 53.

Graber, J. E., Huang, E. S., Drum, M. L., Chin, M. H., Walters, A. E., Heuer, L., Tang, H., Schaefer, C. T., & Quinn, M. T. (2008). Predicting changes in staff morale and burnout at community health centers participating in the health disparities collaboratives. Health services research, 43(4), 1403-1423.

Grant, A. (2001). Psychiatric nursing and organizational power: rescuing the hidden dynamic. Journal of psychiatric and mental health nursing, 8(2), 173-177.

Grant, M. J. (2004). How does your searching grow? A survey of search preferences and the use of optimal search strategies in the identification of qualitative research. Health Information & Libraries Journal, 21(1), 21-32.

Gray, W. (2001). Clinical governance: combining clinical and management supervision. Nursing Management (through 2013), 8(6), 14.

Greenaway, K. H., & Cruwys, T. (2019). The source model of group threat: Responding to internal and external threats. American Psychologist, 74(2), 218.

Greenaway, K. H., Cruwys, T., Haslam, S. A., & Jetten, J. (2016). Social identities promote well-being because they satisfy global psychological needs. European Journal of Social Psychology, 46(3), 294-307.

Greenberg, J., Solomon, S., & Pyszczynski, T. (1997). Terror management theory of self-esteem and cultural worldviews: Empirical assessments and conceptual refinements. In Advances in experimental social psychology (Vol. 29, pp. 61-139). Academic Press.

Guy, J. D. (2000). Self-care corner: Holding the holding environment together: Self-psychology and psychotherapist care. Professional Psychology: Research and Practice, 31(3), 351.

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O' Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: a systematic review. PloS one, 11(7), e0159015.

Hammersley, M., & Atkinson, P. F. (1996). Field methodology. Oslo: Ad Notam Gyldendal.

Happell, B., & Koehn, S. (2011). Seclusion as a necessary intervention: The relationship between burnout, job satisfaction and therapeutic optimism and justification for the use of seclusion. Journal of advanced nursing, 67(6), 1222-1231.

Harries, C., Frois, M., & Healey, J. (1984). The hidden society': the practical use of multi-dimensional scaling to illuminate the pattern of relationships between long-stay psychiatric residents. Journal of Advanced Nursing, 9(6), 619-625.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. Psychotherapy: Theory, Research, Practice, Training, 46(2), 203.

Hart, P. L., Brannan, J. D., & De Chesnay, M. (2014). Resilience in nurses: An integrative review. Journal of nursing management, 22(6), 720-734.

Haslam, C., Cruwys, T., Chang, M. X. L., Bentley, S. V., Haslam, S. A., Dingle, G. A., & Jetten, J. (2019). GROUPS 4 HEALTH reduces loneliness and social anxiety in adults with psychological distress: Findings from a randomized controlled trial. Journal of consulting and clinical psychology, 87(9), 787.

Haslam, C., Cruwys, T., Haslam, S. A., Dingle, G., & Chang, M. X. L. (2016). Groups 4 Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. Journal of affective disorders, 194, 188-195.

Haslam, C., Jetten, J., & Haslam, S. A. (2012). Advancing the social cure: Implications for theory, practise and policy.

Haslam, S. (2014). Making good theory practical: Five lessons for an applied social identity approach to challenges of organizational, health, and clinical psychology. British journal of social psychology, 53(1), 1-20.

Haslam, S. A., Haslam, C., Cruwys, T., Jetten, J., Bentley, S. V., Fong, P., & Steffens, N. K. (2022). Social identity makes group-based social connection possible: Implications for loneliness and mental health. Current opinion in psychology, 43, 161-165.

Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. Applied Psychology, 58(1), 1-23.

Haslam, S. A., McMahon, C., Cruwys, T., Haslam, C., Jetten, J., & Steffens, N. K. (2018). Social cure, what social cure? The propensity to underestimate the importance of social factors for health. Social Science & Medicine, 198, 14-21.

Hawdon, J., & Ryan, J. (2011). Social relations that generate and sustain solidarity after a mass tragedy. Social forces, 89(4), 1363-1384.

Heponiemi, T., Aalto, A. M., Puttonen, S., Vänskä, J., & Elovainio, M. (2014). Work-related stress, job resources, and well-being among psychiatrists and other medical specialists in Finland. Psychiatric services, 65(6), 796-801.

Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. Journal of Systemic Therapies, 29(1), 67-83.

Hernández, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. Family process, 46(2), 229-241.

Hewstone, M., Rubin, M., & Willis, H. (2002). Intergroup bias. Annual review of psychology, 53(1), 575-604.

Hill, Y., Den Hartigh, R. J., Meijer, R. R., De Jonge, P., & Van Yperen, N. W. (2018). Resilience in sports from a dynamical perspective. Sport, Exercise, and Performance Psychology, 7(4), 333.

Hoge, E. A., Austin, E. D., & Pollack, M. H. (2007). Resilience: research evidence and conceptual considerations for posttraumatic stress disorder. Depression and anxiety, 24(2), 139-152.

Hogg, M. A. (2007). Uncertainty–identity theory. Advances in experimental social psychology, 39, 69-126.

Hogg, M. A. (2018). Social identity, self-categorization, and the small group. In Understanding group behavior (pp. 227-253). Psychology Press.

Hogg, M. A., & Ridgeway, C. L. (2003). Social identity: Sociological and social psychological perspectives. Social Psychology Quarterly, 97-100.

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. PLoS medicine, 7(7), e1000316.

Honberg, R., Kimball, A., Diehl, S., Usher, L., & Fitzpatrick, M. (2011). State mental health cuts: The continuing crisis. A report by the National Alliance on Mental Illness. Arlington, VA.

Hou, J. M., & Skovholt, T. M. (2020). Characteristics of highly resilient therapists. Journal of Counseling Psychology, 67(3), 386.

Howard, R., Kirkley, C., & Baylis, N. (2019). Personal resilience in psychiatrists: systematic review. BJPsych bulletin, 43(5), 209-215.

HSE. (2018). A national framework for recovery in mental health 2018 – 2020. Retrieved from https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/national-framework-for-recovery-in-mental-health/national-framework-plain-english.pdf3

Hu, T., Zhang, D., & Wang, J. (2015). A meta-analysis of the trait resilience and mental health. Personality and Individual differences, 76, 18-27.

Hu, X. (2018). Methodological implications of critical realism for entrepreneurship research. Journal of Critical Realism, 17(2), 118-139.

Hurley, D., & Kirwan, G. (2020). Exploring resilience and mental health in services users and practitioners in Ireland and Canada. European Journal of Social Work, 23(2), 340-352.

Hurley, D. J., & O' Reilly, R. L. (2017). Resilience, mental health and assertive community treatment. Social Work in Mental Health, 15(6), 730-748.

Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S., Kendall, T., Medina, J., & Katona, C. (2005). Stress and pressures in mental health social work: The worker speaks. British Journal of Social Work, 35(7), 1063-1079.

Hystad, S. W., Bartone, P. T., & Eid, J. (2014). Positive organizational behavior and safety in the offshore oil industry: Exploring the determinants of positive safety climate. The journal of positive psychology, 9(1), 42-53.

Imai, H., Nakao, H., Tsuchiya, M., Kuroda, Y., & Katoh, T. (2004). Burnout and work environments of public health nurses involved in mental health care. Occupational and Environmental Medicine, 61(9), 764-768.

Irish Hospital Consultants Association. (2021). Resource-scarce Ireland an "outlier" in psychiatric care, but increased beds and fully staffed mental healthcare teams will improve patient outcomes [Press release] https://www.ihca.ie/news-and-publications/resource-scarce-ireland-an-%E2%80%9Coutlier%E2%80%9D-in-psychiatric-care-but-increased-beds-and-fully-staffed-mental-healthcare-teams-will-improve-patient-outcomes

Irving, A. J., Dobkin, P., & Park, J. (2009). Mindfulness-based medical practice: cultivating self-care and mindfulness in health care professionals. Investigating and integrating mindfulness in medicine, health care and society. In Proceedings of the 7th International Scientific Conference for Clinicians, Researchers and Educators (pp. 18-22).

Jackson, L., Tudway, J. A., Giles, D., & Smith, J. (2009). An exploration of the social identity of mental health inpatient service users. Journal of Psychiatric and Mental Health Nursing, 16(2), 167-176.

Jarvinen, M., & Mik-Meyer, N. (2020). Analysing qualitative data in social science. In Qualitative analysis: eight approaches for the social sciences (p. 1-28). Sage.

Jeong, H., Yim, H. W., Song, Y. J., Ki, M., Min, J. A., Cho, J., & Chae, J. H. (2016). Mental health status of people isolated due to Middle East Respiratory Syndrome. Epidemiology and health, 38.

Jetten, J., Branscombe, N. R., Haslam, S. A., Haslam, C., Cruwys, T., Jones, J. M., Cui, L., Dingle, G., Liu, J., Murphy, S., & Thai, A. (2015). Having a lot of a good thing: Multiple important group memberships as a source of self-esteem. PloS one, 10(5), e0124609.

Jetten, J., Haslam, C., & Alexander, S. H. (2012). The social cure: Identity, health and well-being. Psychology press.

Jetten, J., Haslam, S. A., & Haslam, C. (2012). The case for a social identity analysis of health and well-being. The social cure: Identity, health and well-being, 3-19.

Joffe, H. (1996). AIDS research and prevention: A social representational approach. British Journal of Medical Psychology, 69(3), 169-190.

Joffe, H. (1999). Risk and'the Other'. Cambridge University Press.

Joffe, H. (2007). Identity, self-control, and risk. In Social representations and identity (pp. 197-213). Palgrave Macmillan, New York.

Joffe, H. L. N., & Bettega, N. (2003). Social representation of AIDS among Zambian adolescents. Journal of health psychology, 8(5), 616-631.

Johnson, S., Dalton-Locke, C., Vera San Juan, N., Foye, U., Oram, S., Papamichail, A., Landau, S., Rowan Olive, R., Jeynes, T., Shah, P., & Sheridan Rains, L. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: a mixed methods survey of UK mental health care staff. Social psychiatry and psychiatric epidemiology, 56(1), 25-37.

Jones, J. M., Haslam, S. A., Jetten, J., Williams, W. H., Morris, R., & Saroyan, S. (2011). That which doesn't kill us can make us stronger (and more satisfied with life): The contribution of personal and social changes to well-being after acquired brain injury. Psychology and Health, 26(3), 353-369.

Jordan, J. J., Yoeli, E., & Rand, D. G. (2021). Don't get it or don't spread it: Comparing self-interested versus prosocial motivations for COVID-19 prevention behaviors. Scientific reports, 11(1), 1-17.

Jost, J. T., Banaji, M. R., & Nosek, B. A. (2004). A decade of system justification theory: Accumulated evidence of conscious and unconscious bolstering of the status quo. Political psychology, 25(6), 881-919.

Jovanović, N., Podlesek, A., Volpe, U., Barrett, E., Ferrari, S., Kuzman, M. R., Wuyts, P., Papp, S., Nawka, A., Vaida, A., & Moscoso, A. (2016). Burnout syndrome among psychiatric trainees in 22 countries: Risk increased by long working hours, lack of supervision, and psychiatry not being first career choice. European Psychiatry, 32, 34-41.

Jugert, P., & Duckitt, J. (2009). A motivational model of authoritarianism: Integrating personal and situational determinants. Political Psychology, 30(5), 693-719.

Junker, N. M., van Dick, R., Avanzi, L., Häusser, J. A., & Mojzisch, A. (2019). Exploring the mechanisms underlying the social identity–ill-health link: Longitudinal and experimental evidence. British Journal of Social Psychology, 58(4), 991-1007.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future.

Kalathil, J., Bhakta, R., Daniel, O., Joseph, D., & Trivedi, P. (2011). Recovery and resilience: African, African-Caribbean and South Asian women's narratives of recovering from mental distress. London: Mental Health Foundation.

Kellezi, B., Bowe, M., Wakefield, J. R., McNamara, N., & Bosworth, M. (2019). Understanding and coping with immigration detention: Social identity as cure and curse. European Journal of Social Psychology, 49(2), 333-351.

Kellezi, B., & Reicher, S. (2012). Social cure or social curse? The psychological impact of extreme events during the Kosovo conflict.

Kelly, B., Long, A., & McKenna, H. (2001). A survey of community mental health nurses' perceptions of clinical supervision in Northern Ireland. Journal of psychiatric and mental health nursing, 8(1), 33-44.

Kessing, M. L. (2020). "It is a different world in here": collective identification and shared experiential knowledge between psychiatric inpatients. Sociology of health & illness, 42(4), 724-738.

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. Traumatology, 14(2), 32-44.

Kindy, D., Petersen, S., & Parkhurst, D. (2005). Perilous work: Nurses' experiences in psychiatric units with high risks of assault. Archives of psychiatric nursing, 19(4), 169-175.

King, G. A., & Rothstein, M. G. (2010). Resilience and leadership: The self-management of failure. In Self-management and leadership development. Edward Elgar Publishing.

Kleinman, A. (2012). Medical anthropology and mental health: Five questions for the next fifty years. Medical anthropology at the intersections: histories, activisms, and futures, 116-128.

Knekt, P., Virtala, E., Härkänen, T., Vaarama, M., Lehtonen, J., & Lindfors, O. (2016). The outcome of short-and long-term psychotherapy 10 years after start of treatment. Psychological medicine, 46(6), 1175-1188.

Kotfis, K., Roberson, S. W., Wilson, J. E., Dabrowski, W., Pun, B. T., & Ely, E. W. (2020). COVID-19: ICU delirium management during SARS-CoV-2 pandemic. Critical care, 24(1), 1-9.

Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J., & Quill, T. E. (2009). Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. Jama, 302(12), 1284-1293.

Kreindler, S. A. (2005). A dual group processes model of individual differences in prejudice. Personality and Social Psychology Review, 9(2), 90-107.

Kreindler, S. A., Dowd, D. A., Dana Star, N. O. A. H., & Gottschalk, T. (2012). Silos and social identity: the social identity approach as a framework for understanding and overcoming divisions in health care. The Milbank Quarterly, 90(2), 347-374.

Kumar, A., & Nayar, K. R. (2021). COVID 19 and its mental health consequences. Journal of Mental Health, 30(1), 1-2.

Kumar, S., Nath Bhagat, R., Lau, T., & Ng, B. (2006). Psychiatrists in New Zealand: Are They Burning Out, Satisfied at Work and, in any Case, who Cares??. Australasian Psychiatry, 14(1), 20-23.

Laker, C., Cella, M., Callard, F., & Wykes, T. (2019). Why is change a challenge in acute mental health wards? A cross-sectional investigation of the relationships between burnout, occupational status and nurses' perceptions of barriers to change. International journal of mental health nursing, 28(1), 190-198.

Lamb, D., & Cogan, N. (2016). Coping with work-related stressors and building resilience in mental health workers: A comparative focus group study using interpretative phenomenological analysis. Journal of Occupational and Organizational Psychology, 89(3), 474-492.

Lapsley, H., Nikora, L. W., & Black, R. M. (2002). " Kia Mauri Tau!" Narratives of recovery from disabling mental health problems. Mental Health Commission.

Larm, P., Hodgins, S., Tengström, A., & Larsson, A. (2010). Trajectories of resilience over 25 years of individuals who as adolescents consulted for substance misuse and a matched comparison group. Addiction, 105(7), 1216-1225.

Laschinger, H. K. S., & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout engagement. JONA: The Journal of Nursing Administration, 36(5), 259-267.

Lavender, T. (2003). Redressing the balance: The place, history and future of reflective practice in clinical training. Clinical Psychology, 27, 11-15.

Lawn, S., Hersh, D., Ward, P. R., Tsourtos, G., Muller, R., Winefield, A., & Coveney, J. (2011). 'I just saw it as something that would pull you down, rather than lift you up': resilience in never-smokers with mental illness. Health education research, 26(1), 26-38.

Leach, C. W., Ellemers, N., & Barreto, M. (2007). Group virtue: the importance of morality (vs. competence and sociability) in the positive evaluation of in-groups. Journal of personality and social psychology, 93(2), 234.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. The British journal of psychiatry, 199(6), 445-452.

Leichsenring, F., Abbass, A., Luyten, P., Hilsenroth, M., & Rabung, S. (2013). The emerging evidence for long-term psychodynamic therapy. Psychodynamic psychiatry, 41(3), 361-384.

Leichsenring, F., & Rabung, S. (2011). Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. The British Journal of Psychiatry, 199(1), 15-22.

Lennox, R., & Jurdi-Hage, R. (2017, January). Beyond the empirical and the discursive: The methodological implications of critical realism for street harassment research. In Women's Studies International Forum (Vol. 60, pp. 28-38). Pergamon.

Levine, M., Prosser, A., Evans, D., & Reicher, S. (2005). Identity and emergency intervention: How social group membership and inclusiveness of group boundaries shape helping behavior. Personality and social psychology bulletin, 31(4), 443-453.

Linzer, M., Stillman, M., Brown, R., Taylor, S., Nankivil, N., Poplau, S., Goelz, E., Sinsky, C., Barbouche, M., Buhr, C., & Byrne, F. (2021). Preliminary report: US physician stress during the early days of the COVID-19 pandemic. Mayo Clinic Proceedings: Innovations, Quality & Outcomes, 5(1), 127-136.

Liu, X., Kakade, M., Fuller, C. J., Fan, B., Fang, Y., Kong, J., Guan, Z., & Wu, P. (2012). Depression after exposure to stressful events: lessons learned from the severe acute respiratory syndrome epidemic. Comprehensive psychiatry, 53(1), 15-23.

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. JBI Evidence Implementation, 13(3), 179-187.

Luken, M., & Sammons, A. (2016). Systematic review of mindfulness practice for reducing job burnout. The American Journal of Occupational Therapy, 70(2), 7002250020p1-7002250020p10.

Luthar, S. S., & Cicchetti, D. (2000). The construct of resilience: Implications for interventions and social policies. Development and psychopathology, 12(4), 857-885.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. Child development, 71(3), 543-562.

Lynch, L., & Happell, B. (2008). Implementation of clinical supervision in action: part 2: implementation and beyond. international Journal of mental Health Nursing, 17(1), 65-72.

Lyons, A., Fletcher, G., & Bariola, E. (2016). Assessing the well-being benefits of belonging to resilient groups and communities: Development and testing of the Fletcher-Lyons Collective Resilience Scale (FLCRS). Group Dynamics: Theory, Research, and Practice, 20(2), 65.

Mackintosh, C. (1998). Reflection: A flawed strategy for the nursing profession. Nurse education today, 18(7), 553-557.

Maher, P. J., Roth, J., Griffin, S., Foran, A. M., Jay, S., McHugh, C., Ryan, M., Bradshaw, D., Quayle, M., & Muldoon, O. T. (2022). Pandemic threat and group cohesion: national identification in the wake of COVID-19 is associated with authoritarianism. The Journal of Social Psychology, 1-17.

Major, B., & O' Brien, L. T. (2005). The social psychology of stigma. Annu. Rev. Psychol., 56, 393-421.

Mann, S., & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. Journal of psychiatric and mental health nursing, 12(2), 154-162.

Manning, L. K. (2013). Navigating hardships in old age: Exploring the relationship between spirituality and resilience in later life. Qualitative health research, 23(4), 568-575.

Mantzios, M., & Giannou, K. (2014). Group vs. single mindfulness meditation: exploring avoidance, impulsivity, and weight management in two separate mindfulness meditation settings. Applied Psychology: Health and Well-Being, 6(2), 173-191.

Marie, M., Hannigan, B., & Jones, A. (2017). Resilience of nurses who work in community mental health workplaces in Palestine. International Journal of Mental Health Nursing, 26(4), 344-354.

Markwell, A., Mitchell, R., Wright, A. L., & Brown, A. F. (2020). Clinical and ethical challenges for emergency departments during communicable disease outbreaks: Can lessons from Ebola Virus Disease be applied to the COVID-19 pandemic?. Emergency Medicine Australasia, 32(3), 520-524.

Marques, J. M., Yzerbyt, V. Y., & Leyens, J. P. (1988). The “black sheep effect”: Extremity of judgments towards ingroup members as a function of group identification. European journal of social psychology, 18(1), 1-16.

Martin, L. (2020). Critical realism in theory and practice. In Qualitative analysis: eight approaches for the social sciences (pp. 155-172). Sage.

Martini, S., Arfken, C. L., Churchill, A., & Balon, R. (2004). Burnout comparison among residents in different medical specialties. Academic psychiatry, 28(3), 240-242.

Maslach, C. (2003). Burnout: The cost of caring. Ishk.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). MBI: Maslach burnout inventory. Palo Alto, CA: Consulting Psychologists Press.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. World psychiatry, 15(2), 103-111.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. Annual review of psychology, 52(1), 397-422.

Masten, A. S. (2007). Resilience in developing systems: Progress and promise as the fourth wave rises. Development and psychopathology, 19(3), 921-930.

Masten, A. S., & Obradović, J. (2006). Competence and resilience in development. Annals of the New York Academy of Sciences, 1094(1), 13-27.

Maxwell, J. A. (2012). A realist approach for qualitative research. Sage.

McCann, C. M., Beddoe, E., McCormick, K., Huggard, P., Kedge, S., Adamson, C., & Huggard, J. (2013). Resilience in the health professions: A review of recent literature. International Journal of Wellbeing, 3(1).

McCann, S. J. (2008). Societal threat, authoritarianism, conservatism, and US state death penalty sentencing (1977-2004). Journal of Personality and Social Psychology, 94(5), 913.

McDonald, G., Jackson, D., Wilkes, L., & Vickers, M. (2013). Personal resilience in nurses and midwives: effects of a work-based educational intervention. Contemporary nurse, 45(1), 134-143.

McDonald, K. M., Sundaram, V., Bravata, D. M., Lewis, R., Lin, N., Kraft, S. A., McKinnon, M., Paguntalan, H., & Owens, D. K. (2007). Closing the quality gap: a critical analysis of quality improvement strategies (Vol. 7: Care Coordination).

McGeorge, M., Lelliott, P., & Stewart, J. (2000). Managing violence in psychiatric wards: Preliminary findings of a multi-centre audit. Mental Health and Learning Disabilities Care, 3, 366-369.

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. Biochemia medica, 22(3), 276-282.

McKenzie, K., Whitley, R., & Weich, S. (2002). Social capital and mental health. The British Journal of Psychiatry, 181(4), 280-283.

McLarnon, M. J., & Rothstein, M. G. (2013). Development and initial validation of the workplace resilience inventory. Journal of Personnel Psychology.

McMahon, A. (2018). “Part of me feels like there must be something missing”: a phenomenological exploration of practising psychotherapy as a clinical psychologist. British Journal of Guidance & Counselling, 46(2), 217-228.

McNamara, N., Stevenson, C., & Muldoon, O. T. (2013). Community identity as resource and context: A mixed method investigation of coping and collective action in a disadvantaged community. European Journal of Social Psychology, 43(5), 393-403.

Mental Health Act. (2001). Retrieved from https://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/print.html

Mental Health Commission. (2005). Quality in mental health-your views: report on stakeholder consultation on quality in mental health services. -1534.

Mental Health Commission of Canada. (2015). Guidelines for recovery-oriented practice. Recovery Guidelines Ottawa, ON.

Mental Health Reform. (2021). Mental Health Budget 2021 Retrieved from: https://www.mentalhealthreform.ie/wp-content/uploads/2020/09/Mental-Health-Budget-2020-Summary.pdf

Mizuno, Y., Wartelsteiner, F., & Frajo-Apor, B. (2016). Resilience research in schizophrenia: A review of recent developments. Current opinion in psychiatry, 29(3), 218-223.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Annals of internal medicine, 151(4), 264-269.

Molenaar, C., Blessin, M., Erfurth, L. M., & Imhoff, R. (2022). Were we stressed or was it just me–and does it even matter? Efforts to disentangle individual and collective resilience within real and imagined stressors. British journal of social psychology, 61(1), 167-191.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. Administration and Policy in Mental Health and Mental Health Services Research, 39(5), 341-352.

Muldoon, O. (2020). Collective trauma. Together Apart Psychol. COVID, 19, 84-89.

Muldoon, O. T., Acharya, K., Jay, S., Adhikari, K., Pettigrew, J., & Lowe, R. D. (2017). Community identity and collective efficacy: A social cure for traumatic stress in post-earthquake Nepal. European Journal of Social Psychology, 47(7), 904-915.

Muldoon, O. T., Walsh, R. S., Curtain, M., Crawley, L., & Kinsella, E. L. (2019). Social cure and social curse: Social identity resources and adjustment to acquired brain injury. European Journal of Social Psychology, 49(6), 1272-1282.

Mullarkey, K., Keeley, P., & Playle, J. F. (2001). Multiprofessional clinical supervision: Challenges for mental health nurses. Journal of psychiatric and mental health nursing, 8(3), 205-211.

Neighbors, C., LaBrie, J. W., Hummer, J. F., Lewis, M. A., Lee, C. M., Desai, S., Kilmer, J. R., & Larimer, M. E. (2010). Group identification as a moderator of the relationship between perceived social norms and alcohol consumption. Psychology of Addictive Behaviors, 24(3), 522.

Newell, R. (1992). Anxiety, accuracy and reflection: the limits of professional development. Journal of Advanced Nursing, 17(11), 1326-1333.

Ng, S. L., Kinsella, E. A., Friesen, F., & Hodges, B. (2015). Reclaiming a theoretical orientation to reflection in medical education research: a critical narrative review. Medical education, 49(5), 461-475.

NHS. (2010).Cost of violence against NHS staff: A reportsummarising the economic cost to the NHS of violence against staff 2007/8 Service, NHS Counter Fraud Service: N. S. M.London: NHS Business Service Authority.

Norcross, J. C., & Guy, J. D. (2007). Leaving it at the office: Psychotherapist self-care.

Norris, F. H., Stevens, S. P., Pfefferbaum, B., Wyche, K. F., & Pfefferbaum, R. L. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. American journal of community psychology, 41(1), 127-150.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. International journal of qualitative methods, 16(1), 1609406917733847.

Ntontis, E., Drury, J., Amlôt, R., Rubin, G. J., & Williams, R. (2018). Emergent social identities in a flood: Implications for community psychosocial resilience. Journal of Community & Applied Social Psychology, 28(1), 3-14.

Ntontis, E., Drury, J., Amlôt, R., Rubin, G. J., Williams, R., & Saavedra, P. (2021). Collective resilience in the disaster recovery period: Emergent social identity and observed social support are associated with collective efficacy, well-being, and the provision of social support. British Journal of Social Psychology, 60(3), 1075-1095.

O' Connor, C., Kadianaki, I., Maunder, K., & McNicholas, F. (2018). How does psychiatric diagnosis affect young people's self-concept and social identity? A systematic review and synthesis of the qualitative literature. Social Science & Medicine, 212, 94-119.

O’ Connor, J. (2006). Report of the Expert Group on Mental Health Policy: A Vision for Change. Dublin: Stationary Office.

O' Connor, K., Wrigley, M., Jennings, R., Hill, M., & Niazi, A. (2021). Mental health impacts of COVID-19 in Ireland and the need for a secondary care mental health service response. Irish Journal of Psychological Medicine, 38(2), 99-107.

Onyett, S., Pillinger, T., & Muijen, M. (1997). Job satisfaction and burnout among members of community mental health teams. Journal of Mental Health, 6(1), 55-66.

Ouwerkerk, J. W., Ellemers, N., & De Gilder, D. (1999). Group commitment and individual effort in experimental and organizational contexts.

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan III, C. A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: from neurobiology to clinical practice. Psychiatry (Edgmont), 4(5), 35.

Panter-Brick, C. (2014). Health, risk, and resilience: Interdisciplinary concepts and applications. Annual Review of Anthropology, 43, 431-448.

Paredes, B., Santos, D., Briñol, P., Gómez, Á., & Petty, R. E. (2020). The role of meta-cognitive certainty on the relationship between identity fusion and endorsement of extreme pro-group behavior. Self and Identity, 19(7), 804-824.

Pargament, K. I., & Cummings, J. (2010). Anchored by faith. Handbook of adult resilience, 193-210.

Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. The journal of behavioral health services & research, 37(4), 519-528.

Peck, E., & Norman, I. J. (1999). Working together in adult community mental health services: Exploring inter-professional role relations. Journal of Mental Health, 8(3), 231.

Peterson, U., Demerouti, E., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Burnout and physical and mental health among Swedish healthcare workers. Journal of advanced nursing, 62(1), 84-95.

Pickard, J. G., & King, M. D. (2011). African American caregivers finding resilience through faith. In Resilience in Aging (pp. 261-271). Springer, New York, NY.

Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S., & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. The Lancet Psychiatry, 7(10), 883-892.

Pinikahana, J., & Happell, B. (2004). Stress, burnout and job satisfaction in rural psychiatric nurses: a Victorian study. Australian Journal of Rural Health, 12(3), 120-125.

Pipe, T. B., Buchda, V. L., Launder, S., Hudak, B., Hulvey, L., Karns, K. E., & Pendergast, D. (2012). Building personal and professional resources of resilience and agility in the healthcare workplace. Stress and Health, 28(1), 11-22.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme Version, 1(1), b92.

Porges, S. W. (1997). Emotion: An evolutionary by-product of the neural regulation of the autonomic nervous system. The integrative neurobiology of affiliation, 807, 62-67.

Porges, S. W. (2003). The polyvagal theory: Phylogenetic contributions to social behavior. Physiology & behavior, 79(3), 503-513.

Prasad, K., McLoughlin, C., Stillman, M., Poplau, S., Goelz, E., Taylor, S., Nankivil, N., Brown, R., Linzer, M., Cappelucci, K., & Barbouche, M. (2021). Prevalence and correlates of stress and burnout among US healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. EClinicalMedicine, 35, 100879.

Priebe, S., Omer, S., Giacco, D., & Slade, M. (2014). Resource-oriented therapeutic models in psychiatry: conceptual review. The British Journal of Psychiatry, 204(4), 256-261.

Prosser, S. J., Metzger, M., & Gulbransen, K. (2017). Don't just survive, thrive: Understanding how acute psychiatric nurses develop resilience. Archives of Psychiatric Nursing, 31(2), 171-176.

Putnam, R. D. (2000). Bowling alone: The collapse and revival of American community. Simon and schuster.

Råbu, M., Moltu, C., Binder, P. E., & McLeod, J. (2016). How does practicing psychotherapy affect the personal life of the therapist? A qualitative inquiry of senior therapists' experiences. Psychotherapy Research, 26(6), 737-749.

Radey, M., & Figley, C. R. (2007). The social psychology of compassion. Clinical Social Work Journal, 35(3), 207-214.

Ragusa, A. T., & Crowther, A. (2012). 'I think it is the best job… I love it!' Engendering workplace satisfaction in rural and remote Australian mental health nursing. Rural Society, 22(1), 45-58.

Ramalisa, R. J., Koen, M. P., & Du Plessis, E. (2018). Increasing coping and strengthening resilience in nurses providing mental health care: Empirical qualitative research. Health SA Gesondheid, 23(1), 1-9.

Ramsey, J., & Blieszner, R. (2016). Spiritual resiliency and aging: Hope, relationality, and the creative self. Routledge.

Rashid, T., & Ostermann, R. F. (2009). Strength-based assessment in clinical practice. Journal of clinical psychology, 65(5), 488-498.

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Thornicroft, G., Bebbington, P., & Prosser, D. (1999). Explanations for stress and satisfaction in mental health professionals: a qualitative study. Social psychiatry and psychiatric epidemiology, 34(6), 301-308.

Renwick, L., Stewart, D., Richardson, M., Lavelle, M., James, K., Hardy, C., Price, O., & Bowers, L. (2016). Aggression on inpatient units: Clinical characteristics and consequences. International Journal of Mental Health Nursing, 25(4), 308-318.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. Journal of clinical psychology, 58(3), 307-321.

Richardson, G. E., Neiger, B. L., Jensen, S., & Kumpfer, K. L. (1990). The resiliency model. Health education, 21(6), 33-39.

Robinson, E., Sutin, A. R., Daly, M., & Jones, A. (2021). A systematic review and meta-analysis of longitudinal cohort studies comparing mental health before versus during the COVID-19 pandemic. medRxiv.

Robson, C. (2002). Real world research: A resource for social scientists and practitioner-researchers. Wiley-Blackwell.

Roebuck, D. C., & Reid, K. (2020). How trainee therapists experience resilience: An interpretative phenomenological analysis. Counselling and Psychotherapy Research, 20(3), 545-555.

Romanò, M. (2020). Between intensive care and palliative care at the time of CoViD-19. Recenti progressi in medicina, 111(4), 223-230.

Roney, L. N., & Acri, M. C. (2018). The cost of caring: an exploration of compassion fatigue, compassion satisfaction, and job satisfaction in pediatric nurses. Journal of pediatric nursing, 40, 74-80.

Rössler, W. (2012). Stress, burnout, and job dissatisfaction in mental health workers. European archives of psychiatry and clinical neuroscience, 262(2), 65-69.

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. Professional Psychology: Research and Practice, 38(1), 88.

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. Professional Psychology: Research and Practice, 36(5), 544.

Rutter, M. (2006). Implications of resilience concepts for scientific understanding. Annals of the New York Academy of Sciences, 1094(1), 1-12.

Rutter, M. (2012). Resilience as a dynamic concept. Development and psychopathology, 24(2), 335-344.

Rutter, M. (2013). Annual research review: Resilience–clinical implications. Journal of child psychology and psychiatry, 54(4), 474-487.

Sachs, J. D., Karim, S. A., Aknin, L., Allen, J., Brosbøl, K., Barron, G. C., Daszak, P., Espinosa, M. F., Gaspar, V., Gaviria, A., & Haines, A. (2020). Lancet COVID-19 Commission Statement on the occasion of the 75th session of the UN General Assembly. The Lancet, 396(10257), 1102-1124.

Salins, N., Mani, R. K., Gursahani, R., Simha, S., & Bhatnagar, S. (2020). Symptom management and supportive care of serious COVID-19 patients and their families in India. Indian journal of critical care medicine: peer-reviewed, official publication of Indian Society of Critical Care Medicine, 24(6), 435.

Salyers, M. P., Fukui, S., Rollins, A. L., Firmin, R., Gearhart, T., Noll, J. P., Williams, S., & Davis, C. J. (2015). Burnout and self-reported quality of care in community mental health. Administration and Policy in Mental Health and Mental Health Services Research, 42(1), 61-69.

Sansó, N., Galiana, L., Oliver, A., Pascual, A., Sinclair, S., & Benito, E. (2015). Palliative care professionals' inner life: exploring the relationships among awareness, self-care, and compassion satisfaction and fatigue, burnout, and coping with death. Journal of pain and symptom management, 50(2), 200-207.

Sayer, R. A. (1992). Method in social science: A realist approach. Psychology Press.

Scanlan, J. N., Meredith, P., & Poulsen, A. A. (2013). Enhancing retention of occupational therapists working in mental health: Relationships between wellbeing at work and turnover intention. Australian occupational therapy journal, 60(6), 395-403.

Scheepers, D. (2009). Turning social identity threat into challenge: Status stability and cardiovascular reactivity during inter-group competition. Journal of Experimental Social Psychology, 45(1), 228-233.

Scheepers, D., & Ellemers, N. (2019). Social identity theory. In Social psychology in action (pp. 129-143). Springer, Cham.

Scheepers, D., Spears, R., Doosje, B., & Manstead, A. S. (2006). The social functions of ingroup bias: Creating, confirming, or changing social reality. European review of social psychology, 17(1), 359-396.

Schön, D. A. (1987). Educating the reflective practitioner: Toward a new design for teaching and learning in the professions. Jossey-Bass.

Schury, V. A., Nater, U. M., & Häusser, J. A. (2020). The social curse: Evidence for a moderating effect of shared social identity on contagious stress reactions. Psychoneuroendocrinology, 122, 104896.

Segal, K., Jong, J., & Halberstadt, J. (2018). The fusing power of natural disasters: An experimental study. Self and Identity, 17(5), 574-586.

Shanafelt, T. D., Bradley, K. A., Wipf, J. E., & Back, A. L. (2002). Burnout and self-reported patient care in an internal medicine residency program. Annals of internal medicine, 136(5), 358-367.

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: results from a randomized trial. International journal of stress management, 12(2), 164.

Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. Journal of clinical psychology, 62(3), 373-386.

Sherif, M., & Sherif, C. W. (1969). Social psychology. Harper & Row.

Shiao, J. S. C., Tseng, Y., Hsieh, Y. T., Hou, J. Y., Cheng, Y., & Guo, Y. L. (2010). Assaults against nurses of general and psychiatric hospitals in Taiwan. International archives of occupational and environmental health, 83(7), 823-832.

Silveira, F. S., & Boyer, W. (2015). Vicarious resilience in counselors of child and youth victims of interpersonal trauma. Qualitative Health Research, 25(4), 513-526.

Sjølie, H., Binder, P. E., & Dundas, I. (2017). Emotion work in a mental health service setting. Qualitative Social Work, 16(3), 317-332.

Skitka, L. J., Bauman, C. W., Aramovich, N. P., & Morgan, G. S. (2006). Confrontational and preventative policy responses to terrorism: Anger wants a fight and fear wants" them" to go away. Basic and Applied Social Psychology, 28(4), 375-384.

Skovholt, T. M., & Trotter-Mathison, M. (2014). The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals. Routledge.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry, 13(1), 12-20.

Slettebø, T. (2021). Participant validation: Exploring a contested tool in qualitative research. Qualitative Social Work, 20(5), 1223-1238.

Sloan, G. (1999). Understanding clinical supervision from a nursing perspective. British Journal of Nursing, 8(8), 524-529.

Sloan, G., & Grant, A. (2012). A rationale for a clinical supervision database for mental health nursing in the UK. Journal of Psychiatric and Mental Health Nursing, 19(5), 466-473.

Smith, N., O' Connor, C., & Joffe, H. (2015). Social representations of threatening phenomena: the self-other thema and identity protection. Papers on Social representations, 24(2), 1-1.

Smoot, S. L., & Gonzales, J. L. (1995). Cost-effective communication skills training for state hospital employees. Psychiatric Services.

Sood, A., Sharma, V., Schroeder, D. R., & Gorman, B. (2014). Stress Management and Resiliency Training (SMART) program among Department of Radiology faculty: a pilot randomized clinical trial. Explore, 10(6), 358-363.

Sørgaard, K. W., Ryan, P., Hill, R., & Dawson, I. (2007). Sources of stress and burnout in acute psychiatric care: inpatient vs. community staff. Social psychiatry and psychiatric epidemiology, 42(10), 794-802.

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives. European journal of psychotraumatology, 5(1), no. 1 (2014): 25338.

Stake, R. E. (1995). The art of case study research. sage.

Stebnicki, M. A. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. American Journal of Psychiatric Rehabilitation, 10(4), 317-338.

Stedmon, J., Mitchell, A., Johnstone, L., & Staite, S. (2003). Making reflective practice real: problems and solutions in the South West. Clinical Psychology, 27(7), 30-33.

Steffen, S. L., & Fothergill, A. (2009). 9/11 volunteerism: A pathway to personal healing and community engagement. The Social Science Journal, 46(1), 29-46.

Steffens, N. K., Cruwys, T., Haslam, C., Jetten, J., & Haslam, S. A. (2016). Social group memberships in retirement are associated with reduced risk of premature death: evidence from a longitudinal cohort study. BMJ open, 6(2), e010164.

Steffens, N. K., Haslam, S. A., Schuh, S. C., Jetten, J., & van Dick, R. (2017). A meta-analytic review of social identification and health in organizational contexts. Personality and Social Psychology Review, 21(4), 303-335.

Steffens, N. K., LaRue, C. J., Haslam, C., Walter, Z. C., Cruwys, T., Munt, K. A., Haslam, S. A., Jetten, J., & Tarrant, M. (2021). Social identification-building interventions to improve health: a systematic review and meta-analysis. Health psychology review, 15(1), 85-112.

Stevens, M., Rees, T., & Polman, R. (2019). Social identification, exercise participation, and positive exercise experiences: Evidence from parkrun. Journal of Sports Sciences, 37(2), 221-228.

Stoner, J. B., Bock, S. J., Thompson, J. R., Angell, M. E., Heyl, B. S., & Crowley, E. P. (2005). Welcome to our world: Parent perceptions of interactions between parents of young children with ASD and education professionals. Focus on Autism and Other Developmental Disabilities, 20(1), 39-51.

Tajfel, H. (1970). Experiments in intergroup discrimination. Scientific american, 223(5), 96-103.

Tajfel, H. (1974). Social identity and intergroup behaviour. Social science information, 13(2), 65-93.

Tajfel, H. (1981). Human groups and social categories (p. 6). Cambridge: Cambridge university press.

Tajfel, H., Billig, M. G., Bundy, R. P., & Flament, C. (1971). Social categorization and intergroup behaviour. European journal of social psychology, 1(2), 149-178.

Tajfel, H., Turner, J. C., Austin, W. G., & Worchel, S. (1979). An integrative theory of intergroup conflict. Organizational identity: A reader, 56(65), 9780203505984-16.

Tajfel, H. E. (1978). Differentiation between social groups: Studies in the social psychology of intergroup relations. Academic Press.

Testard, C., Larson, S. M., Watowich, M. M., Kaplinsky, C. H., Bernau, A., Faulder, M., Marshall, H. H., Lehmann, J., Ruiz-Lambides, A., Higham, J. P., & Montague, M. J. (2021). Rhesus macaques build new social connections after a natural disaster. Current biology, 31(11), 2299-2309.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. The British Journal of Social Work, 42(3), 443-460.

Thomas, D., Mitchell, T., & Arseneau, C. (2016). Re-evaluating resilience: from individual vulnerabilities to the strength of cultures and collectivities among indigenous communities. Resilience, 4(2), 116-129.

Thompson, A. R., Powis, J., & Carradice, A. (2008). Community psychiatric nurses' experience of working with people who engage in deliberate self-harm. International journal of mental health nursing, 17(3), 153-161.

Townend, M. (2005). Interprofessional supervision from the perspectives of both mental health nurses and other professionals in the field of cognitive behavioural psychotherapy. Journal of Psychiatric and Mental Health Nursing, 12(5), 582-588.

Trepte, S., & Loy, L. S. (2017). Social identity theory and self-categorization theory. The international encyclopedia of media effects, 1-13.

Tuck, I., & Anderson, L. (2014). Forgiveness, flourishing, and resilience: The influences of expressions of spirituality on mental health recovery. Issues in mental health nursing, 35(4), 277-282.

Turner, J. C. (2010). Towards a cognitive redefinition of the social group. In Research Colloquium on Social Identity of the European Laboratory of Social Psychology, Dec, 1978, Université de Haute Bretagne, Rennes, France; This chapter is a revised version of a paper first presented at the aforementioned colloquium.. Psychology Press.

Turner, J. C., & Brown, R. (1978). Social status, cognitive alternatives and intergroup relations. Differentiation between social groups: Studies in the social psychology of intergroup relations, 201-234.

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). Rediscovering the social group: A self-categorization theory. basil Blackwell.

Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective: Cognition and social context. Personality and social psychology bulletin, 20(5), 454-463.

Ungar, M. (2015). Social ecological complexity and resilience processes. Behavioral and Brain Sciences, 38.

Van Bogaert, P., Kowalski, C., Weeks, S. M., Van heusden, D., & Clarke, S. P. (2013). The relationship between nurse practice environment, nurse work characteristics, burnout

and job outcome and quality of nursing care: A cross-sectional survey. International Journal of Nursing Studies, 50(12), 1667-1677.

Van Dick, R., Ketturat, C., Häusser, J. A., & Mojzisch, A. (2017). Two sides of the same coin and two routes for improvement: Integrating resilience and the social identity approach to well-being and ill-health. Health psychology open, 4(2), 2055102917719564.

van Schaik, S. M., O'Sullivan, P. S., Eva, K. W., Irby, D. M., & Regehr, G. (2016). Does source matter? Nurses' and physicians' perceptions of interprofessional feedback. Medical education, 50(2), 181-188.

Van Zomeren, M., Postmes, T., & Spears, R. (2008). Toward an integrative social identity model of collective action: a quantitative research synthesis of three socio-psychological perspectives. Psychological bulletin, 134(4), 504.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. BMC medical research methodology, 18(1), 1-18.

Vella, S. L. C., & Pai, N. B. (2019). A theoretical review of psychological resilience: defining resilience and resilience research over the decades. Archives of Medicine and Health Sciences, 7(2), 233.

Verkuyten, M., & Lay, C. (1998). Ethnic minority identity and psychological well-being: The mediating role of collective self-esteem. Journal of Applied Social Psychology, 28(21), 1969-1986.

Volpe, U., Luciano, M., Palumbo, C., Sampogna, G., Del Vecchio, V., & Fiorillo, A. (2014). Risk of burnout among early career mental health professionals. Journal of psychiatric and mental health nursing, 21(9), 774-781.

Wagner, W., Kronberger, N., & Seifert, F. (2002). Collective symbolic coping with new technology: Knowledge, images and public discourse. British Journal of Social Psychology, 41(3), 323-343.

Wagnild, G. M., & Young, H. M. (1993). Development and psychometric. Journal of nursing measurement, 1(2), 165-17847.

Wakefield, J. R., Bowe, M., Kellezi, B., McNamara, N., & Stevenson, C. (2019). When groups help and when groups harm: Origins, developments, and future directions of the "Social Cure" perspective of group dynamics. Social and Personality Psychology Compass, 13(3), e12440.

Waldman, J. D., Kelly, F., Arora, S., & Smith, H. L. (2010). The shocking cost of turnover in health care. Health care management review, 35(3), 206-211.

Walsh, K., Nicholson, J., Keough, C., Pridham, R., Kramer, M., & Jeffrey, J. (2003). Development of a group model of clinical supervision to meet the needs of a community mental health nursing team. International Journal of Nursing Practice, 9(1), 33-39.

Wampole, D. M., & Bressi, S. (2020). Exploring a social work lead mindfulness-based intervention to address burnout among inpatient psychiatric nurses: a pilot study. Social Work in Health Care, 59(8), 615-630.

Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., McIntyre, R. S., Choo, F. N., Tran, B., Ho, R., Sharma, V. K., & Ho, C. (2020). A longitudinal study on the mental health of general population during the COVID-19 epidemic in China. Brain, behavior, and immunity, 87, 40-48.

Wharne, S. (2020). Trauma, empathy, and resilience: A phenomenological analysis informed by the philosophy of Edith Stein. The Humanistic Psychologist.

WHO. (2018). Mental Health Atlas 2017. Geneva: World Health Organization; 2018.

Willard-Grace, R., Hessler, D., Rogers, E., Dubé, K., Bodenheimer, T., & Grumbach, K. (2014). Team structure and culture are associated with lower burnout in primary care. The Journal of the American Board of Family Medicine, 27(2), 229-238.

Williams, R., & Drury, J. (2009). Psychosocial resilience and its influence on managing mass emergencies and disasters. Psychiatry, 8(8), 293-296.

Windle, G. (2011). What is resilience? A review and concept analysis. Reviews in clinical gerontology, 21(2), 152-169.

Wityk, T. L. (2003). Burnout and the ethics of self-care for therapists. Alberta Counsellor, 28(1), 4-11.

Wood, V. J., Curtis, S. E., Gesler, W., Spencer, I. H., Close, H. J., Mason, J. M., & Reilly, J. G. (2013). Spaces for smoking in a psychiatric hospital: Social capital, resistance to control, and significance for 'therapeutic landscapes'. Social Science & Medicine, 97, 104-111.

Wright, M. O. D., Masten, A. S., & Narayan, A. J. (2013). Resilience processes in development: Four waves of research on positive adaptation in the context of adversity. In Handbook of resilience in children (pp. 15-37). Springer, Boston, MA.

Yadav, B. L., & Fealy, G. M. (2012). Irish psychiatric nurses' self-reported barriers, facilitators and skills for developing evidence-based practice. Journal of Psychiatric and Mental Health Nursing, 19(2), 116-122.

Yanos, P. T., Rosenfield, S., & Horwitz, A. V. (2001). Negative and supportive social interactions and quality of life among persons diagnosed with severe mental illness. Community Mental Health Journal, 37(5), 405-419.

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. Training and Education in Professional Psychology, 11(4), 283.

Zaki, J. (2020). Catastrophe compassion: Understanding and extending prosociality under crisis. Trends in cognitive sciences, 24(8), 587-589.

Zambrelli, E., Canevini, M., Gambini, O., & D'Agostino, A. (2020). Delirium and sleep disturbances in COVID–19: a possible role for melatonin in hospitalized patients?

Zamirinejad, S., Hojjat, S. K., Golzari, M., Borjali, A., & Akaberi, A. (2014). Effectiveness of resilience training versus cognitive therapy on reduction of depression in female Iranian college students. Issues in mental health nursing, 35(6), 480-488.

Zander, M., Hutton, A., & King, L. (2010). Coping and resilience factors in pediatric oncology nurses CE. Journal of Pediatric Oncology Nursing, 27(2), 94-108.

Zarea, K., Nikbakht-Nasrabadi, A., Abbaszadeh, A., & Mohammadpour, A. (2013). Psychiatric nursing as 'different' care: experience of Iranian mental health nurses in inpatient psychiatric wards. Journal of psychiatric and mental health nursing, 20(2), 124-133.

Zerden, L. D., Lombardi, B. M., & Richman, E. L. (2019). Social workers on the interprofessional integrated team: Elements of team integration and barriers to practice. Journal of Interprofessional Education & Practice, 17, 100286.

Zhai, Y., & Du, X. (2020). Mental health care for international Chinese students affected by the COVID-19 outbreak. The Lancet Psychiatry, 7(4), e22.

Appendix A: Coding Frame

CODE NAME		DEFINITION	EXAMPLE
A New Normal *As the world was thrust into the unknown with the onset of the pandemic, staff in approved centres had to adjust to a new normal almost overnight. This involved taking on additional role demands and making unprecedented adaptations to their practice. An atmosphere of fear and uncertainty prevailed which lowered morale; a process exacerbated by rapidly evolving infection control guidance.*			
An Invisible Spray	**(code: SU threat)**	Staff became hyper-alert to the threat posed by Service Users (SU) in the context of Covid risk.	Yeah, I think it caused almost a bit of tension because ... service users with mental health challenges don't really take into account on occasions, social distancing, and maybe hearing impairments visual impairments where you have to get close to someone. And once you kind of come within that distance, you you're more alert to the fact that there's aerosol being produced because the bulk of people here don't wear masks or face coverings, you know? So that was on your mind that you were ... getting a kind of an invisible spray.
	(code: staff threat to SUs)	Staff became hyper-alert to the threat they posed to SUs *Staff paranoia about bringing Covid onto the unit, felt responsible for their welfare, influencing their behaviour outside of work	I suppose the sheer responsibility you feel for your residents and ... you know, at the end of the day, we were coming into work to protect those and keep them safe and well and do our best for them, and that was constantly in the back of your mind, you know, and every decision you made

			throughout was always you were thinking of work and the knock-on effects for work really, especially initially ....
	(code: Covid threat)	Staff became hyper-alert to the threat posed by Covid *Staff struggled to balance professional responsibilities vs ensuring the safety of their families	I mean, it was weighing, you know, you're suddenly dealing with something, but it's not tangible you can't see it.
No Clear Roadmap	**(code: lack of clear guidance)**	Sense of uncertainty exacerbated by lack of clear guidance on infection control due to rapidly evolving situation *Also include management perspective (not knowing if it was going to be ok but having to present a calm demeanour)	There was a pan pandamonium, perhaps a bit strong, you know, but definitely a sense of confusion leading to bewilderment, you know what I mean, amongst the people because, it was like eh ... the blind leading the blind, nobody knew exactly what they were doing
	(code: info overload)	Staff were inundated with updated policy documents daily due to the rapidly evolving infection control guidance, adding to the uncertainty and further overwhelming staff.	It was funny, because it was changing so rapidly, any guidance that was that was coming in, eh I set up a folder on my desktop, just lobbing (sic) in the emails that were coming through, eh regarding infection prevention and control measures, new guidance, new changes, every day there seemed to be a fresh email dumped into your inbox telling you to do something different than you had done it the previous day. So, that was kind of strange, because you you had, you were unclear, the guidance was unclear, because it was all evolving so quickly, em that the initial measures we were taking seemed to be

			changing and the the what, what was expected of you seemed to be growing each day.
Low Morale	**(code: low morale)**	Initially, the fear and uncertainty around Covid had an adverse impact on the atmosphere at work and morale among staff. *Includes the following: - split, staggered breaks reduced potential for positive interactions between staff - staff had to work extra hours (short staffing etc.) - limited opportunities to check-in with colleagues (social connection) - staff couldn't go off-site for breaks, they were welded to the unit and had no breathing space - sense of loneliness, isolation among staff - the pressure of the unknown - tenser atmosphere - heightened staff anxiety levels - paranoia about bringing Covid into the unit - pregnant staff disappearing - harder to leave work at work - hard to witness the adverse impact on SU wellbeing	Now, when you're limited to a certain number in any room ahm ... people are split for breaks, things are staggered, there's not the same meet-up time or check-in time with each other during the day, we're all focused on the job we're doing, and I think eh ... now it's improved as time goes on but definitely the atmosphere at work, the morale staff morale had really dipped, you know, because they were everyone was carrying that pressure of the unknown, that there wasn't the same what would you call it fun aspect. But there wasn't any any humorous side to work, it was all quite serious for so, so long, that em ... that people didn't have that kind of eh a light atmosphere. It was all it was kind of dull, heavy, and morale was dipped and, you kind of felt, God we were just trudging around, does that make sense? And then as it as we've adapted more and more that kind of has lifted a bit.

Another Layer to the Role	**(code: additional role demands)**	Additional role demands placed on MHPs to safeguard SUs through encouraging adherence to public health measures during Covid caused a shift in staff-patient dynamics. (e.g., staff having to constantly explain and enforce public health measures could at times strain staff-patient relations)	I suppose, with the relationship between the nurse and a patient is, all of the information that they get about Covid is through us, so when they come to us and ask, em nurse, can I can I go to the cinema? It's me telling them, no, you can't go to the cinema and it's because of Covid things are closed. Therefore, it's, I suppose at a certain point, they look and they say, oh it's your fault that I can't go to the cinema. So I think a lot of them might belief that it's us reinforcing it, and not really bigger idea that it's out there, you know, and the more you're reinforcing guidelines, and suggestions and all that type of thing, that does damage the relationship, like every second thing they come and ask us for is no, because of Covid. Like that has to damage your relationship with people, you know? No matter how hard you try or give an alternative, like it does, you know?
	(code: role adjustment)	Staff had to adjust their clinical practice overnight and had to come up with novel and innovative ways of supporting SUs and their families	I had to devise strategies and ways by which I could engage with individuals so … I kind of I set up a production line, em in one of the rooms that we use for therapeutic interventions, and I took fish nets … and I got, you know, we got our needles and threads, you know, for repairing the nets and things like that. And I I'd wake him up and tell them we're gonna (sic) go off, we're

			gonna (sic) head into the factory and he will follow with me you know what I mean and I said, show me how to repair them nets …
Group Divisions *Refers to how collegial relationships were challenged because of Covid.* Divergent voices emerged within staff cohorts, where individual colleagues held different attitudes towards the public health crisis, and how best to respond at any given time. This led to the formation of new group divisions between colleagues and an upsurge in intra-group tension, which left some more vulnerable to marginalisation and intolerance. Staff also report an escalation of inter-group conflict, where pre-existing interdisciplinary tensions were magnified and hierarchical divisions at these centres became more entrenched for a period.			
Intra-group tension	**(code: intra-group tension)**	Individual colleagues had different attitudes towards Covid which caused them to respond in different ways at different stages. This could often be a source of tension, in some instances leading to intra-group off-shoots/divisions. *Includes the following: - staff annoyances with covid dominating workplace conversations - different opinions/attitudes to Covid and Covid risk, safety protocols, patient welfare/safeguarding among staff - strong, fixed beliefs about Covid damaged collegial relationships - people critical towards dissenting voices - discriminatory attitudes towards colleagues	It's very hard to. I suppose you just have to look at, you know, like I said, they are people's beliefs. And I have to respect that that's what they think, that's what they're afraid of, and that's their perspective on it. And I just kind of allowed that but then it's hard when they don't afford you that same courtesy. And that's where the kind of the resentment comes, or the anger, I suppose, towards your colleagues is that they don't afford you the same respect. So I suppose you wouldn't, I'm not fully at piece we'll say with it like, or I haven't fully dealt with it, I suppose. My way has been to come away from them colleagues, which I don't know is the right ... solution, because you have to work with them and then, like, you say, like, if if we were in environment together, you have to put their opinions aside and sometimes that's not an easy thing to do.

		- tendency to gravitate towards those with similar beliefs/opinions and step back from others - inconsistencies in staff adherence to Covid safety protocol a source of stress, tension, frustration - fear and uncertainty made staff more agitated, judgemental towards one another - role envy (e.g., Shift staff vs. 9-5 staff), resentment towards other colleagues - some staff had to work additional hours due to others refusing to work - familiar staff vs unfamiliar staff - feeling judged by other staff for contracting Covid - night staff vs. day staff - pro-tunic staff vs. no-tunic staff	ahm when a person's environment changes and uncertainty's brought to the fore, I believe, you know what I mean, especially when you're working in a dangerous or frontline environment, people's insecurities, and their doubts and our their own, you know, their or their own personal issues, I believe came to the fore people were more snappy, they were more agitated, and things like that.
Hierarchical Divisions	**(code: hierarchical tension)**	Covid exacerbated hierarchical divisions among staff. *e.g., between staff and management, between management on the ground and upper management, between low- and high-ranking staff (e.g., Jnr and snr staff, student nurses) *Feeling unsupported at an organisational level	I would have been sure that this was my job for life, but it has made me see that I'm not minded in this job and nobody really cares about my wellness, or my mental health or my, you know, resilience, except me and it has made me have a change of mind going Is there something else that isn't this job because em (.) you're never going to be minded and really difficult things can happen and there will be absolutely no flexibility. So in your darkest hour or your hour of need you you're nobody has your back. Like I don't feel supported or minded or whatever.

Inter-disciplinary Relations	**(code: inter-group tension)**	Covid inflamed existing interdisciplinary tensions between professions early on. The Medical-Social Divide. *Includes the following: - medical vs. social model disparity - tensions between medical/allied health staff - physical health vs. psychological wellbeing/wellness - developed strong bond with intra-group colleagues in context of inter-group threat - jnr colleagues bullied by staff from other disciplines - better support structures within certain disciplines - management inaction in context of inter-disciplinary conflict - escalation in inter-disciplinary conflict led to more inter-group cooperation, forging of strong intra-disciplinary bonds - difficult social environment to work in/personal toll of inter-group conflict - fighting for space - power struggle between disciplines - disrespect, discrimination, judgement, - powerlessness: powerless to change a culture of disrespect - voice of allied health professionals silenced by the dominant medical culture - things settled over time	I think that other professions have so little say in how they're working or where they're working or flexibility of work that small things become like really important. And we had our own therapy kitchen that was basically stolen from us at the start of the pandemic as a as a nursing staff room. And that was huge there was huge tension around that, we still haven't gotten it back, it was our only space in the department and now, we still don't have it. It's the space adjoining group programs as well and, it meant that there was no privacy even for group programs, because there's like eh, you know, so it was like, when you're talking about the social environment and the atmosphere, it was really heavy back then, like so, and it just exacerbated tensions that were probably underlying anyway, or almost addressed anyway. But eh it made it really affected us negatively.

		- general healthcare vs. mental health division - healthcare workers vs. other professions in wider society	
The Vaccination Question	**(code: conflict re vaccination)**	Divisions emerged between staff due to vaccination. *Includes the following: - vaccination a stressful topic for some - felt pressured, coerced into getting vaccinated by majority group - felt disrespected, judged discriminated on basis of vaccination status - issue of vaccination handled insensitively - fears re future implications of broken trust among colleagues and damaged collegial relationships - personal toll - student nurses forced to get vaccine before going on placement -staff fearful of the threat posed by unvaccinated staff	Em people saying that they would refuse to work with people that weren't vaccinated. Ahm that, you know, it was reckless that it was selfish. Ahm and that has continued through the whole year, even post other people that I suppose are at risk and who did want the vaccine who got it, it's still a subject of conflict now, that there's still half around the place that haven't got the vaccine. So that is one of the biggest, I suppose times that has been stressful around it. Because there is pressure there, no matter how hard you do kind of question, will I just get it just to stop this talk and stop this conflict, you know, and that's not a right reason to consent to a vaccine. It's through pressure or other people's beliefs, you know?

Solidarity

A strong sense of solidarity emerged between colleagues in the context of a shared experience - a sense that by working together, they have the capacity to accomplish shared goals. Staff became interdependent whereby they relied on each other for mutual support. Staff also describe a sense of shared experience with SUs, with some viewing SU's more positively as a result.

Collective Efficacy	**(code: collective efficacy staff)**	A sense of collective efficacy developed among colleagues – a sense that by working together, they have the capacity to accomplish shared goals.	I saw a number of colleagues … there was (sic) areas that had broken down, you know what I mean, due to the toxicity of working together and have a differences of opinions, and then all of a sudden, they saw there was a kind of em ... there was a, there was a kind of a primary focus, a primary goal, that we have to work together to get this thing. And you know, that was nice to see I saw people formed alliances because of that … there were very positive alliances that were formed and friendships that were made, you know?
	(code: collective efficacy staff/mgmt)	between staff and management	… I feel like maybe there was a sense of pulling together but I think that a lot of that had to do with man- em that approved center and the way it was being run, and it's highlighting of the eh value of having people who actually work on the on the ground being in management meetings, that was very positive.
	(code: collective efficacy SUs)	A sense of collective efficacy developed between staff and Sus	… we never had someone in a group program ahm not socially distance. And if they did, we could, you know, if they were very say, you know, energetic or whatever, we could say, oh, we can't do that in here because of social distancing and they'd happily leave. Like, we never had problems with that. We never had problems with getting people to sanitize or explaining why

			we couldn't do something because of Covid. Even like the group numbers, whatever, that was really people can take that kind of responsibility, which it just strengthened that I think.
Interdependence	**(code: interdependence)**	An interdependence developed between colleagues whereby they could lean on each other and access mutual support within their group. *Includes the following: - Colleagues were kind and supportive to one another, loyal - Interactions with other colleagues provided a social outlet – social connection - Colleagues could lean on one another - Colleagues didn't want to let each other down - Could confide in one another and talk things through/vent - Support via supervision and reflective practice - Spent more time with colleagues than family - Camaraderie with colleagues - Interdependence between colleagues and their roles	Yeah, I think, and I think, eh definitely em people checked in with each other, like, you know, people were conscious that someone might be stressed about it. And in the space, again, where I work here, people tend to come and have check in with each other here, you know, this is a this is an office where a lot of things are discussed. But it's, I suppose, an ancillaryTea Room, if that makes sense. So I think the tea breaks where people shared a bit of space and chat was a that was almost a kind of where the valve would be opened, you could release the pressure.
A Shared Experience	**(code: shared experience with colleagues)**	Sense of shared experience with colleagues.	I felt I felt everyone's going through it at the same time like, it was almost like a collective herd of staff coming to work

	*Integrated into Collective efficacy sub-theme	- Bond different to that between community-based counterparts - Went through it together - Sense of collective pride	experiencing the same thing. And I think that's what kept people going, knowing that you're not on your own doing it you weren't expected to go into the coalface solo.
	(code: shared humour) *Integrated into interdependence sub-theme	Colleagues shared humour with each other *Also include shared humour between SUs and staff	I think a lot of it positivity because we kind of we did have a good laugh as well because if you didn't laugh, you'd cry, you know, and it kind of, you know, we had to make light of the situation by putting on all the gear and the whole lot, you know, and you know, to see the you have to kind of see the humor in some of this traumatic event, you know, we've very dark humor now in psychiatric nursing, but that's just part of our job.
	(code: shared experience with SUs) *Integrated into Collective efficacy sub-theme	Sense of shared experience between colleagues and service users.	I suppose ... the support that like us being there, we were the only people that they were seeing and how important it was for us to be ahm a reassuring face or, you know, to be there for them, ahm definitely my attitude towards them is that, how much more difficult it is for them to go through something like Covid
A Different Light	**(code: SUs in new light)**	MHPs viewing SUs in a different light due to Covid - e.g., more empathy, more respect (reflections)	Ahm I'm definitely very empathetic towards them ahm, as in from the perspective that how much they rely on certain things to get through their day, how much routine is

			important to them, and I suppose ... the support that like us being there, we were the only people that they were seeing and how important it was for us to be ahm a reassuring face or, you know, to be there for them, ahm definitely my attitude towards them is that, how much more difficult it is for them to go through something like Covid compared to someone I suppose, like myself or, you know, whoever so that how easy they can be knocked because they're predisposed, I suppose with a mental illness ahm and that that something like this can be really hard on them. I suppose I'm very empathetic towards them for that reason.
	(code: colleagues in new light)	MHPs viewing colleagues in a different light due to covid – e.g., more understanding, more respect (reflections), more appreciation, strengthening group ties	There are people who embrace that, that level of we're here now, you know, we're here to do a job and we're here to be respecting everybody else and that's grand but you know, you don't need to be ... given that praise and thumbs up and likes and everything, I don't anyway, you know what I mean? I just I had a newfound respect for those who stayed on the front-line, you know what I mean? I'm doing this because I have autonomy to do so. Because it was part of my - if it's part of my personality to want to walk towards danger, it might be somebody else's

			personality to wish to step back because they have children also and they have the autonomy to make choices about what they want to, you know, focus on themselves primarily and their wellbeing, you know what I mean, and maybe it was selfish of myself to think that, "Yeah I can come in here without vaccinations or without you know just whatever PPE we were told to wear at the time," you know?
The Covid Barrier *Covid created a communication barrier between staff and patients (and a barrier to equality in staff/SU interactions), a spatial barrier between staff, patients and their families, and a barrier to meaningful therapeutic engagement in the form of individual and group-based supports.*			
Social Distancing	**(code: social distancing)**	Staff forced to step back from SUs due to Covid in order to keep a safe distance – this placed a spatial barrier between staff and SU. *Includes the following: - Covid safety protocols a barrier to building rapport with SUs, social distancing creating a spatial barrier between staff and SUs	Yeah, I ... I don't know, I grew up shaking hands and to kind of meet and greet you know so I kinda (sic) think It's something you automatically do, you throw your hand out to someone, and it would have been received as something something comforting before, or drops that barrier of like, you're a mental health professional, you're a service user, we're all on the same level here, like, you know but, if you can't do that with someone, you're ... and you're standing back a pace, and you're trying to build a rapport with someone, it's very difficult, you know? I find that challenging,

		- a barrier to equality in staff/patient interactions - barrier to meaningful therapeutic engagement - mismatch between needs of dementia patients and Covid protocols - had to step back from SUs - had to step back from each other, become more cognisant of personal space of colleagues - social distancing particularly impacting on more vulnerable, elderly clients who can't use tech, SUs not able to use tech likely to miss out going forward	I still find it challenging. And I sometimes even forget myself, you know? Where I'll maybe take my hand to raise it and then realize like I'll kind of just lick my fingers and just nod and talk, you know (laughs)?
	(code: human touch)	Public Health Measures were an obstacle to connecting with service users on a human level. E.g., Unable to comfort SUs and their families with touch. - no longer able to comfort SUs in distress - would sit down and provide reassurce with SUs pre-Covid - especially challenging in palliative care - family members not able to comfort SUs - staff not able to comfort each other (hugging)	I'm quite a tactile person, and there's nothing like the human touch, you know, there isn't ahm to touch someone's hand or I tend to give hugs out, you know, because the patients in here have never had that kind of physical ... someone to put their arms around you to know that we are with you on this one, we're all the same. So you're kind of stepping back and you're nearly becoming nearly OCD when it comes to things, do you know?
	(code: group limits)	Staff were forced to limit group numbers due to Covid, representing a barrier to SU recovery in the form of their ability to	… what happens is that, I could get people in for a group activation, and I can sit down with them and I could do behavioural

		access meaningful group-based therapeutic supports. Includes: - Staff frustration at not being able to fully engage SUs therapeutically as a result of this - Hard to say no to people in crisis beginning their recovery journey Things done to compensate for this	activation, I created me own form of therapeutic intervention as well which would be eh like reminiscence and behavioural activation as well, so it would be a case of reminiscence with tools and things like that. And, and you couldn't do that anymore like, you know the HSE have announced that, you know, you can't have any more groups, and you can't have any more than eight people in the one room at the one time and if you do you have to keep them two meters apart. And it's, it's just not feasible. It's baloney. Do you know what I mean? I remember having to go back and tell people that the group was full and (.) I actually I can remember that it happened a few times, and that (.) it's a devastating thing to do to someone when they're in (.) inpatient …
The PPE Barrier	**(code: PPE Barrier)**	PPE a barrier to staff/SU communication *Includes the following: - impact of facemasks, PPE gear etc. staff/SU communication, particularly with elderly SUs - impact of PPE on SU wellbeing (confusion, distress), particularly in context of supporting dementia patients	I remember particularly in that setting how difficult the mask wearing was? Because you're dealing with a lot of elderly clients and you realize how much they rely on your, your verbal cues, I suppose, and your facial expression, and you know, a lot of them will be hard of hearing and I don't know what you're saying to me, and really difficult to communicate with that group of people ahm not understanding, you know, people with dementia, I remember that

			being very, very difficult, sometimes so much so you'd be tempted to have to step back and take down your mask and give them a simple cue, and how much they relied on that. And that that barrier was a big thing in care of the elderly.
Restricted Movements	**(code: visiting restrictions)**	Restrictions on visitations a barrier between patients and their families. Could also be a source of tension in the context of staff interactions with patients and their families	…. I could use the word I could use the word pandemonium to that then with that individual because there was like she was in a s- she was like a headless chicken running around she was looking out through the glass and knocking on the door, and I would say no through the glass, you know what I mean? It was like, without exaggeration, it something like Chernobyl that's what it reminded me of, you know, I was thinking, I never thought I'd be in this position to tell a woman she can't visit her husband. A woman I was eh who I'm very fond of, you know?
	(code: SU/community barrier)	SU's were sealed to the space – this placed an additional barrier between them and the wider community, and their reintegration into same. *Includes the following: - detachment from wider community a concern - lack of opportunities for community inclusion - lack of outside input/supports coming in	Yeah, I ... I think we were heading to such a good place where I'm working and like part of my role was going to be actually ... ahm for service users to be going off-site for ... making trips or just just exercising or getting getting off the footprint. And I think the fact that we're sealed to the space now that's kind of really kinda (sic) I suppose that's kind of got me down in one sense, I think ahm ... it's that kind of detachment from the community and to feel that ... your

			your workplace now, it's not ... it's quite rigid, it's not movable. Our exit doors are pretty much sealed and that's a big thing that kind of gets in on you over some time because you feel you're in a capsule or or a bubble here and not, not the space where you thought you could actually leave with little notice, does that make sense?

Appendix B: Interview Schedule

Question: Take me back to the beginning. Can you tell me about your experience of working at the centre in the initial stages of the Covid-19 pandemic? What was this like for you?

Prompt: Going through your head at the time? Atmosphere like?

Prompt: Looking back, what stands out the most?

Question: While most of the country were in lockdown during the early stages of the pandemic, you had to keep showing up for work as an essential frontline healthcare worker. Can you talk me through what this experience was like for you?

Prompt: What was helpful in managing this for you?

Prompt: Did you feel safe and supported in your role at an organisational level?

Prompt: Has this experience changed over time as things have developed?

Question: Covid-19 has profoundly changed all of our lives, particularly in terms of how we behave and interact with each other. How has this adjustment been for you in the context of your work at the centre?

Prompt: Biggest challenge for you personally? Specific examples?

Prompt: Impact on personal resilience, health, and wellbeing?

Prompt: Helpful in managing this for you?

Question: As someone with first-hand experience of working in an approved centre during a global pandemic, would you say your attitudes towards patients have changed compared to how they were pre-Covid and if so, how?

Prompt: How would you compare staff/patient relations now to how they were pre-Covid-19? Examples? Biggest change in terms of how you interact with patients?

Prompt: How, in your opinion, have patients responded to the new normal?

Question: What's been your experience of working with colleagues since Covid-19?

Prompt: positives/challenges – examples?

Prompt: How does this differ compared to working as a team pre-Covid-19?

Prompt: Has this been your experience throughout Covid or are there times when this wasn't the case?

Question: We've spoken at length about the immediate impacts of Covid on your work at the centre. How would you describe the longer term, more far reaching implications of the pandemic on your practice?

Question: Do you think that your experience of working at the centre during Covid has changed you at all, as a person? Your outlook on life? How you view yourself as a person?

> ***Prompt****:* examples?
>
> ***Prompt:*** What about how you view yourself as a mental health practitioner?
>
> ***Prompt:*** What helps you to keep going, 15 months into this?
>
> ***Prompt:*** What has been the biggest personal cost of this whole experience for you?

Question: Is there anything we have not discussed about your experiences?

‘An exploration of the lived experience of mental health practitioners working in regional approved centres during a global pandemic’

Principal investigator’s name:	**Mr Colm Hayes**
Principal investigator’s title:	**Psychologist in Clinical Training**
Telephone number of principal investigator:	**+353 86 1455427**
Consultant co-investigator’s name:	**Dr Clíodhna O’ Connor**
Consultant co-investigator’s title:	**Assistant Professor**
Data Protection Officer’s Identity:	**Ms Mary Deasy**
Data Protection Officer’s Contact Details:	**mary.deasy1@hse.ie**

You are being invited to take part in a research study to be carried out by a research team affiliated with the Psychology Services in the HSE South and the School of Psychology at University College Dublin.

Before you decide whether or not you would like to take part, you should read the information provided below carefully. You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as ‘Informed Consent’.

You don't have to take part in this study. You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out. You don't have to give us a reason.

Who is organising the study?

This study is being conducted by the following research team: Colm Hayes, Trainee Clinical Psychologist, Dr Clíodhna O’ Connor, Assistant Professor at UCD School of Psychology, and Dr Tom Pender, Principal Clinical Psychologist, HSE South.

Ethical approval for this research project has been granted by the Research Ethics Committee, HSE, South East.

What is this research about? What are the benefits of taking part?

This study is being carried out to understand the lived experience of frontline mental health staff of working in approved centres during an unprecedented, novel public health crisis. We wish to develop an understanding of what staff consider the immediate and residual impact of Covid-19 on their practice, wellbeing, attitudes and morale. We are also interested in exploring how staff at these centres managed the challenges that accompanied Covid-19 and whether staff think the crisis has inadvertently stimulated intra or intergroup social identity process at these centres. The study will give staff an opportunity to discuss their experience of working during an extraordinary time in history and reflect on how 'the new normal' impacted their interactions with colleagues and service users.

Why I am doing this Research?

The information gathered from this study will help us to better understand how a novel public health crisis of this scale impacts on staff working in inpatient mental health settings and to find better ways of supporting staff in these circumstances in future. The study also stands to help us to better understand social identity processes in inpatient mental health settings in the context of Covid-19.

Why have you been invited to take part?

You have been asked to take part as you are a mental health professional working in an approved centre in the South East of Ireland during Covid-19. Your participation will help us better evaluate the change in practice you are undertaking, so we can make better decisions about service provision going forward.

Who can take part in the study?

Mental health professionals working in regional approved centres can take part in the study if:

- They are working directly with service users in a nursing or allied health professional capacity on a full-time or part-time basis in any of the following sites:
    1. The Department of Psychiatry, University Hospital Waterford, Dunmore Road, Waterford
    2. Grangemore Ward, on the grounds of St. Otteran's Hospital, John's Hill, Waterford
    3. St. Aidan's Ward, on the grounds of St. Patrick's Hospital, John's Hill, Waterford
- They were employed in their roles during the Covid-19 pandemic.

However, mental health professionals will not be able to take part in the study if:

- They primarily work outside of the identified sites in a community-based capacity.
- For any reason, they cannot provide informed consent.
-

What will happen to me if I agree to take part in this research study?

Upon receiving information about the study, you will be asked to email Colm at colm.hayes@hse.ie. Colm will tell you more about the study and answer any questions you

may have about taking part; this may be done via email or phone as you so wish. If after this, you still want to take part, Colm will send you an electronic participant information sheet and an accompanying consent form for you to sign and return. Then, upon receipt of your signed consent form, we will organise a suitable time for your interview. This will take place remotely via Microsoft Teams or in-person as per your personal preference. It is important to note that the possibility of in-person interviews is dependent on national healthcare direction in the context of Covid-19; public health advice may require that all interviews take place remotely. If at all possible, your interview will take place during your own time rather than work time to minimise any service implications.

The interview will last for approximately 45-60 minutes and the questionnaire will be administered (orally or in-person) immediately beforehand. Prior to the interview starting, you will have an opportunity to clarify any aspect of the study that you are unsure of time will be allocated to answering any questions you may have. In order to protect the identities of others and respect their right to anonymity, you will be asked to refrain from referring to staff, service users or their families by name in interviews.

At the end of the interview, Colm will discuss the experience with you there will be another opportunity to discuss any queries you may have. You will be reminded that your individual contributions will only be used as data for the stated research purpose. Should you subsequently feel in any way distressed, dissatisfied, or uncertain about whether you are comfortable with your data being used in the study, reassurances will be given about confidentiality and you will be reminded of your right to withdraw data should you so wish.

What are the risks of taking part in this research study?

There is a possibility that some of the following may arise during the study:

Feelings of distress

Given the extent of the personal and professional adjustment arising from Covid-19, it is possible that interview questions may cause you emotional distress. Should you become emotionally distressed during or following an interview, please make your feelings known to Colm, who will ensure that you have access to appropriate support structures to safeguard your welfare.

Pressure to participate

You may feel pressure to participate in the study. You may consider there to be an implicit expectation that you take part and that your refusal to do so will be noted by your superiors and result in negative personal or professional implications. Please be assured that your participation in this project is entirely voluntary and you are fully within your rights to not participate should you so wish. The identities of participants who opt-in will be held in the strictest confidence and their contributions will only be used for the stated research purpose. Identifying information will NOT be disseminated to management.

Identifiable quotes

There may be a concern that even pseudonymised quotes may be identifiable given the small sample of people who know each other that will likely make up the participant sample. While this risk cannot be eliminated completely with pseudonymised interviews, every possible step will be taken to protect participants' right to privacy.

Disclosure of sensitive information

As mentioned previously, you will be asked to refrain from referring to colleagues, service users, or family members by name prior to the interview's commencement to protect their identities and respect their right to anonymity. That said, you may inadvertently disclose sensitive information about someone who has not consented to this process during the interview, for example, you may accidentally refer to someone by name. Rest assured that no real names or identifying information will appear on interview transcripts or in the final study. Any inadvertent disclosure of sensitive information will be altered during the transcription process and the subsequent deletion of the audio file will ensure the prevention of any disclosure.

Is the study confidential?

Strict participant confidentiality will be maintained throughout the study. Questionnaire and interview data will be pseudo-anonymised, whereby we will give you a unique study ID at the start of the study and this code will appear on every record associated with you. It will be the only identifier on transcribed interviews.

The results of the study will be submitted as part of Colm Hayes' thesis, for publication in academic journals, and presented at future conferences, however there will be no identifying information of any individuals involved.

Importantly, confidentiality is limited as the researcher, Mr Colm Hayes, is professionally responsible for reporting any allegations of professional misconduct.

Can you change your mind at any stage and withdraw from the study?

It is completely voluntary and your choice if you would like to participate. You do not have to take part in this study. Participants will be able to withdraw their data from the study at any point up within 14 days following the interview, as this is the point when the data will be analysed. To do this, you can contact Colm via phone or email and request that your data be withdrawn. You will not have to give a reason for this. The questionnaires and interview data will then be removed from the study at your request and destroyed. Withdrawal from the study will have no negative personal or professional repercussions.

Data Protection

We will be using your data in this research to help us understand the lived experience of frontline mental health staff working in approved centres during Covid-19.

The legal basis for processing your data relates to the researcher's pursuit of legitimate interests for scientific research purposes as per Article 6 and 9 of the General Data Protection Regulation 2016. Importantly, no personal data shall be processed in this study without having obtained your explicit consent.

As mentioned previously, questionnaire and interview data will be pseudo-anonymised, whereby we will give you a unique study ID at the start of the study and this code will appear on every record associated with you. It will be the only identifier on transcribed interviews. The named researcher, Colm Hayes, will retain the 'key' to identify the data. The key will be kept in an encrypted file separate to the data. During the analytic phase, Dr. O' Connor will require access to full pseudonymised transcripts of interviews to ensure research integrity. Dr O' Connor will not have access to personal data of interview participants or data collected via demographics questionnaires.

Interviews will take place in-person or remotely via secure remote platform approved by the HSE (i.e., Microsoft Teams) as per your choosing. All in-person interviews will be recorded on a Dictaphone, which will be both encrypted and password protected. Remotely conducted interviews will be securely recorded via Microsoft Teams. Those recorded in-person via Dictaphone will be transferred immediately to a designated, password protected HSE laptop. All interview recordings will be immediately deleted post-transcription.

The only data which will not be pseudo-anonymised in this way are the consent form which will contain your signature and work-related email addresses for the purpose of official correspondence. Consent forms will be stored separately from and not linkable to the data files. Work email address will not be processed (i.e. collected, shared, or used) as part of this study.

All Data will be securely stored in digital form to safeguard its protection. Hardcopies of participant data will be digitalised upon receipt, i.e., scanned to a secure HSE password protected laptop and subjected to an encryption process by the researcher. Hardcopies will then be subsequently destroyed (i.e., shredded). If data must be transported from one site to another, it will be stored in a locked and password protected suitcase.

The researcher and lead data controller, Mr Colm Hayes, will destroy all data securely after 10 years, i.e., digital files pertaining to the study will be erased. This is in line with guidelines as per the Medical Research Council in the UK (2017) suggesting that for *"basic research, research data and related material should be retained for a minimum of 10 years after the study has been completed."* Data will thus be retained in the interest of transparency and destroyed securely after by the researcher after 10 years. As previously noted, all digital files will not be stored in an identifiable format – identifiable data i.e., audio files will have been immediately deleted post-transcription following data collection.

You have the right to withdraw consent for your personal data being used in this research project at any point up within 14 days following the interview, as this is the point when the data will be analysed. You can do this by contacting Colm via phone or email. You will not have to give a reason for this. The questionnaires and interview data will then be removed from the study at your request and destroyed. Withdrawal from the study will have no negative personal or professional repercussions.

Similarly, You also have a right to have any inaccurate information about you corrected or deleted.

Importantly, you have the right to lodge a complaint with the Data Protection Commissioner should you so wish. You also have the right to request access to your identifiable data and a copy of it where possible; a request can be made by emailing Colm at colm.hayes@hse.ie.

Where can I get further information?

If you have any further questions about the study or if you want to opt out of the study, you can rest assured it won't have any implications on you personally, or professionally.

If you need any further information now or at any time in the future, please contact:

Principal Investigator: Colm Hayes
Address: UCD School of Psychology, Newman Building, Belfield, Dublin 4.
Tel: +353 86 1455427
E-mail: colm.hayes@hse.ie

Co-investigator/Academic Supervisor: Dr Cliodhna O' Connor
Address: UCD School of Psychology, Newman Building, Belfield, Dublin 4.
Phone no: +353 1 716 8612

'An exploration of the lived experience of mental health professionals working in regional inpatient mental health settings during Covid-19'

I have read and understood the **Information Leaflet** about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	**Yes** □	**No** □
I have had time to consider whether or not to participate in the study.	**Yes** □	**No** □
I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I can withdraw my data up until 14 days after the interview occurs. I understand that I don't have to give a reason for opting out and I understand that opting out won't negatively affect me, personally or professionally.	**Yes** □	**No** □
I understand that if the study team learns that anyone is at risk during the study that they may need to break confidentiality.	**Yes** □	**No** □
I understand that the results of the study will be submitted as part of a doctoral thesis, for publication in academic journals, and presented at future conferences. I understand that there will be no identifying information of any individuals involved.	**Yes** □	**No** □
I am aware that my interview will be recorded and I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications	**Yes** □	**No** □
I am aware of the potential risks, benefits and alternatives of this research study.	**Yes** □	**No** □
I have been given a copy of the Information Leaflet and this completed consent form for my records.	**Yes** □	**No** □
I consent to take part in this research study having been fully informed of the risks, benefits and alternatives.	**Yes** □	**No** □
I give informed explicit consent to have my data processed as part of this research study.	**Yes** □	**No** □

Participant Name (Block Capitals)	Participant Signature	Date

To be completed by the Principal Investigator.

I, the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

--Name (Block Capitals)	Qualifications	Signature	Date

2 copies to be made: 1 for participant and 1 for PI.

UCD School of Psychology
Scoil na Sícolaíochta UCD

Doctoral Programme in Clinical Psychology
Newman Building
University College Dublin
Belfield, Dublin 4, Ireland

T: +353 1 7168120

Clár Dochtúrachta sa Siceolaiocht Cliniciúil
Áras John Henry Newman
Ollscoil na hÉireann, Baile Átha Cliath
Belfield, Baile Átha Cliath 4, Éire

www.ucd.ie/psychology

DEMOGRAPHIC QUESTIONNAIRE

Study ID: **Researcher Initials:** **Date of Completion:**

Please read through and answer the following questions. If there is any question that you do not feel comfortable answering you can skip it.

What age category applies to you? (Please circle as appropriate)	20 – 29 years/30 – 39 years/ 40 – 49 years/ 50 – 59 years/ > 60 years
What is your gender? (Please circle as appropriate)	Male/Female/Other
What is your occupation?	
What is your occupational status i.e. scale/rank?	
Do you work full-time? (Please circle as appropriate)	Yes/No
Are you employed in your current role via an agency? (Please circle as appropriate)	Yes/No
How many hours per week do you work on average? (Please circle as appropriate)	< 40 hours per week/ > 40 hours per week
How long have you worked in your current role? (Please circle as appropriate)	<1 year/1–3 years/ 3–5 years/ 5–10 years/ >10 years

What category most accurately represents your clinical experience i.e., time spent working as a fully qualified mental health professional? (Please circle as appropriate)	<1 year/1–3 years/ 3–5 years/ 5–10 years/ 10-20 years/ >20 years
Do you consider yourself to have an underlying condition that renders you vulnerable to Covid-19? (Please circle as appropriate)	Yes/No

Appendix F: Recruitment Poster

Exploring the lived experience of mental health practitioners working in regional approved centres during a global pandemic

Meet the team!

You are invited to take part in a research study to be carried out by:

- Colm Hayes, *Trainee Psychologist*
- Dr Clíodhna O' Connor, *Asst Prof at UCD School of Psychology*
- Dr Tom Pender, *Principal Clinical Psychologist, HSE South*

What is it about?

We want to understand the lived experience of frontline mental health staff working in approved centres during a novel public health crisis and explore whether the pandemic has inadvertently triggered any intra or intergroup social identity processes.

Why is it important?

It will give staff an opportunity to discuss their experience of working during an extraordinary time in history. The information gathered from this study will help us to better understand how a novel public health crisis of this scale impacts on staff working in inpatient mental health settings and to find better ways of supporting staff in future.

What will I have to do?

Participation is voluntary. If you want to take part, you can request a participant information leaflet with additional details. After signing a consent form, you will be invited to attend a 45-minute one-to-one interview prior to which you will be asked to complete a short demographics questionnaire. Any outstanding queries will be addressed directly by the researcher afterwards.

Is it confidential?

Strict participant confidentiality will be maintained throughout the study. Questionnaire and interview data will be pseudo-anonymised. Results will be submitted as part of Colm Hayes' thesis, for publication in academic journals, and presented at future conferences, however there will be no identifying information of any individuals involved.

Sign me up!

Call or text Colm at +353 86 1455427 if you would like to take part!

You are welcome to leave a voicemail with your name and contact details if you are unable to get through. Colm will return your call as soon as possible.

Appendix G: Summary of Data Protection Officer advice following UCD Data Protection Impact Assessment

Based on the information provided, both UCD and the HSE had influence over the *how* and *why* of the project. Mr Colm Hayes works for the HSE and is undertaking Psychologist in Clinical Training studies in UCD. The project 'The lived experience of clinical practitioners working in inpatient mental health settings during the Covid-19 pandemic' _forms part of his studies. It is supervised by a UCD academic and supported by the HSE. The project consists of a limited number of qualitative, semi-structured interviews with frontline workers, which have the potential to inform future improvements.

The development of participant recruitment strategies and accompanying privacy notices were given considerable consideration and pay attention to privacy requirements. Potential participants get a clear picture of how the process will work, should they decide to participate. The way interviews will be managed, recorded, and transcribed also reflect that data protection were taken on board. The legal basis for data processing is participant consent. Interviewed data subject will be given as much control over their data as possible, while still delivering on the objectives of the project. The security, confidentiality and integrity of personal data processed is addressed in the project.

The information provided in this DPIA describes a range of technical and organisational, as well as mitigation measures that were put in place. Therefore, it can be anticipated that the project will not result in a high level of risk to the rights and freedoms of data subjects. Should any of the parameters described in this DPIA change during the project, then this DPIA needs to be reviewed.

Appendix H: Ethical Approval from HSE Research Ethics Committee

Ospidéal Ollscoile Phort Láirge
University Hospital Waterford
Regional Cancer Centre South East

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Research Ethics Office Old School of Nursing
University Hospital Waterford
Tel: 051- 842026/051-842391

16th November 2020

Mr Colm Hayes
School of Psychology
Newman Building
University College Dublin
Belfield
Dublin 4

STUDY TITLE: "Exploring the lived experience of staff at regional inpatient mental health settings during the Covid-19 pandemic"

STUDY STATUS: APPROVED

Dear Mr Hayes,

The Research Ethics Committee Co-ordinator, REC, HSE, South East reviewed the above study.

Expedited ethical approval has been granted for the above study and constitutes full ethical approval.

The following documents were reviewed and approved:

1. Research Ethics Standard Application Form
2. Research Proposal
3. Provisional Interview Schedule
4. Demographics Questionnaire
5. Participant Information sheet
6. Participant Consent Form
7. Letter to Department Head
8. Declaration Form
9. CV of Principal Investigator – Colm Hayes
10. GDPR Cert – Colm Hayes
11. DPIA

In addition this study will be outlined at the next planned Research Ethics Committee Meeting for the HSE, South Eastern Area by the Research Ethics Committee Coordinator and any comments made at this meeting in relation to your study shall be communicated to you in writing.

It is a requirement of the REC, HSE, South East that you send copy of your study results to the Research Ethics Office on completion.

Yours sincerely,

Caroline Lamb

Ms Caroline Lamb
Research Ethics Committee Coordinator
Health Service Executive, South Eastern Area

The Research Ethics Committee, HSE, South East is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human use) Regulations 2004 and as such is authorized to undertake ethical review of clinical trials of all descriptions and classes for the Republic of Ireland.
The Research Ethics Committee, HSE, South East issues ethical approval on the basis of information provided. It is the responsibility of the researcher to notify the Research Ethics Office of any changes to a study to ensure that the approval is still relevant.

Appendix I: Ethics Exemption from UCD Ethics Committee

S-E-21-75-Hayes-OConnor Exemption
External
Inbox

exemptions.ethics@ucd.ie

Thu, 20 May 2021, 12:48

to Clióchna, me

Dear Clióchna,

Thank you for notifying the Human Research Ethics Committee – Humanities (HREC-HS) of *your declaration* that you are exempt from a full ethical review. Should the nature of your research change and thereby alter your exempt status you will need to submit an application form for full ethical review. Please note for future correspondence regarding this study and its exemption that your Research Ethics Exemption Reference Number (REERN) is: **HS-E-21-75-Hayes-OConnor. This exemption from full ethical review is being accepted by the Office of Research Ethics on the condition that you observe the following:**

- **External REC Approval and/or Permission to Access/Recruit Human Participants/or their Data:** *(if applicable)* Please be aware that recruitment of participants or data collection should not begin until written permissions are secured from external organisations/individuals.

- **COVID-19:** Please note that for any future changes to face-to-face data collection will require a complete a self-assessment using the Human Research Risk Assessment form from SIRC**.** This may be required as part of any future request to amend.

- **UCD Insurance Requirement:** I confirm that the public liability insurance cover is in place for this project.

- **Researcher Duty of Care to Participants:** please ensure that ethical best practice is considered and applied to your research projects. You should ensure that participants are aware of what is happening to them and to their data whether a study is de-identified or not. All researchers have a duty of care to their participants who have the right to be informed, the right to consent to participate and the right to withdraw from the study.

Any additional documentation should be emailed to exemptions.ethics@ucd.ie quoting your assigned reference number (provided above) in the subject line of your email.
Please note that your research does not require a committee review and also note that this is an acknowledgment of your declared exemption status. All Exemptions from Full Review are subject to Research Ethics Compliance Review.
Regards
Tom

Tom Seaver
Office of Research Ethics
Roebuck Castle
Belfield
Dublin 4