Discourses of Compassion from the Margins of Healthcare: Perspectives of Mental Health Nurses and Patients with Lived Experience of Mental Health Care

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Thesis submitted to The University of Nottingham
for the degree of Doctor of Philosophy
September 2022

'The art of governmentality involves a power that "incites, it induces, it seduces, it makes easier or more difficult, but it relies above all on influencing 'acting subjects' who possess volition, desire and agency"'

- Foucault, 1982, p.220

ABSTRACT

UK healthcare policy has observed over a decade of changes that have arisen from a discourse of compassion as a marker for high-quality experiences of care. However, at the time of writing this thesis, there is little empirical work that has attempted to describe the political influences on the contemporary conceptualisation of compassion and how those influences might have shaped how compassion is understood in healthcare. In addition, despite a growing body of global research on compassion, the practical setting of mental health is largely absent. This thesis sought to address these gaps by using a critical lens to explore compassion and to examine how it is discursively constructed in relation to power, institutions, and social practices. This study adopted a critical discourse method to examine various dimensions of discourse, at multiple social strata. Conducted in three phases, it encompassed data arising from a document analysis (political and organisational discourse), interviews with mental health nurses (n=7), and interviews with patients[1] (n=10). Results were compared to the existing literature and to the chosen theoretical concepts to offer insight into how the data confirmed, contradicted, or expanded current knowledge.

Findings revealed how compassion had been presented as a way of having solved the problem of a perceived compassion deficit in nursing, with political strategies described in detail that were implicated in having made the solution

[1] The terms ‘patient’ and ‘service user’ are often used interchangeably in the healthcare literature. In this thesis I have chosen to use the term ‘patient’ (Pugh, 1996) to refer to participants with lived experience of accessing mental health services - primarily because this is how (patient)participants requested to be referred to in this work.

(compassionate care) capable of being realised. Both mental health nurses and patients constructed compassion as an innate ‘natural’ trait. Mental health nurses resisted state regulation of compassion in their practice, arguing instead that they were the embodiment of compassion. Although compassion was considered essential for mental health and the recovery process, unseen forces in the social world inhibited compassion. For instance, the structure of mental health services made it difficult for patients to access care. Medical discourses were shown to dominate the discipline and practice of psychiatry, which were theorised to have influenced individual and group systems of attitudes, beliefs, and values such that discourses of compassion and humanistic approaches were marginalised. Hence, the implicit value and function of compassion to positively impact health and wellbeing was easily overlooked.

Impact Statement

The University of Nottingham has an international reputation for research excellence and is acknowledged as leading in the translation of research to real-world outcomes. As a postgraduate research student at the University of Nottingham, I have conducted this work with integrity and independence to influence the world beyond academia, for the benefit and wellbeing of society. My primary objective is, and will remain, to achieve impact from the current study.

This thesis has addressed significant challenges in conducting research, such as accessing underrepresented and marginalised groups. This work has provided a platform to illuminate those voices. Hence, it is important to ensure that knowledge generated from this thesis has benefit to society and makes a difference to peoples' lives. I plan to take steps to progress this work by utilising the stories embedded within the chapters of this thesis. Moving forward, I will seek to work with those in a position to guide me in utilising this research to do what I can to make the social world a better place for those who work in and use mental health services.

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Acknowledgements

I would like to thank my supervisors Professor Stephen Timmons and Dr Ada Hui for their constant support and encouragement throughout the PhD journey. I would also like express my sincere gratitude to the research participants for sharing their lived experiences stories.

A special thank you to Professor Shane Sinclair and the Compassion Lab team. It was such a privilege to travel to the University of Calgary, to share knowledge and understanding with them.

I am thankful to the Economic and Social Research Council (ESRC) for providing funding for my PhD fees and stipend.

Finally, and outside of this study, I wish to thank my family and friends for providing me with a sense of balance.

Publications, Presentations & Prizes

Publications From this Thesis

Bond, C., Hui, A., Timmons, S., Wildbore, E., & Sinclair, S. (2022). Discourses of Compassion from the Margins of Healthcare: The Perspectives and Experiences of People with a Mental Health Condition. *Journal of Mental Health.* https://doi.org/10.1080/09638237.2022.2118692

Bond, C., Hui, A., Timmons, S., & Charles, A. (2022). Mental Health Nurses' Constructions of Compassion: A discourse analysis. *International journal of mental health nursing.* https://doi.org/10.1111/inm.13026

Bond, C., Stickley, T., & Stacey, G. (2022). Caring: The Essence of Mental Health Nursing. In Callaghan, P., Playle, J., & Cooper, L (Eds.) Mental Health Nursing Skills (2nd Ed.) Oxford University Press.

Additional Publications in the Funded Period

Bond, C., Stacey, G., Charles, A., Westwood, G., & Hearn, D. (2022). In Nightingale's Footsteps: a qualitative analysis of the impact of leadership development within the clinical learning environment. *Journal of Nursing Management.* https://doi.org/10.1111/jonm.13732

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Presentations

University of Nottingham, 3MT® Final *'The A.B.Cs of Compassion in Mental Health Care'* – June 2022

University of Nottingham, NUBS Conference. *'Discourses of Compassion from the Margins of Healthcare'* – June 2022

University of Calgary, Compassion Lab, Visiting Scholar. *'Discourses of Compassion from the Margins of Healthcare'* - April 2022

University of Plymouth C4CHEd Conference. '*Effects of Compassion-based feedback on Wellbeing Ratings During a Professionals Healthcare Task'* - December 2021

Cumberland Lodge, Life Beyond the PhD Conference. '*The Concept of Compassion in the Experiencing of Mental Health Care'* - August 2021

Sheffield Health and Social Care Nurses' Conference. '*The Concept of Compassion in the Experiencing of Mental Health Care'* - May 2021

8th NET/NEP International Nursing Conference (Poster). '*Effects of Compassion-based feedback on Wellbeing Ratings During a Professionals Healthcare Task'* - April 2020

Prizes

University of Nottingham, Faculty of Social Sciences 3MT® Prize Winner – May 2022

Nottingham University Business School, Prize for Best Presentation in Health, Innovation & Entrepreneurship – June 2022

Winner of the 2021 British Sociological Association (BSA) Phil Strong Memorial Prize - Sept 2021

Competitively funded conference at Cumberland Lodge, Windsor. *'Life Beyond the PhD'* - Sept 2021

List of Acronyms & Abbreviations

CBT	Cognitive Behavioural Therapy
CCGs	Clinical Commissioning Groups
CDA	Critical Discourse Analysis
CIP	Compassion in Practice Strategy
CN	Community Based Nurse
CPA	Care Programme Approach
DOH	Department of Health
ESRC	Economic and Social Research Council
FDA	Foucauldian Discourse Analysis
GEN	Graduate Entry Nursing
IAPT	Improving Access to Psychological Therapies
HEE	Health Education England
HRA	Health Research Authority
IAPT	Improving Access to Psychological Therapies
IRAS	Integrated Research Application System
NHS	National Health Service
NMC	Nursing and Midwifery Council
OT	Occupational Therapist
PD	Personality Disorder
PICU	Psychiatric Intensive Care Unit
RC	Responsible Clinician
RCN	Royal College of Nursing
REC	Research Ethics Committee
RT	Rapid Tranquilisation
SN	Staff Nurse
SNP	Specialist Nurse Psychotherapist
TR	Therapeutic Relationship
WB	Ward Based Nurse
VBR	Values Based Recruitment

Chapter 1: Introduction

At the beginning of this research, the concept of compassion in the context of healthcare systems had received significant attention in the public, professional, and academic press (Campbell, 2013a; Fotaki, 2015; Sinclair *et al.,* 2016a). This was prompted by previous failures in care within the United Kingdom (UK) National Health Service (NHS) where it had been reported that patients had been humiliated, neglected, and had died as a result of an organisational culture where staff were focussed on meeting targets rather than providing care to patients (Francis, 2010, 2013). Published findings noted how management lacked insight and awareness into the poor 'quality' of patient care, which had gone undetected and uncorrected for some time. The most significant conclusion was that a common culture of openness and compassion needed to be created within the NHS. This led to international concerns surrounding the level of compassion in healthcare settings (Sinclair *et al.,* 2016a *in* Bond *et al.,* 2018). Fuelled by these notable concerns, scholars began to focus on demonstrating how compassion might produce more positive and enriching experiences of care, particularly in terms of nursing processes (Dewar, 2013), and developing compassionate healthcare leaders (West, Eckert & Collins, 2017).

This thesis explores compassion in the context of giving and receiving 'mental health' care, including what constitutes compassionate care and how this is believed to be achieved in mental health nursing practice. It also considers how various discursive practices influence people's experiences of mental health

care. However, prior to exploring the literature, and discussing what has been investigated previously, I would like to provide the reader with insight into how I became interested in the topic of compassion.

It is important to acknowledge my role as a registered mental health nurse with a background of working in older-adult acute care settings. I have a keen interest in how health and social care services are organised, and how organisational practices impact peoples' experiences of care. I also have a strong interest in discourse studies and understanding discourse as a social practice. Sociological thinkers and discourse scholars like Van Dijk (1993, 1995, 2006, 2009), influenced me throughout my nursing studies. These interests led to an intellectual curiosity about how discourse practices can influence what we do, what we say, who we believe we are, and how we behave in the social world more broadly.

During my nurse education, and beyond, I have viewed my role as an extremely privileged position, where I have cared for adults/older adults who were admitted to hospital and acutely unwell. I have viewed my position as enabling wellbeing, with compassion at the core of my nursing practice. However, on becoming registered nurse, the subject of compassion felt like a source of tension, and I was often torn as I encouraged patients to take antipsychotic medications and administered medications against people's will. I told myself this was a compassionate act, because eventually the person might begin to have a reduction in symptoms.

Another thing that sparked my interest in compassion was undergoing student assessments in clinical practice placements within the academic setting. Students were being assessed in terms of their individual level of compassion. For me, the subjective nature of compassion cast doubt on how it was being determined that one student (or experienced 'registered' nurse) was more, or less, compassionate than another. Indeed, everything was subjective, and these differences of opinion would easily manifest in disputes, not just in terms of compassion, but with respect to what was viewed as being *'in someone's best interests'* or what the meaning of an observed (patient) behaviour was. For instance, what staff regarded as 'normal' or 'abnormal' behaviour, and what the right treatment options might be, were always debated. If this were true when referring to those in our care, then the same notion could be applied to the behaviour of nurses. I began to ask myself questions, *'How am I perceived as a compassionate nurse?', 'What does it mean to be compassionate in the context of mental health nursing care?', 'What do patients consider as compassionate practice?'* and '*What role might compassion play in the process of recovery?'*

Despite having been introduced to the importance of compassion in nursing practice as a student, the reality of nursing work was a stark contrast. There was never enough time to spend with patients but, at the same time, always frequent requests to work more hours and do more shifts. Staffing was always an issue, and it felt like we were effectively being asked to do more caring with fewer resources. This left me questioning my nursing philosophy, which I had written of

during my student nursing course, and I questioned whether I was delivering the care I had aligned with my caring values when I first joined nursing.

Why was it that the ideals I had been exposed to while completing my nurse training were not as easily reflected in practice? For instance, I was aware that, according to the Department of Health (DOH, 2012a), how people receive care should be characterised by *"compassion, dignity, and respect"*, and "*being treated with compassion"* was expressed as *"core to providing safe, high-quality care"* (p. 13). The UK regulatory body for nurses and midwives, the Nursing and Midwifery Council (NMC) (2015), also stated that treating people with *"kindness, respect and compassion"* (p. 6) is fundamental to professional nursing practice and integral to the professional conduct of the nursing profession. Yet, as I had experienced as a student nurse and a registered practitioner, it was apparent that compassion was not straightforward. I was aware (anecdotally) that differing views on compassion existed. There was also widespread debate across the healthcare literature in terms of how compassion is defined (Sinclair *et al.,* 2016a; Ledoux, 2015). This got me thinking about the broader social structures, particularly the way in which the political regime might influence the development of a profession like nursing. How might the current political structures impact the conceptualisation of compassion in the social world? Moreover, how was this shaping my own sense of professional identity and clinical practice? Returning to the sociological thinking I had been interested in during my nursing studies, I considered that the way people act in society is related to the governing of individuals, which is understood to occur through various social policies,

institutions, and ideologies (Bröckling *et al.,* 2010a). As I had come to understand discourse as a social practice, I considered how the political discourse on compassion might have influenced nursing work. Specifically, had I constructed a sense of myself as a nurse according to the discourses I had been exposed to as a student nurse…first and foremost, 'was I 'compassionate'?' Had I become an agent of socio-political control or was there another way to consider the concept of compassion in healthcare? As I had noticed in my clinical practice, not everyone simply adhered to the practice of compassion as prescribed and defined by the DOH (2012a) and the NMC (2015). When I began searching the academic literature, I was unable to find any empirical study that examined the political discourses, and the impact of these discourses on nursing work, or mental health patients' care experiences. As I set out on this PhD journey, it was evident that the academic literature was devoid of any empirical study of compassion where mental health patients had been spoken to directly. Hence, this research set out to address these gaps, with the view to making a clear empirical contribution to knowledge.

The initial plan for this work was to explore the potential influences of the wider policy discourse about compassion on mental health nursing practice and patients' experiences of care. However, it would be amiss to assume the reader has comprehensive knowledge of the mental health practical setting. Therefore, in the following section I will provide a brief overview of the origins of mental health nursing care, broadly locating contemporary mental health nursing practice within the historical context. This is intended very much as an

introduction, to offer the reader insight to the practical and cultural setting in which the data collection for this thesis is situated.

1.1 A Brief History of Mental Health Care

The need to care for vulnerable members of society has long been recognised. Orphans, the sick, the elderly, and the mad have often been the ones seen to need care (Stickley & Stacey, 2009). The idea of 'madness' however, and the thought of 'losing one's mind' is perhaps one of the greatest human fears, and the cause of madness has been the focus of intrigue within society, culture, and philosophy since the Middle Ages (Killaspy, 2006). Madness was once viewed as a *"medical, or moral, or religious, or, indeed, Satanic"* affliction (Porter, 2003, p. 9), and until the late 18th century, care of the mad and/or insane was very much based upon subjective interpretations of behaviours, and religion was an influential factor for understanding what were deemed immoral and strange behaviours (Schmidt, 2016). During this period of time, *"lunatics were dealt with locally under poor law, vagrancy law or criminal law*" (National Archives, Linked para. 3) and rather than being 'cared' for, mentally ill people were placed in prisons or workhouses (Murphy, 2006).

In the late 1800s, in search of a more humane approach to treating the mentally ill, Britain passed the County Asylums Act (Duffy & Kelly, 2020). A large state-led effort began in providing care for those considered to be 'insane', people were removed from their homes and locked up in newly established institutions, or asylums (Porter, 2002). It was not until the establishment of mental asylums, and

the introduction of staffing for them, that the practice of mental health nursing began to emerge. Those who worked within the asylums practised alongside medical doctors who had begun to view their scientific approach and the search for diagnosing and treating the ‘insane’ or ‘lunatics’ as distinct from general medicine (Freeman, 2010). Hence, the development of mental health nursing can be located in close alignment with the early establishment of psychiatry.

In the 1900s, the institution of psychiatry was founded on the medical model and the basis that all mental illnesses had a biological cause, with a focus on curing the individual (Freeman, 2010). On the back of this, there has been a significant growth in pharmaceutical treatments for mental health conditions (Abraham, 2010), supported by the collection of epidemiological data relating to disease burden (Moreno-Agostino *et al.,* 2021; Murray, Abbafati & Abbas, 2020). However, the growth of psychotherapy and the psychological sciences have argued for a different approach to understanding and treating mental ill-health (Evans *et al.,* 2019). For example, psychologists considered behaviours that were viewed as dysfunctional (and therefore reflective of some mental abnormality) through the scientific study of perceptions, emotions, attention, motivations, and decision making.

To the psychologist, human behaviours are understood to be external manifestations of internal phenomena and over the years the psychological sciences have undergone several theoretical paradigmatic shifts in reasoning about ‘dysfunctional and/or abnormal’ behaviours, i.e. structuralism, functionalism, psychoanalysis, behaviourism, and cognitivism (Haslam & Lusher,

2011, *in* Wittchen*,* Härtling & Hoyer, 2015). These approaches have typically been underpinned by the biomedical, clinical, social, evolutionary, developmental, and sociological fields. Where psychologists have sought these various explanations, psychiatry has remained firmly attached to the medical model of mental illness.

In 1948, shortly after the NHS was established, mental health asylums were absorbed into the NHS, however, patients continued to be detained for long periods of time under the supervision of medical doctors. Debates began to surface in terms of regarding mental illness in the same way as physical illness (Millard & Wessely, 2014) and 1959 observed the first parliamentary Act on mental health with the aim of beginning to realise parity of esteem for the treatment of mental health conditions. The Mental Health Act of 1959 removed the distinction between psychiatric hospitals and other (physical, general) hospitals. The amendment of the Mental Health Act 1983 saw the large-scale closures of asylums (Kings' Fund, 2022) but, it was not until the 1990s that the 'journey' of the patient within mental health services began to change with the introduction of the Care Programme Approach (CPA) (NHS England, 2021a). This meant that the majority of mental health care could be provided in the community, and GPs were given more control in referring patients to specialist (either psychiatric and/or psychological) services within the community (Turner *et al.,* 2015).

Today, mental health nurses work in hospitals, the community, and across various specialist services (Kane, 2015). These different therapeutic approaches

to caring for mental ‘illnesses’ have meant that mental health nurses have been required to shift their care in conjunction with the beliefs, treatments, therapies, and changes in thinking about mental ‘illness’ over the decades. These historically influenced approaches and ways of thinking about mental health and mental ill-health are considered within contemporary mental health nurse training and education (Evans *et al.,* 2019). Consequently, higher education institutions typically deliver a curriculum that includes various ways of conceptualising mental health, including biological, psychological, and social schools of thought (Santos *et al.,* 2018). However, many stress the recovery principles and a model of care which underscores the need to move away from the historical conceptions of mental illness (madness). This is described next.

1.2 The Contemporary Context of Caring in Mental Health Nursing[2]

The current context of caring in mental health is one of transformation, reflecting a movement towards understanding mental health as occurring on a continuum (Johnstone, 2019). This directs thinking away from a traditional biomedical model and towards a ‘recovery-focussed’ approach. The recovery approach is centred around a number of principles that emphasise the importance of working in partnership with patients and carers to identify realistic life goals and enabling them to achieve them. Recovery is seen as an individual journey, acknowledging that the person is the ‘expert’ in their own life (Jackson-Blott, Hare & Davies, 2019).

[2] A large part of this section has undergone full peer review and is published as a book chapter in Callaghan, P., Playle, J., & Cooper, L. (Eds.) Mental Health Nursing Skills (2nd edn.) Open University Press.

Care should therefore be guided by the person, accepting that each person's recovery journey will be unique.

The principles of recovery are crucial for maximising choice and autonomy in the care people receive. These principles have been reflected in policy reforms (Department of Health and Social Care, 2019; NHS England, 2019); changes to the Mental Health Code of Practice (Mental Health Act, 2007; Sustere & Tarpey, 2019); and the mental health nursing competency framework (Health Education England, 2020). The following models form the basis of recovery principles: the tidal model (Barker & Buchanan-Barker 2004); the wellness recovery action plan (WRAP®) (Copeland, 1997); and strengths perspective (Rapp, 1998; Rapp & Goscha, 2005, 2006). A caring approach therefore represents the foundation for the therapeutic relationship (TR) (explained in chapter 2, section 2.2.3) which can act as a vehicle towards recovery (Freshwater, 2002; Felton, Repper, & Avis, 2018). Therefore, forming positive human relationships is considered essential for providing mental health care.

1.3 Organisation of This Thesis

Chapters 2 & 3: Literature Review(s)

This thesis has two distinct literature reviews. In chapter 2, I offer an overview of both the historical and contemporary debate on compassion. The existing scholarly literature on compassion fundamentally exposes a significant lack of any critical exploration, or empirical study of compassion in the context of giving and receiving mental health care.

In chapter 3, I outline the theoretical concepts that have informed this thesis and suggestions have been made regarding how to address the identified gap(s). The closing section demonstrates how the literature and theoretical framework have shaped the design, research aims, and objectives of the study.

Chapter 4: Methodology

Following on from the research aims and objectives, I have presented the principles and plan for the inquiry. The suitability of the underpinning philosophy for the methodological approach to address the research aims and objectives has been justified. I have outlined my rationale for adopting a multi-level analytical approach to the study, and the advantages and disadvantages of the chosen method. This research was conducted within the context of mental health care in the NHS, which generated significant ethical issues. I discuss how I planned and prepared for these issues within the study design. To conclude, a transparent account of the overall research process has been provided.

Chapter 5: Findings - Healthcare Policy Document Analysis

This is the first of three chapters in which the empirical data have been presented. Here I outline how I have disentangled the discourses on compassion, with a focus on the language of healthcare policy, politics, and organisational text and talk. Having adopted a critical discourse method, I have examined how a programme of compassion has been constructed politically and subsequently disseminated as policy.

Chapter 6: Findings from Interviews with Mental Health Nurses

Chapter 6 is concerned with mental health nurses' constructions of compassion. Results have been presented from the interviews with mental health nurses. The data show how mental health nurses have discursively constructed notions of compassion, and notions of themselves as compassionate practitioners. This practical setting has filled a gap in the academic literature and provided the basis for understanding compassion within a governmentality conceptual framework.

Chapter 7: Findings from Interviews with Patients

In chapter 7, the discursive constructions of compassion from the perspectives of patients with lived experience of mental health care are presented. Again, I have used a critical discourse method to explore patients' experiences of compassion, the discourses at play in participants' accounts, and inferred the social and psychological realities of their experiences. Findings demonstrated the importance of compassion in the process of healing and recovery for patients. The data also reveal how wider social discourses have led to patients having experienced stigma, marginalisation, and discrediting of voice.

Chapter 8: Discussion

In this chapter, I have discussed the findings in relation to the theoretical framework and existing literature. Theoretical interpretations of the empirical data, obtained from all three phases of data collection, have been considered.

Chapters 9 & 10: Conclusions & Recommendations

In chapter 9, I demonstrated how I met the research aims and objectives, and how this thesis has contributed to sociological scholarship. At the end of the chapter, the methodological and theoretical strengths and limitations of this research and the broader implications of the study have been outlined. In chapter 10, I have presented my recommendations for research, practice, and the future policy agenda that have arisen from the findings.

Chapter 2: Literature Review

Discourses on Compassion

2.1 Introduction

The broad aim of this thesis is to explore the concept of compassion in the context of mental health care. This necessitates a critical consideration of the broader perspectives on compassion in contemporary nursing, and the NHS. In this chapter I plan to situate this study within these wider perspectives and set out the existing research in this area.

This chapter has been organised into three sections. I begin (in section 2.2) by situating the concept of compassion more broadly by summarising a variety of perspectives, e.g. historical, ethical, and ethics in nursing. I then contextualise the current research with an account of the debate on compassion in healthcare in relation to existing care standards and healthcare policy in the UK (section 2.3). Finally, an overview of the academic literature on compassion in healthcare is presented (section 2.4), which has informed the focus of this study.

2.2 Searching for Compassion

Compassion is defined within the dictionary as a *"[s]ympathetic pity and concern for the sufferings or misfortunes of others"* (Oxford English Dictionary, 2009). The English noun is rooted in the Latin *'compati', 'pati'* meaning '*to suffer'* and the prefix '*com'* meaning '*with'* - literally meaning *'to suffer together with'* (Lopez, 2011). Compassion is an extensive topic. In October 2020 there were 1,620,000

results for *'compassion'* via Google Scholar. By June 2022, this number had increased by 113,000.

After narrowing this down to thinking about the meaning of compassion in the context of healthcare, 153,000 and 183,000 results were yielded respectively. Evidently, a wide variety of scholarly work has focussed on the topic of compassion. Not all will be discussed here, and I do not intend to present a systematic evaluation of the literature on compassion. The following sections are very much an introduction. However, I have outlined the broad historical perspectives and, given that I intend to explore compassion in the context of nursing and healthcare, I have sought to locate compassion within the context of nursing ethics.

2.2.1 Compassion: Historical Perspectives

Throughout history, the principles of compassion have been thought to be at the core of all religious, spiritual, and ethical traditions (Armstrong, 2011). Davies (2016) provides a comprehensive overview of theological conceptions of compassion, which generally suggest that the notion of sharing the suffering with another human being is grounded in metaphysical beliefs about morality. The notion of a compassionate person has long been equated with being a 'good' person, and this was thought to be important to human life and virtuous living (Bein, 2013). A 'good' or compassionate person was understood to be associated with our ability, as human beings, to see beyond our own self-interests.

In terms of religious belief, compassion can be observed to be part of all religious thinking and different religions have referred to compassion in various ways (shown in Table 1).

Table 1: References to compassion within the major world religions (adapted from Lampert, 2005).

Religion	Notation
Christianity	God is referred to as 'the Father of compassion', 'God of all our comfort'
Islam	Allah is referred to as 'the compassionate, the merciful'
Judaism	God referred to as 'The compassionate one who takes pity on the one in distress and has a desire to relieve it'
Buddhism	A prominent Buddhist, the Dalai Lama, suggests that compassion arises through entering the subjectivity of another. The practice of compassion is equal to happiness
Hinduism	Compassion has many forms and is viewed as a necessary path to a happy life. *Daya* is the most common form of compassion – defined by a desire to alleviate suffering and to try in whatever way to do so

With respect to compassion in contemporary Western research, a Buddhist perspective is often discussed (Gilbert, 2017). From this point of view, compassion is likened to a mind-state of loving kindness for fellow human beings (Goodman, Plonski & Savery, 2018). It is said to involve acknowledgment that all humans go through difficult experiences and that those experiences can be responded to with kindness and caring action (Neff & Sands, 2011; Strauss *et al.,* 2016).

Clearly, compassion as a way of showing concern for human suffering has been established as central to many religious beliefs. However, Outram (2019) notes that in the late 1700s philosophers began to consider that individuals may have

differing degrees of compassion. Wicks (2019, see footnote) suggests that this was driven by the idea that compassion was the foundation of morality, whereas egoism and malice were immoral alternatives to compassion[3]. Consequently, a new way of thinking developed whereby the motives underpinning a person's behaviour became to be understood to be driven by their individual degree of compassion (Bein, 2013). This implied that not everyone has a compassionate disposition and individuals were considered to differ in their moral values and, as a result, would therefore differ in their responses to suffering. It has since been proposed that these personal differences in compassion are the result of social circumstances and linked to the way in which the social shapes personhood. This is reflected in Nussbaum's (1996) account of compassion as a basic social emotion.

2.2.2 Contemporary Ethics

Nussbaum (a Professor of Law & Ethics) presented her version of compassion as a human emotion shaped by our moral reasoning and personal circumstance. Nussbaum (1996) has argued that compassion as an emotion is directed at another person's suffering and misfortune. Emotions, she contends, are value judgements. Therefore, value judgements (and hence, emotions) are a type of belief, and from this perspective our emotions may be true or false. Nussbaum (1996) goes on to suggest that compassion has limits, and those limits are marked by three salient cognitive conditions. The first condition is a judgement of

[3] Schopenhauer (1788 -1860) made this famous claim. His philosophy acknowledged the need for traditional moral values without believing in the existence of God (see Cartwright, 2010; also, Wickes, 2019).

size. This is based on the perceived severity of the other person's suffering, e.g. is the person's suffering perceived as trivial or severe? The second is a judgement of *non-desert*, where the person is understood to have not brought about suffering upon themselves. It is pertinent to note here how individuals may be judged when presenting themselves to mental health services after having deliberately self-harmed. Research shows that individuals who self-harm feel that the individuals who are employed to help often them have negative attitudes toward them, and that being offered compassion is an exception (McHale & Felton, 2010; Mughal & Quinlivan, 2021). This resonates with my own experiences where I have observed nurses and other healthcare professionals (in both physical and mental health services) to express negative attitudes towards individuals who self-harm (Bodner *et al.,* 2015).

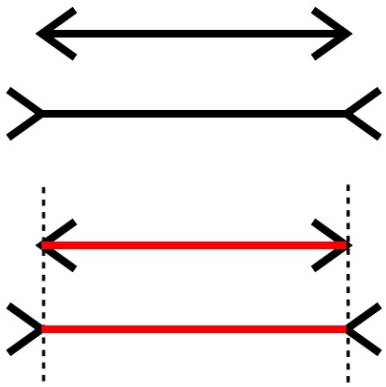
Nussbaum (2004 *in* Solomon, 2004) refers to eudaimonistic judgment as the final condition. This is based on whether another living being is significant to the goals and/or schemes of the other, meaning that someone else's suffering is more likely to be responded to if they are familiar to the other – or if helping them will be of benefit to the other's long-term goals in some way.

However, critics of Nussbaum's theory argue it is faulty, on the basis that her claims originate from the Stoic conception of judgement (Weber, 2005). In the Stoic tradition, judgement involves mastering our perception of the world by seeking objective truths, devoid of 'unnecessary' value judgements. Yet, our perceptions of the world may be challenged, for example, we may be unable to put our initial opinion of something aside, even after we have been presented with

evidence to the contrary (Dedeke, 2015). The Müller-Lyer illusion is a good example of this (Figure 1).

Figure 1: The Müller-Lyer Effect

The Müller-Lyer effect is an optical illusion where both lines measure the same, yet the placement of the arrows makes them appear different. (Brain Stuff, 2019)



When we first see the two lines, we see them as having different lengths. After measuring them, we have proof that they are indeed the same length. There always remains a tendency to resist how they appear, and form an opinion based on our initial perception. Thus, having a disposition to form a judgement is different from having a judgement (Pohl, 2016). The point here is that if we initially perceive or judge a person to be worthy or unworthy of our care, this initial judgement may be difficult to alter.

2.2.3 Foundations of Nursing Ethics

Noted for her continuous care of wounded soldiers in the Crimean war, Florence Nightingale is a remarkable 19th-century pioneer of modern nursing. Rafferty (2011) argues that Florence Nightingale's (1820-1910) original training of nurses

was related to Christian beliefs about moral values. The ideals for nursing, developed by Nightingale, are said to be condensed into the version of compassion associated with nursing today. These historical ideals about morality and values are thought to characterise the professional 21st-century nurse (Straughair, 2012).

Nightingale emphasised a strict moral code of practice for aspiring and trainee nurses with the aim of establishing nursing as an honest and ethical vocation (Hoyt, 2010). Nightingale introduced the concept of *ethical knowing*, challenging her students to question the daily decisions in relation to the care of patients. Ethical knowing involved making decisions about what was *right* and *wrong* (Fawcett, 2006). In her notes on ethics, Nightingale stresses ethical decision-making in relation to:

- Advocacy for the patient
- The nurse's conduct (personal & professional)
- Responsibilities in a wider sense, including the hospital environment; and
- Responsibility to society in general (see Nelson & Rafferty, 2012).

Arguably, the impact of Nightingale's writings can be observed with the current structure of the UK professional body for nurses, the NMC. The NMC's Code of Conduct (2018) for nurses and aspiring nurses assumes a set standard for the behaviour of nurses, both in their personal and professional lives (Kangasniemi, Pakkanen & Korhonen, 2015; Sellman, 2011). It is contended, however, that nurses working in 21st-century healthcare organisations are required to negotiate

multiple responsibilities and high workloads, often with little support (MacKusick & Minick, 2010; NHS Staff Survey, 2019). Crawford *et al.* (2014) have written about how organisational structures can cause conflict with the underlying ethical principles of nursing practice. Nightingale too identified conflicts in nursing practice, where the nurse was constrained by the hospital system in practicing ethically and was prevented from doing what was *right* for her patients (Dingwall, Rafferty, & Webster, 2002; Sellman, 2011).

Nightingale set out to resolve difficult working situations for nurses, so that the nurse–patient relationship could be foregrounded. She believed that the ethical ideal of the nurse could only be achieved through the development of the nurse–patient relationship, whereby the nurse attends to the needs of the whole person, not just the illness (Wagner & Whaite, 2010). This approach to nursing involved considering the patient holistically, for example, looking after their physical, mental, spiritual, social, nutritional, and emotional needs.

In relation to mental health nursing, Hildegard Peplau's (1952, 1992, 1997)[4] theories dominate the literature (Shattell, Starr, & Thomas, 2007). Peplau was considered the first to articulate the idea of 'interpersonal relegating' to nursing. She regarded the interpersonal process to be the crux of mental health nursing practice. This is significant in that the 'interpersonal relationship' or nurse–patient engagement was considered to operationalise therapeutic modality[5] (see

[4] Hildegard Peplau (1909-1999) was an American nurse. While her scholarship originated from general nursing, Peplau is remembered as the 'mother of psychiatric nursing'. Her theories provided the basis for understanding nursing as both a science and an art (see Haber, 2000).
[5] Therapeutic modality refers to the methods used to create healing, mental and/or psychological recovery (Gabrielson et al., 2020).

footnote). Peplau's revolutionary scholarship stressed that the essence of all nursing hinged on the sharing of experience in which the patient was active in their care, and central to this relationship. As such, relationships are considered extremely important in the context of contemporary mental healthcare (Gilbert, Rose & Slade, 2008).

After Peplau's (1952) ideas, *'person-centred'* care began to develop when psychologist Carl Rogers (1902-1987) introduced the term 'client-centred' into psychotherapy. The main tenet of the 'client-centred' approach (Rogers, 1961) was that the therapist must be willing to suspend judgement and approach the client with empathy. However, as I have pointed out previously, and based on Nussbaum's account, suspending judgement may be difficult to achieve (Diprose & Reynolds, 2014).

2.2.3 Issues in Contemporary Mental Health Nursing: The Therapeutic Relationship

As the nursing profession is the largest group of healthcare professionals, they are regarded as safety critical to patient care (De Sousa Gomes, Araújo, & Sousa, 2021; Rafferty & Holloway, 2022). Nurse education is central to the early development of critical thinking skills that are essential to ensure future patient care is delivered effectively and safely (Hundial, 2020). Moreover, when aspiring nurses are exposed to compassionate practices (such as self-care and developing emotional intelligence) during their nurse education and training, this is believed to help newly qualified nurses maintain compassion in practice (Stacey *et al.,* 2020). These practices are believed to be central to supporting all

nurses to maintain compassion in their practice (Health Education England, 2019a, 2019b). As discussed in chapter 1 (section 1.2), contemporary mental health nursing is underpinned by an education focussed on delivering a broad base of biological, psychological, and sociological knowledge to identify the needs of people who experience mental distress (Jayatilleke *et al.,* 2018; Santangelo, Procter & Fassett, 2018). Relationships based on empathy and trust are especially important as they are seen as being characteristic of effective recovery-oriented practice (Barron, Deery & Sloan, 2017). This recovery-focussed approach relies predominantly on the use of 'the self' as a vehicle to convey hope, promote recovery, and role-model psychologically safe, interpersonal, therapeutic relationships (Bond, Stickley, & Stacey, 2022; McAllister *et al.,* 2019; Norman & Ryrie, 2013; Summers, 2013; Cleary & Dowling, 2009).

The TR is considered to actively support individuals to have positive mental health and improve quality of life (Lorien, Blunden & Madsen, 2020). However, therapeutic engagement is known to be emotionally exhaustive for nurses and involves a sustained effort on behalf of the nurse to contain their own emotions while attending to the distress and anxieties of others (Edward, Hercelinskyj & Giandinoto, 2017). This is referred to as emotional labour, which is believed to be substantial across all areas of nursing (Jackson, Anderson & Maben, 2021), but is believed to be particularly significant in mental health nursing (Delgado *et al.,* 2020; Lachowska & Minda, 2020). Mental health nurses have a unique role in the workforce due to the use of various restrictive practices that are integral to the

practice of psychiatry, e.g. restraint, seclusion, and rapid tranquilisation[6]. It is worth clarifying here that reference to 'restrictive practices', used throughout this thesis, refers to interventions over and above the 'usual' restrictive practices that mental health services present (e.g. locked doors, ward routines etc). In mental health services, people can be detained on a voluntary or involuntary basis, which is much more of a grey area in terms of whether this is a restrictive practice. These 'restrictive' practices are thought to create a working environment imbued with various power dynamics and ethical tensions for mental health nurses (Mercer, 2015). As such, it is important to explore how compassion is identified and understood by nurses working in this setting.

2.2.4 Locating Compassion in Nursing Work

Chaney (2021) traced the concept of compassion, as an emotion in nursing, back to the interwar period (1918-1939). In doing so, she has illustrated how the word 'compassion' has changed over time. She does not attempt to deny the existence of compassion in nursing work, rather she demonstrates how it has been referred to differently. For example, she notes how the nurse was required to have sympathy for the patient and be tactful when dealing with doctors (Lawrence, 2006). This change in how compassion is talked about, she argues, is marked by a series of high-profile reports of significant care failures in the NHS, in which it was suggested that nurses lacked compassion (Berwick, 2013; Francis, 2013; Parish, 2013). I shall discuss these events this in more detail in the following

[6] Rapid tranquilisation refers to the use of medication (usually via injection) to manage highly agitated or aggressive individuals who are experiencing mental distress (National Institute of Health and Care Excellence, 2015).

sections. Chaney's (2021) account correlates with that of other writers (Dutton, Workman & Hardin, 2014; Simpson, Clegg & Pitsis, 2014), who argue that the term 'compassion' in nursing has been politically influenced. However, what is missing from this discussion is an analysis of the political discourse in relation to compassion. If the word 'compassion' has been influenced by a political rhetoric, *how* has this been achieved, and what is the impact of this discourse on nursing work and patient care?

2.3 Contemporary Debate on Compassion in UK Healthcare

Expectations for better quality of healthcare services were outlined in the report 'High Quality Care for All' (Darzi & Johnson, 2008), which sparked interest in the notion of person-centred care. Suggested improvements focussed on enablement and empowerment for healthcare consumers, and compassion was noted to be central to this 'person-centred' framework (Collins, 2014). However, the term 'person-centredness' has been criticised in the sense that, like compassion, it is considered difficult to define and operationalise and is seen as an empty rhetoric – something of a 'tick-box' exercise for organisations (Kreindler, 2015; Miles & Asbridge, 2017). Along a similar line of argument, nurse academics like Maben (2014) and Traynor (2014) have emphasised that after newly qualified nurses join the profession, concepts like person-centredness and compassion are quickly forgotten about due to the increased work pressures placed on nurses in the current system (West, Bailey & Williams, 2020).

Other commentators have questioned, 'do we really need compassion?' For example, Smajdor (2013) argues that *"…one can remove an appendix without caring about the person from whose body it is taken, empty a bedpan without caring about the patient who has filled it, or provide food without caring about the person who will eat it"* (p. 112). This statement implies that compassion may not be a necessary component of healthcare today. This is compelling in its logic and would benefit from further consideration in terms of the effects on healthcare staff and patients. However persuasive this argument may appear, this is rather a solitary voice amid the overwhelming volume of concern and evidence about the impact of the reported failures in compassion (Francis, 2010, 2013). According to the DOH (2012a), compassion should be typical to how people experience care. As such, compassion has become recognised as an important part of contemporary healthcare and said to be relevant to the practices of all healthcare professionals across all settings.

The debate about compassion in the NHS was prompted by reports of neglect and unavoidable patient deaths at Mid-Staffordshire Hospital[7]. In 2010, Sir Robert Francis QC began a three-year investigation into finding out what had happened. He referred to widespread systemic failures and problems within the working environment that had led to a 'somebody else's problem' attitude among hospital staff at Mid Staffordshire Hospital (Francis, 2013). While the Francis report made a wide range of recommendations[8], it was implied that the values of nursing-staff

[7] Reports of care failures emerged between 2005 and 2009.
[8] Sir Robert Francis (2013) made a total of 290 individual recommendations.

were to blame for unavoidable patient deaths. In his final report, Francis (2013) advised that the future of nurse education be focused towards developing *"a culture of compassion"* (p. 76), and that compassion be increased in nursing. Hence, it was implied that the enactment of compassion is thought of as being central to the role of the nurse. These events triggered a considerable media discussion, and, in some cases, a critique was aimed specifically at nurses, suggesting that nurses' clinical abilities and education were insufficient (Adams, 2012; Hayter, 2013). Willis (2012) implied that the requirement for nurses to be educated to degree level had removed compassion from the role, proposing that an increased focus on the technical elements of care had caused the values of compassion to become eroded. These assertions overlooked existing evidence that had already demonstrated the positive impact of graduate nurse education on mortality rates (Aiken *et al.,* 2014). Nevertheless, attempts were made to focus on (re)humanising the healthcare system, placing dignity and respect at the centre of patient care (Meguid, 2016).

Over a short period of time the compassion debate intensified in the UK (Care Quality Commission (CQC), 2011; Keogh, 2013; Health Service Ombudsman, 2011) and the values of staff emerged as a topic, across a series of public reports, e.g. Report of the Mid Staffordshire Hospital NHS Foundation Trust Public Inquiry (Francis, 2013), the Winterbourne View report[9] (Parish, 2013), and the Berwick Review (2013)[10]. A range of problems were acknowledged across these

[9] In June 2011, undercover filming by the BBC uncovered abuse at Winterbourne View. a private learning disability hospital near Bristol.
[10] The Berwick report highlighted the main problems affecting patient safety in the NHS and made recommendations to address them.

documents, including a lack of experienced management and an obsession with bureaucratic targets. However, the dominant discourse in the media at the time was one that purported a ‘lack of compassion’ in the UK NHS (Adams, 2012). A similar narrative emerged within political and academic spheres, pointing to a ‘compassion deficit’, and this time the narrative was specific to the nursing profession (Smith, 2013).

How it is that this one statement, ‘compassion deficit’, appeared dominant and became prevalent over other possible statements (Jäger & Maier, 2009)? Despite alternative discourses in circulation at the time (Aiken *et al.,* 2014; Maxwell, 2017), the government responded to the apparent ‘lack of compassion’ by implementing several initiatives (outlined next), including the introduction of new policies and legislation.

2.3.1 The UK Government’s Response to the Perceived Compassion Deficit

Shortly after reports of failings in care at Mid-Staffordshire Hospital, the UK government published the *2010 to 2015 government policy: Compassionate care in the NHS* (DOH, 2015a). Within the space of a few years, a range of government-endorsed initiatives appeared. Jeremy Hunt (then Health Secretary) stated that compassion in nursing must be increased by making prior care experience compulsory for all aspirant nurses (Allen, 2015). This was suggested with little or no evidence to substantiate whether having prior care experience before entering nurse education would yield the improvements suggested by government.

In 2012, the then Chief Nursing Officer for England, Jane Cummings, developed and introduced the 'Compassion in Practice Strategy', known as the 6Cs[11] (DOH, 2012c). This national strategy outlined the six 'necessary' values required to realise the improvements proposed by government and was aimed at all nurses and midwives. A year later, the NHS constitution (2015) and the Health and Social Care Act (2012) were revised to reflect compassion as core to care delivery (see Appendix 1 for an overview of the structure of health & social care in England since 2013). Values Based Recruitment (VBR) also surfaced as an approach that intended to guarantee trainee nurses and indeed all prospective NHS employees be selected based on their *"individual values and behaviours - aligned with the NHS constitution"* (Health Education England (HEE), 2016, p. 21). Professional Duty of Candour was introduced in 2014 and became compulsory for all NHS and non-NHS organisations (CQC, 2014). This made it the legal duty of the organisation to be open and honest when things go wrong with someone's treatment or care. All registered healthcare organisations were held responsible for training their staff in compliance with this new regulation.

These government initiatives were backed by the NMC, who revised the professional Code of Conduct in 2015, making compassion essential to the provision of person-centred care. The NMC (2013, 2017) also stated that those who wished to enter nursing would be assessed with a focus on their good character, and ability to respond compassionately. This meant that, from this point onward, student nurses could be failed if they did not continue to

[11] Compassion, Care, Courage, Competence, Commitment, Communication.

demonstrate compassion throughout their education and post-registration preceptorship period. These policy changes paved the way for a punitive approach to those individuals who did not display the correct values of compassion.

Changes also occurred to policy and legislation specific to mental health. Substantial amendments were made to The Mental Health Act Code of Practice (2007/1983) in 2015, to include the notion of 'least restrictive practice'. This legislation aimed to reduce restrictive practices and/or interventions such as the use of restraint, or rapid tranquilisation to sedate or calm a person. The intention was to make improvements to mental health services, where high variation was observed in the use of such practices to manage individuals presenting with challenging and/or aggressive behaviours (CQC, 2017). Guidance (National Institute for Health and Care Excellence, 2015) for local commissioners and healthcare providers was published relating to the short-term management of challenging behaviours in mental health. The principles underpinning this guidance was that it is the responsibility of staff to:

- Improve the experiences of care for mental health patients
- Provide a person-centred approach to care
- Anticipate and manage behaviours using de-escalation[12] techniques
- Use any restrictive measures in accordance with the Human Rights Act 1998 and

[12] The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

- reduce the use of seclusion[13].

The rationale for this was said to be the result of increased knowledge regarding managing violence and aggression and the efficacy of drugs used for tranquilisation. While there is a wide body of evidence to suggest that limiting the use of restrictive practices and/or interventions reduces the distressing effects for both patients and staff (Lawrence *et al.,* 2021), this is not common. In some areas, such as secure settings, the use of physical restraint has been reported as beneficial to patients (Hui, Middleton & Vollm, 2016) as it can help them to feel safe and give them time to regulate their emotions (Brophy *et al.,* 2016).

2.3.2 Commissioning Compassion

It has been argued that the government reforms (see Appendix 4), implemented following the 2013 Francis report, were executed with little evidence to support their effectiveness in ensuring the correct values for healthcare staff, or whether the principles of compassion and caring would be instilled in those wishing to join the profession (Bond *et al.,* 2018). Government, and government-endorsed responses, have been viewed as reinforcing the idea that nursing-staff values were to blame for the poor standards of care and lack of compassion observed within the NHS care failures at Mid-Staffs (Maxwell, 2017). Maxwell (2017) maintains that, because of these initiatives, it is now a social expectation that compassion is the primary function of a nurse's role, which undervalues the intellectual and

[13] In accordance with the Mental Health Act, as amended in 1983 Code of Practice, seclusion is defined as: "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others".

technical proficiency required to join the profession. Crawford *et al.* (2014) discussed the policy and organisational response to the implied compassion deficit, arguing that these have been too focussed on individual accountability for the delivery of compassion in clinical practice. Hence, policy has neglected, importantly, government austerity measures (Tucker, Moffatt & Timmons, 2020) and the architectural design of services (Ham, Berwick & Dixon, 2016). Crawford *et al.* (2014) argue these aspects of services need to be systematically altered to create spaces and opportunities *"for compassionate engagements to occur between patients and practitioners"* (p. 3593).

Regardless of these academic discussions, sustained talk of a compassion deficit within the news media caused anxiety within nursing, in relation to how the correct values might be enacted, especially since it was felt those values were already being expressed (Maben, Latter & Clark, 2007). Arguably, this has been exacerbated by a lack of clarity in the healthcare literature regarding how compassion is defined (discussed in more detail in section 2.3). This has implications for the nursing profession, for example, how nurses are perceived may negatively affect professional morale, which may have had repercussions for staff retention, as well as attracting people to join nursing.

It is well known that healthcare staff work in clinical environments where they are regularly exposed to abusive behaviour from patients and conflict with colleagues (Bailey, 2019). Healthcare organisations and governing bodies have therefore increasingly begun to recognise their responsibility to support the wellbeing of healthcare staff and address the accumulative demands of nursing practice and

education (Stacey *et al.,* 2017; Health Education England, 2019). In recognition of these factors that are prevalent within healthcare cultures, the government released its mandate for compassion, which aimed to make the NHS a compassionate organisation to work in. This reflected the recommendations made in the Francis Report (2013). The UK government continued to promote the NHS as *"the safest, most compassionate, highest quality healthcare in the world"* (Glasper, 2018, p. 9), citing that the development of a positive workplace culture must be underpinned by a strong 'compassionate' leadership structure. However, what makes a compassionate leader or a compassionate organisation, one might argue, are equally contestable in terms of the socially constructed, abstract nature of these terms (Oates, 2012; Ogawa, 2005).

In 2018, NHS England published 'Towards commissioning for workplace compassion: a support guide', a document based on case studies and social media responses to *#ShowsWorkplaceCompassion* (NHS England, 2018). This document outlines ways of achieving compassionate workplace cultures in the NHS. However, comments from clinical commissioners within this document are ambivalent in terms of compassion, stating that it (compassion) is nice but not necessary (NHS, 2018). It is suggested that the enactment of compassion can be overlooked in high-pressured clinical areas, indicating that the prioritising of compassion is context dependent. Furthermore, commissioners were reluctant to refer to healthcare staff as recipients of compassion, asserting firmly that they are the ones who *deliver* compassion, not receive it (NHS, 2018). This seems unusual

considering the desire to promote healthy working environments for NHS staff (NHS England, 2018).

Compassion in contemporary healthcare has not been perceived across all contexts as advocating a universally positive agenda. For example, commentators from the field of organisational studies have argued that compassion can be utilised as *"a technology of power and subjectivity within organisations"* (Simpson *et al.,* 2014, p. 347). This means that the discourse on compassion is produced through dominant structures, e.g. government, politics, and policy, which serve to subjectify the individual and/or group within an organisation. In other words, the organisation has the power to present a version of compassion for staff to adhere to, which has wide-reaching consequences for the way in which nurses are viewed as social agents. For instance, are they seen to be inherently compassionate, or forced to deliver compassion via the associated policies? If they are expected to deliver compassion, do they not require compassion from the organisation to maintain their own level of compassion?

It is worth asking then, is compassion the solution or a behaviour historically presented as stereotypical of healthcare staff, and therefore now a social expectation? Hochschild (2012) has argued that *"behavioural displays are established, not through private negotiation but through the company manual"* (p. 19). In other words, human emotions can be commercialised through the organisational values. This suggests that from an organisational perspective, it is easier to promote compassion as an individual disposition, thereby placing the responsibility for delivering compassionate care with the individual healthcare

professional. Presenting compassion in this way also makes it cost neutral, whilst ensuring the enactment of compassion continues to be thought of as being intrinsic to professional labour in healthcare.

Ultimately, who is thought of as being responsible for compassion? If 'the organisation is responsible for delivering compassion', this would involve an increased focus on training and education and a move away from knowledge-based skills and competencies. More dedicated time would be required to focus on the cultivation of the skills and practices associated with compassion (Bray *et al.,* 2014; Sinclair *et al.,* 2016a). Allocated time for training, as well as funding, would be essential in achieving this. Of course, this is assuming that compassion can be coherently defined and conceptualised as something that can be measured, or a skill that can be taught.

Tierney, Bivins, and Seers (2018) have argued that if compassion is presented as being 'the responsibility of the individual nurse', then this stereotypes compassion *"as cost-neutral in economic terms, and something that nurses are expected to express, as a consequence of their vocation or as a product of their training"* (p. 4). Thinking about compassion in this way relies on compassion as being inherent to the dispositional characteristics of the nurse. Similar themes have emerged across the academic literature, outlined next in the research response.

2.4 Compassion Research

2.4.1 Proposed Definitions of Compassion

An increasingly complex picture of compassion has emerged as having a neurological, genetic, social, cultural, and environmental basis (Kim, Cunnington & Kirby, 2020; Baránková, Halamová, & Kóróniová, 2019; Irons, 2014; Gilbert, 2014). This view has become particularly salient within research in the fields of positive and social psychology. Compassion is believed to be the foundation for all human relationships (Gilbert, 2010) and current definitions, within psychology, present compassion as a two-stage process: 1) the recognition of human suffering, and 2) the action taken to prevent and relieve suffering (Gilbert, 2017). Professor Paul Gilbert, OBE, has made a significant contribution to the field of psychotherapy[14] by combining Buddhist, social, developmental, and evolutionary psychology with neuroscience to define compassion as having these two components (Lopez, 2011). Gilbert (2017) has since extended this definition to include the prevention of suffering:

1. The ability to *understand, approach and engage* with suffering and distress.
2. The desire and *motivation* to *alleviate* suffering, uproot its causes, and seek to prevent suffering in the future.

[14] Gilbert (2009) developed compassion focussed therapy as a treatment for those with enduring mental illness (see Gilbert, 2009 and Gilbert & Irons, 2005).

However, some commentators have previously suggested that if there is no notable reduction in suffering, then compassion has not occurred (Burnell, 2009). On the other hand, it has also been argued that withholding action may also be considered as compassionate (Dutton, Workman & Hardin, 2014). Either way, Gilbert (2017) has maintained that compassion has a distinct 'active' element, which involves an understanding and willingness to engage in the experience of being human. This is of relevance to healthcare settings, in which nurses inevitably encounter a range of human experiences such as grief, anxiety, isolation, physical pain, and mental or emotional distress (Hovey & Amir, 2013; Wilkinson, 2005).

2.4.2 Defining Compassion in Healthcare

Not long after the public reports of care failures were circulated in the media, an international debate on compassion began to dominate the nursing literature (Straughair, 2012; Chapman & Martin, 2013). A range of research has since been undertaken regarding the concept of compassion in healthcare. Most of this research has focussed on understanding how compassion is defined in healthcare and its role in caring behaviours (McCaffrey & McConnell, 2015; Durkin, Usher & Jackson, 2019). Various authors have justified their research using different definitions of compassion (Kneafsey *et al.,* 2016). Some have adopted basic dictionary definitions (Horsburgh & Ross, 2013), whereas others appear to reaffirm either the philosophical roots of compassion and its relation to nursing (Sacco & Copel, 2018) or utilise the DOH's (2015) definition (Bond *et al.,* 2018). Most have concluded that compassion is multidimensional (Durkin *et al.,*

2019; Baránková, Halamová, & Kóróniová, 2019), making coherently defining the concept increasingly complicated.

Confusion over similar terms like ‘sympathy’ and ‘empathy’ can be seen in much of the current literature (Sinclair *et al.,* 2016a; Sinclair *et al.,* 2016b; Sinclair *et al.,* 2017; Strauss *et al.,* 2016). Singer and Klimecki (2014) used neuroscience to demonstrate the difference between empathy and compassion. In contrast, Bray *et al.* (2014) explored nurses’ understandings of compassion using surveys, asking them to rank statements that matched most closely to their own perception of compassion. They included statements linking empathy and compassion, for example “*acting with warmth and empathy”* (p. 482). However, Bray *et al.* (2014) failed to provide any clear definition of compassion. So, while their statements may have been relative to nursing practice, they may not necessarily have captured the notion of compassion.

Sinclair and colleagues have undertaken a variety of work on compassion in healthcare (see Sinclair *et al.,* 2016a, Sinclair *et al.,* 2016b; Sinclair *et al.,* 2017; Sinclair *et al.,* 2018; Malenfant *et al.,* 2022). They developed an empirical model highlighting the perceived relational and virtuous aspects of compassion from the perspectives of both patients and healthcare professionals. Principally, this work has determined the characteristics of compassion in palliative care environments. While this work has made significant contributions to the field of compassion, much of the existing scholarship on compassion remains theoretical in nature (Malenfant *et al.,* 2022).

Arguably, the quantitative studies discussed here have been conducted in the absence of a reliable tool to measure compassion, therefore affecting their overall validity (Durkin, Gurbutt & Carson, 2018). This might mean that what was being measured may not be relevant to individual real-life experiences of compassion or individual subjective perceptions of what compassion means in the context of someone's life.

Moreover, in the context of healthcare more broadly, there is not much scholarly agreement on how compassion is configured in various contexts (Durkin *et al.,* 2019). In paediatric settings, compassion is related to communication, coordination, and continuity of care (Sinclair *et al.,* 2020). Adult healthcare patients often view nurses' attitudes as an important factor for receiving compassionate care (Bramley & Matiti, 2014). In palliative care, compassion is considered more widely in terms of integrating care services to enable effective support for families of those undergoing treatment (Brito-Pons & Librada-Flores, 2018).

Considerable efforts have focused on developing an understanding of various nursing professionals' perspectives of compassion (Ortega-Galán *et al.,* 2021; Ferraz, O'Connor, & Mazzucchelli, 2020; Durkin *et al.,* 2019; Sinclair *et al.,* 2018). Whilst searching the literature, there is a notable body of work that has focussed on identifying and mapping the concept of 'compassion fatigue' (Cavanagh *et al.,* 2020), which relates to the idea prolonged exposure to the suffering of others, for example, when working in healthcare professions, can lead to a reduction in the expression of compassion – as well as negatively impact the mental health and

wellbeing of nurses and other healthcare professionals (Alharbi, Jackson, & Usher, 2019). In the context of working in both physical (general) (Papadopoulos et al., 2020) and mental health (Brown *et al.* 2014) the organisational constraints have been noted to significantly limit the time practitioners have to reflect on aspects of their practice that related to fatigue and/or burnout.

Although Felton, Repper, & Avis, (2018) have noted the pressures mental health nurses might feel due to the need to deliver *"care and compassion, alongside holding legally sanctioned powers to restrict freedom and deliver enforced treatment"* (p. 1138) there is a shortage of research that can explain how the notion of compassion is defined in the context of mental health (Gerace, 2020; Barron, Deery & Sloan, 2017). Given that compassion may be understood very differently in different healthcare environments, it is important that an understanding is generated in the mental health practice setting. This way, nursing practice can be appropriately aligned with patients' expectations of care across diverse disciplinary contexts.

2.4.3 Subjective Nature of Compassion

Compassion remains a complex concept to study and has been defined and interpreted in a variety of ways. This is demonstrated by several systematic reviews which have highlighted the multidimensional nature of compassion (Strauss *et al.,* 2016; Durkin *et al.,* 2019). These differing definitions, used interchangeably across the literature, have meant that compassion has been a poorly understood concept in the context of healthcare (Dewar *et al.,* 2014; Perez-

Bret, Altisent & Rocafort, 2016). With no inherent regularity to the way in which compassion is described and conceptualised, and without any reliable measure of compassion, valid assessments and evaluations of compassion are difficult to determine in healthcare practice (Bond *et al.,* 2018).

Durkin *et al.* (2019) have noted that the unseen nature of compassion makes it difficult to research, often resulting in researchers measuring what may be easy and not what is necessarily important. Thus, a continued lack of agreement within the healthcare literature about compassion (what it is and how it can be defined) makes it difficult to convert to an operationally useful measure (Skwara, King & Saron, 2017). Hence, whether an individual nurse has the correct level of, values connected with, or skills relating to compassion remains highly subjective.

Despite the subjective nature of compassion some studies have indicated that when compassion is felt to be present among healthcare teams it can improve the overall culture of healthcare environments (Scarlet *et al.,* 2017). When healthcare teams work together in a compassionate way, it is thought to have lasting positive effects on the wellbeing nurses, which, in turn, can directly influence patient satisfaction and improve the overall standard of care (Ross *et al.,* 2012). Conversely, a perceived absence of compassion is suggested to have a profoundly negative impact on patient care (Frampton, Guastello & Lepore, 2013; Francis, 2010, 2013). More recently, research has begun to indicate that compassion can have a positive influence on health and wellbeing (Kang, Go, & Bruera, 2018; Kirby, Tellegen, & Steindl, 2017). However, the contexts of mental health and

mental health populations have been neglected (Hammarström *et al.,* 2020; Rooney, 2020).

2.4.4 Research on Compassion in Mental Health Care

In a scoping review of the literature, which covered the last 25 years, Sinclair *et al.* (2016a, p. 10) noted that *"three quarters"* of empirical research on compassion had been published in the last 5 years of their review. This highlights the increased focus on the concept of compassion in healthcare from 2011 onward. Whilst almost half of the studies reviewed came from hospital, educational, and mental health settings, few had incorporated patients' views. Sinclair *et al.* (2016a) also remarked that, despite high expectations for compassion, the concept was predominantly theoretical, and there was a significant lack of applied studies. The latter is incredibly important so that healthcare and educational providers can better understand how compassion is understood and experienced by those who receive care.

In an updated version of Sinclair et al's. (2016a) scoping review, the authors (Malenfant *et al.,* 2022) noted that the perspectives of patients have been embedded in more studies. They also stressed the focus for future research to be on implementation of theory into practice – specifically training healthcare professionals in the relational and interpersonal aspects of providing healthcare.

Within the contemporary healthcare literature[15], compassion is identified as relational in the sense that it is recognised as a response to suffering whereby the person delivering care feels (within themselves) for the suffering of the other person. This 'feeling' is thought to then be expressed from healthcare professional to the person receiving care (Sinclair *et al.,* 2016a), whereby a little as a 40 second interaction (perceived as compassionate) is believed to have a positive impact on patient's experience of care (Trzeciak, Mazzarelli, & Booker, 2019). As previously noted, the theoretical basis of caring in mental health, through interpersonal relating, is grounded within Rogerian theory (1951, 1963) and the understanding that a person-centred approach enables therapeutic work to be carried out (Hartley *et al.,* 2020; Sweeney *et al.,* 2018). If a trusting relationship can be developed between the person delivering care and the patient, in a way which focusses first and foremost on the patient, then healing is believed to be made possible (Tolan & Cameron, 2016). It is argued that when care occurs 'with' the person this enables health outcomes to be enhanced through the development of positive relationships (Stacey *et al.,* 2016). Furthermore, interventions underpinned by compassion (Rooney, 2020) have been found to be efficacious in the delivery of mental health care, yet, the identification of (and the meanings attributed to) compassion by those who access mental health services remain absent from the existing literature.

[15] Part of this section has undergone full peer review and is published in a paper (Bond, Hui, Timmons, Wildbore, & Sinclair, 2022. Discourses of Compassion from the Margins of Healthcare: The Perspectives and Experiences of People with a Mental Health Condition. *Journal of Mental Health.)*

2.4.4.1 Patients' Perspectives

Qualitative research has continued to engage in understanding compassion from the perspective of those who receive care, for example, Sinclair *et al.* (2016c) who conducted interviews with patients in a palliative care setting. Patients identified a number of interpersonal factors which they related to compassion in healthcare practice, such as healthcare students having a baseline *"compassion aptitude"* (p. 4), the ability to *"build a relationship and understand the patient as a person"* (p. 6) and linked to person-centred communication which was recognised as a *"foundational skill that healthcare providers need to develop in order to provide compassionate care"* (p. 7). Likewise, Baránková, Halamová, & Kóróniová (2019) conducted 10 focus groups with lay persons (who were not healthcare professionals) to explore how compassion was defined. Questions aimed to explore the emotional, behavioural, biological, evaluative, and cognitive aspects of compassion. Only 2% of statements related to the cognitive aspects or intellectual capacity of the healthcare provider, whereas over half of the statements made by participants described emotional and behavioural aspects such as displays of help, support, and non-verbal communication, for example, facial expression(s) of the healthcare professional.

However, when presented and described as a discrete emotion (discussed in section 2.2.1), it is not surprising that compassion is often interpreted through the outwardly observable behavioural patterns of communication. For example, facial expressions, vocal tone, and postural gestures (Goetz & Simon-Thomas, 2017, *in* Seppälä *et al.,* 2017). Interestingly, Baránková, Halamová, & Kóróniová (2019)

observed that participants felt compassion was an evaluation made by the healthcare professional and felt that this appraisal occurred before any action took place. They referred to this as an *"evaluation of adequacy of situation",* for instance *"It depends on what caused the situation and why it occurred"* (p. 17). This assumes that compassion, from the patient's perspective, is fundamentally embodied through their care experiences, and primarily the way they experience the person who is providing care – and the attitude of the person and their motivation to provide (or not provide) compassionate care. This insight is echoed by Straughair, Clarke, and Machin (2019), who state compassion is viewed as caring for *and* about the person. Fundamentally, compassion was identified as *"dependent on the nurses' ability to acknowledge the individual as a human being"* (p. 12). The 'humanising' of healthcare was found to be a core category for compassion. However, as Baránková, Halamová, & Koróniová (2019) also noted, Straughair, Clarke, and Machin (2019) discussed how the human experience of compassion was thought to be influenced by various factors such as biological, psychological, social, and contextual that could either constrain or facilitate individual experiences of compassion. Bramley and Matiti (2014), also Tierney, Bivins, and Seers (2018), support this individualised (as opposed to systems-level) perspective of compassion being tied up with the patient's experience of care. However, compassion is thought to be an ideal, which is known to cause anxiety, particularly for student nurses when they are unable to evoke compassion within their practice as they may feel compassion is a

standard that must be attained for entry to the profession (Dashtipour, Frost & Traynor, 2020).

The focus of research studies discussed here are explicitly concerned with compassion in healthcare. Many of the studies reviewed make recommendations or suggest strategies to develop from the findings and claim these to be suitable to implement in clinical practice. Yet, there is little critical consideration of the complex interrelationship between discourse, social structure, staff, patient, and practical setting(s). The focus on developing knowledge at one specific level of analysis assumes that the findings will unproblematically translate to providing solutions applicable to healthcare education, policy, and practice alike. Furthermore, as well as question the influential discourses on the production of knowledge in the social world, it is important to adequately represent all clinical contexts within a diverse and multifaceted healthcare system. However, it remains unclear how compassion is configured across all care settings as the scholarly research has, so far, overlooked the context of mental health.

2.4.5 Discussion Papers

In comparison to the empirical work on compassion, a much larger proportion of scholarly debate can be found in opinion pieces, discussion papers, and theoretical papers. Fotaki's (2015) discussion piece on 'Why and how is compassion necessary to provide good quality healthcare?' sparked a lively debate about ethics in nursing, referring to the philosophical roots of compassion in relation to nurses' ethical framework. In response to Fotaki (2015), Mercer

(2015) asserted that any ethical framework is difficult to achieve for those working in mental health care. He argued that the power of disciplinary regimes (Foucault, 1975) permeates the enactment of practices that are integral to mental health care. For example, the legislative frameworks that mental health practitioners work within enable them to hold or detain patients whom they believe to be a risk and/or a danger to themselves or others (Mental Health Act, 2019/1983). Mercer (2015) argues that this constrains mental health professionals in the delivery of compassionate care.

As noted in chapter 1 (section 1.5), mental health practice involves being intrinsically caught up in human relationships. It is at the relational level of interaction that compassion is believed to be experienced, yet, as Mercer (2015) has suggested, unseen forces may unconsciously limit or reduce the effect of compassion within such interactions. Thus far, however, there is a significant lack of understanding regarding compassion in the context of mental health and whether mental health professionals indeed feel these tensions. It is important therefore to take the opportunity to explore the context-bound scenarios that are embedded with the unique setting within mental health practice and care delivery.

Spandler and Stickley (2011) noted a distinct absence of the context of mental health in the contemporary research on compassion. Crawford *et al.* (2013) explored the language used by mental health professionals when communicating about compassion and found that time was frequently referred to. Time for building a rapport between nurse and patient was considered highly valued in mental health

where the use of therapeutic engagement[16] is foregrounded and is considered (theoretically) essential to recovery for many people (Summers, 2013).

Crawford *et al.* (2014) have also argued that research has neglected to account for the organisational factors, which might inhibit the enactment of compassion. Similarly, within the organisational studies literature, Simpson *et al.* (2014) explored compassion in organisations. They concluded that knowledge in this area is currently insufficient as it fails to account for the power dynamics that are inherent in relationships. This is because current knowledge neglects to ask *"who benefits from what knowledge, what are its power effects and what types of subjects it constitutes"* (p. 356). Simpson *et al.* (2014) proposed that, rather than advocating a universal positive agenda, compassion can be utilised as *"a technology of power and subjectivity within organisations"* (p. 347) – more on this in chapter 3. This implies that healthcare staff are subjected to institutional discourses and behave or act according to the way in which compassion is presented in those discourses. Still, it remains evident there is a scarcity of critical scholarship regarding how compassion might be configured within organisational environments (like mental health) where unequal power dynamics exist (Barron, Deery, & Sloan, 2017).

[16] Therapeutic engagement involves nurses spending quality time with patients and is seen as the basis for developing a therapeutic relationship (TR) in mental health nursing. The aim being to empower the patient to actively participate in their care, with the view to increasing positive outcomes for mental health service users.

2.4.6 Summary of Academic Literature

The published literature presented here illustrates that compassion is complex and a range of definitions have been observed. However, despite a lack of consensus among scholars, research has focused on attempting to define the characteristics of compassion and differentiate it from similar terms. Many articles have acknowledged the need to identify the values and behaviours of compassion as an indicator for quality healthcare provision, and there remains an acceptance that nurses are responsible for the delivery of compassionate care. Yet, there is minimal research concerning nurses' views of compassion from the organisation within which they function (Crawford *et al.,* 2014). I argue that this indicates the influence of dominant social and political narratives on current research approaches to compassion.

In recent years, an attempt has been made to understand compassion from the perspective of patients. However, much of the existing research has been carried out in physical health settings. As such, what is known about compassion in mental health is essentially theoretical and there is no empirical work to illustrate these assertions. Despite the apparent necessity of compassion to quality care, the pervasive usage of the term throughout the literature, and the focus on compassion within major health care reforms, an understanding based upon the perspectives of people with lived experience of mental health care is lacking. For the current research, it is important to consider how this gap might be addressed.

Chapter 3: Theoretical Framework & Concepts

3.1 Introduction

This review will outline the theoretical framework for this thesis. As a result of the literature presented in the previous chapter (section 2.3), it is apparent just how limited the published research on compassion is in the context of mental health. Considering the field of mental health nursing practice from a historical perspective, this specialist nursing profession has its roots interconnected with the field of psychiatry. This is thought to enable a power–knowledge nexus from which mental health professionals gain legitimacy, and, in turn, is understood to shape behaviours, actions, and identities of individual mental health care professionals (Mercer, 2015; Simpson *et al.,* 2014). From this perspective, and with the introduction of new legislation in psychiatry[17], those who work in mental health environments have been required to (re)configure their position to meet changing policy requirements, as well as the needs of patients (Bracken, Bracken & Thomas, 2005).

Therefore, it is essential to understand the potential influence of various discourses (Rabinow, 1984) on the nursing profession and the extent to which unseen forces might limit or enable nurses' views and perspectives on compassion. The theoretical concepts presented in this chapter offer a unique opportunity for these lines of inquiry to be explored, and for the existing knowledge on compassion to

[17] Please refer to chapter 2 section 2.2.1.

be expanded. Sections 3.3 to 3.8 outline and summarise these theoretical concepts. The chapter closes with the aim and objectives for this research.

3.1.1 Choosing the Theoretical Framework

It was important that an appropriate theoretical framework was chosen for this research in which mental health nurses could be, at once, considered 'apparatuses' of power and appreciate the types of power, e.g. disciplinary and regulatory (control), and pastoral (care), involved in the practice of mental health (Mercer, 2015). Moreover, a suitable theory must be chosen, which has the potential to permit thinking about how mental health nurses might identify as compassionate.

A widely cited sociological perspective for understanding the concepts of knowledge, power, and the subject can be obtained from the work of Michel Foucault (1926-1984). Informed by diverse theoretical sources and intellectual traditions, Foucault's work crosses various disciplinary boundaries (Danaher, Schirato & Webb, 2010; Lemke, 2016). Several studies are noted to have been undertaken at an international level, across the nursing and healthcare literature and employing Foucault's theories (Reich & Turnbull, 2018; Van Rensburg *et al.,* 2016; Moffatt, Martin, & Timmons, 2014; Holmes, 2005; Sheaff *et al.,* 2004; Holmes & Gastaldo, 2002). Moreover, Foucault's theories have been used to write about the interplay of power and knowledge in the shaping of worker subjectivities (Adelstein & Clegg, 2013; Simpson *et al.,* 2014; Townley, 1993, 1994, 1999;

McKinlay & Pezet, 2010). Therefore, for the current study, Foucault's ideas about power, knowledge, and the subject provide a suitable lens.

3.2 Power

The ideas proposed primarily by Foucault (1926-1984), and those building on his work, are considered highly relevant to the topic of this thesis and offer a theoretical framework through which to consider the existing literature on compassion, including mental health nurses' and patients' views and experiences. This theoretical approach is particularly useful for thinking about 'how' nurses have situated themselves within wider social discourse, and the impact of this on patients' experiences of care.

Foucault (1975) assumed a historical approach to detailing the emergence of complex social practices which work on human behaviour to shape it such that people are ultimately forced to take responsibility for their own conduct (Rose, 1999, *also* see Mckee, 2009). In *Discipline and Punish* (1975) (DP from herein), Foucault describes how changes in penal style created a structure of domination where actions and behaviours were normalised through the disciplinary practices of the prison (Garland, 1991). Individuals were subjected to everyday routines and training until they became docile, efficient, function-performing machines, controlled and regulated through the 'normalisation' of behaviours (Foucault, 1975). Here Foucault's emphasis is on the body as the target of power. This can be used to understand nurses as subject to power, as their conduct is set out and

regulated by the authorities, for example, national and local policies and the NMC Code of Standards for Professional Conduct (NMC, 2008, 2015, 2018).

Foucault viewed modern society as a disciplinary one, in which the role of power operates in a considerably wider sense. However, the body is observed to have remained central to Foucault's analysis.

> The body now serves as an instrument of intermediary…The body, according to this penality, is caught up in a system of constraints, obligations, and prohibitions. Physical pain, of the body itself, is no longer the constituent element of the penalty.
>
> - Foucault, 1975, p. 11

Here the idea is that power consists of the exercise of constraining, obligating, and prohibiting the body, physical pain having been reconceptualised as abstract consciousness. As previously mentioned, we can consider this in terms of how a range of different institutions (e.g., politics, medicine, and education) create different bodily constraints and obligations on the practice of nursing in the present-day social world. At the same time, the practice of mental health nursing, within the disciplinary field of psychiatry, has power over the body. For example, policies and legal frameworks exist that legitimise the use of objects and people to restrain the bodies of patients, detain the bodies of patients, and deprive the bodies of patients of their liberty, therefore having a justifiable *"hold on individuals"* (DP, p.18). On the other hand, this could be viewed as a positive set of actions which protects and prevents individuals from causing harm.

However, Foucault's description of the repeated exercise of training the body (DP, part 3) implies training is repressive. Contrary to this idea, Wehrle (2016) insists that training can be thought about as bringing stability to the body, and a sense of cohesion with others who share the same experience. For example, structure is considered to provide a sense of control over illness, particularly in mental health where a routine provides constancy and is reported to improve psychological functioning (Koome, Hocking & Sutton, 2012; Bejerholm & Roe, 2018). Moreover, modern nursing is an educational exercise requiring self-discipline to achieve one's personal goals and ambitions. Furthermore, nurse training and education involves the development of advanced technical skills, which are required to cope with the increasing demands of a contemporary society. Repeated training can therefore lead to the acquisition of such skills (Abe *et al.,* 2013). Arguably, external power structures, as Foucault described in his analysis (DP), do not equal mastery of skills. Moreover, Merleau-Ponty (1962) observed that training is an active-body process, which presupposes certain capabilities which are already there. Such capabilities are often determined by various specific cultural repertoires and existing abilities (Crossley, 1996).

Visker (1995) argued that Foucault's version of power, outlined in DP, as external (historical political) forces present a depressing, nihilistic view of power in modern society. For example, disciplinary power is considered to be *inscribed* upon a 'passive' receptacle (the body, therefore, being one that lacks creativity). The idea of a simply obedient, docile body implies that a non-docile, original, or natural

body is hidden beyond the ‘normalised’ one, one that can question normative subjugation, as theorised by Foucault (Butler, 1989; Visker, 1995).

Foucault (1982) made a subtle and sophisticated turn, in his essay ‘Subject and Power’, in which he paid attention to construing power in relational terms, explaining how power is only made possible through agency, and by the attempts of one person to ‘conduct the conduct’ of another. Likewise, Fairclough (2013) states that individuals can interpret, recreate, and act on power structures, and other aspects of the social world, to otherwise sustain, re-produce or transform existing structures. In addition, Rose (2006) has written about how our individual values, attitudes, and beliefs may be shaped by networks of power that enable us to adopt certain identities, while simultaneously restricting other possibilities.

The critical point I am making here is not to make the distinction between what is viewed in society as normal or abnormal *per se*, it is to question that very distinction (Weiss & Haber, 1999). Power, as it is construed by Foucault, establishes the body as both acted upon and active in questioning socially normalised ways of existing. In summary, power cannot be simply oppressive and unequal, but a dual notion that can be considered to both constrain and enable the body. Therefore, “*To ‘do Foucault’ is to understand that there is always more than one discourse in play”* and that *“FDA provides the means to delve into the multiple discourses that complement and oppose one another”* (Springer & Clinton, 2015, p. 89). Using FDA it is possible to appreciate the intersect of power, agency, space and resistance, and the influence of this on the body. In understanding that individuals are exposed to an array of often

competing and overlapping discourses within multiple contexts, this provides the means to question, evaluate, and criticise discourse(s) in the social world. In the following section, the concepts of space and resistance are briefly outlined as these concepts are viewed as important for understanding the healthcare environment within which nurses work, as an organisational system.

3.3 The Ethical Body

In recognition that there is a critical body, able to position itself outside of the relational norms of power (Han, 2002), in his later work Foucault (1988a/1978, 1988b/1984, *also see* Martin, Gutman & Hutton,1988) began to concentrate on the intrinsic relationship between government and ethics (Figure 2). Here the body is seen as a self-determining ethical subject, with free choice to adopt and inhabit the *norms* it wishes, within the cultural and societal rules it finds itself in (including those of its social group) (Allen, 2011; Wehrle, 2016).

Individuals can be considered active in constituting themselves through the intersection of deterministic structures (techniques of domination) and techniques of the self, thereby generating what Foucault defined as ‘subject positions’ (Foucault, 1988b/1984; Martin, Gutman & Hutton, 1988). Rose, O’Malley and Valverde (2006) describe techniques of the self as *“ways in which human beings come to understand and act upon themselves within certain regimes of authority and knowledge, and by means of certain techniques directed to self-*

improvement" (p. 90). Technologies of 'the self' were specified by Foucault (1990/1984)[18] as having four dimensions:

- *Substance éthique* (ethical substance), the part of the self that is involved in moral conduct (feelings, intentions, and desires)
- *Assujettissement* (modes of subjection) which *"people are invited or incited to recognize their moral obligations"* (Foucault, 1984, *as cited in* Rabinow, 1984, p. 353), e.g. divine laws, natural laws, or rational rules
- *Self-forming activities:* activities performed on the self to transform the self
- *The telos,* or *"the kind of being to which we aspire when we behave in a moral way"* (free, immortal, or master of itself) (Foucault. 1984, *as cited in* Rabinow 1984 p. 355).

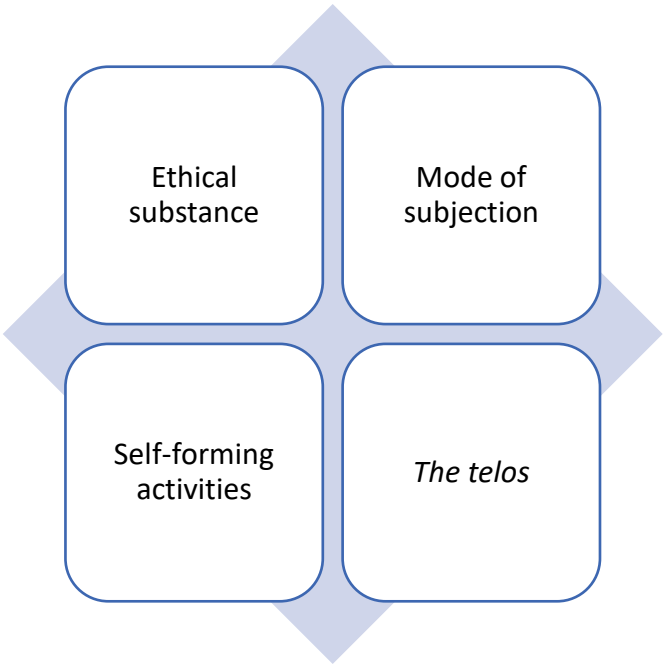


Figure 2: The four dimensions of 'technologies of the self'

[18] Foucault developed his understanding of the constitution of the self as 'subject' (and the dynamics involved in its elaboration) in *The History of Sexuality Volume II, The Use of Pleasure* (1990/1984).

The rhetoric of compassion in modern healthcare organisations has implied that nurses are accountable, within the political agenda, for the practice of compassion. Therefore, those who work in these roles may have found it necessary to (re)construct their professional sense of self, in relation to the emergent discourse on compassion. On the other hand, nurses may have also found it necessary to challenge discourses in which they have been presented as 'lacking in compassion'. Either way, there is an acceptance of or resistance to the *"changing discursive productions of the world and their effects in shaping that world"* (Walters, 2012, p. 3). Acceptance involves agreement with the discourse and becoming passive to its effects (Foucault, 1975), or in other words, 'one does as one is told, without resistance'; where resistance is considered to involve questioning and criticising. Fairclough (2013) suggests that an analysis whereby the discursive practices of government, the social discourse practices, and the way in which these discourses are responded to, can be understood within a 'governmentality'[19] framework.

3.4 Governmentality

Considering the question of 'what is government?', Bröckling, Krasmann and Lemke (2010b) illustrate how Foucault traced the move from sovereignty in Western Europe to technologies[20] of government, and how these technologies

[18] The term 'governmentality' was coined by Foucault in the later part of his life. Foucault spoke about governmentality in his lectures at the Collège de France between 1977 and 1984. The term has been understood as 'the art of governing'; the 'how' of governing; the 'rationality' of governing; 'techniques' of governing society. Hence, it has generally been considered to be a way of linking the act of governing to 'modes of thought' about governing.

[20] Technologies of power (e.g. social policies) determine the conduct of individuals and submit them to dominant structures (politics).

form *subjects*. The words ‘neoliberalism’ and ‘globalisation’ are associated with reconfigurations to the political and economic landscape that took place at the same time Foucault proposed *governmentality* (Walters, 2012). Profound political, societal, and economic changes saw the construction of ‘socialised’ subjects, endowed with social rights and responsibilities, obligated to be responsible not just for themselves, but also for the welfare of society as a whole. According to Maasen and Sutter (2007), Foucault (1991/1978) viewed the mechanics of this new socio-political rule as producing individuals who are willing to exist as subjects.

Governmentality aimed to address how techniques of rule operate on subjectivities, exploiting the self-regulating tendencies of social agents (Lemke, 2016). This approach has been employed by several authors to analyse how power operates on subjectivities in various contexts, including healthcare and hospitals (Ferlie *et al.,* 2012; Martin, Gutman, & Hutton, 2013). These authors do not view disciplinary power and governmentality as distinct regimes (Martin, Gutman, & Hutton, 2013). In fact, many describe regimes of power as a continuum, for example, Lemke (2012) writes that governmentality is *“a continuum which extends from political government through to self-guidance, or ‘technologies of the self’”* (p. 85). Springer (2015) views governmentality as a distinct form of neoliberal ideology which is circulated through leadership, policy, and ideology. Likewise, Metcalf (2017 in Cosgrove & Karter, 2018) defines neoliberalism as a worldview in which the individual is believed to be a self-concerning agent.

Rose *et al.* (2006) suggest that governmentality is not a theory that can offer a causal explanation for societal change or propose *"a philosophical interpretation of such change"* (Walters, 2012, p. 2), but is an "*analytical toolbox"* (Rose *et al.,* 2006, p. 18) within which subject positions can be explored. As such, governmentality permits an analysis of Foucault's concepts in tandem, whereby both disciplinary power and the micro-level effects of power can be explored (see Figure 3).

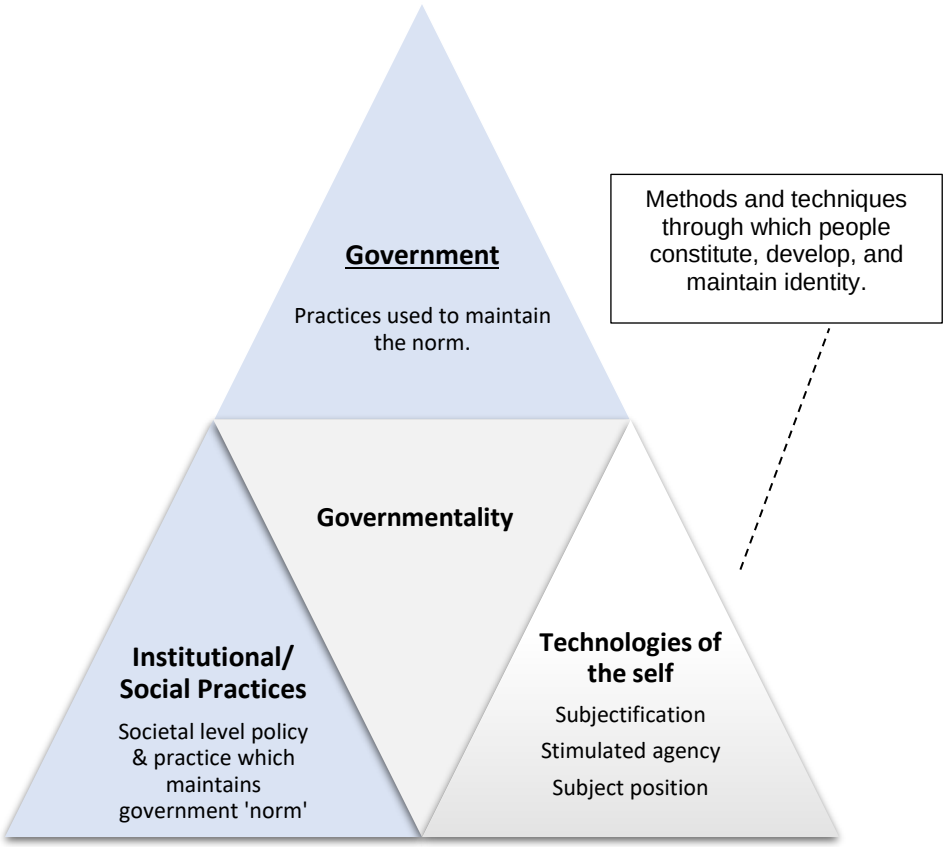


Figure 3: An overview of 'Governmentality'

Foucault's conceptualisation of governmentality has come under scrutiny for being too vague and unclear (Blau, 2017). In his lecture 'Security, Territory and

Population', Foucault (2007/1977-1978) provides a definition of governmentality with three components, all of which have been interpreted differently. This may be partly due to the translation of Foucault's work from the French. For example, Blau (2017) argues that when Foucault talks about government, he is not referring to it in the English sense of the word, rather he is referring to government apparatus. Government, from a Foucauldian perspective, is considered to mean the 'type' or 'form' of power exercised by those in government. As such, governmentality can be understood as a process that consists of power exercised in the fo rm of techniques and rationalities of individuals in government (Blau, 2017).

Miller and Rose (1990) and Rose and Miller (1992) used Foucault's original terminology, alongside concepts of their own, to develop the concept of governmentality. This resulted in a distinctive theorisation involving an analysis of political power in terms of 'the problematics of government' or 'problematisations'[21], which assumes that problems are constructed or made visible through three inter-related aspects of the problematisation process. These are: rationalities of government, programmes of government, and technologies of government (conceptual framework shown in Table 2). The concept of governmentality connects the technologies (and rationalities) of the social body with the technologies, programmes, and rationalities of the political authority (Foucault, 2007/1977-1978).

[21] The notion of problematisation is not explicit in Foucault's work, the idea was advanced and made explicit by Miller and Rose (2008) - from Foucault's seminars and writing on governmentality.

Table 2: The problematisation process as outlined by Miller & Rose (1990) and Rose & Miller (1992)

Dimension	Brief Description
Rationalities	Making problems thinkable
Programmes	Making problems amenable for intervention
Technologies	Intervention aimed at addressing the problem

This conceptual framework allows pertinent analytical questions to be constructed to investigate *how* the political community has employed technologies and rationalities to apply influence on healthcare organisations. In the context of this thesis, this relates to the rights and responsibilities of nurses, and how nurses negotiate those rights and responsibilities. For example, how a compassionate, professional sense of self (discussed in the next section) is constructed, maintained, and enacted within the existing regime.

3.5 Organisational *S*pace and Resistance

For Foucault the organisational designation, design, equipping of, and utilisation of space constitutes power over the body (body-power) (Garland, 1991). Foucault used the idea of The Panopticon[22] (Figure 4), which epitomises the practices of power-knowledge.

[22] The "Panopticon" or "Inspection House", designed by Jeremy Bentham in 1791, was seen by Foucault to epitomise the practices of *power-knowledge* (Garland, 1991).

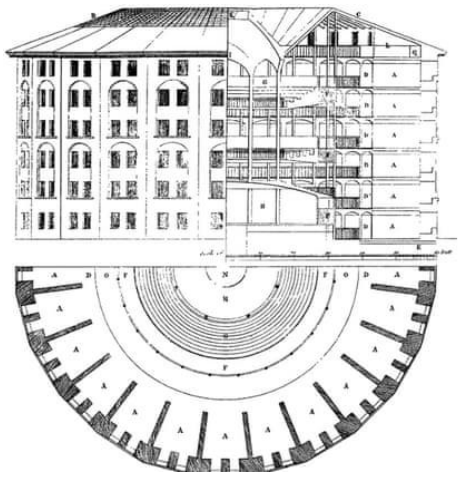


Figure 4: The Panopticon

A circular building with individual cells arranged around a central inspection tower so all cell occupants were clearly visible. The lighting and opaque glass of the tower made it impossible for individuals in cells to tell whether they were being observed.

Foucault (1975) used the notion of the panopticon, metaphorically, to represent surveillance and control of the body by the authorities. In its ideal architectural form, the panopticon was understood as constantly subjecting individual bodies to the power-knowledge of the authority which occupied the institution. The design style could be applied, not just to the prison but, to all institutions.

According to Foucault (1975), the organisational use of space serves to control the body, transforming it to make it functional. However, this presents a negative view of the body as being shaped through situated activity and external control, e.g. supervisors, managers, and so on. Alternatively, it is argued that the body becomes familiar with a space which it inhabits, can act upon that space, and form intersubjective accounts of a shared space (Seale, 2004).

Crossley (1993) notes that an organisational and institutional space can only serve a political function when the bodies that occupy that space execute those functions. Hence, no matter how the space is designed, equipped, or meant to be used, space does not enforce or control the body. The main downfall to this argument, however, is that it does not apply to an unmastered body that does not have the capabilities or understanding to implement the desired actions to transform space. However, Foucault's argument (as explained in the following sections) holds that the organisational space is designed such that it becomes a 'tactic' used to control people's thoughts and actions.

Subjects are able to resist the spatial aspects of power. Resistance is said to be achieved through the skills and competencies that have developed in an individual's own choice to subject themselves to the discipline and repeated training of the organisational system. For example, by choosing to train to become a nurse, doctor, or teacher etc., Crossley (1993) provides a practical example of 'a pupil who behaves in the classroom as though they were in the playground', meaning, therefore, that the functionality of a space is always under the threat of resistance from subjects who are able to, and can, resist power.

Fundamental to the concept of governmentality is Foucault's critique of the sorts of theories of power where either violence or accord is emphasised. These theories have presented resistance to power as negative (Lemke, 2002). Governmentality, on the other hand, emphasises choosing subjects, who make choices which are constrained by a combination of forces, in play between technologies of domination and technologies of the self. Foucault's theory of

governmentality therefore underscores the positive aspects of resistance. For Foucault (2007/1977-1978), the principle of resistance lies in the notion of what he termed ‘counter-conduct(s)’, which relate to the struggle to find alternative forms of governing where choices can be structured differently (Ahrens, Ferry & Khalifa, 2020).

3.6 Theorising the Professional Self

The concept of professional identity and its formation is a contentious one, with various positions having been taken in relation to the degree to which identity is influenced by individual agency and/or organisational and societal structures (De Fina, Schiffrin & Bamberg, 2006). However, before discussing how professional identity is understood, it is pertinent to look at how a profession is constructed. Freidson (2001) provides a useful summary of the history of professions. He observes how three learned professions emerged from medieval universities in Europe. These were the clergy, medicine, and the law, and were viewed as ‘true’ professions against which other professions could seek to compare themselves in order to gain their own professional status (O’Day, 2007). It is generally agreed that the defining characteristics of a profession are, *“professional association, cognitive base, institutionalised training, licensing, autonomy and control, and code of ethics”* (Larson & Larson, 1979, p. 221).

Professions are viewed in all societies as autonomous, insofar as they can make independent judgements about their work and have freedom to exercise professional judgement (Bayles, 1989). However, sociological studies have

begun to consider the discourses, techniques, and practices those professions use to construct themselves, and to separate themselves from other professions (Evetts, Mieg & Felt, 2006; Cohen *et al.,* 2005). It has been argued that professionalism privileges one profession with economic and social status, enabling them to have dominance over similar competing professions (Martimianakis, Maniate & Hodges, 2009). Moreover, being a professional allows a person to conceptualise their role within the social context (Fagermoen, 1997).

Historically, the move from layperson to professional is said to have been achieved through the *"public pronouncement by an individual on certain principles and intentions"* (Keogh, 1997, p. 303). This involves an ideological commitment of a person to become part of that profession where some aspects of the chosen occupation become more prominent than others. In nursing, for example, professional status requires undertaking lengthy training and education, adhering to a professional code, and upholding professional standards through legislation and the maintenance of a body of knowledge.

The acquisition of expert knowledge is therefore essential to the process of being able to construct a professional identity. Freidson (2001) views this as facilitating the knowledge–power relationship from which a profession draws its legitimacy. The institutionalisation of knowledge–power is said to shape behaviour and the position of individuals within a profession. As previously discussed, this thread is noted through much of Foucault's work on power.

According to Hood (2013), a nurse is considered to have developed professionalism when they can clearly articulate their own ideological commitment to the role, command competence, and actualise the ethical principles of nursing. Additionally, as Mead (1964) previously noted, the internalised values of a socially active individual are said to be important in the development of a 'moral being', which is believed to be fundamental to becoming a professional nurse (NMC, 2018). Existing values and beliefs may therefore be important for shaping professional identity (Fagermoen, 1997). While this may be so, Mackintosh (2006) notes how the ethos of nursing is continually being discouraged by a focus on prioritising task-based activities over the fundamentals of caring. Arguably, contemporary nursing may have shifted towards foregrounding competency-based technical abilities and tasks, rather than nursing ethics. As previously discussed, religion has been recognised as being an influence on Western nursing, particularly in terms of cultural practices relating to taking care of the sick (Gunn *et al.,* 2019a). The media is also well known to have, over time, disseminated negative portrayals of nurses, who have belittled nursing work, and nursing as a profession (Gill & Baker, 2021; Summers & Summers, 2014). Nevertheless, the professionalisation of nursing has strengthened the visibility and credibility of nurses within the healthcare workforce (Gunn *et al.,* 2019b). Moreover, since nurses have become highly educated, they have strengthened the infrastructure of the welfare state, improved health outcomes, and reduced mortality rates (Aiken *et al.,* 2017).

There is also a recognised argument regarding medical dominance within healthcare (Allsop, 2006; Sweet & Norman, 1995). Control over decisions involving patient care has long been seen to rest with the doctor. For example, in psychiatric environments, agreeing patients' leave and deciding on the need for close observations is often paid to the 'expertise' of the psychiatrist, despite the fact that nurses have considerably more face-to-face contact with patients (Fagin & Garelick, 2004). As previously discussed, the nurse–doctor relationship (within mental health) evolved in psychiatry (see chapter 1, section 1.4). Despite non-medical prescribing by nurses having begun to disrupt this notion of medical dominance, a history of medical dominance exists which is thought to continue to influence the culture of healthcare institutions today (Weiss, 2021). This may be one factor that has, as noted by Morrall (1998), caused mental health nurses to struggle to form a distinct profession identity.

Neary (2014) describes professional identity as the way we perceive ourselves within our occupational context and how we communicate this to others. This emerges through a combination of social interaction and the balancing of prescribed attributes of professionalism, as well as the internal and external motivational forces such as will, drive, insight, and ability (Hoeve, Jansen & Roodbol, 2014). Rasmussen *et al.* (2018) propose that all qualified nurses configure their professional identity into three categories. These are the self, the role, and the context, whereby *"the self is the nurse who enacts the role in practice, and the context is the practice setting"* (p. 225). A strong alignment to

these categories is said to lead to high levels of career satisfaction (Rasmussen *et al.,* 2018).

However, some authors have argued that reforms in healthcare have been overly concerned with repeatedly attempting to modify the professional identity of nurses, causing confusion within the profession regarding the nature of professionalism (Halford & Leonard, 1999; Moir, 2019). In the last decade, major public sector changes in the UK (as previously discussed in chapter 2, section 2.3) nurses have been required to (re)configure the professional self within a role that may differ substantially between various settings; changes having a significant effect on occupational roles and identity.

How nurses configure the professional sense of self, understand what they do (and do not do) within their roles is necessary for understanding how people manage themselves within an organisation (Carroll & Levy, 2008) and within changing structural discourse(s) based on socially generated 'truths' (Alvesson & Willmott, 2020). The data captured from this thesis will offer qualitative insights into how nurses view the professional self, in the context of mental health and within the existing discourse on compassion. What follows is an overview of discourse theory and how this relates to the understanding of the self.

3.7 Discourse and *'The Self'*

Discourse refers generally to written and spoken communication, although it is a widely used abstract term and the meaning often varies across disciplines

(Connors, 1981; Salkind, 2010). Studies of discourse have recently become the focus of a variety of research concerning the formation of identity (Bamberg, De Fina & Schiffrin, 2011; Elliott, 2020). According to Weedon (1987, *in* Walters, 2012) discourse "*constitutes the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern"* (p. 113). As such, an analysis of discourse is said to be a useful method in exploring how people think, how meaning is produced, and the power dynamics involved in these productions. This is consistent with Davies and Harré's (1990, p. 45) statement, *"to know anything is to know in terms of one or more discourses".* Hence, the questioning of 'who am I?' or 'what am I?' can be thought about in terms of discourse (Rabinow & Rose, 2003; Hothersall, 2004).

Discourse is considered to emerge from an institution such as education, media, medicine etc. (Wodak & Meyer, 2009). An institutional discourse can be at the structural (relating to government and/or management), cultural, group, or individual level (Davies & Harré, 1990) and can be about a particular topic, for instance, gender, class, or in this case, compassion (Macaulay, 2005). From this perspective, the self and how we understand our sense of self can be produced through a system of discourses, institutions, and the relationships or interactions we have with others in the social world. Therefore, our individual, social, and psychological realities are regarded as being discursively constructed. In other words, it is asserted by discourse scholars that our ideologies (systems of values and beliefs) and how they are shaped within the minds of language users are

shaped through our interactions with discourse in the social world (Bond *et al.,* 2018).

Foucault (1991/1978) was committed to thinking about '*how'* we have become and thinking broadly about 'how' we understand ourselves as a certain 'type' of person, and 'what' shapes this thinking about ourselves. Therefore, the individual and/or group thinking and conduct of nurses can be understood as being grounded in institutional discourses. Likewise, how nurses view themselves and how they relate to this through the interactions they have with patients might impact on care experience. Institutional discourses therefore essentially outline the organisational values and ways of doing things (Hochschild, 2012). Foucault's notion of discourse has been viewed as reducing human behaviour and identity to the social systems at large (Crossley, 1993; Hearn, 2012). Although, as explained previously, Foucault also stressed the body as active in self-formation, with discourse(s) capable of both enabling and limiting *how* we can be in the world.

From this poststructuralist perspective, the psychological and social self is viewed as situated among the constitutive force of discourse, also considering the capacity of people to make choices in relation to discursive practices they are exposed to (Davies & Harré, 1990). Therefore, the study of discourse is necessary to explore how mental health nurses configure themselves professionally and as compassionate professionals. Though, until now, the discursive practices of nurses, in relation to the topic of compassion, have yet to be explored in the practical setting of mental health. Likewise, the views and

experiences of compassion as understood by those who receive mental health care have yet to be empirically studied. Accordingly, it is necessary to think about questions pertinent to this thesis: '*How do mental health nurses discursively configure themselves as compassionate practitioners?'*, *'How might compassion be identified by patients with lived experience of mental health?',* and *'What are patients' lived experiences of compassion in the mental health setting?'*

3.8 Chapter Summary

This chapter has introduced the theoretical framework for the research. Foucault's (1982) construction of power and the subject, the notion of socialised subjects, was contemplated for this work. His conceptualisation of the ethical and/or moral being relating to the idea of the modern self was central to this (Rosenwald & Ochberg, 1992). Foucault considered everyone as a political body, directly involved in power relations that have *"an immediate hold upon it [the body]; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs"* (1975, p. 25). From such a perspective, nurses and patients are both understood to be consumers of political and organisational discourses – discourses which simultaneously bring about the positive and repressive effects of power (Foucault, 1975 *in* Levin, 1989; Rose, 1993). Here nurses can be understood as a powerful group, capable of self-governing via their own actions and through the benevolent bodies which govern them professionally, yet, at the same time, less powerful than the operation of the political community in which they function.

From a governmentality perspective, power is conceived as multidirectional, inherent in everyday social practices, and not conceived simply as a monopolistic force exercised by government. This thesis provides a unique opportunity to explore Foucault's (1975, 1991/1978) ideas about power in relation to compassion and understand compassion as it is conceptualised from the power nexus of mental health practice (Mercer, 2015).

Foucault's theories will be adopted as a basis for the analyses, which will ultimately seek to describe the accounts of mental health nurses, and people with lived experience of mental health care, to arrive at an understanding of how individuals experience the giving and receiving of mental health care within the current political regime. This can facilitate an exploration of individual and shared thoughts, feelings, and perceptions of compassion, and will provide insight into *how* compassion is experienced and what the function of compassion might be in this context, therefore providing the opportunity to undertake multiple levels of analysis.

3.9 Research Aims & Objectives

The broad aim of this thesis is to explore the influence of discourse on the experiences and subjectification of mental health nurses and people with lived experience of mental health care.

Therefore, the research objectives are to investigate:

1. The political influence on the development of the concept of compassion, considering how compassion has been constructed in healthcare policy.

2. The discursive construction of compassion as understood by nurses working in the practical setting of mental health. This phase of the research considers how nurses configure themselves as compassionate practitioners, and how their perspectives of compassion might relate to the wider discourses.
3. The discursive construction of compassion from the perspective of mental health patients.

Chapter 4: Methodology & Methods

Since all social practices entail meaning, and meanings shape and influence what we do - our conduct – all practices have a discursive element.

- Hall, 1992, p. 291.

4.1 Introduction

This research sought to address significant gaps in the existing literature on compassion by exploring the various dimensions of discourse on compassion. For example, healthcare policy discourse, mental health nurses' constructions of compassion, and mental health patients' views and perspectives on compassion.

This chapter will present the plan and principles of the research and begins with an explicit account of the epistemological assumptions and methodology for the inquiry. The aim of this is to demonstrate that using critical discourse analysis as the chosen approach (explained in more detail in section 4.4) is an appropriate way to address the research objectives. Section 4.5 describes the study setting, and participant characteristics. The final section (4.6) of this chapter presents the ethical considerations and ethical principles of this research.

4.2 Epistemological Assumptions

Debates about what constitutes valid knowledge and the best way to obtain that knowledge are rooted in two opposing schools of thought, 'positivism *versus*

interpretivism' (Chalmers, 2013). Social research is underpinned by several sets of assumptions, often referred to within the two conflicting traditions (Bryman & Bell, 2001). The positivist tradition is influenced by empiricism and rationalism. Empiricism assumes that all knowledge is based on experience gained from the senses. This approach would apply the same assumptions made about objects of the natural world to those of the social world, i.e. that the objects of inquiry have a stable regularity and that the external conditions in which those objects exist remain constant (Sayer, 2000). To apply this philosophy to study the social world, the human mind would be regarded as starting out as a *tabula rasa* (or blank slate) in which knowledge of the world is acquired through observation and sensory experiences (Clark, Lissel & Davis, 2008). However, this approach is criticised for presenting an inaccurate picture of the human mind and human thought because the social world is considered to be an 'open system' where the objects of study, 'human actors', inevitably interact and form relationships (Pawson, 2006; Edgley *et al.,* 2016).

In contrast, rationalism claims that knowledge can be gained independently of our sensory experience. The criterion of the truth, for rationalism, is intellectual and deductive, whereby knowledge is gained through reasoning, logic, and intuition that appeals to reason (Arrington, 2019). This perspective has been criticised for creating the problem of mind–body dualism, where the mind (spirit or soul) is regarded as being able to occupy a realm that is separate from the physical world (Hart, 1996). This would not sufficiently explain the influence of social culture and the individual construction of meaning that is made as the body interacts with the

material world, for example, the bodily experience of pain and its effect on the mind and vice versa (Crossley, 2001). Furthermore, dualism cannot explain the intentionality that mental states exhibit. As Brentano (1874 & 1973, *in* Rey, 1997) asserts, *"the reference to something as an object is a distinguishing characteristic of all mental phenomena. No physical phenomena exhibits anything similar"* (p. 97).

Although, previous research has suggested that compassion is related to a variety of attributes, skills, and behaviours (Durkin *et al.,* 2019). Arguably, these events are (in a variety of ways) empirically quantifiable, thus, a positivistic epistemological position could be taken, and an experimental method employed. If using quantitative methods (collecting and analysing numerical data), it could be argued that any causal relationships/patterns in the data could be viewed as law-like universal rules that can explain observable behaviours relating to compassion (Gill & Johnson, 2010). However, the idea that universal laws can be created from the study of human beings is often difficult to achieve as human behaviour is inconsistent and the social world is irregular (Ritchie *et al.,* 2013). However, it is possible that any future behaviours could prove to be completely different and, as such, we could justify a scientific approach as a way of demonstrating that any claims we make could indeed be false (Chalmers, 2013). Yet, in using a purely scientific method, it is not possible to illustrate the internal processes and mechanisms by which the results have been produced. This could be achieved by following up with a qualitative method whereby participants are provided with the opportunity to explain their thinking processes, reasoning, and feelings.

Thus, an experimental method alone is considered unsuitable for the current research, on the basis that it would reduce the social world and our knowledge of it and neglect the ability to understand why events happen or how meaning is formed (Clark, Lissel, & Davis, 2008). Moreover, a quantitative method would imply that any errors are due to the human mind, and anomalies deemed human error and therefore not an accurate description of reality. This would reject *real* differences and facts about the way the world is experienced. Human beings in the social world are not objects in the same way as objects of the natural sciences. Human beings in the social world are autonomous individuals, capable of making rational and irrational choices. As such, they cannot be *"isolated from all other factors"* (Maggetti, Radaelli & Gilardi, 2012, p. 46) in the same way as one might attempt to isolate naturally occurring phenomena as someone studying the natural sciences might. It is on this basis that I have chosen to employ a qualitative approach to the current research.

Interpretivism is an alternative approach that might be considered more appropriate for the current research. Interpretivism challenges positivist assumptions based on the belief that there are ways of knowing the world that we use all the time, other than direct observation, that are human interpretive aspects of knowing. Human beings are understood to have an inner mental and emotional life that is influenced by free will and self-consciousness (Dilthey, 1961). Hence, interpretivism upholds the view that the object of study will already have an understanding of itself. This view is supported by many social scientists, who argue that within the qualitative, interpretivist paradigm, the researcher's perspective is

essential as it enables insight into understanding the individual frameworks of meaning, leading to the production of in-depth knowledge (Bryman, 2016).

Within the interpretivist tradition, the role of the researcher is to learn to communicate with the object of study to understand the given meanings ascribed to action. Weber (1949 *in* Outhwaite, 1975) describes this as '*verstehen'*, which refers to the idea that to gain knowledge, the researcher must examine how the individual being studied thinks, while also acknowledging that actors subjectively assign meaning to their everyday events and experiences through the process of interpretation. This position is viewed as more appropriate for the current research as it identifies meaningful action that is shaped by history, culture, and the effect of these on the individual constructions of meaning, language, thought, and expression. From a positivist perspective, these influences would be viewed as unobservable entities and therefore not an appropriate way of making valid and rigorous claims to knowledge (Benton & Craib, 2010). However, the task of the current research is not to attempt to produce scientific law-like claims. Instead, it acknowledges the construction of individual accounts and their view of their social world as being influenced by factors that are distinct to them, which does not necessarily represent the general population. Building on Weber's (1949) argument, phenomenologist Alfred Shütz (1954) claimed that constructs are understood to be grounded in everyday activities and the 'typifications' and 'expectations' about behaviours that we are subjected to every day. This means that how we are situated in the world affects the way in which we interpret the world around us. As such, not all interpretations will be equal.

This research accepts the influence of history and culture on individual and collective constructions of meaning, language, thought, and expression (Lyas, 2014; Winch, 2008/1958). As such, the current author will draw from a constructivist school of thought to provide epistemological justification for the current research. A qualitative approach to the generation of knowledge will be taken, whereby all knowledge is viewed as being constructed by human beings and inseparable from the characteristics of what it means to be human in the social world (Crotty, 1998). From this perspective, a world without consciousness is a world without meaning. *"All knowledge and therefore all meaningful reality is contingent on human practices, being constructed in and out of interaction between human beings"* (paraphrased from Crotty, 1998, p. 42). Within a constructivist perspective, knowledge of the world is not a simple dichotomy of objective or subjective; rather, objectivity and subjectivity are viewed as inseparable. The latter is supported by writers like Heidegger and Merleau-Ponty who claimed that the natural world is always there, that natural objects exist independent of our consciousness (Crotty, 1998), and are assigned meaning only through our conscious interaction with them. We come to understand particular objects in a certain way because our ancestors have previously ascribed meaning to them, which we continue to accept as valid for us. Furthermore, social concepts, such as bureaucracy, are made real (constructed) because this is necessary to understand how and why people act. This philosophy was upheld by Michel Foucault (1926-1984), who argued that knowledge and existence are profoundly historical, not in a traditional sense but in relation to the way in which knowledge

is produced (Kearney, 1994). He referred specifically to the social construction of madness, punishment, and sexuality, and the socially determined way in which subjects structure their identity and their practices (Schirato, Danaher & Webb, 2020).

4.2.1 Positionality

It is important to consider my own social identity and how my position might influence and shape this research. Adopting a qualitative methodology for the current research means that my position as researcher is not value-neutral (Crotty, 1998; Archer, 2007, 2009). This presents a dilemma due to my position as an insider and member of the group being studied (qualified mental health nurse with experience in the field). From this position, I am personally and historically situated within the research and maintain a professional interest in the subject matter being studied (Berger, 2015). To some extent, it is inevitable that this position will influence data collection, analysis, and interpretation. Taylor (2003) states that this can be viewed as epistemological bias, which might blind the researcher to the nature of the object of study. Nevertheless, this insider position is regarded as a valuable perspective and beneficial to the interpretive and analytical process (Patton, 2001).

4.2.2 Position Statement

The following position statement is in line with my epistemological assumptions and supports my choice in adopting a constructivist philosophy for the current research.

- This research is not concerned with attempting to make statistical generalisations.
- The exploration of meaning ascribed to the accounts of experiences is a key focus of the study. Therefore, no attempts will be made to control for any influencing factors as this would be considered as reductionist and limiting to the research.
- The individual accounts collected through the research process are influenced by history and power, which define the expressions of the individuals and group being studied.
- The constructs and their expressions (in the individual accounts obtained) are considered to change over time.
- My position as insider provides a valuable and insightful perspective to the research process. This is due to my professional experience and awareness of the cultural norms, accepted practices, and shared language of the nursing profession. In addition, I have an awareness of the phenomena being studied from both a professional and personal perspective.
- The insider position allows me to acknowledge prejudices, which can be applied during the analytical and interpretive process in a

transparent and reflexive manner (Tomkins & Eatough, 2010). An appreciation of this prejudice also allows me to consider what is expected to be found during this process and compare this with what has been previously reported.

4.3 Methodology

4.3.1 The Qualitative Research Paradigm

This study is broadly concerned with the influence of discourse on mental health nurses' and patients' understandings and experiences of compassion. A qualitative methodology was selected for this purpose. A qualitative approach is consistent with my epistemological position since qualitative research is predicated by a set of beliefs about the nature of reality that are fundamentally different from the positivist paradigm (Table 3). For example, qualitative research accepts that there are multiple versions of social reality (Marshall & Rossman, 2006). Epistemologically, it emphasises the subjective perspective, therefore, methodologically the use of a hypothetico-deductive method is not necessary (Creswell & Creswell, 2017; Ormston *et al.,* 2013).

Table 3: Research Paradigms

Features	Orientation			
	Positivism		Interpretivism	
	Positivism	Post-positivism	Interpretivism	Constructivism
Ontology	Objective reality	Reality is imperfectly apprehensible Critical Realism	Reality is constructed The subject and object are dependent	
Epistemology	Reality is deduced and explained through reproducible 'true' findings	It is impossible to fully explain reality Replicable findings are 'probably' true	Knowledge is interpreted	Knowledge is constructed
Methodologies	Experimental methods Statistical analysis of quantitative data Cause-effect relationship	Experimental/quasi-methods Generally, statistical analysis of quantitative data	Mainly qualitative methods	

*Table created and adapted from Guba & Lincoln (1994), Creswell (2003, 2013), Bryman (2016), and Kivunja and Kuyini (2017).

The defining characteristics of qualitative research are that it places emphasis on words, context, interactions, and processes (Marshall & Rossman, 2006; Mason, 2002, 2006). As a method of inquiry, qualitative research aims to gain insight into how individuals make sense of the social world they occupy and their life experiences within that social world (Holloway & Galvin, 2016; Sarantakos, 2012). This permits the researcher to ask open questions regarding a particular topic or phenomenon within the contextual setting (Mohajan, 2018; Wertz, 2011). This

approach provides a detailed description of participants' feelings, opinions, and experiences through interpretation of the meaning of their actions (Denzin & Lincoln, 2008, 2011).

The use of qualitative research for the current study permits an exploration of the social world of nurses and patients in the context of mental health. Specifically, this thesis aims to examine how nurses construct themselves as compassionate practitioners in relation to their individual understanding of compassion. In addition, the plan is to investigate the experiences of compassion from the perspective of those who receive mental health care. This approach facilitates exploration in much greater depth than could have been achieved using purely quantitative methods.

4.4 Critical Discourse Analysis (CDA)

Discourse analysis is a widely used interdisciplinary research method for studying spoken and written language and their relation to the social context (Bhatia, Flowerdew & Jones, 2008). It is an increasingly popular choice for researchers across various disciplines, although deciding on a discourse analytical method can be confusing (Juez, 2009; Yazdannik, Yousefy & Mohammadi, 2017; Meyer, 2001; Rogers, 2011). Oswick (2012) explains that there are a variety of ways that a discourse analysis can be approached and there are as many analytical approaches as there are analysts. Normally, the preferred approach is informed by the epistemological commitments of the researcher, the analytical focus of the

study, and the aims and scope of the analysis (Bryman, 2016). Phillips and Hardy (2002) illustrate four types of discourse analysis research. Categorised along two axes, this shows the primary focus and epistemological foundation of each type (Figure 5).

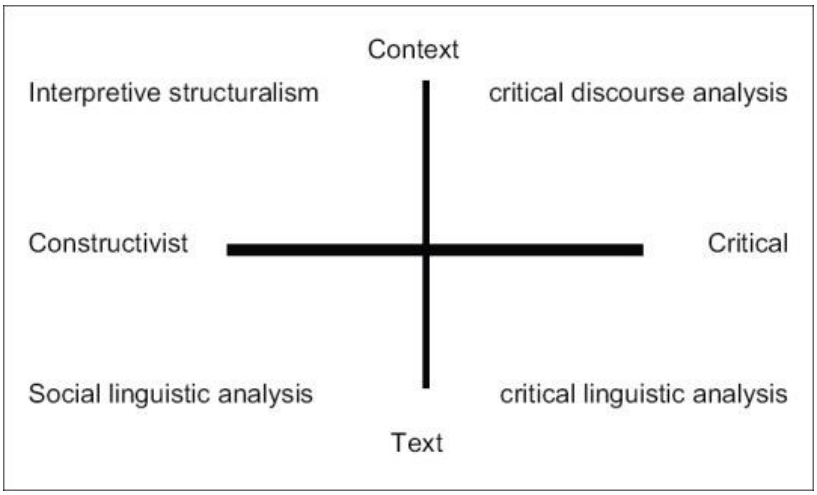


Figure 5: Four types of discourse analytical research approaches (Phillips & Hardy, 2002)

The aim of this study is to *"deconstruct how language and discourse shape how people think or feel, what they do, and the context within which these occur"* (Willig, 2008, *in* Van Ness *et al.,* 2017, p. 109). In this view, language is understood as a tool for generating meaning and representing the social world, an understanding that extends to include the construction of identity (Jørgensen & Phillips, 2002). Nurses can be considered as seeking to gain their status as professional selves by taking up a position within a pre-existing discourse (Van Langenhove & Harré, 1999; Gergen, 2007). Likewise, the available (wider)

discourse also makes available subject positions within networks of meaning (Willig, 2008a).

Given these discussions, the use of discourse analysis in attempting to explore the subject positions of mental health nurses would appear to fit with the constructivist-context approach (Phillips & Hardy, 2002). However, several features of this study lean towards critical theory (Han, 2002). This is reflected in the interdisciplinary nature of this research, and it attempts to make visible the interconnectedness of things (Fairclough, 2013; Wodak & Meyer, 2009). In addition, having made my position as insider and interpreter of the data explicit (see position statement in section 4.2.2), I acknowledge that *"my work is driven by social, economic, and political motives like any other academic work"* (paraphrased from Wodak & Meyer, 2009, p. 7).

These statements justify a critical approach to the discourse analysis at this phase of the study. Thus, a 'constructivist-critical' analytical approach to the interrogation of the language was adopted, and a move from discourse analysis to a type of *critical* discourse analysis (CDA) known as a Foucauldian discourse analysis (FDA).

4.4.1 Foucauldian-Inspired Discourse Analysis

Foucauldian discourse analysis (FDA) is a relative of CDA, inspired by the work of Michel Foucault (1975, 1984, 1995/1972), in which discourses are regarded as *"a set of statements that construct objects and allow [an array of] subject positions to be taken up"* (Rabinow, 1984, p. 245). These constructions make possible certain

ways of seeing the world and being in the world (Van Langenhove & Harré, 1999). As such, discourses are implicated in the exercise of power, where dominant discourses are regarded as favouring a certain version of social reality that reinforces existing social/institutional structures. Equally, the adopting of certain subject positions might also justify and legitimise existing discourse(s), thereby supporting prevailing social structures (Willig, 2008b).

FDA was considered relevant for this research due to its focus on asking questions beyond the immediate context, analysing the relationship between discourse, in terms of how individuals think and feel (subjectivity), what they do (practice) and the material conditions within which experience takes place (Jäger & Maier, 2009 *in* Wodak & Meyer 2009; Gavey, 1989; Ussher & Perz, 2014; Willig, 2008a). Weedon (1987) claims the method is flawed due to the fact that subjectivity can be contradictory and constantly reconstituted each time we speak or engage with discourse. The social world is also dynamic and constantly changing, therefore, any data collected can only be seen to represent a snapshot of the reality of the social world at a particular moment in time. Nevertheless, FDA is concerned with challenging the rules and power dynamics within which discourses are formed (Cunliffe, 2008; Arribas-Ayllon & Walkerdine, 2008). Hence, it offers the opportunity for alternative or counter-discourse to be revealed, which is an advantage of the method.

The choice of discourse analysis in the current study is a product of the theoretical commitments of the researcher and the contribution that they seek to make. Critics of the method (Breeze, 2011; Hammersley, 1997) insist it cannot offer a

comprehensive understanding of society. However, consistent with the research objectives of the current study, it might offer unique insight into the expression and construction of the social world of individual participants (Stubbs, 1997). Alternate methods (like surveys, for example) would not do justice to the notion of professional identity as it might be constructed socially, and/or the interpersonal accounts as defined within study participants' existing internal structures of meaning. However, it is not always possible to access meaning-making (Young, 1981) since the focus for FDA is analysing the conditions of existence for meaning (Breeze, 2011). This 'Foucauldian' perspective is particularly relevant in the context of the current study, where the principles of meaning in relation to compassion and the nursing profession are viewed as being a product of historical, political, and institutional discourse(s). This post-structuralist approach to textual analysis enables the deep, hidden meanings behind the play of language to come to light (Kearney, 1994; Miller, 2008; Parker, 1994).

4.4.2 FDA Method

FDA is situated within the broader context of critical discourse studies. However, it is a much more abstract analytical approach (Cunliffe, 2008), so much so that some commentators conclude that *"there is no such thing as Foucauldian Discourse Analysis*" (Arribas-Ayllon & Walkerdine, 2008, p. 120). FDA addresses the role of language and discourse in constructing social and psychological realities (Willig, 2008b). As discussed in the previous chapter, this approach is inspired by the work of Michel Foucault and his interest in how knowledge, power, and discourses are connected, and how this is tied to historical contexts (Foucault,

1990/1984). It is therefore applied where a researcher wishes to consider how discourses are bound up with social practices, whilst also recognising that discourses arise within given cultural contexts. This was appropriate for this research, which planned to consider the wider social and political constructions of compassion, the micro connections with these discourses at the individual level, as well as individual constructions of compassion.

The different versions of FDA procedure make it difficult for those wishing to conduct critical discourse analysis to decide on a specific approach. Moreover, the term ‘critical’ is often confusing and is regularly misunderstood. It does not mean focusing purely on the negative aspects of social interactions and processes. To the contrary, it means denying dichotomous explanations, characterising the complexity, and making any contradictions transparent (Parker, 1994). ‘Critical’ also implies that the researcher be self-reflexive while undertaking the research. The object of study is often chosen by the researcher, defined, and evaluated by them. The analyst does not separate their own values and beliefs from the research they conduct, rather they recognise how their own interests and knowledge unavoidably shape their work (Silverman, 1993; Zienkowski, 2017).

There are various approaches to conducting FDA. Kendall and Wickham (1999) offer an approach with but a few steps, however, assume the researcher has a superior level of knowledge surrounding Foucault’s original method. Hence, the text reads as elliptical as Foucault’s own work. Parker (1992) proposes a 20-step method. This includes an explanation of how to select texts, the identification of

subject and objects that are constructed within the texts, and the way in which power structures are recreated.

Willig (2008a) reduces Parker's (1992) 20-step method to six and includes discursive constructions and subject positioning. Since this research is concerned with identifying subject positions and how nurses manage their moral location within the social world, Willig's (2008a) six-step method (summarised below) is therefore considered appropriate and more easily accessible to the current research.

Willig's (2008a) six-step approach to FDA:

- **Stage 1: Discursive Constructions** – An analysis of the way in which discursive objects are constructed. In this case, the focus of the study is compassion. Hence, this stage involves identifying the different ways that compassion is considered in the text, requiring the researcher to highlight all the instances of both explicit and implicit reference to compassion.
- **Stage 2: Discourses** – After having identified all references to compassion within the text, the next stage involves focusing on the differences between the constructions. These constructions are then located with reference to the discursive object within the wider discourse.
- **Stage 3: Action Orientated** – This stage takes a closer look at the discursive contexts within which the different constructions of the discursive object are being deployed. Consideration is given to thinking about 'what is the function of constructing the object in this particular way'?

- **Stage 4: Positionings** – Once the various constructions of compassion have been identified within the text and wider discourse, the subject positions they offer can be observed: "*A subject position within a discourse identifies a location for persons within the structure of rights and duties for those who use that repertoire"* (Davies & Harré, 1999, p. 35).
- **Stage 5: Practice** – This stage considers the relationship between discourse and practice. It involves the researcher exploring ways in which subject positions either support or limit opportunities for action. The positioning of individuals in certain ways within a constructed version of the social world either enables or constrains what can be said/done.
- **Stage 6: Subjectivity** – This last stage explores the relationship between discourse and subjectivity, considering how discourse makes certain ways of seeing and being in the world. Having explored what can be said and done, this final stage asks what can be felt, thought, and experienced from a certain subject position.

Many researchers often take a 'themed' approach to analysing and presenting data using CDA and FDA. This is due largely to the fact that a consistent way of conducting FDA has not yet been concretised. This is like Thematic Analysis (TA) (Braun & Clarke, 2006, 2013) but when conducting FDA, data are analysed slightly differently to other qualitative approaches. Discourse analysts often analyse data by hand without the use of computer software. Although this is time consuming, there is a need to identify both explicit and implicit references to the object of

investigation (compassion), which might be missed using a computerised approach.

Stage 1 of Willig's (2008a) analysis is typically conducted and presented akin to the first three phases of TA, e.g. familiarising oneself with the data, generating initial codes, and searching for themes. However, rather than conceptualising segments of data as 'codes' or 'themes', in FDA they are considered as discursive constructions (and discourses) that are tied to the analyst's underlying epistemological position. Statements, or references (Willig, 2008b), are seen as the smallest units of material for analysis in FDA.

The second stage of Willig's (2008a) FDA framework pays close attention to the difference in how participants talk about compassion, both within individual accounts and across participants' shared accounts. Again, while this may share some practical similarities with TA, FDA is markedly different in that there is a search for qualitative meaning, which involves the need for the analyst to trace, for example, the broader discourses or historical discourses and the implication of these statements or references and their potential 'functional' effect(s). Stage 3 requires the context to be considered, and the function of the discursive constructions. It is suggested (Owen, 2019) that stages 1 to 3 be presented together, and stages 4 to 6 be presented together.

4.4.3 Challenges of Discourse Analysis

As previously mentioned, discourse analysis (DA) is an umbrella term for a collection of approaches to the analysis of discourse across different philosophical

traditions (Morgan, 2010). Therefore, the first challenge is choosing from the array of options available and ensuring coherence with the epistemological assumptions of the researcher (Breeze, 2011). Of importance, and of major concern for all qualitative research, is the issue of quality measures used to establish the value and integrity of a study. This is necessary so that the researcher can convince an audience of the trustworthiness of their work.

While CDA is established as a valuable methodological approach in the social sciences (*see* Fairclough, 2013; Gee & Greene, 2005; Rogers, 2011; Van Dijk, 1993), challenges continue to be encountered in relation to rigour, transparency, evidence, and representation (Greckhamer & Cilesiz, 2014). Rigour is thought to be achieved through a systematic approach to the analysis, and a design grounded in the researcher's values and epistemological assumptions, as well as the theoretical foundation of the study. This allows the researcher to make what is viewed as 'trustworthy' conclusions, rather than (what could be viewed as) simple observations and/or opinions (Greckhamer & Cilesiz, 2014).

The concept of rigour involves the transparent conveying of the analytical process. However, Hammersley (2007) argues that complete transparency cannot be easily achieved as it is difficult to convey each decision that the researcher makes. As an alternative, researchers should strive to provide a high degree of transparency in explaining the research process, such as decisions about design, analysis, results, and interpretation. However, with CDA this is constrained by the complex nature of the analytical method and the representation of this in visual terms (Harry, Sturges & Klingner, 2005). Greckhamer and Cilesiz (2014) recommend narrating

the analytical process in a simple way alongside the displayed results, while clearly communicating the steps taken in the analysis, presenting ‘appropriate’ evidence as per the theoretical perspective of the researcher.

The final challenge is representing what has been learnt by the researcher. A representative analysis may be difficult to convey, particularly where the analytical process has been iterative and intertextual relationships between texts have been examined (Greckhamer & Cilesiz, 2014). Denzin (2001) notes that we can only know *“the world through our representations of it”* (p. 5). Therefore, what the researcher chooses to present is vital for how the reader understand the concept and/or knowledge that is being presented, and to the acceptance of any knowledge claims being made. The researcher must therefore ensure their interpretations accurately reflect participants’ accounts (Iphofen & Tolich, 2018).

4.5 Data Collection Strategy

To explore the different dimensions of discourse, this research employs critical discourse analysis (outlined in section four of this chapter) to generate knowledge across three distinct phases of data collection.

1. Examination of national and local policy documents that relate to compassion in healthcare (document analysis)
2. Examination of mental health nurses’ discursive constructions of compassion (interviews)
3. Exploration of mental health patients’ views, perspectives, and experiences of compassion (interviews)

This was viewed as being sufficient to answer the complexities of the research objectives posed by this study, which encompasses an analysis of structural level text and talk, as well as the micro narratives found at the individual level (Souto-Manning, 2014). The approach to data collection was that each phase would be undertaken in sequence. This sequential approach to data collection is considered beneficial as the analysis can be mutually informing at each phase. This presents the possibility of the findings being brought together synergistically to provide a more detailed description of compassion within the practical setting of mental health.

4.5.1 Phase One – Document Analysis

The first phase of the current research involved examination of the political and professional discourse on compassion. This step was undertaken to understand 'how' compassion had been conceptualised by government. Specially, this phase analysed the use of language as a social practice, with a focus on the use of linguistic techniques and the rationalities of government in this process of conceptualisation (of compassion). This enabled inferences to be made regarding 'how' mental health nurses might individually and collectively construct notions of compassion – considering this discourse as influential to their professional practice. Hence, this phase of study drew from the wide range of literature (chapter 1), and a discourse strand was assembled accordingly.

When choosing the documents for analysis, I adopted an approach outlined by Reisigl and Wodak (2016 *in* Reisigl, 2017), whereby texts relating to the macro-

topic ‘compassion in nursing and healthcare policy’ were chosen. When assembling the discourse strand, I noted that the concept of compassion had been widely mobilised within the policy and professional literature following care failures identified in the Francis Reports (2010, 2013). This was apparent in terms of the frequency of documents relating to the topic of compassion (and publications dedicated solely to the issue of compassion in healthcare) from this turning point. As noted within the literature review (chapter 2) this turning point appeared to be marked by the events at Mid-Staffordshire Hospital (2005-2009), the launch of the Francis Inquiry (2010, 2013), and subsequent national efforts to improve standards of care within the NHS. Accordingly, public policy and professional documents, published from this point, were chosen where they directly referenced compassion or where compassion was a major theme within the document.

After having explored the documents from this point to 2019 (when this research began), it was clear that from 2009 onwards, the compassion discourse had become embedded nationally (NHS Constitution), and at the organisational level (across NHS Trusts). As such, I decided on documents that spanned an eight-year period from 2008-2015. Documents immediately prior to the reported care failures (2008) were included, however, after 2015 the only notable mention of compassion was observable within the government and/or NHS/healthcare literature. Documents originating from independent think-tanks like The King’s Fund and Nuffield Trust[23] were also considered as they were recognised to be influential in informing and shaping healthcare policy and practice. This approach is consistent

[23] The King’s Fund and the Nuffield Trust are independent charitable organisations with an interest in improving healthcare.

with a governmentality perspective, which acknowledges the existence of multiple agents and sources. Within this perspective, as outlined in Figure 3 (Chapter 3, section 3.4), this initial phase of the research allowed the technologies (and rationalities) of political authority to be observed. The documents chosen for the analysis are shown in chapter 5 (section 5.1).

4.5.2 Phase Two – Interviews with Mental Health Nurses

The aim of this phase of the study was to collect data that could provide insight into the potential influence of the compassion discourse on mental health nurses' constructions of the professional self. A critical discourse analysis was employed, the overall aim being to better understand the interplay between 'technologies of governing' and 'technologies of self' (Walters, 2012). It was anticipated that this methodological approach would offer insight into whether mental health nurses had taken up the political discourse on compassion. In other words, how had this group of nurses positioned themselves within this discourse? Prior to starting the interviews, and prior to gaining ethical approval for the study, consultation took place with mental health nurses who were known to me via my professional network. This enabled me to consider the practicalities of the research, for example, how nurses might prefer to be interviewed (face-to-face or via telephone), and the length of time they might be willing to spend taking part.

4.5.3 Phase Three – Interviews with Patients

The intention for this phase of the study was to explore the subjective experience of compassion from the perspective of patients. Having explicitly acknowledged the potential for bias in the construction and production of knowledge, it was essential that the value of the experiential perspective or 'expertise by experience' be realised in the design of the current research (Noorani, 2013; Telford & Faulkner, 2004). I decided to consult people with lived experience of mental health to contribute to a consultation exercise, which would enable me to understand the practical aspects involved with recruitment. I approach a lived experience advisor, known to me through my own personal networks, who spoke to me via social media and email. This snowballed into an additional face-to-face consultation at the Institute of Mental Health, University of Nottingham, with a further two advisors (also known to me personally). All those who took part in these consultations were happy to contribute and did so freely in their own time.

These consultations, prior to any ethical approval, aimed to ensure that a lived experience perspective had informed the research, rather than reflecting only a clinical view. It is recognised that including the voices of people with lived experience is a much more powerful statement than the sole voice of the researcher and provides much more meaningful information for policy makers (Slade *et al.,* 2012). This process was also important to establish whether the recruitment process would be practical, feasible, and accessible for those who wished to participate (National Institute for Health Research, 2020). Lived experience advisors provided a sense test of the language contained within the

study information sheets. I believe that this process provided an opportunity for people to contribute to and potentially influence social change in the future.

4.5.4 Planning: Participants, Sampling, and Recruitment Processes

4.5.4.1 Phase Two

For phase two of the study, it was anticipated that participants would be recruited from a large NHS trust in the North of England. The initial consultations, prior to the start of the study, had indicated that the research would benefit from including individuals who had been involved in the involuntary detention of patients. This is because this aspect of mental health practice is what makes it unique from general (physical) health nursing. To ensure as much participation as possible, the study was open to mental health nurses working in any area of mental health services.

4.5.4.2 Phase Three

For the final phase of the study, it was expected that participants would be current patients attending mental health services at the study site or who had previously used these services. As was noted in the prior consultations held before ethical approval was sought, it was important that all areas were included as this would provide the opportunity for anyone within any care area (acute, community, forensic) to take part in the study. This was particularly important so a range of voices could be represented within the study, including those voices that might otherwise have remained hidden. However, it was felt to be crucial that participants have capacity to give consent as this is noted as a contentious issue

in mental health practice and could invalidate any consent given (Nicholson, Cutter & Hotopf, 2008). For research purposes, capacity is necessary for consent to be both legal and ethical (HRA, 2019).

Exclusion criteria were children and adolescents under 16 years of age, non-English speakers, and those with indirect experience of using mental health services, for example, carers, family members, and mental health advocates.

The study assumed a purposive approach to recruiting participants to the interviews (Campbell *et al.,* 2020). The sample involves seeking participants strategically to gain a range of views pertaining to the research questions posed (Bryman, 2016). A copy of the relevant sites was provided by the research team at the study site. This meant that a copy of participant information sheets (PIS), providing full details of the study, could be distributed to all relevant sites within the trust. Packs also contained a copy of the consent form and a poster for display at each site. The plan was that, initially, packs would be sent directly from the researcher so that participants were not influenced, e.g. by the organisational management, in their decision to participate. Electronic copies of posters were prepared so that these could be emailed to the Trust communications department for circulation via the organisational intranet.

4.6 Ethical Considerations

In designing, conducting, analysing, interpreting, and disseminating this research, a wide variety of ethical challenges were presented for consideration.

For the current study, the following ethical principles were adhered to; The Declaration of Helsinki (World Medical Association, as amended, 2013), the principles of ethical research practice provided by Health Research Authority (2017) and the University of Nottingham Code of Research Conduct Ethics (University of Nottingham, 2020).

The key challenges to consider in conducting this study ethically were the guiding principles as noted above. Also, to safeguard human participants from harm, to safely manage any distress that might emerge during the collection of data, to safely govern the data collected in line with ethical principles, and to respect the rights and decisions of research participants. These ethical principles will be discussed in the following section.

4.6.1 Ethical Approval

In accordance with ethical principles, a submission was made to the NHS Integrated Research Application System (IRAS) on 22nd April 2020. Ethical approval was granted from the Health Research Authority (HRA) and Coventry & Warwick Research Ethics Committee (REC) on 24th June 2020 (see Appendix 2). The following section outline the documentation and processes, as approved by the ethics committee.

4.6.2 Informed Consent & Capacity

All participants were provided in advance with informed consent forms and information sheets. The decision to enter the study was entirely voluntary and

participants were given the option to withdraw at any time without giving a reason. A deciding period of 48 hours was suggested, between the participants receiving the study information and providing their consent. Wilson, Draper, and Ives (2008) recommend that participants should be allowed to waive this rule as it can be perceived as paternalistic. However, in a medical environment, the issue of consent can easily be confused with consent to treatment. This waiting period was deemed to be necessary here to protect vulnerable participants (patients). Thus, it was made explicit both on the PIS and during the consenting process that *research* was being consented to and not treatment (Richardson & McMullan, 2007).

For staff (nurse) participants, the consenting process involved them either requesting a stamped addressed envelope to return to the researcher, or the trust headquarters. An electronic copy with an electronic signature was also acceptable. Completed consent forms were all provided in written form via packs send in the post to managers and clinical leads across the trust sites.

4.6.3 Autonomy & Confidentiality

Participants were informed of their right to withdraw their participation at any time, without needing to give reason. Interview data were collected and stored using a password-protected Dictaphone, transcribed and immediately stored on the University of Nottingham's cloud storage. Data were accessible only to the research candidate and supervisory team. It was made explicit to all participants that any excerpts used in any future journal publications would be anonymised.

It is pertinent to note that, since starting this research, much of the findings of this thesis have been published as journal articles and a book chapter. In doing so, and keeping with the ethical principles outlined in this section, the anonymity and confidentiality of all participants have been preserved by removing any names or locations, adding pseudonyms, and changing any details that might have inadvertently identified any of the participants. This can be difficult to achieve with qualitative excerpts where participants might be more easily identifiable (Stark & Hedgecoe, 2010). Therefore, any extracts where participants had specifically referred to themselves, the title of their role, or mentioned any sensitive third-party information (that may have been identifiable) have not been used in any dissemination activity.

4.6.4 Non-malevolence & Beneficence

All research with human participants has ethical concerns and dilemmas which may be unforeseen at the start of any project. Researchers have a responsibility to all those being researched; not just by simply following ethical principles but by thinking carefully about any risks associated with the group being accessed and continuing to conduct research in an ethical way after approval is gained (Richardson & McMullan, 2007).

To do no harm is one of the central tenets of conducting ethical research. This was of particular importance here, as mental health patients are considered a particularly vulnerable group, at increased risk of abuse, exploitation, social exclusion, victimisation, and stigmatisation (Galderisi *et al.,* 2015). The ethical

application and process was therefore thought about very carefully prior to any ethical submission. The researcher's experience of working in mental health services was particularly valuable at this point as it allowed a range of potential scenarios to be considered prior to obtaining ethical approval. This was balanced with the feedback received during consultations with people who had lived experiences of mental health. The risk versus benefits of this research were considered in collaboration with these consultations and a plan of action/protocol was created for use during the data collection phase of the study.

It was considered unlikely that any of the participants would come to any physical harm during the process of being interviewed. However, talking about compassion in the context of providing and receiving care within statutory mental health services was potentially a highly emotive topic. Hence, it was necessary to recognise the likelihood of participants becoming distressed when discussing issues relating to their lived experiences. Accordingly, to address the potential for distress during the interviews, separate distress protocols (staff and patient versions) were developed and followed during data collection (see Appendix 3). Signposting was also provided with the participant information sheets, should additional support have been needed during or following data collection.

4.6.5 Data Management Plan

The planned ethical approach to data management was as follows. Interviews were recorded using a password-protected Dictaphone to ensure confidentiality. Each interview was immediately transcribed onto an MS Word document which

included (on the front sheet) the date, time, and place of data collection, along with participants' gender, and a unique code number or pseudonym which was applied to each participant.

Additional demographics/characteristics of participants in phase one were: length of time qualified, and designation or role. An MS Excel file containing the information provided on the front sheet of each transcript was uploaded onto the University of Nottingham's secure cloud storage. After transcribing, each transcript was placed onto the same secure cloud storage facility. Computer-held data were held securely and password-protected. Hard copies of all consent forms were kept in a locked cabinet according to the University of Nottingham Code of Research Conduct and Research Ethics (University of Nottingham, 2020). At all times during the study, the Data Protection Act (2018) was adhered to and access to the study data was restricted to PhD supervisors.

4.7 Transparency & Trustworthiness in Qualitative Research

Throughout the analytical process, consistent with Tracy's (2010) criteria for excellence in qualitative research, I engaged in a process of immersion. This involved connecting with the data through repeated reading and reflecting on language use, structure, placement, or emphasis on certain words and any relationship with the wider discourses on compassion – while continually referring to the theoretical/conceptual framework being used. This approach was considered to aid the interpretative process and the overall construction of the results. However, it is important that participants were given the opportunity to

check the accounts they provided so that the accuracy of those accounts could be validated by them (Birt *et al.,* 2016). This is known as member checking and allows the researcher to comment on the perceived genuineness of the accounts in any publications.

Rather than attempting to make generalisations, the focus of this research is on the quality of description of the data. In agreement with Dant (1991), I maintain that *"Accounts in discourse are not simply accounts of the world; they are also among those human practices that constitute the world"* (p. 207). It is the constitutive nature of discourse which gives the analyses presented in this thesis depth and reflects the reality of the individual participants. The perceived genuineness of participants' accounts is a strength of this research.

As a qualitative research approach, discourse analysis offers a way in which to explore and challenge thinking about aspects of reality. However, various writers in the field of discourse analysis, for example Parker (1992) and Fairclough (2015), explain that discourses have ideological effects that support institutions. As such, it was important that consideration was given to my position and experience of the phenomenon under discussion (see section 4.2.1). I view myself as an insider, due to my shared membership with the group under discussion (mental health nurses). This willingness to account for the ways in which the researcher can influence the interpretation of data is regarded as a mark of quality research (Sandelowski & Barroso, 2006).

The insider position provides a valuable and insightful perspective to the research process because of the wealth of professional experience, tacit knowledge, awareness of the cultural norms, accepted practices, and language of the nursing profession (Tracy, 2010; Chavez, 2008; Patton, 2001). However, amongst the scholarly community, it is anticipated that peer review of the analysis will take place (Henry, 2015; Rolfe, 2006). This helps to establish trustworthiness in the results and mediates personal bias that may result from the insider position (Jootun, McGhee & Marland, 2009).

4.8 Chapter Summary

This chapter has described and justified the methodological choices that have been made to realise the research aims and objectives. The theoretical debates relating to the creation of knowledge have been addressed and the current researcher has clearly presented their own assumptions and values in relation to knowledge claims.

The strategy for collecting and analysing the data has been laid out, drawing upon a wide variety of literature to justify the appropriateness of each method. It has been argued that adopting a qualitative research design provides the most appropriate framework within which to separately explore the discursive nature of compassion presented by government; nurses' constructions of compassion; and how patients construct compassion in the context of mental health care.

This research was accomplished utilising linguistically based approaches concerned with the close reading of discursive accounts. In phases two and three, this approach enabled in-depth insight into participant groups that are currently underrepresented within the literature and allowed the opportunity to gain knowledge of the phenomena being studied in a practical setting that has yet to be explored. This strategy was enhanced by the early engagement with an established network of nursing colleagues, and the patient ambassador for the Trust. All provided valuable contributions to the design and ethical considerations for this study.

Chapter 5: Analysis of Political & Professional Discourses

5.1 Introduction

The preceding chapter outlined the methodological approach taken to realising the research objectives for this study. This chapter is the first of three chapters to present empirical data from the study. The intention of this first phase of the study was to disentangle discourses on compassion within healthcare policy and organisational text and talk. The aim of this was to situate professional nursing in the context of external influences, thereby drawing out the broader perspectives regarding the way in which compassion in healthcare has developed over the last ten years. This also identifies how compassion has been presented and re-presented within these different forms of professional text and talk. Table 4 shows

the documents used in the analysis. All of the documents can be found in the public domain and are available online.

Table 4: Corpus of texts examined

Document title	Type	Published	Author/Publisher
The Code: Standards of conduct, performance and ethics for nurses and midwives	Regulation/standards for nurses	2008	Nursing and Midwifery Council
The point of care: Enabling compassionate care in acute hospital settings	Independent think tank report	2009	The King's Fund (Firth-Cozens & Cornwell)
HM Treasury: Spending Review	Execution of government's public finance & economic policy	2010	Chancellor of the Exchequer
Health and Social Care Act	Act of Parliament	2012	Stationary Office: Bill passed in Parliament
Compassion in Practice: Nursing, Midwifery, and care staff. Our Vision and Strategy	Chief Nursing Officer for England's response to reported fallings in care	2012	NHS England – Department of Health. Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser
Quality with compassion: The future of nursing education	Willis Commission	2012	Royal College of Nursing
Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary	Independent public inquiry	2013	Sir Robert Francis QC
Nurses told, 'you're not too posh to wash a patient': Minister orders student nurses back to basics to improve compassion in NHS	Political comments referred to in media-generated discourse	2013	Chapman & Martin Daily Mail
David Cameron's prescription for NHS failings: target pay of nurses	Political comments referred to in media-generated discourse	2013	The Guardian (Campbell, 2013b)

Cameron and Hunt hit back at RCN over nurse training reforms	Political comments referred to in media-generated discourse	2013	Press Association Guardian Online
After Francis: making a difference. Third Report of Session 2013-14. Report, together with formal minutes and oral written evidence	Review of Francis' independent public inquiry in the House of Lords	2012-2013	House of Commons Health Committee
The Government Response to the House of Commons Health Committee Third Report of Session 2013-14: After Francis: making a difference	Government white paper	2013	Department of Health and Social Care
2010 to 2015 government policy: compassionate care in the NHS	Government policy	2010-2015	Department of Health and Social Care
Delivering high quality, effective, compassionate care: Developing the Right People with the Right Skills and the Right Values	Government mandate	2013	A Mandate from the Government to the Health Education England
Compassion in Practice: One year on	Review of nursing practice – post compassion in practice strategy	2013	Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser NHS England – Department of Health
Hard Truths: the journey to putting patients first	Government report	2014	Department of Health and Social Care
The NHS Constitution for England	Sets out the principles and values of the NHS in England	2015	NHS England – Department of Health
The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates	Regulation/standards for nurses	2015	Nursing and Midwifery Council

5.1.1 Conceptual Framework for the Document Analysis

The methodological position to undertake an analysis of documents within this study was to critically explore the construction of compassion in healthcare in national policy political reports, and professional responses to these reports at national and local level (meso-level discourses). Data collection proceeded (see chapter 3, section 3.4) according to the governmentality conceptual framework provided by Miller and Rose (1990), whereby issues are said to be constructed, made to appear problematic by the media, experts, professionals, pressure groups, politicians, and other groups such as activists.

Once the corpus of texts had been decided upon, documents were coded by a thorough and repeated reading of each text, checking primarily for explicit and implicit constructions of compassion. Recurring themes were observed alongside any inconsistencies, comparative to the general societal discourse.

5.1.2.2 Applying the Chosen Framework & Presenting the Analysis

A corpus of texts will often comprise various sub-topics; these are identified and summarised into groups and noted with what frequency they occur. In this phase of the study, sub-topics were examined for the way in which they might be distributed over time and entangled with different discourse strands. A procedure offered by Miller and Rose (1990) and Rose and Miller (1992) was used as a framework, attending to context, surface text, rhetorical means, and content and ideological statements.

In the following sections of this chapter, the analysis unpicks representations of compassion in contemporary healthcare. This is necessary to understand the assumed rights and responsibilities of nurses, in relation to compassion, within a multifaceted healthcare system, managed at numerous levels. The analysis is guided by the concept of *governmentality*, which stems from the notion of 'conduct of conduct'[24], an activity that aims to shape and influence the conduct of individuals or groups (Dean, 2010; Miller & Rose, 2008). It is pertinent to note that there is not a clearly identified or recommended methodology for this type of inquiry. However, in their study of governmentality, Reich and Turnbull (2018) advocate paying attention to the way in which diverse discourse(s) can constitute our identity in varied ways. This means taking note of the links between social, organisational, and professional fields of discourse, in particular, the underpinning domains of knowledge and authorship in the construction of subjects.

The text and talk observed in the chosen documents reveal how the problematisation of conduct has led to the 'responsibilisation of individualised compassion' and the construction of compassion as a behaviour necessitating disciplinary action when absent. The analysis presented in this chapter illustrates *how* these discourses have developed and specifically explores the emergence of new norms or standards presented within both macro-level NHS policy and meso-level professional reports and guidance.

[24] Introduced by Foucault in his lectures between 1978 & 1979.

5.2 Macro-Level Analysis

5.2.1 A Focus on Nurses' Conduct as a Problem

Guided by Miller and Rose (1990) and Rose and Miller (1992), the conceptual starting point for this analysis was the rendering of *problematisation*. According to Kendall and Wickham (1999), Foucault observed that looking for problems is a form of critical thinking in order to come up with new ideas. Therefore, by detaching oneself from the object of thought, it is possible to reflect on it as a problem. This initial stage involved an examination of the way in which nurses' problematic conduct (lacking compassion) has been 'made thinkable' (through the dissemination of discourse), and subsequently identified as requiring intervention.

Problematic nursing conduct was made visible a media article that reported on the events at Mid-Staffordshire in 2010, where a *"lack of compassion"* and *"uncaring attitude of staff"* were described (BBC News, 2010). Despite implications of having an uncertain political alignment (Ofcom, 2019), the longevity of a media source such as the BBC suggests that the public believes the messages it disseminates. This widely circulated discourse may have influenced public opinion of nurses, and in turn, questioned the government's ability to effectively lead the NHS. The government's statement that care failings had *"cast a shadow over the reputation of the NHS for safe, high-quality patient care"* (HoCHC, 2013, p.11) accords with this. Hence, the government responded to deflect attention away from itself.

Francis (2013, pp. 76-105) stressed the need for *"caring, compassionate and considerate nursing"*. Although caring and compassion may have long been

thought of as distinct to the nursing profession (Benner & Wrubel, 1989), publicised statements like this have provided compelling evidence for those in power to (re)state an emphasis on compassion. Subsequent reporting of nurses being responsible for the perceived *compassion deficit* targeted nurses' values, clinical ability, and education (Campbell, 2013a; Darbyshire & McKenna, 2013). Competing discourses circulated, which argued that national reporting had highlighted the poor behaviour of a *minority* of nurses (Bond *et al.,* 2018). However, these conversations may have been largely invisible and given little exposure, compared to national news media outlets. Hence, the idea of nurses lacking compassion would have reached more of the publics' collective consciousness (Foucault, 1983, *in* Dreyfus & Rabinow). The construction and generalisation of nurses 'lacking compassion' therefore provided impetus for the compassion agenda to be implemented across the healthcare system (Pedersen & Roelsgard Obling, 2019).

The narrative of a compassion deficit in nursing, across national discourse(s), allowed for a comparison to take place between any existing assumptions about nurses generally (within the social world) and the individual conduct – described as problematic. For example, following the Francis[25] report (2013), the government continued to note the *"terrible failings in professional conduct, leadership, safety and compassion"* (DOH, 2013a, p. 3). Yet, prior to the emergence of these discourses compassion was not considered a requirement of nurses' professional

[25] Sir Robert Francis' initial inquiry report was published in 2010 and his concluding report and recommendations were published in 2013.

conduct; the Nursing and Midwifery Council's 2008 professional code of conduct made no mention of compassion. Despite contradictory discourses in circulation at the time, the *problem* of conduct appeared to lack consistency with any existing notions of nursing and therefore necessitated intervention.

The identified 'problem of conduct' made possible a dialogue between different groups (e.g. the media, health experts, lead nursing professionals, politicians, and trade unions) regarding the expressed 'lack of compassion'. These groups were then able to treat the matter as being resolvable (through intervention) via a collective representation of compassion in relation to individual conduct, proposing the need for there to be an increased culture of compassion.

At the time, a dispute arose between the government and the Royal College of Nursing (RCN) after the RCN criticised the government for accepting Sir Robert Francis' (2013) recommendations to improve compassion in nursing; the RCN indicated that government reforms were '*a stupid idea'* (my italics). This was in response to a statement made by the Health Secretary that patient-care scandals were partly the fault of the RCN. The government retort was that the RCN had put the interests of their profession above patient care and openly accused the RCN of doing little to uphold professional standards among nursing staff (Press Association, 2013). This contributed to a discourse that implied the nursing profession was to blame for the reported failings in care; blame was aimed at the nursing trade unions. This attack toward nurses specifically illustrates governmentality, as defined by Foucault (1979) *"the ensemble formed by institutions, procedures, analyses, and reflections, the calculations and tactics, that*

allow the exercise of this specific albeit complex of power, which has at its target population" (p. 20). In this sense, the power of government is not fixed within one institution or another; rather there exists a network of hierarchical power relations in which each agency and/or authority seeks to shape conduct through *"a variety of techniques"* (Dean, 2010, p. 18). Within this network there may be unequal power relations, and cases where complete domination is exercised, e.g. political opinions and parliamentary acts. There are therefore ways in which, through these specific power mechanisms, some knowledge is marginalised while other is legitimated as truth (Rose, 2006). For instance, the political discourse on compassion suggested that compassion was an emotion and/or feeling that may or may not be present in nurses' conduct. This has the potential to influence and shape employee subjectivity by suggesting and demanding a baseline standard of 'moral' character for all nurses. This reflects Foucault's view that power relations rely on subjectivation, by which he means *"the way in which people are invited or incited to recognize their moral obligations"* (Foucault, 1984a, p. 264). Hence, the RCN may have been more likely to accept the compassion agenda so as to align the public image of nursing with compassion as an ethical profession.

Since the problematisation of nurses' conduct was made it *real* via the social, political, organisational, and professional fields of discourse, it is possible to draw out the practical rationalities of government, which sought *"to shape the real in specific ways and dimensions"* (Lemke, 2012, p. 82) by linking these rationalities with programmes of government.

5.2.2 Compounding Compassion & Care

The requirement for all care to be 'compassionate' made compassion amenable to intervention and susceptible to a set of instruments (technologies) that allow the problem of conduct to be acted upon and transformed into unproblematic conduct (Miller & Rose, 1992). Several political debates took place to ascertain a resolution to the problem of conduct. According to Radcliffe (1998), such debates often involve a process whereby politicians compare the activities of groups and/or individuals to be governed. Political debates tend to lead to idealised representations of the world, which are usually expressed through political rhetoric as moral imperatives. These claims are not noted in isolation but are observed across a wide range of statements, allowing individuals and groups to continue in power.

In the House of Commons Health Committee (HoCHC, 2013a) parliamentary report, and on the issue of media reporting of *compassionless nurses* (questioning whether this was due to 'quantity or quality' of nursing staff), Sir Robert Francis stated that he had found *"inexcusably callous treatment of patients, which had absolutely nothing do with whether there were sufficient staff around or not, but simply…..people who did not care"* (Ev 6).

Within the documents analysed, the word *compassion* can be observed to be discursively constructed alongside the word *care*. Thus, compounding (combining two words to yield a new meaning) the two words '*compassionate'* and *'care'* implies that 'to care', one must also be compassionate. Another

publication by Firth-Cozens and Cornwell (2009) of the King's Fund, which was released at the height of the Mid-Staffordshire scandal[26], stressed the need to transform staff culture to become a 'compassionate culture'. The reason being that this would improve patients' experiences of care (Firth-Cozens & Cornwell, 2009). The word 'culture' is often associated to the idea of the attitudes, behaviour, and characteristics of a particular social group (Cooper, Kelly & Weaver, 2001). The suggestion that a change in culture was what was needed cast doubt on the existing behaviour(s) of individuals working in healthcare at the time of the Francis (2010, 2013) reports, therefore exacerbating already negative media reporting.

It is possible that the idea of *compassionate care* and the need for a *culture of compassion* was embedded and reproduced through texts (i.e. Cummings & Bennett, 2012; NMC 2015, 2018) and everyday discursive practices to make compassion conceivable as an object of knowledge (Miller & Rose, 1990). This would transform the nature of compassion into an object that could be governed within the existing system of care. Arguably, the term '*compassionate care'* has since been linked to initiatives that set out to address the identified problem of nurses' conduct. These initiatives suggested that what was needed to address the situation was a required form of '*discipline*'. For example, Trusts were expected to implement the national nursing vision 'Compassion in Practice' (DOH, 2012b). The NMC's (2017) revised code of conduct stated that in order to prioritise people nurses ***"must"*** treat people with compassion (p. 6). and nurses

[26] Poor standards of care at Mid-Staffordshire hospital were reported between 2005-2009 (see Appendix 5).

*"**must**"* respond compassionately (p.7). The word 'must' is a modal auxiliary verb (see Wright, 2018, for more examples) which signals obligation from the authority (or the producers of the text, the NMC) to the people for whom it is intended (Fairclough, 2015). This text imposes the obligation to enact compassion onto the nursing and midwifery professions without making explicit the power relations between the authors and the reader. This text further supported the government's mentality that compassion is a conduct that can be made unproblematic through intervention. Following on from this change to the NMC code, the Care Quality Commission was granted increased power in setting out *"inviolable principles of safe, effective and compassionate care that must underpin all care in the future"* (DOH, 2014, p. 10). Therefore, this made compassion a fundamental, core standard of care, with the fear of prosecution if this standard was not met. This indicates the attempts of government to direct human conduct through normalising judgements, making individualised subjects visible such that their performance can be compared to a set standard or norm (Brivot & Gendron, 2011).

However, the act of governing in relation to compassion may be much more complex, unfolding from the links between *"questions of government, authority and politics, and questions of identity, self and person"* (Dean, 2010, p. 20). Within the national-level discourse(s) there were instances of nursing professionals being implicated in contributing to reinforce the government's suggestion that conduct was the problem. One example was the Compassion in Practice

Strategy[27] (2012c) for nursing, which aimed to transform care to ensure a "*culture* of *compassionate care*" (DOH, 2012c, p. 6). This document contains frequent reference to the strategy having been developed based on: "***Your*** (nurses, midwifes, care assistants) responses", "***your*** input", and "***you*** said it was important" (p. 7). This suggests nurses accept that they themselves had been the problem (problematic conduct) and that they also agree to carry out the political functions necessary to correct this, i.e. they will transform their behaviours into unproblematic conduct (Crossley, 1993). A yearly review of the Nursing Directorate's Compassion in Practice Strategy notes that *"compassion is recognised by nurses as a value"* (DOH, 2013, p. 3). This indicates that compassion is understood as being a trait, characteristic of nurses.

This type of discourse emergent from the nursing profession further implies the responsibilisation of nurses (Rose *et al.,* 2006). The initiation of the compassion in practice (CIP) strategy (2012), alongside the requirement for overall culture change across the NHS essentially presents compassion as a cost-neutral solution (Tierney, Bivins, & Seers, 2018). This implies that existing staff can be managed through the embedding of the strategy, and any aspiring nurses' *values* can be developed through education. On the other hand, this also underlines the dynamic nature of power and the ability of individuals within the nursing profession to interpret and act to transform existing structures (Fairclough, 2015). The CIP strategy, however, also presented the broader ideals for nursing practice

[27] The compassion in practice strategy (2012c) was developed and co-authored by Professor Jane Cummings, the CNO for England (and also the Executive Director at NHS England) at the time, and Viv Bennet, the Director of Nursing Department of Health and Lead Nurse.

generally, which enabled the translation of political rationality into something that could be initiated on a practical level.

The CIP strategy (2012c) demonstrates the programmatic nature of governmentality, as discussed by Rose and Miller (1992), as presupposing that *"the real is programmable"* (Rose & Miller, 1992, p. 183). It does this by presenting evidence which assumes individuals can be governed effectively through the implementation of this intervention. Moreover, the legitimacy of its authors (Chief Nursing Officer and Lead Nurse for England) allowed for the document to *"lay claim to a specific knowledge of the problem to be addressed"* (Rose & Miller, 1992, p. 183). This enabled the presentation of an alternative solution, from within the nursing profession, which promised to achieve the practical rationalities of government.

The use of experts as authors, in the assembly of the CIP strategy, was both an advantage and a problem for the political authority. Knowledge and the legitimacy of knowledge is important within a governmentality study as it demonstrates how, in developing programmes, the government seeks to exercise power over the group to be governed (Rose, O'Malley & Valverde, 2006). Experts play a critical role in legitimising the power of government, yet, also have the capacity to generate *"relatively bounded locales or types of judgment within which their power and authority is concentrated, intensified and defended"* (Rose & Miller, 1992, p. 188). Hence, by means of expertise, executive-level nurses are in a position to instil, within those they seek to govern, self-regulating tendencies. Experts utilise their influence to align themselves and their choices (and by

inference, the nursing profession) with the aspirations of government. This allows the political power to operationalise their programmes by allying themselves with professions they may not have direct control over.

However, as noted by Rose *et al.* (2006), the different ways of directing and managing behaviour may well have different objectives and do not arise from a single body or authority. However, the potential gain or loss of funding is a forceful incentive employed by government: *"The continued supply of financial resources is conditional upon the conviction that an alignment of interests exists, that the local authorities, firms and so on will remain more or less faithful allies"* (Rose & Miller, 1992, p. 189). This ensures that government concerns/problems continue to be addressed and that any suggested strategies are mutual and can be translated.

Government programmes can only be achieved through the application of the appropriate mechanisms or technologies of government. Political technologies include *"methods of examination and evaluation and assessment; the standardisation of systems for training and the inculcation of habits and the inauguration of professional specialisms and vocabularies"* (Lemke, 2012, p. 30; *see also* Miller & Rose, 2008; Inda, 2005; Rose & Miller, 1992). The following section outlines the inferred technologies of the (then) coalition government.

5.2.3 Responsibility was Shifted

The election of the coalition government in 2010 focussed on a number of strategic reforms to the healthcare system, underpinned by commitment to a

programme of austerity, restructuring, and increased competition of market forces (Pownall, 2013). The mechanisms employed within this programme sought to shape, through the assemblage of different agencies, the conduct, decisions, thoughts, actions, and aspirations of those individuals to be governed (Lemke, 2012).

Failings in care at Mid-Staffordshire Hospitals (see Appendix 4) took place amidst a major economic recession. The 2010 spending review (HM Treasury, 2010) reveals the government's adoption of measures aimed at making savings across a number of public services; the NHS being required at that time to make efficiency savings of £20 *billion*. This led to the implementation of austerity measures at workplace level and a reduction in the scale of the public sector workforce in order to make the necessary savings (Pownall, 2013; *see* ONS Statistical Bulletin, 2012). In addition, the government's amending of the Health and Social Care Act (2012) led to the decentralisation of services, giving local providers more control over spending. The aim of this was to place responsibility for driving up the quality of care locally (DOH, 2012b). This tactic reduced the government's accountability for improving standards of care. The decreasing role of government in the state economy is a classic strategy of government and central to Foucault's (1979) understanding of power (Boas & Gans-Morse, 2009).

Governmentality is founded on the principle that such tactics offer a pragmatic solution, justified in terms of expanding individual freedom (McKinlay & Pezet, 2018; Pyysiäinen *et al.,* 2017). Furthermore, this also allows for certain individuals to be targeted for specific types of intervention – the impact of which can be

evaluated, costed, and contested (Foucault, 1980). Therefore, improvements to standards of care become less about the direct provision of services by government and more about *how* individuals within the healthcare organisation become increasingly responsible for the fate of the organisation (McKinlay & Pezet, 2018).

Prior to the events at Mid-Staffordshire, the narrative of the Conservative Party (2005) had focussed on fragmenting the healthcare workforce and increasing competition by expanding the number of private and voluntary care providers. This was presented, at the time, as a positive change that would allow public sector workers to become more mobile and potentially command higher salaries within the private sector (Pownall, 2013). It was also noted that patient satisfaction would be the key indicator of improved standards of care.

However, a reduction in the number of public sector frontline staff, coupled with significant efficiency targets, undoubtedly posed an additional organisational burden. This rationality undermined the recommendations made by Francis (2010, 2013) to improve standards of care. For example, Francis (2013) noted that inadequate staffing levels had resulted in an inadequate standard of nursing and that *"Staff did report many incidents which occurred because of short staffing"* (p. 45). This suggested that the appropriate number and mix of clinical staff was vital to providing high-quality safe patient care.

5.2.4 Compassion was Mandated

Shortly after the Francis report, compassion began being referred to by scholars as a *valuable commodity* that *can be taught* (Kelley & Kelley, 2013), and in the Government's mandate[28] to NHS Health Education England, Dan Poulter (the Minister at the time) begins by describing compassionate care as *"dependent on the quality of training and education of staff"* (DOH, 2015a, p.1). By implying that compassion is 'teachable' and 'measurable' in relation to educational assessment in healthcare, this policy suggested that the responsibility for improving the quality of services lay outside of State control. This made it necessary for compassion to become quantifiable for the purposes of evaluating and examining aspiring nurses and students.

From that point forward, nursing students were required to have their values and behaviours of compassion assessed. Yet, the DOH (2013c) referred to compassion as *"difficult to describe"* and a "*force within you", "an emotional energy"* (p. 8). Academics cautioned the difficulty of putting these "more abstract *ideas [compassion] promoted in the Francis inquiry"* into practice (Holmes, 2013, p. 522). Regardless, at organisational level and/or within local Trusts' vision/mission statements comments like, *"It is part of our humanity to desire to be compassionate"* (organisation blinded) were being made. Counter (academic) discourses also presented evidence with which to challenge the idea that compassion could be easily assessed. At the same time, however, these

[28] A Mandate from the Government to the Health Education England (2013) 'Delivering high quality, effective, compassionate care: Developing the Right People with the Right Skills and the Right Values'.

scholarly discourses were also pushing forward the need for knowledge of compassion to be increased by emphasising the importance of compassion in healthcare more broadly.

The introduction of frameworks (providing payments to local providers) for improving the quality and experience of care[29], and the integration of care metrics into the regulatory processes of the CQC, increased the need for compassion to be measurable and knowable. Compassion as an object of possible knowledge then became much more complicated as it (compassion) diffuses into other disciplines, such as economics and pedagogy. This would mean that additional funding is required to support the development of knowledge of compassion with which to transform healthcare education systems accordingly.

5.2.5 Quality Care & Patient Experience

There is a notable sub-theme of *patient experience* interrelated with the *quality of care* across the documents selected for analysis. This was initially made visible in the government's commitment to quality care within the reformed NHS constitution (2015). This involved getting *"the basics of quality of care – safety, effectiveness and patient experience – right every time"* (NHS England, 2015, p. 5). It suggests that this can be achieved by ensuring compassion is central to the care provided:

[29] The commissioning for quality and innovation (CQUIN) framework was first introduced in 2009/2010 as a national framework for locally agreed quality improvement schemes. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals (see RCPSYCH, 2022).

> ***We*** *ensure that* ***compassion*** *is central to the* ***care we*** *provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.* ***We*** *search for the things* ***we*** *can do, however small, to give comfort and relieve suffering.* ***We*** *find time for patients, their families and carers, as well as those* ***we*** *work alongside.* ***We*** *do not wait to be asked, because* ***we care****.*
>
> - NHS Constitution (2015, p. 5)

"The quality of the experience undergone by patients" is stated in the Health & Social Care Act (2012, *c*7, p. 19) as an indicator for improvement. Although accountability for improving the quality of services may be thought to rest with the Secretary of State, the repeated use of the word 'we' presents this as a commitment of every person working in the NHS. The author here is speaking on behalf of itself, and its readers who are all involved in health***care*** practice. In doing so, the writer is making an authority claim – they have the authority to speak for others (Fairclough, 2015). The government's commitment here may be more apparent than real, given that, in reality, improving quality (through the provision of compassionate care) is made *real* through the actions of individuals working on the front line; particularly since frontline workers are the people who come into contact with patients on a day-to-day basis. The use of the word 'we' could be viewed as a tactic that underpins the coalition government's commitment to neoliberal values, which are realised through policy aimed at economic reform and a tight control (by government) on state spending (Boas & Gans-Morse, 2009). The government agenda for reforming the NHS with an alternate programme of restructuring could be understood to have orchestrated a neoliberal framework. For instance, the responsiveness to patients' needs at a

local level removed direct state accountability for improving services. The latter is reflected in the wider research and/or policy in which compassion is presented as key to improving the quality of care, patient safety, and patient experience. Using the word ‘we’ in relation to compassionate care delivery, compassion as an indicator of quality improvement has become dependent on the behaviour of the workforce rather than increased state expenditure *per se*.

In the examples provided, connections can be observed across the documents, between political rationalities and programmatic solutions, beginning with the problematisation of nurses’ conduct, which was made *real* through various fields of discourse (political, professional, and academic). Nurses were presented to lack compassion, therefore, the perceived ‘compassion deficit in nursing’ could be rationalised as being a problem specific to the nursing profession. This made compassion open to intervention and susceptible to a set of mechanisms (linguistic and political technologies), which allowed the problem of nurses’ conduct to be acted upon (Miller & Rose, 1992). The responsibilisation of nurses via the CIP strategy (DOH, 2012c) and changes to the NMC (2015, 2018) code reinforced the idea that compassion delivered through individual conduct, and rectifiable through governance. HEE’s subsequent mandate on compassion made compassion ‘thinkable’ as a possible object of knowledge, which provided those in authority (NHS managers and higher education institutions) with the capacity to define, monitor, and assess the nursing population. Additionally, care reforms provided a sense of organisational freedom and greater individual choice (McKinlay & Pezet, 2018). However, this freedom was superficial in the sense

that these changes shifted responsibility for improving care standards to the individuals and the organisations in which they are employed (Pyysiäinen, Halpin & Guilfoyle, 2017). These reforms may be viewed as reflecting the contemporary *"arts of governing"* as ways of *"arranging things so that this or that end may be achieved through a certain number of means*" (Foucault, 2007/1977-1978, p. 99).

5.2.4.1 Summary

This analysis has opened up a way of thinking about compassion in relation to how it has been discursively constructed. The achieved outcome was the *responsibilisation* of the nursing profession as a group, and individual practitioners, to perform compassion within a legislative framework which functions using punitive measures to regulate elements of social and economic life *"at a distance"* (Miller & Rose, 1990, p. 186). What has been achieved from these programmes of government is the establishment of a standard norm. This means that individuals must measure up to a certain level, and those who are unable to reach the set level may be regarded as 'abnormal', i.e. not compassionate (Brivot & Gendron, 2011). A student nurse may be failed if they do not demonstrate compassion at the level believed to be necessary by the organisations who judge their performance. Nurses may be required to answer to the NMC if their conduct is judged to deviate from that prescribed within the professional code of conduct (NMC, 2015, 2017). Individuals therefore become both a *target* and *product* (my italics) of the normalisation process, as they strive to be seen as 'normal' and fear being viewed as 'abnormal', which may potentially result in their effort(s) to modify their professional identity. This attempt to

normalise behaviour(s) is recognised as a strategic technology of government (Brockling *et al.,* 2011) which solidifies the notion that, through disciplinary power, individuals can be assembled into manageable, measurable, and transformable subjects (Brivot & Gendron, 2011).

5.3 Meso-level Discourse

The previous sections have outlined the macro-level external influences in relation to compassion in healthcare. In this section, an analysis of the messages and statements, and reports communicated by (and about) the local health authority[30] (referred to from now on as 'Trust') has permitted the issues discussed in the previous section to be explored at the meso-level.

Similar to the national literature on compassion, the term *compassionate care* was discerned to be interrelated with quality and patient experience. The emergence of discourse of compassion as an expected form of conduct can be seen in within the Trust's values; compassion presented as *"a behaviour that everyone is expected to live and breathe"*. A CQC (2020) inspection report noted one area of the Trust as being good at caring because *"Staff treated patients with compassion and kindness"*. Yet, in other areas patient feedback had suggested that staff did not always behave compassionately, and patients were not treated with dignity and respect. The same report commented negatively in relation to

[30] To preserve the anonymity of the study site and participants, local documents used in the analysis are described but have not been formally referenced.

the lack of *“suitably qualified, competent, skilled and experienced staff, and how this had impacted on quality and safety of care”*.

The difference in expected and observed conduct indicates the interplay between the guidance provided by others and forms of self-conduct. This was conceptualised as a rationality of government, in which nurses’ conduct has been regarded as part of the problem and also the solution to improving the *quality* and *safety* of patient care. These examples demonstrate the importance (for local authorities) in implementing strategies which align with discourses that legitimise government policy. Moreover, they reflect the framework devised through government reforms (previously noted), which relies on the responsiveness to patients’ needs at a local level.

These discourses were framed within the themes of responsibility and duty. Improving care is presented to nurses as an obligation, *“staff are responsible for delivering high standards of care and working to improve the quality of care they provide”* (organisation blinded). There was also the explicit threat of being removed from the practice register if they nurses fail to *“treat people with kindness, respect, and compassion”* (NMC, 2018, p. 6). This created a psychological threat as a certain degree of individual security is provided through employment, with the risk of loss of earnings if individuals do not comply with their social and professional responsibilities. But what did this discourse set out to achieve?

This discourse clearly legitimised the notion of compassion as essential to the individual behaviours and actions of the nurse. It also built on the notion of nursing as ethical vocation with strict moral principles. The ideal nurse was presented as possessing the personal capabilities with which to drive improvements to the quality of care and, by association, the NHS (DOH, 2008). It is also implied across the local media (including advertisements for recruitment) that personal and organisational priorities were in alignment, which was not necessarily the case. To ascertain whether this was indeed correct, one would need to question *why* individuals joined the nursing profession.

Clearly, some NHS Trusts recognised the CIP strategy within local policy, by acknowledging the need for compassion as a form of conduct. Examples of privacy, dignity, and compassionate care policies can be identified, in which compassion has been constructed as a "*fundamental right for all patients and carers"* (organisation blinded). Equally, there is an acceptance that nurses are responsible for compassion, and that compassion is something nurses consider a professional duty. This is realised by the idea that teams and individuals could be recognised for compassionate practice using initiatives, for example, the Dr Kate Granger awards for compassionate care (NHS England, 2014)[31].

The analysis presented here demonstrates the multiple yet delicate connections between the aspirations of the government, organisations, and the lives of individuals. This has enabled some insight into *how*, apparently mundane

[31] These awards are named after Dr Kate Granger and were launched in 2014 to recognise people and organisations that have delivered care with compassion at its heart.

programmes, documents and procedures (through which multiple authorities have presented the concept of compassion) have given effect to governmental ambition (Rose & Miller, 1992*).* As explained by Miller and Rose (1990), 'technologies of government' are a set of heterogenous domains that bring together 'representations' of that which is to be governed, through an active, process. The concept of compassion became a rhetorical mechanism, disseminated through healthcare policy, in which compassion was constructed as a responsibility (and encouraged as a duty), necessary to perform to provide quality care.

Whilst these examples highlight that government ideology was successfully disseminated through policy, it is unclear to what extent this translated into the everyday practice of nurses. The extent to which compassion policy was internalised by nurses (specifically in the context of mental health care) cannot be established from the documents that have been studied thus far. It is necessary, therefore, to explore the methods and techniques through which nurses constitute, develop, and maintain their professional identity. In other words, the degree to which nursing identity is influenced by individual agency, as well as organisational and societal structures (de Fina, Schiffrin & Bamberg, 2006). Furthermore, it has not been possible to determine the impact of the introduction of compassion policy on patients' experiences of care or understand how patients (with lived experience of mental health) conceptualise compassion. Therefore, nurses' views on compassion have been explored (chapter 6), as well patients' construction of compassion (chapter 7). The aim of this was to meet

objectives two and three (see chapter 3, section 3.9) of this research in the context of mental health.

5.4 Summary of Key Points

This chapter has presented an analysis of national and local healthcare policy and professional documents with the aim of unpicking a complex web of discursive constructions of compassion. Adopting a framework based on Foucault's concept of governmentality, a critical appraisal has been provided, as per the key theoretical notions provided by Miller and Rose (1990) *and* Rose and Miller (1992). As suggested by Reich and Turnbull (2018), the links between social, organisational, and professional fields of discourse have been explored, illustrating the rationalities, technologies, and programmes of government that are inferred to have led to the current programme of compassion in healthcare.

The discourses analysed at national and local level appear to share a common theme, which is the idea that nurses' conduct was problematic (and is problematic if they do not perform compassion). Both discourses articulate the problem of conduct in specific ways, such that it could become programmed. For instance, compassion was presented in policy as a way of solving the problem of a perceived 'compassion deficit' in nursing, with strategies being described in detail to make the solution 'compassionate care' capable of being realised. While the national discourse(s) rationalised compassion as a solution, the local discourse(s) set out to operationalise this by encouraging values and behaviours

that were intended to shape conduct. In terms of power and regulation (control of conduct), these discourses suggested empowerment through professional self-regulation. However, this exposes ‘the self’ to scrutiny through the processes that have been put into place, processes that work through constant surveillance of behaviour.

The UK government’s presentation of compassion demanded certain behaviours and values be performed by nurses, which may be far removed from the reality of the over-stretched environments nurses work within. As such, the potential for normalising judgements from colleagues, patients, and carers is made possible. Given the highly complex, subjective nature of the identification of *compassion* – noted within the scholarly debate - such judgements may be felt as erroneous at the individual level.

The next two chapters are concerned with the effects of the programme of compassion within the current political regime, e.g. how nurses and patients construct compassion. Using a critical discourse method, the following chapter illustrates how mental health nurses discursively constructed compassion, including what they believe constitutes compassionate care and how this is understood to be achieved in practice.

Chapter 6: Results from Interviews with Mental Health Nurses

6.1 Introduction

In the previous chapter, I presented an analysis of macro- and meso-level healthcare policy documents. The analysis showed how political thought had focussed on creating a programme of compassion in healthcare, whereby compassion has been constructed as a duty and individual responsibility for all healthcare professionals. However, the socio-political rhetoric at the time was pejorative, and specifically aimed at the nursing profession. The extent to which the political construction of compassion as a 'duty to be performed' may have been internalised by nurses, or, indeed, taken up by nurses in their everyday practice, was not possible to discern from the document analysis. Therefore, to understand how this policy discourse has influenced 'specifically' mental health nurses' sense of professional identity, it was necessary to engage directly with mental health nurses to explore how they individually/collectively discursively construct compassion. This was achieved by conducting semi-structured interviews.

The current chapter[32] will present the findings from telephone interviews, which sought to explore how mental health nurses (also referred to as nurse-participants) discursively construct notions of compassion and notions of themselves as compassionate practitioners. This fills a gap in the academic literature (presented

[32] A significant part of this chapter has undergone full peer review and is published as a paper (Bond, Hui, Timmons & Charles, 2022. Mental Health Nurses' Constructions of Compassion: A discourse analysis. *International Journal of Mental Health Nursing.)*

in chapter 2) and provides the basis for understanding compassion (in nursing) within a governmentality conceptual framework (see chapter 3).

6.1.1 Participants, Materials, and Approach to Data Collection

Seven (*n* = 7) nurse-participants were recruited for this phase of the research. In addition to demographic information, shown in Table 5, the interview schedule included three key open-ended questions which intended to explore nurse-participants' views and experiences pertaining to compassion in their everyday practice. These were: *'What are your thoughts about compassion in the context of mental health care?'*; *'How do you consider yourself to be a compassionate practitioner?'*; and *'What do you think about compassion policy?'*. Follow-up questions were asked to affirm thinking, clarify points, or request that participants develop their answer.

Table 5: Nurse-participant characteristics

General characteristics	All participants (*n* = 7)
Gender	
Male	2
Female	5
Number of years post-registration	
1-4	3
5-10	3
10-20	-
20 +	1

Area of practice	
Ward Based (WB)	2
Community Based (CB)	4
Specialist Nurse Psychotherapist (SNP)	1

Interviews (telephone) were audio recorded and transcribed verbatim. Before the interview recording started, the aims of the research, and the processes involved in the collection and storage of data were explained. Reassurances were provided about confidentiality and the anonymisation of data. Participants were given the opportunity to ask questions before providing informed consent. The purpose of this approach was to make participants feel comfortable during the interview so that it could continue in a conversational style. Interviews lasted between 35 and 90 minutes.

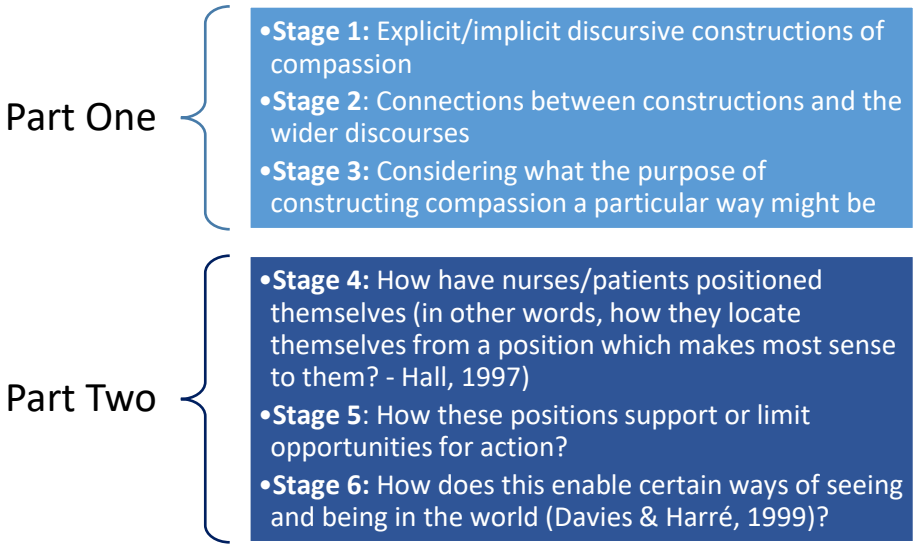
6.1.2 Presentation of Results

My intention for the current chapter is to demonstrate how critical discourse analysis can further our understanding of compassion in the mental health practice setting. As outlined in chapter 4, as a methodological approach CDA allows the examination of the constitutive role that discourse plays in the contemporary social world by underlining the links between discursive and other social practices (Wodak & Meyer, 2009).

Unlike other discourse analytical methods, CDA does not reduce everything down to discourse, rather it enables us to understand the role of discursive practices in

the statements made by social actors (mental health nurses). In the current chapter, mental health nurses' discourse signifies the 'micro' dimensions of society. These microstructures allow the analyst to observe how abstract structures (found in the macrosocial dimensions of society) are expressed locally in the social practice of discourse, and in the specific context of mental health.

The following results have been guided by a Foucauldian-inspired discourse method, as prescribed by Willig's (2008a) conceptual framework. This can be found in Chapter 4, section 4.5.3. Willig's (2008a) framework is useful in elucidating discursive accounts and experiences, prompting the analyst to compare and contrast participant accounts, and encouraging comparison with the wider discourses on compassion. The remainder of this chapter has therefore been organised in two parts, as follows. Part one presents the data according to stages 1 to 3 of Willig's (2008a) framework and part two presents the data according to stages 4 to 6 of the framework. Chapter 7, which presents the data from interviews with patients, has also been organised into two parts.



At this point, it is worth referring to pages 96 to 105 of chapter 4, where I make clear the approach taken by many discourse analysts when presenting CDA and when using Willig's (2008a) framework. It is also worth emphasising that the main intention of CDA is to work abductively to understand how language is utilised in the exercise of power. This is a form of reasoning whereby conclusions are probable and based upon the information that is known. Wodak (2004) recommends that working abductively should involve a necessary *"constant movement back and forth between theory and empirical data"* (p. 200). A simplified view of this approach in CDA research is provided in Figure 6.

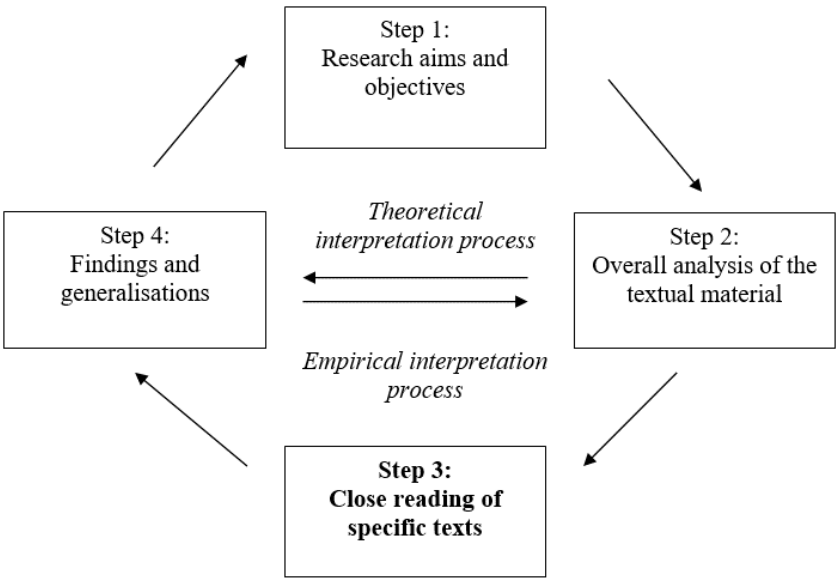


Figure 6: CDA as Abduction (adapted from Vaara & Tienari, 2004)

Typically, discourse analysts adhere to the use of description, interpretation, explanation, and analysis. The application of stages one of Willig's (2008a)

conceptual framework may appear somewhat descriptive, as the analyst begins by simply noting ‘how’ the object of the discussion (compassion) is being constructed by participants. This is necessary to first establish how participants individually and collective talk about compassion before any of the abductive, analytical, work can be done.

Part One

6.2 Discursive Constructions, Discourse, and Action

The interviews with mental health nurses revealed that compassion is constructed as an inherent and natural part of the person. Individual and collective accounts demonstrate that compassion is viewed as necessary to 'do' the job of a mental health nurse. Notions of compassion, as defined by nurse-participants, are depicted in Figure 7.

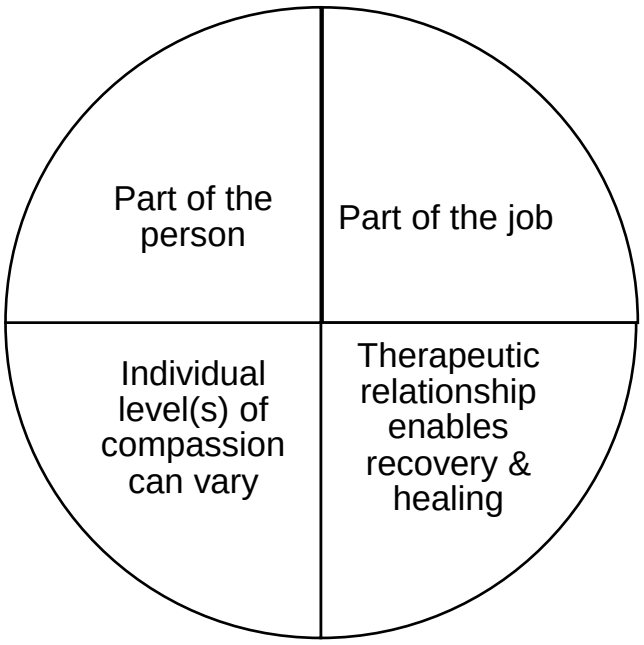


Figure 7: Mental health nurses' discursive constructions of compassion

The following sections summarise how mental health nurses discursively constructed compassion, what discourses are underpinning these quotes, and how they connect with the concepts in the literature.

6.2.1 Inherent to the Individual Person

It was apparent that at the very beginning of the interviews with mental health nurses, compassion was difficult to describe. When asked to communicate how they identified compassion in the context of mental health care, this question was met with hesitancy and long pauses before answering.

> *"Until you sit down and think about what compassion is, it's quite difficult to describe it"* (George – WB)

> *"It is quite difficult to explain it when you're asked it"* (Megan - CB)

After having some time to think, participants clearly identified compassion as an 'inherent' individual trait. This notion of compassion as an inherent trait was noted to be subsumed within the majority of participants' quotes.

> *"I think it just comes natural to be quite honest"* (Alison - WB)

> *"Definitely I just think it is just something that comes naturally, yeah. It is intertwined with all the other things that I do"* (Kelly - CB)

Compassion was considered as 'intrinsic' to the person, and inherent to an individual. Compassion was also felt to be an emotional response, inherent to the person. A compassionate person was understood as someone who seeks to

understand another person, and in the context of the nursing role, to understand distress.

> *"I express compassion, I feel it, it's a feeling"* (Joanne – CB)

> *"To try and understand their (patients) distress and trying to feel for them and having a desire to try and alleviate that distress with them. To be aware of other people's distress and try and have an internal desire to [pause] stop that distress"* (Alison – WB)

Compassion in mental health nursing was constructed as a feeling and intention to seek to understand the source of another person's distress, and to relieve distress. Compassion was clearly characterised as a human concept.

6.2.1.1 Perceived Variations of Individual Compassion

Rooted in the data were descriptions of variations to the personal qualities of each individual nurses and, regarding compassion, these variations influenced how they believed their colleagues might appraise them – or indeed how they perceived themselves comparative to others.

> *"I do think environment plays a key part, but in terms of compassion it is personality, you know, 'are you a compassionate person in general', 'what are your standards of care'?"* (Kelly – CB)

> *"I think everyone practises in their own way, I guess, I think everyone practises in a way that's different to others… there are others who maybe compassion comes a bit more easily to them and then I think there are others where compassion doesn't really. It is just what I've witnessed looking at people from the outside, so I think there is a whole spectrum, but I think that just perhaps represents, [pause] people are different and erm, people's situations are different at different times. Erm, yeah so, I do think that I'm different, but I think*

everyone is different if you know what I mean?" (Ryan – CB)

"I think I do kind of operate a little bit differently to my colleagues...I think for me I probably show it (compassion) a little bit more than others" (Joanne – CB)

These quotes suggest the idea of the compassion being on a continuum and influenced by personal differences. However, there was no suggestion that these differences were equated with morality, religiosity, or spirituality, and at no time did any participants refer to these as potential facilitators of compassion. In the second quote above, the appraisal of the compassion of others is constructed according to the externally observable behaviour of others. There was a perceived variation in individual levels of compassion, and it was implied that compassion was different in mental health nursing.

"We're not fitting catheters….so, not only have I got it [compassion] intrinsically, but I've also modelled myself on senior nurses' role models that clearly fit with my own sense of self and my values" (Erin – SNP)

"I think there is a different expectation from a general nurse to a mental health nurse. We are expected to contain distress and compassion is at the core of that" (Joanne – CB)

Within mental health, the environment may also influence compassion, e.g. community, inpatient, or secure services, yet perceived individual levels of compassion were fundamentally associated with personal qualities and/or personality traits. This suggests that the act of being compassionate is not coincidental but involves personal choice. In terms of restrictive practices participants also noted that there were individual differences in the way these

practices were *'delivered by individual workers'* and that this was where there was a disparity in how compassion is 'done'. These differing perceptions may call into question the ethical foundation of the actions of some nurses, which could lead to a division among mental health nurses whereby nurses position themselves against one another as normal 'compassionate' or abnormal 'not compassionate' (Foucault, 1975).

In the context of mental health nursing, it was important that nurses had time with patients, to get to know and understand the context of peoples' mental health difficulties. In this sense, a distinguishing feature of compassion was rooted in the nurse's authenticity or genuineness, and this was believed to be easily recognised by patients.

> *"I think we can demonstrate it [compassion] and we have to demonstrate it overtly erm….I think clients know, clients will say to me I know I can tell you anything and that it is safe. So, clients know, clients will perceive, especially clients who have had early abuse they will read your face, your tone of voice your nonverbals"* (Erin – SNP)

> *"I do think people know when you're doing it [compassion] because it is your job, or you're doing it because you genuinely care"* (Alison – WB)

There was a sense that authenticity could be demonstrated by doing the 'real' work (on the frontline) with patients on a day-to-day basis. This meant a long-term commitment to facilitating the continuity of care in mental health.

> *"I think in that sense it [compassion] needs to find a balance of going back to basics really. People embracing the job more, I think it that would help erm [pause] service users as well…someone who is there*

and you (patient) genuinely think wants to be there and they (nurse) are not thinking about progression at the forefront" (Ryan- WB)

"What I do see now is that student nurses they want be ward managers within two years, you know and they want to be a director within three [laugh] and I think….well make some bloody beds first" (Erin – SNP)

The above quote implies a culture where student nurses are regarded to be obliged to spend time doing what is perceived as the 'real' work before they could be considered ready, or able to, progress in their career. Most participants referred to themselves as compassionate, in comparison to other nurses (colleagues), in terms of their level(s) of compassion and personality traits that were perceived to be linked to compassion. These differences serve to locate members of the same profession as belonging to distinct subcategories (more or less compassionate). According to Davies and Harré (1990), positioning the self as belonging to a certain group *"entails an emotional commitment to the category membership and the development of a moral system organised around the belonging"* (p. 47) and learning the categories that include some people and exclude others. This could indicate that there is a need for aspiring and established mental health nurses to carefully consider the various areas of mental health practice, and the range of ways of working in these diverse contexts; and to think carefully about the categories which they ascribe to themselves. Otherwise, contradictory views may become problematic and difficult to reconcile (Davies & Harré, 1990), and may ultimately become a source of tension in teams.

6.2.2 Professional Self & Clinical Skills

Most participants spoke about compassion as an inherent trait, and part of who they were as a person. They found it difficult to separate the idea of the personal self (as compassionate) from the professional self (as compassionate practitioner).

> *"I don't think there's much separation between me as a practitioner and me as a person really. I hope I'm just being me when I'm being a nurse erm, so in a sense, I know compassion is that considered to be one of the cornerstones of nursing, I think I can't really be a compassionate practitioner without being a compassionate person"* (George – CB)

> *"Really difficult…to articulate just as you are as a person is really difficult…I think it is at the core of my practice, you know, compassion is something that 'you have', otherwise you probably wouldn't go into this job….I don't think it is something that I need to be told to do or learn, it is just something, that's how I am. That's why I came into this job, because I am sympathetic to people with mental health problems, and I wanted to help people"* (Alison – WB)

> *"It (compassion) is a large part of the job, which is essentially getting to know a person and building that therapeutic relationship*[33] *with them"* (Megan – CB)

The interconnection between personal and professional self may have been the reason why compassion was difficult to immediately define (at the start of the interview). Participants reported feeling that compassion was integral to the professional identity of mental health nurses. Compassion was a major driver for participants and underpinned their desire to become a mental health nurse.

[33] The TR, or therapeutic alliance, refers to the relationship between a nurse and a patient. It is how a nurse and a patient engage with each other, with the hope of bringing about a beneficial change in the patient (Bordin, 1979)

> *"I am compassionate, if I wasn't I would be working in banking or something…I wouldn't be doing this job"* (Erin – SNP)

> *"I think it (compassion) is deep seated within and you've either got it or you've not. And I don't believe that anybody - and this is very opinionated - but I don't think that anyone should be in the healthcare profession if they haven't got compassion"* (Joanne – CB)

> *"I just felt like I don't really get it, care, compassion, courage, erm, commitment you know all these personal qualities, which are so connected to the person rather than to the profession"* (Ryan – CB)

Mental health nurses' construction of compassion as inherently human, consciously manifested through human-human connection is supported by contemporary research, which also suggests nurses (in physical, general, health fields) feel they embody compassion in their clinical practice (Durkin *et al.,* 2019). This also aligns with the way in which, through their training, aspiring mental health nurses are encouraged to recognise 'the self' as a conduit for hope and recovery in mental health (Freshwater, 2002; McAllister *et al.,* 2019; Summers, 2013). Why then, does compassion need to be regulated by State? In part five of *Disciple and Punish*, and in his examination of the means of correct training, Foucault (1975) notes:

> *"The success of disciplinary power derives no doubt from the use of simple instruments, hierarchical observations, normalising judgments and their combination in a procedure that is specific to it, the examination"*
>
> - p. 170

The idea here is that those who are undergoing training (student nurses) need to be watched and, therefore, the architecture must be changed such that it allows evaluations of the person to be made. Those who are positioned to appraise student nurses (mentors and/or academics) according to the architecture or tool(s) in place (such as, CIP strategy, 2012c; NMC Code of Conduct, 2017), are therefore in a position of power, such that they can remove those who are considered 'abnormal' (lacking compassion) – using the available tools to justify the removal of those deemed 'abnormal'. It is through this differentiation of behaviours that individual nurses and/or student nurses are made to feel the same or different. Hence, each institution creates their own set of norms through the student examination. This interpretation would suggest that nurses have been subjected to techniques of 'correction' through what Foucault (1975) argues is the most insidious form of discipline, in that much of the work of power is then done internally, by ourselves and to ourselves.

6.2.2.1 'Therapeutic Relationship' and the Compassionate Self

Evident within the data was how technologies of the self (Foucault, 1988a/1978), for example, nurse education and training, had become central to transforming the self to the perceive oneself as 'professional'. Core to this transformation was the development of the notion of the therapeutic self, which was considered core to delivering compassionate care.

Seeking to understand the source of a patient's distress was viewed as essential to the mental health nursing role. This was achieved by building a rapport with

someone (patient), engaging therapeutically; getting to know someone. This core element of the mental health nurses' role was said to be essential to patients' recovery. For episodes of care, and interactions with patients, to be compassionate meaningful engagement was necessary (nurse-patient). Nurse-patient engagement was discussed as central to the delivery of compassionate care.

> *"It is mainly the therapeutic relationship that fosters trust, and compassion. Erm because you are key to recovery really… it is not going to be the sole cure, but it is definitely the route to success, making some changes you know, if it is medication that people need then you need a trusting therapeutic relationship that demonstrates compassion"* (Alison – WB)

> *"You have got to kind of help them (patient) to reflect. It might be painful sometimes, but we have got to tolerate that discomfort and yes, sometimes, obviously it is about helping people feel better, feel calmer, self-soothing, but we might also have to have some difficult conversations and we need to be able to tolerate that"* (Erin – SNP)

However, in the context of mental health, recognising and responding to psychological distress was not seen as straightforward. Therapeutic engagement was facilitated by the unidirectional sharing of stories, whereby the mental health nurse listened, and could tolerate and contain distress. This was different from other kinds of professional nursing, for example, physical health nursing.

> *"I wouldn't expect that if I was admitted a general ward that there would be staff to talk to because I know how busy they are and….I think it is a different expectation from a general nurse to a mental health nurse, we should be more present, we should be more accessible it shouldn't be about sort of just coming to see you when you need procedures or when you need support with something, it should be about establishing a therapeutic relationship. That's what it should be about"* (Joanne – CB)

"I suppose in mental health I just think it is a lot more of an emotional kind of job role….. whereas the general side somebody will come in for a, I don't know, for a broken hip or something and you'll get the very basic story…and start the treatment whereas I think with mental health we delve a lot deeper, and the stories tend to be a lot more emotive …. and I think a lot of the time it can be a lot heavier on like the professional that is taking that information"" (Kelly – CB)

"I think sometimes distress can be very well hidden, but you know, as mental health nurses you kind of can learn to see [pause] there are some signs and symptoms that someone is in distress that's not physical pain, but sometimes you won't be able to see it but I think when you are working in an acute ward [pause] someone probably wouldn't be there if they weren't in some form of distress so, it is just working out how distressed" (Alison – WB)

While speaking with patients and 'being with' patients were considered vital to the development of the TR, there was also an understanding that the increased emotional labour (Jackson, Anderson, & Maben, 2021) in mental health nursing and the absorbing of patients' stories were psychologically and emotionally exhausting. This (exemplified in the above quotes) illustrates constructions that set out to delineate mental health nursing from other forms of nursing work. Nursing self-identity is the expression of a form of self-knowledge in which the individual reveals something about who they are, their role, what they think, and the context of their work (Rasmussen *et al.,* 2018). The principles of professional self as therapeutic self are core to the theory of mental health nurse education. For instance, Peplau (1952) viewed the nurse–client relationship as the way in which health and wellbeing were made 'possible'. This is reflected in contemporary nurse education, which is focussed on acknowledging the importance of the TR in

fostering life-sustaining, recovery-orientated, interpersonal relationships (Jackson-Blott *et al.,* 2019).

In the context of mental health nursing, compassion was a complex response to distress, involving understanding that some patients mask distress, or that distress was not always easy to determine. This confounded the identification of distress. However, generally, the role of the mental health nurse was to actively respond to distress and help alleviate that distress. Incorporated in all participants' constructions of compassion was the understanding that the ultimate goal of compassion in mental health nursing practice was the amelioration of psychological distress, achieved via the application of the TR.

6.2.2.2 Compassion and Person-centred Care

A second area that was discussed in terms of the professional self was the idea that all care should be person-centred. As previously defined by nurse-participants, compassion was viewed as inherent to the personal qualities of the individual. It was also considered to be at the heart of the delivery of a person-centred approach to care.

> *"I think it (compassion) is just something that comes naturally but mostly it is about making sure that care is person-centred"* (Megan – CB)

Mental health nurses stressed this throughout all the transcripts, and it was considered key to providing 'quality' care. Clearly, from mental health nurses' constructions of compassion, there is a profound version of the word 'compassion', which is (for them) highly relevant to the discipline of mental health nursing. The

interpersonal nature of mental health nursing practice meant that, for this group of nurses, the desire to enact compassion in their everyday practice was felt intensely and they all believed that they expressed compassion in terms of person-centred working. This is thought to improve experiences of care by enabling and empowering patients, with compassion at the core of this practice (Collins, 2014).

Mental health nurses' notions of compassion were referred to in terms of the drive for person-centric focus, and there was a desire to fulfil this within their roles. However, nurse-participants understood that person-centred approaches were not always easy to achieve, as mental health practice was perceived to be *'unnatural'* due to the power dynamics associated with psychiatry (restrictive practices). However, in the context of their professional roles, power was considered to have a useful purpose, which was to 'do things in people's best interest', manage risks, and keep people safe. Examples included detention under the Mental Health Act (2007/1983) and the use of physical restraint to administer prescribed medications.

6.2.3 Rejection of Compassion Policy

Most participants were not aware of the concept of compassion in nursing having become more prevalent over the last decade. Those who had qualified within the last ten years could recall compassion having been introduced during their nurse education but did not see their education and training as something that could equip them with it. When prompted to think about the notion of compassion policy and how policy fits with contemporary mental health nursing, most participants were resistive of there being a need for policy at all, either at national or local level.

"I don't need a policy to tell me to be compassionate....I mean yes there is a compassion policy, but good God unless that's intrinsic we are losing something here. The idea that you have even got to have a policy on it for me it is [laughs]" (Erin – SNP)

"I don't think any policy has made me act more compassionately because I think that is at the core of my practice, you know, compassion is something that 'you have' ….They (organisation) introduce a policy that says we've all got to do these things like, you know, reflections on where we have been compassionate; we are doing that (compassion), that is in us" (Alison – WB)

"Do I think about compassion because of the trust values? No [laughs], I think about them because erm, it is part of nursing and part of what I do essentially" (Megan – CB)

This discourse affirms that nurse-participants believed compassion was part of who they were as an individual. In attaching themselves to these beliefs about compassion (as inherent to the self), participants demonstrate how they have interacted with specific knowledge (mental health nursing) to internalise their understanding of compassion, which is exemplified through professional and clinical practices. This makes evident how a structured body of knowledge, associated with mental health nursing, has become central to the participants' discourse and how they construct compassion from within that discourse.

However, participants believed that nurses would gain employment based on their ability to demonstrate their values, including compassion. There was a firm expectation that student nurses (and experienced nurses) would have a strong commitment to the nursing role before thinking about career progression.

"There was a big drive, and it became in values-based interviewing erm, so we only allow people to obtain jobs in the trust if they can display values erm, and

that's how we interview as a trust, so I guess it (compassion) does underpin pretty much everything. All the questions are based on a person's values and hopefully that is a good measure, good measure of whether they are displaying the right amount of compassion for what we are looking for as a trust in a role. It would be the person who displayed the most compassion would get a role in nursing" (Joanne – CB)

"I talk about high standards and certainly as a mentor, I find it very difficult if I have got someone (student) who is displaying a difficulty in understanding people's stories, or not being able to empathise with them (patients) and they potentially have highly opinionated, responses when we do the reflection afterwards erm, and certainly for me I don't believe that you can teach compassion" (Kelly – CB)

As has been convincingly asserted by Maxwell (2017), government-endorsed initiatives such as values-based recruitment[34], which focus on the foregrounding of compassion, have led to the idea that compassion is a social expectation. This was made real through mental health nurses' discursive constructions of compassion. However, acceptance of the self as the one who has responsibility for enacting compassion, and improving care experiences, had consequences for mental health nurses' subjective experiences.

On one hand there was a sense of validation of the self as a functional therapeutic space, which may have been felt as professionally satisfying. Conversely, participants shared stories where organisational discourses and institutionalised practices inhibited compassion (to follow, in part 2). Mental health nurses' desire to fulfil what they perceived to be their duty as compassionate practitioners meant self-sacrifices and reliance on good will and individual kindness. For example,

[34] Values-based recruitment emerged as an approach in 2014.

when they were unable to enact compassion, due to time constraints, they used their own time to deliver compassion to patients. This created personal dissatisfaction with the organisation and, in some cases, disillusionment with the role. This reflects nurses' feeling of responsibility for patient care and experiences (including compassion).

Considering some of the previous responses to compassion policy, for example Cummings and Bennett (2012), a narrative of *responsibility* for compassion is therefore evident from within the nursing profession. This discourse, as constructed by nurse-participants, essentially reinforces the government rhetoric of compassion as a duty to be performed. Nurses may have felt this more intensely since they are the largest patient-facing professional group, and, in effect, have more face-to-face time with patients than other healthcare professionals.

Despite rejecting the idea of their conduct being controlled by government, the data uncovered clear discursive constructions of compassion as being distinct to the professional identity of mental health nurses. Along these lines, during the interviews (and when the question was framed in relation to their professional practice), mental health nurses were able to promptly provide answers which indicated that compassion underpins their practice.

> *"You always have to manage other people's emotional responses but not get draw into them. Compassion is a part of that"* (Kelly – CB)

> *"You just do it, in everything that you have to implement"* (George – WB)

> *"It's a principle that you have to adopt"* (Megan – CB)

Use of the words ‘have to’ implies that nurses feel they must employ a compassionate approach to their day-to-day practice – whether they wish to or not. Sharing their thoughts regarding how they considered themselves to be compassionate practitioners seemed to be easier for participants, and they intuitively seemed to be able to draw upon aspects of ‘the self’ associated with their professional role.

> *“In my role obviously I meet a lot of people in quite acute distress and it (compassion) is about being able to try and understand their distress and trying erm [pause] to feel for them and having a desire to try and alleviate that distress with them and [pause] erm, at times it can be difficult but you need that motivation to be caring and supporting and I think that if you don’t have that, you’re not gonna be able to continue to work with people in such acute distress”* (Alison – WB)

In this and previous examples, it is suggested that mental health nursing is underpinned by dimensions of the self that relate to nurses’ ethical character (Foucault, 1984). Conduct is framed around feelings, intentions, and desires grounded in their clinical practice and the desire to take action to alleviate distress.

Compassion is described as requiring motivation, which echoes the psychological literature where compassion is noted to be a mental proficiency involved in care giving – underpinned by an innate ‘motivation’ to care for others (Gilbert, 2017; see also Fogel, Melson & Mistry, 1986). This belief was communicated across the transcripts meaning a shared agreement was evident among mental health nurses that it would be difficult to be in the profession if individuals did not have ‘natural’ compassion.

6.2.4 Discursive Action: A Strategy of Positive Self-Presentation

It is apparent that relationships are exceptionally important in mental health nursing practice. The nurse–patient relationship is characteristic of effective recovery-oriented practice (Barron, Deery & Sloan, 2017). This practice is underpinned by use of 'the self' and the inherent traits, which nurse-participants spoke about as a conduit for developing therapeutic relationships. This is noted within the literature as the way in which mental health nurses build hope for recovery (McAllister *et al.,* 2019; Norman & Ryrie, 2013; Summers, 2013; Cleary & Dowling, 2009).

The notion of the 'nurse-patient' relationship has a history of being central to the way in which mental health nurses seek to actively support individuals to have positive mental health, and improve the quality of their lives (Bordin, 1979; Peplau, 1952). On the other hand, therapeutic working within mental health nursing is known to be emotionally demanding (Delgado *et al.,* 2020), which makes it difficult in terms of the recharacterisation of compassion, as per definitions in policy and professional literature, where the interpersonal has had increased focus (NMC, 2018; DOH, 2012a, 2012b, 2012c). Nevertheless, when constructing the professional self as compassionate practitioner, nurse-participants understood themselves as the embodiment of compassion. This discourse is underpinned by the philosophical foundations of mental health nursing (Norman & Ryrie, 2013; Peplau, 1952). By taking up this discourse it offers a sense of freedom from policy influence (Fairclough, 2015) as the concepts are associated with 'caring work' and 'therapeutic work'. Nursing work can be considered a vocational calling, and the act of caring a 'technology of the self' through which individuals who work in

healthcare have come to realise this calling (see Fejes & Nicoll, 2010). In this sense the body is seen as a self-determining ethical subject, with free choice to adopt and inhabit the *norms* within the cultural and societal rules of the mental health nursing profession (Allen, 2011; Wehrle, 2016).

What can be gained from constituting compassion as a natural, inherent aspect of the self? If compassion is not a product of social construction (as defined by participants), it cannot be removed from the body. This might enable nurses to take ownership of compassion, which challenges the power (and its effects) of political discourse on participants' capacity for action (Foucault, 2007/1977-1978). Perhaps this offers a sense of separation from other professional groups, while at the same time 'positively' positioning mental health nurses as a highly ethical group, which may lead to increased morale within the profession (Bond *et al.,* 2018). This suggests that the implementation of the government discourse on compassion does not represent a triumph of disciplinary power (Foucault, 1979). Rather, the compassion discourse may have enabled nurses to explore the 'professional self' from a new starting point and negotiate any ambivalence within their existing professional practices.

Part Two

6.3 Positioning, Practice, and Subjectivity

6.3.1 Discursive Positioning

As previously described, nurse-participants described their subjective experiences by discursively positioning themselves (Willig, 2008b) as the *'source'* of compassion, i.e. part of the person and the profession. Compassion was felt to be core to the therapeutic self, and the essence of nursing practice. This allows mental health nurses to attribute certain characteristics (compassion) to their role, strengthening their collective sense of professional identity.

This discourse may have a positive function for the mental health nursing profession as, in the past nurses have struggled to establish their professional identities (Morrall, 1998). It was not until 1919 and the introduction of the Nurses Registration Act that mental health nursing was viewed as a 'profession' in its own right (Stickley & Stacey, 2009). In addition, nursing generally has traditionally been shaped by a well-documented argument about medical dominance and discourses of nurses playing a *"handmaiden role"* to physicians (Buchanan-Barker & Barker, 2005, p. 541).

Despite commentaries that technological transformations and nurse education have shifted nursing away from the stereotypes (see Kalisch & Kalisch, 1987), Gill and Baker (2021) have convincingly demonstrated how the mass media continues to represent nursing, using ill-defined and outdated images that can negatively

impact public perceptions of nurses' professional identities. These images become socially ingrained, influencing individual and collective mental representations of a society's' members (Van Dijk, 2009).

Hence, media reporting post-Francis (2010, 2013) reinforces the suggestion (presented in chapter 5) that nurses were attacked, specifically by focusing primarily on presenting the apparent lack of compassion as situated 'locally' and 'internally'. Therefore, this allowed blame for care failures to be placed on individual nurses by drawing attention away from any organisational issues associated with the technocratic knowledge elites in society who ultimately have control over public spending (Larsson, 2020). This argument supports what Foucault (1980) contended, that knowledge and power are inseparable and deployed through a matrix of practical reason. However, as a response to suffering, if compassion is understood to be engendered by the virtues of the nurse (which leads to positive health outcomes), then the positive effects of compassion serve to sustain compassion as a concept of interest for organisations and policymakers.

6.3.2 Positioning of Self: Nurse as Physician

Mental health nurses' position as compassionate practitioners, as reported here, resonates with discourses within the contemporary research which claims compassion can improve health outcomes and increase patient satisfaction (Gilbert, 2010; Hammarström *et al.,* 2020). Nurses' constructions of compassion therefore have the capacity to fundamentally transform the nurse-physician power dynamic; particularly as mental health nurses consider themselves to employ the

therapeutic use of (compassionate) self to aid the recovery process for patients. Returning momentarily to Freidson's views on professionalism (2001), the idea of the institutionalisation of compassion as 'belonging' to nurses facilitates a knowledge/power relationship from which the mental health nursing professional can draw legitimacy. Therefore, by positioning themselves as compassionate practitioners in this way, mental health nurses become the ones who can deliver 'care' as well as 'treatment'. This shifts the power dynamic historically associated with medical dominance.

6.3.3 Responsibilities and opportunities for action

Having positioned themselves as the embodiment of compassion, nurse-participants described various personal and professional challenges to enacting compassion in their everyday practice. Compassionate practice was felt to be limited by numerous organisational constraints, described in section 6.3.6. The attitude was, that compassion relied very much on the nurses' generosity, to devote their own time to spend with patients because there were so many pressures on time during working hours.

> *"I have had to made sacrifices because I've wanted to spend time with that service users in that crisis and I know that that means going home an hour or two late because of that list of things that I have to do still needs to be done"* (Alison – WB)

Conversely, participants also indicated that, despite a desire to 'express' compassion, they often had to make a conscious choice to focus on risk

assessment. It was felt that risk assessment was necessary in terms of accountability of the individual nurse.

> *"Someone might say 'I'm going to kill myself today'…they might say that and then it becomes, I've kind of got two simultaneous responses to that so…one is 'oh my God, you're a person in front of me who is saying that they are going to kill themselves, what is happening for you that must be so awful to even have those thoughts'…. the other side of that is 'okay someone's just told me that they're going to kill themselves so I need to ask this question this question and this question so I can document it in the risk assessment'"* (Ryan – CB)

While participants were aware of the underlying expectation for compassion, the need to assess risk was considered mechanistic and this diverted time away from developing therapeutic relationships. Participants felt the need to continually weigh up risks, which contributed to the role of mental health nurse as being a particularly challenging one. Participants described how their thoughts would be immediately directed to the potential for sanctions to be imposed if risks were not correctly documented, and the need to be compliant with the rules – in this case, the NMC's Professional Code of Conduct (2015). This placed participants in situations where they felt themselves judged, as well as feeling susceptible to external judgement (by professional bodies like the NMC).

> *"I think going hand in hand with that, is this always having to have one eye on risk. I've always had this, I've often felt that the emphasis on risk assessment and risk …it is important to have conversations about those things but the inevitably they are difficult conversations to have, much more anxiety provoking and stressful and the whole kind of thing like coroner's court and all that kind of stuff, you know, that kind of hangs over you whether you like it or not"* (Ryan – CB)

> *"How do we make someone's experience of care better and it is by caring, it is not by processes it is not by, that comes later, but I think one of the fundamental key factors for me is definitely compassion. I don't think, I can't think of anything else that is up there that has more of an all-encompassing role in someone's recovery"* (Joanne – CB)

This caused feelings of guilt that accountability meant following an objective measure (risk assessment), rather than exploring thoughts and feelings with a person. However, this structured approach could immediately prioritise preservation of life and was understood to be unavoidable in this context. In addition to this complexity of the nursing role there was an intrinsic understanding that patients had an expectation for compassionate care. The level of felt responsibility for compassion was clearly high and, as participants suggested, compassion was viewed as a way of improving patients' experiences and contributing to recovery.

By taking up this discourse of responsibility, and by implication, an 'irresponsible' nurse would be considered one who does not enact compassion. The effect of this is that it places increased pressure and feelings of guilt on an already stressed workforce (West *et al.,* 2020). According to Springer (2016) this is precisely what neoliberal discourse seeks to achieve, ensuring compliance through governance at a distance. For Willig (2008a), certain practices become legitimate forms of behaviour from within a particular discourse, thus, participants' discursive constructions of themselves as 'the essence' of compassion reinforces the idea that frontline workers are responsible for enacting compassion. Thereby, supporting existing policy discourse.

It is in this sense that the policy discourse on compassion has functioned to 'conduct the conduct' (Foucault, 1978 *in* Burchell, Gordon, & Miller, 1991) of nurses by creating and projecting a coherent programme of images and interpretations onto the world, regarding the way nurses (according to the discourse of technocratic elites) 'should' perform. Conduct is not governed in the same way as theorised by Bentham's (1791) panopticon, where there is a direct line of visible power over the body via the gaze of the guard upon the prisoner. Rather, as Rose (1999) suggests, this form of control involves a reconfiguring of the private self, in ways that aim to make professional nurses' 'souls' more effective. This type of power of is an unseen force, conducting nurses' conduct from a distance (Foucault,1978 *in* Burchell, Gordon, & Miller, 1991).

6.3.4 Organisational Limitations

There was a real sense of failure described by participants, in terms of nurses and patients perceived to have been let down by the current healthcare system. Nurse-participants gave clear examples of where person-centred care was not being delivered. Indeed, several challenges and barriers to delivering compassionate care were perceived to be related to the organisational structure.

Where compassion was understood to be related to the job, participants articulated situations whereby mental health nurses had a desire to enact compassion but were not able to do so. The desire to relieve distress for patients was often constrained by the processes and systems in place (in the service being studied). For example, most participants agreed that the delivery of compassionate care

was through the application of the principles of patient-centredness. For them, this was defined by involving the patient in decisions made about their care, in a collaborative way. However, participants described a lack of co-created care in general within the service (Trust) studied here. Nurse-participants expressed frustration and anger at this apparent lack of compassion from the organisational level.

> *"Everyone who I know, and I practice with, acts with compassion and does the best that they can to help people feel better. No one is trying to make people feel worse, but I think sometimes management and the organisation and stuff might not know that they are making people feel worse. You know, by not including them in their ward round and sometimes we don't take positive risks and, let people go out on leave to alleviate things for them, but we can only do what we can do"* (Alison – WB)

This quote suggests a sense of dissatisfaction with the way services are managed, implying a disconnect between those working directly with patients and those in management positions. Dynamics within the multidisciplinary team contributed to a perceived disparity in compassion across the different professional groups.

Nurse-participants expressed anger and frustration regarding the way in which some responsible clinicians (RC)[35] had failed to include patients in decisions that were being made about them. This was perceived to negatively impact patients' care experiences.

> *'When I am on the wards, I hear a lot of service users [patients] saying "look I've been here two weeks and I haven't seen a doctor and stuff" and I just think what*

[35] The responsible clinician (RC) is the psychiatrist with overall responsibility for the patient's care.

are we doing?... I think ward rounds take place just for staff…It is so very strange, yeah, when ward rounds are going ahead, I have not known one patient go into ward round' (Alison – WB)

Participants spoke on and off the record about the lack of shared decision-making within the service being studied and a failure to acknowledge the importance of patients being present at their ward round[36]. Most participants felt that they were often put in a difficult position 'professionally' because nurses were the ones left to manage patients' expectations of their care and treatment. One participant described going home after shifts feeling angry and emotionally distraught by these experiences.

While reflecting on their experiences of working in in-patient services, another participant explained how, as a nurse not long qualified, they felt unable to raise issues with the patient's doctor.

"He was medicated by his psychiatrist who prescribed a depot[37] and he cried when he was told that that was the plan and I was on shift when I had to give him his test dose[38], and I didn't want to give him this medication and you know perhaps I could have disagreed, but I was a staff nurse, I was band 5[39] and I'd not been there that long and…obviously this consultant psychiatrist is experienced she must know best…anyway after he had the depot he became extremely depressed and then he blended into the background. He became the perfect patient, but he had no quality of life, he didn't interact with other patients, and he just, he was just like a chair, you know what I mean, just like a piece of furniture on the ward and then erm, I came onto my shift erm, one day…and I sat

[36] A ward round is defined as a visit paid by a doctor/psychiatrist in a hospital to each of the patients in their care in a particular ward or wards.
[37] A depot is a slow-release form of antipsychotic medication, administered by injection.
[38] Where a person is new to a particular drug, they may be exposed to the drug orally, or a small amount may be administered via injection. This is known as a 'test dose'.
[39] A band 5 nurse is a nurse with <2 years to 4+ years' experience. This includes many newly qualified clinical professionals (*see* NHS 2022, healthcareers.nhs.uk).

down and they said we think he's killed himself this patient X…..I just thought, you know it was erm, it resulted in his death at the end of the day, and I was just, I can't like, I knew, I felt like that medication was wrong." (Kelly – CB)

The participant above spoke out about how they had felt incredibly uncomfortable and disagreed with the treatment they had felt obligated to deliver. In this participant's view, failure to work collaboratively with the patient and to talk to them about their wishes had led to their death by suicide. This had a negative impact on this nurse-participant's own mental and emotional health. The above example is one where the nurse had attempted to work compassionately (in a person-centred way), and had been impeded, in their view, by the organisational and institutional norms within the system.

Other participants talked about the everyday practices, which they felt the service needed to do more of to enable compassionate ways of working.

"There is a lot more compassionate care that we could be doing in this Trust…. simply, people (patients) can be very anxious about what's happening with their medication, are they (referring to staff) increasing the dose, are they changing it to a depot and people (patients) are very anxious about that, and we could alleviate that by at least including them (referring to patients) in the discussion" (Alison – WB)

This quote is another example of where nurses felt changes needed to happen to improve care experiences for patients. Alison described various scenarios where she had administered medication and discovered this had been changed without the patient's knowledge, consultation, or involvement in any discussion. In Alison's view, these occurrences had a direct correlation with increased levels of violence

and aggression (from patients towards staff). Nurses (Alison insisted) were often left to manage these difficult situations, which she claimed could be avoided by the practice of co-producing care (or shared decision-making) with patients.

Despite the idea that contemporary healthcare is believed to be focussed on ‘shared decision-making practices’ (see Slade, 2017) or ‘shared-power’, the physicians (as described by nurse-participants) were perceived to be managing their position of authority in a paternalistic way. This prevented any attempt to equalise the professional power imbalance. The examples given by nurse-participants also suggest that some psychiatrists may be aware of the power available to them but choose not to share it. In recognising that power is not necessarily owned, rather it is viewed as relational (Foucault, 1982), the power balance might be equalised (or shared) in practice through the psychiatrist having a conscious awareness and/or purposefully implementing strategies during interactions that are aimed to improve patient experience. For example, the clinician might provide the patient with their professional opinion and offer options about certain treatments. The patient can then make choices and ‘lead’ the decision making, and in collaboration with the clinician *“select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences”* (Coulter & Collins, 2011, as cited in Slade, 2017, p. 146).

6.3.4.1 Administrative Burden(s)

Reflecting on their prior experiences of having worked in (mental health) acute services, and psychiatric intensive care units (PICU), participants felt that these

areas of practice radically reduced the time staff had for enacting (and expressing) compassion. For some this illustrated a deep disillusionment with the role of mental health nurse, which was mismatched with their expectations of nursing, prior to completing their nurse training and education.

> *"I think when you are working in an acute ward [pause] the work load and all of the other sort of administrative duties and the other stuff that is just…I [pause], I thought I would be doing a job similar to support workers and getting to develop those relationships and spend time….I wanted to be the person that can provide the compassion not the practical side of stuff. So [sigh] you know, erm, that part is my job so those are challenges to providing compassionate care because there are other practical tasks that I need to complete"* (Alison – WB)

There was far too much activity to manage effectively and too little time to think about the clinical aspects of the job – including compassion. This caused frustration and the feeling that staff could not realistically deliver the service that patients might expect.

> "*In in-patients, things are going off left, right and centre and you've not got that capacity to reflect…it is frustrating because you don't feel like you're providing a service that you're supposed to"* (George – WB)

This led to concerns about patients' experiences of care.

> *"That's surely got to have an effect on what they [patients] think, like nobody's listening to me"* (George – WB)

In ward-based settings, insufficient staffing and a high-administrative burden were reported to significantly limit staff's ability to demonstrate compassion within the role – as they would wish to.

> *"In mental health we are running on low numbers and sometimes inadequate staffing. Sometimes I can see someone in distress, and I can't go because I am in the middle of another …you can't be everywhere at once and sometimes you are seeing someone in distress and you can't get to them cause you're with someone else in distress….I'm one person who can only deal with one person at a time [pause] so, the acuity of the ward, the staffing levels, the skill mix of the staffing, the amount of things – you know I often start my shift with an unimaginable list of things to do before I then even think about any clinical activity"* (Alison – WB)

It was clear during the interviews that these types of environments meant there were definite increased pressures on staff. These working conditions contributed to fatigue and exhaustion.

> *"Working in this job there's many factors to it and it is not a simple as being able to support someone...it is trying to maintain people, like, well from burning out really and that is not compassionate er, like fatigue just, it is, it is really difficult"* (George – WB)

Participants were passionate about needing to have time to listen to patients, and not missing out on what George described as *"opportune moments"* to explore patients' experiences and issues. Indicators of distress could be easily overlooked as a result.

> *"I think all the external pressures sometimes, you know, they de-sensitise people, I think erm [pause] then they forget, they forget, sometimes you forget that not like somebody's that they're unwell. Like I said, it is sort of misinterpret things and you miss out the whole cues for how someone [patient] is feeling and then, sometimes you make the wrong decision then about how you support somebody"* (George – WB)

This quote indicates that the pressure to work with continually high levels of administration, and with insufficient numbers of staff took a toll on compassion; and that could lead to someone making wrong decisions in terms of how to respond to distress. The time to practically demonstrate compassionate care, by working with patients to explore thoughts and feelings was limited by task-based activities.

> *"I do think the support workers probably take the reins on the frontline compassion really because they are there, on that one to one with that patient, they have got a whole hour and I will never find that, or rarely will find myself in that position. I am often there when it's crisis, I am called when it's crisis [sigh] so I think it is challenging and you might have days when you think - I haven't spoken to someone for longer than 10 minutes"* (Alison – WB)

Despite wanting to, those participants who were working on the wards had little time to speak to patients. The responsibilities of the nursing role meant that often it was the nursing assistants and/or support workers[40] who had the time with patients. Nurses were therefore unable to fulfil their ideological commitment to the role (Hood, 2013), which was reported to be the reason 'why' they had chosen to join nursing as a profession. Hence, the effects of this high-pressure environment could cause dissatisfaction with the role and lead to moral injury as nurses were not able to be the kind of person they aspired to be, for example, delivering the type of care, in a moral sense (Foucault, 1984), that they had envisaged before they began nursing.

[40] Nursing assistants and support workers are non-qualified members of staff who are not clinically trained.

6.3.5 Frustrating System

Nurse-participants described how they were faced with similar problems each day, which were felt to be equally frustrating for nurses and patients. One participant explained how this involved continually feeling responsible for maintaining positivity within the team. A lack of 'timeliness' and failure to effectively integrate care services were blamed for frustrations among the team, which made it difficult to ensure the necessary follow-on packages of care were *in situ* when patients were ready for discharge, or at a stage in their recovery where they could move forward. External factors, such as a lack of social care, were reported to block patients in their recovery journey, which frequently caused lapses in mental health or a lengthier stay in hospital.

> *"He (referring to patient) had a moment where he was like a couple of months where he was improving …and then it was, in a way 1 step forward 2 steps back. Then he had 2 months where he was really really good...and 'right he is ready', we think we've got somewhere and [pause] then it just comes down to cost and erm [pause] yeah you can sort of see it in people's (referring to other staff) faces and they're like here we go again and it's just trying to maintain positivity (emphasis)"* (George – WB)

Recovery[41] was of paramount importance to nurse-participants, yet a variety of issues were often out of the nurse's individual control and confounded their efforts to help patients progress in their recovery journey. Therefore, those working full-time in inpatient services had adopted the philosophy that compassion was only

[41] In mental health, recovery can mean something different to everyone. It is generally defined as a process of achieving a sense of wellbeing. The emphasis is on supporting a person to reach their full potential (mentalhealth.org.uk, 2022).

achievable when nurses had ‘time’, when care was ‘timely’, and services were integrated. Ultimately, the conditions needed to be right for compassion to flow.

> *“There are times when you know where compassion can just flow so easily and then there are times when it’s just a bit harder you know. And maybe what I’m saying is that my experience as a clinician is that erm, that the conditions for whatever reason – stretched services etc. it might be because you are short staffed or stressed or because you’ve got things going on at home or you haven’t slept very well the night before or whatever, but often I found that it comes down to the conditions that can make it more difficult compassion to flow”* (Kelly – CB)

It was acknowledged that sometimes the responses of individuals were a reaction to the pressures and demands of the job, and these responses were not always compassionate.

> *“If you’ve got someone (referring to patient) who you’re normally compassionate towards and you’ve got ten other people demanding crisis contact and things like that, you’re short staffed, and you’re on duty, and there isn’t enough staff erm, and there isn’t enough supervision, and you’re feeling overwhelmed and that’s when you shout down the phone, you raise your voice, you’re frustrated and pissed off about everything, so compassion goes out of the window a little in those cases”* (Megan – CB)

> *“Underneath it is like, my life, my emotional life where I feel just pissed off or fed up and then there’s my life underneath where I know that person is a traumatised person and that it is my job to try and support them the best way I can…so, I am not always compassionate, no.”* (Joanne – CB)

Failure to demonstrate compassion caused internal conflict within the individual as they remind themselves about the principles of their job role. Nurse-participants clearly viewed themselves as the essence of compassion, and therefore

compassionate (moral) beings. Foucault (1990/1984) described technologies of the self to include four dimensions (see Chapter 4, section 3.3). For Foucault (1984), the ethical body is one where the self-forming activities can be realised through the moral obligations, which, for mental health nurses, were related to the feelings, intentions and desires to provide compassionate care. Given that they had undertaken nurse training to fulfil their intentions to enact moral intentions (compassionate action), the difficulties caused by the system constrained the ethical body in those obligations. Again, this caused frustration and moral injury to mental health nurses in their attempts to aid patients recover through compassionate action.

6.3.6 Limiting Thinking About Development

The government's response, post-Francis Report (2013), was focussed on nurse-to-patient ratio (Griffiths *et al.,* 2016). An overarching focus on the number of physically present nurses implies nurses will enable the fulfilment of service requirements if they remain on the frontline. However, the monitoring of 'safe' staffing levels ignores the complexities of contemporary mental health nursing practice (Aiken *et al.,* 2017) and suggests that the number of nurses alone addresses every aspect of patient safety and quality. This neglects other aspects of safety such as the appropriate skill mix and a variety of expertise and experience. To fulfil all aspects of patient safety, an investment in education and staff development are crucial. In economic terms, compassion is, as Tierney, Bivins, and Seers, (2018) have asserted, simply a cost-neutral commodity and

feelings of responsibility to perform compassion may distract nurses from thinking about progression and development.

Various national polices have focused on nursing career frameworks and professional development, for example, *Modernising Nursing Careers* (DOH, 2006). Post-registration[42] education and development were viewed as significant factors for ensuring nurses continue to grow to provide optimum patient care (Price & Reichert, 2017). They are also key factors in issues such as recruitment and retention of the nursing workforce, one of the greatest challenges facing the NHS at the time of undertaking the current research (see Buchan *et al.,* 2019). Nevertheless, perhaps the notion of compassion, linked with quality, safe care (Willis, 2012), has become crystalised in the minds of nurses. So much so that delivering compassion directly to patients has become antithetical to the idea of the need to develop the self.

Demands on nurses to spend more time with patients, with little resources, conflicts with and constrains their ability to maintain a compassionate demeanour. Participants indicated that low numbers of mental health nurses decreased their personal capacity to consider post-registration education and/or development opportunities. Participants described the lack of staff and the mountains of tasks, alongside the high levels of emotional labour (this refers to the emotional effort involved in containing the anxieties and distress of others (see Jackson *et al.,* 2021) that is considered inherent in mental health nursing. This made it

[42] Post-registration refers to the period after a nurse has undertaken a recognised qualification to become a registered member of the profession.

increasingly difficult to find time to think about anything other than getting through, *as Erin remarked, 'one shift at a time'.*

> *'At the moment nurses generally, all we're ever trying to do is survive….you plough on and you plough on and you're embedded in your job but you're not necessarily thinking about your own needs and your own development'* (Erin – SNP)

Embedded within all participants' discourse was a repeated understanding that compassion may be at odds with thinking about professional development. As participants described it, being a compassionate practitioner in the context of mental health involved being present, emotionally available, open, and attentive. These aspects of compassion refer to the personal and relational characteristics of the nurse. However, all participants talked about the severe limitations to time caused by various factors, associated with the breadth and depth of the role, which diluted nurses' capacity to connect with patients. This suggests that the contemporary discourse on compassion represents a productive power, which can limit thinking about career development. On the other hand, the suggestion that nurses were simply 'trying to survive' is understandable given the situation at the time of writing (amid a pandemic). Data collection occurred during the coronavirus pandemic, where the nursing workforce had been under significantly increased pressure for several months.

Adequate time to spend with patients was particularly difficult to achieve in an inpatient context. For mental health nurses' everyday practices, the everyday reality was that a number of *self-sacrifices* were essential (my italics). Nurse-participants were acutely aware of the need to demonstrate compassion within the

context of nurse–patient interactions. For them, compassion was a high priority, and the patient experience was regarded as an important aspect of quality mental health care. The patient experience was also viewed as being underpinned by the directive within the NHS Constitution (2015) "*to ensure that compassion is central to the care provided*" (Linking section, para. 17). In this study, therefore, nurse-participants were reminding themselves that they are effectively public servants, on stage, in a very public arena.

6.4 Summary of Key Findings

The motivation to care, underpinned by compassion, was described as a key driver for those joining the mental health nursing profession. Compassion was viewed as being intrinsically embedded in mental health nursing and nurses' professional responsibilities to their patients, which were felt to be different from, and much more complex compared to other areas of nursing. Seeking to understand the person and the context of their distress was felt to be underpinned by compassion. However, this was believed to be difficult due to the nature of patients' stories, crossover with individual nurses' lived experiences, and ethical tensions felt by some nurses because of the restrictive practices that were often implemented.

The burden of responsibility for patients' recovery was felt deeply. However professional, organisational, and administrative responsibilities also posed a heavy burden on participants' ability to regularly deliver compassionate care. There were concerns about low numbers of staff, yet the economic state of the service and in the social world more broadly was rarely mentioned by nurse-

participants. Regardless of the limitations to enacting compassion, described by participants, compassion was expected from new nurses joining the profession. An overview of the findings from this chapter are presented in Table 6. The chapter after this will present the results of interviews with mental health patients.

Table 6. Summary of findings – Phase two

Stage of Willig's (2008a) Analysis	Summary of Findings
1. Discursive Constructions	Embodiment of compassion – inherent to the individual person Central to the job mental health nurses do, e.g. clinical skill of therapeutic engagement via the TR
2. Discourses	Rejection of compassion policy on compassion in nursing work Nursing discourse evident in discursive constructions - TR - Person-centred care - Motivation to care (genuine care) - Perceived variation in individual baseline levels of compassion
3. Action-oriented	Speaking positively about the self may be part of a larger social-psychological strategy to present the self (and therefore the ingroup – mental health nursing) in a positive way.
4. Positionings	Discursive constructions enable mental health nurses to position themselves as: - Owners of compassion - Nurse physicians – able to provide care and treatment
5. Practice	Responsibility for compassion placed on individual nurses
6. Subjectivity	Feelings of frustration, inadequacy because of not being able to deliver compassion (via the TR) Thinking about professional development is limited Individuals may be judged as irresponsible if they do not deliver compassion

Chapter 7: Results from Interviews with Patients[43]

7.1 Introduction

Having explored mental health nurses' constructions of compassion and notions of themselves as compassionate practitioners, this chapter will present the results from (*n*=10) interviews with patient-participants. The interviews aimed to explore patients' perceptions and experiences of compassion. Employing Willig's (2008a) framework also made it possible to explore the wider discourses at play in participants' accounts, and the social and psychological realities of their experiences.

7.1.1 Interview Process & Participant Characteristics

Interviews (face-to-face) were open and conducted using a conversational style. The purpose of this was so that the interview process was as natural as possible. The interviews intended to give participants space to reflect on and share their lived experiences of compassion. Patient-participants were free to recall events or experiences from any point in time relating to their previous or current contact with mental health services. They were also encouraged to reflect on past experiences and reconstruct these by talking about their thoughts and feelings within the context of receiving mental health treatment and care. Patient-participants were also prompted (if the participant had directly experienced these) to describe their

[43] A significant part of this chapter has undergone full peer review and is published as a paper (Bond, Hui, Timmons, Wildbore, & Sinclair, 2022 Discourses of Compassion from the Margins of Healthcare: The Perspectives and Experiences of People with a Mental Health Condition. *Journal of Mental Health.)*

experiences of restrictive practices. As previously mentioned, restrictive practices are utilised in the context of mental health care and can be defined as the use of restraint, rapid tranquilisation, seclusion, and voluntary or involuntary detention[44] under the Mental Health Act (2007/1983). As mentioned at the beginning of this thesis, I am referring to restrictive interventions i.e. over and above the 'usual' restrictive practices that occur within mental health services (e.g. locked doors, ward routines, etc).

During the interviews, each participant gave examples of what compassionate care meant to them. They also all gave many examples of having received care that was not underpinned by compassion, as they perceived it, explaining the impact of this on subsequent health and wellbeing. Participants were offered prompts to draw upon during the interviews, based loosely on the interview questions (see Appendix 4), however, they were encouraged to speak freely and openly about any experience that they considered involved compassion, and the importance of those experiences. The participants' accounts offer in-depth insight into the function of compassion in mental health recovery and emphasise the importance of receiving compassion in this context. Participant characteristics are shown in Table 7.

[44] Please refer to the definition and descriptions outlined in Chapter 1 of this thesis.

Table 7: Patient-participant characteristics

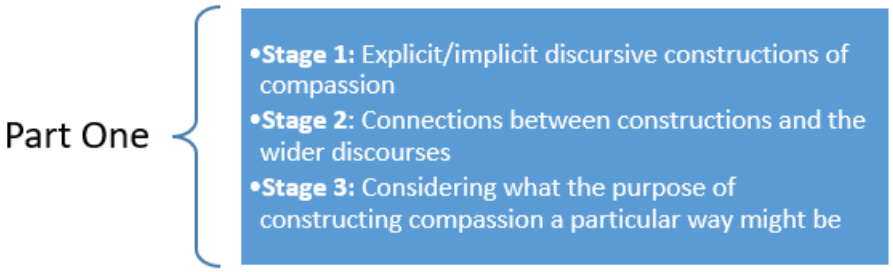
Age group (mean = 47)		**Gender**		**Detention or restrictive practices experienced**		**Participants' self-referenced lived experiences**		**Year/s contact with mental health services (mean = 15.8)**	
Range	*n*		*n*		*n*	Experiences	*n*	Range	*n*
<21	-	M	3	Y	6	Illness	1	1-5	3
21-30	2	F	7	N	4	Trauma	3	6-10	1
31-40	1					Trauma + psychosis	1	11-20	1
41-50	3					Health anxiety	1	21-30	3
51-60	1					Bipolar	1	31-40	2
>61	3					Alcoholism	1	40+	-
						Post-partum psychosis	1		
						Eating disorder; Body dysmorphic disorder; Autism; Anxiety and depression	1		

7.1.1 Presentation of Results/Analysis

As per the previous chapter, the results presented here have been guided by a Foucauldian-inspired theoretical framework, as prescribed by Willig (2008a). Accordingly, the following sections have been organised in two parts (see chapter

6, section 6.2.1), and begin by describing the discursive constructions of compassion evident within the interview transcripts. The wider social discourses at play in participants' accounts are explored, and the subject positions made available by these discourses. The chapter ends by illustrating how these subject positions enable or limit patient-participants' experiences of compassion in the social world.

Part One



7.2 Patients' Discursive Constructions, Discourses and Action

Having listened to patient-participants during the interviews, and after reading and re-reading the transcripts (as outlined in chapter 4 - methods), it was clear that there were numerous elements to the experience of compassion within the mental health care context. As one participant, Mary, summarised, *"it's all part of one large complex thing…it's like a jigsaw puzzle".* Disentangling the various aspects of compassion from participants' discourse was indeed like putting together all the pieces of a complex puzzle. Through immersion with the data, discursive

constructions became evident regarding the experience of compassion at the interpersonal level of interaction. This is shown in Table 8.

Table 8: The key components and features of compassion identified by patient-participants

Key Constructions	Features	Description
Compassionate virtues of the nurse	Warm	The nurse displays a warm and calm demeanour
	Calm	
	Authentic/Genuine	The nurse presents authentic self during interactions
	Honest	
	Non-judgemental	Judgemental attitudes were antithetical to compassion
Compassionate Engagement	Active listening	The nurse uses communication skills to understand the patient in the context of their life
	Trauma-informed approach	Nurses recognises that impact of prior trauma on peoples' lives Nurse considers 'what happened to you' rather than 'what's wrong with you'
Compassionate relational space & patient's felt-sense response	Feeling of connection on a human–human level	The focus is first and foremost on the patient/client
	The patient's felt-sense response is enabled through validation & non-judgement	The patient feels that the nurse (or other healthcare professional) is exhibiting compassion through validating their lived experiences and displaying a non-judgemental attitude

The key aspects of compassion emergent from the data generated three distinct components, each containing several features. These core components were constructed in the context of the relationship between mental healthcare nurse and patient.

7.2.1 Compassionate Virtues of the Nurse

The first core discursive construct of compassion that emerged from the data, which was found to underpin all the categories discussed, was that of *'the compassionate virtues of the nurse'*. Participants talked about how they had thought about, prior to the interview, and recalled specific individuals with whom they had interacted in the process of receiving care. Compassion was identified as centred around the nurses' virtues independent of a patient's behaviour, or ways in which the patient's distress was expressed. Virtues were listed as *'warm, calm, authentic/genuine, honest, and non-judgemental'* and were felt to be embodied in the individual characteristic traits of the person delivering care. For participants, virtues functioned as prerequisites to (nurses') individual behaviours and expressions of compassion.

> *"The person who gives the feeling – even if they don't verbalise it – that they are there for that person and they are calm. But the most important thing in terms of compassion is to let them [patients] know that they can trust you [nurse] because that is a big thing when people are unwell. Speaking for myself, I get exceedingly suspicious when I am unwell. And I think that is part of my illness that I do. So, I think to summarise somebody who is there, trustworthy, and warm"* (Zoe)

> *"She was really calm, understanding and warm, and just listened; I think that is a really big part of it - she*

didn't just make assumptions - she actually listened. Erm so that stuck out as a huge moment for me" (Lilly)

A compassionate nurse was defined as someone who displays a warm, calm demeanour. Someone who embodied these traits was perceived to be trustworthy, which was viewed as especially helpful when someone is feeling unwell.

Although virtues were seen as a predisposition for compassion, they were in themselves insufficient for care to be deemed compassionate. Virtues needed to produce an external response to suffering within the interpersonal space to be considered compassion. In turn *'compassionate engagement'* would generate internal feelings of care from the nurse to the patient.

The extent of the nurse's efforts to relieve distress or seeking to understand the person in the context of their life, enabled the patient to feel compassion. This was made possible by the intentional effort(s) of nurses – moving from virtues to action and being mindful of the patient's needs, including previous trauma.

"It's definitely a relational thing to me...there is a kind of movement to meet, and willing and open-heartedness to meet with someone, a patient. You know, I am (patient) reaching out and so they (nurse) are reaching out to me too" (John)

"There was this one time where I was really upset, and he came and sat next to me. All he did was put his hand on my arm and it was just a loveliest gesture actually. And that meant a lot actually because it was like just very small thing but a really powerful thing…… he put his hand on my arm, with my permission, I think that was really lovely" (Sara)

This shows that compassion is a deliberate action or response to distress and that compassion was fundamentally embodied through the patients' experience of

care, primarily as a result of the actions and behaviours of the person providing that care.

7.2.2 Seeking to Understand

A defining characteristic of compassionate engagement was mediated through the skills of the nurse, particularly active listening. This was underpinned by displays of communication that conveyed the nurse's underlying virtues and interpersonal responses, which also reflected an awareness of trauma.

For compassion to flow, the nurse needed to combine their virtues with the skill of active listening. Listening was said to be active in that it was believed to be more than just allowing the person (patient) to speak. Active listening provided a sense that the professional was in some way 'trying' to understand the unique perspective and experiences of the person (patient).

> *"It (compassion) is trying to get alongside somebody and try and...you can't understand how somebody felt because you can't get in their head. But you can listen and relate to them (patient) by what they are saying"* (Zoe)

> *"Compassion to me means someone who really listens to you and tries to see the world through your eyes so they can actually get an idea of what it is like for you…Compassion is also about asking questions so if someone doesn't understand where you're coming from, they are getting a greater understanding of what that is and they're not just assuming based on their own experience"* (Sara)

> *"Well, he (nurse) could communicate on a person level, he wasn't going to judge people on whatever their experiences were. He actually heard what you were talking about and took it on board. He wouldn't pass any sort of, not judgement, I guess, opinion"* (Kevin)

The above quotes really align with the idea that where the nurse had an opinion about someone whom they care for, it was much better for the patient if those opinions were not externally verbalised. Active listening is a skill that is taught to mental health nurses as part of their training (Stickley & Stacey, 2009). However, it takes practice and time to develop. When done effectively, active listening provides space for the nurse to engage with the patient and to begin to build the TR. This then enables in-depth personal knowledge to be acquired, which is key to working collaboratively to find solutions and move towards recovery (Shattell Starr, & Thomas, 2007). However, as Sara's quote illustrates, for this to be compassionate engagement, listening must be approached in a non-judgemental way. The sense that the nurse was genuine and authentic was felt to be an essential component of compassion, particularly when a person (patient) was experiencing a mental health crisis.

> *"Don't feel like you (referring to the nurse) have to go into a situation and meet someone in crisis and fake that you are really happy…. it doesn't feel very personable and natural...particularly, I am talking about when people are suicidal, is to go (meaning the nurse) 'all we have to do right now is to help you feel like you can be safe if, and what is it that is going to make you be safe'"* (Sara)

For patient-participants, when they became unwell, they appreciated knowing that the nurse(s) supporting them were also able to support their immediate family. Addressing the needs of the patient, and those of their friends and family, were identified as equally important. As such, it was crucial that nurses and other healthcare professionals understood them holistically, in the wider context of their life.

"I think things like looking after your basic needs, like eating and sleeping are so important around the time of the crisis… my care coordinator that I have got at the moment she has shown a lot of compassion…offering support to my friends and family was something that was really special and important because I knew how much they (friends/family) needed care and support during this time as well" (Chloe)

"The nurses took time to talk to him [partner] without me - talk to him about the things that he was worried about. They were kind to my parents, my mum is bless her, she is bonkers, but she has to know everything and they gave her that time which meant that she wasn't hassling me. My parents at one point…they were coming too much and I was getting overwhelmed and so that wasn't helping my recovery but the fact that they could see that and they had time to say this isn't right let's look at a plan with me and [partner] about what would help made to manage my parents' visits" (Jane)

It was imperative that the nurse tried to see beyond a diagnosis and this was achieved by providing a 'sense or feeling' of compassionate care for a patient. This included thinking about the broader, practical aspects of the person's life. Hence, the discursive construction of compassion is viewed as much more that the virtues and actions of the nurse. Compassion was considered as 'going the extra mile', doing beyond what was expected by recognising that the person's family and friends may be experiencing distress (when their family member is unwell). This construction is synonymous with the contemporary definition as a 'response to suffering', 'action taken to relieve that suffering' and, in addition, 'having the forethought to prevent further suffering in the future' (Gilbert, 2017; Sinclair *et al.,* 2016a).

Patient-participants 'ideally' wanted to receive care from someone who 'genuinely' showed an interest in them and could easily distinguish a compassionate nurse from a non-compassionate nurse. For Sarah, compassionate engagement meant being given choice and control. She recalled having been detained by the police following attempted suicide; experiences were validated, and agency and autonomy were honoured.

> *"Giving me choice and control in the situation which was odd because I was being held by the police, and she was 'well you are here voluntarily but not entirely because if you say you want to leave and go to leave that's it' [laughs]. It was a very ambiguous space, but she was working really hard to give me the choice. Empowering me and validating the fact that I felt the way that I did, and it was okay"* (Sara)

Sara expressed having felt safe*. "I felt really safe, it did feel safe though even though I was with the police. I felt really safe with her in particular".* Sara was very clear that this was a good example of compassionate engagement. The policewoman displayed the virtues of compassion and Sara's experience was that this person was honest, accepting, and authentic.

7.2.3 Socio-normative, Medical, and Political Influences

Many examples were provided of clinical encounters where compassion was absent for patients' experiences. Zoe explained *"Some nurses are exceptionally good. They will – no matter how you are – they are there with you. Sadly, that is rare".* Participants used words like *self-centred, critical, inconsiderate, inhumane, painful, harmful, judgemental, abusive, degrading, traumatising, depersonalised, inappropriate, discrediting, being gaslit, devalued, and discriminating,* in their

constructions of individuals who lacked compassion. Participants placed emphasis on these words in speech to demarcate the unacceptable nature of their experiences. This shows participants' efforts to share the strength of their feelings (and desire for compassion). Participants had a fundamental need for compassion, and an expectation for compassionate care, yet easily recognised that individuals within the mental health care system had differing degrees of compassion.

> *"Within that system you sometimes have people who are not compassionate, and sometimes you have people who are, and you sometimes have people who are compassionate but are unable to convey that because of the stress that they are under as an individual worker within that system"* (Mary)

> *"Some of the things that she said… I found that I was having to defend things whereas it shouldn't have been like that and so there was absolutely no compassion whatsoever…I used to look at her bookshelf and she had all these books about her profession, and I used to think 'have you actually bloody read any of those books'"* (Anna)

Anna notes her expectation was that the nurse would have the appropriate level of knowledge (and compassion) to produce a healing effect. The apparent expertise and authority of the nurse places them in a privileged position whereby there is the potential to realise the positive effects of power (healing) for whom it is intended (patient). The lack of a compassionate response exposes something about the internal system of values and beliefs of the nurse, which may have been shaped according to socio-normative and/or dominant representations, e.g. monogamy. Hence, rather than listening to Anna, assumptions were made based on the beliefs of the therapist. The participant's discourse reflected expectations

within society that having a ‘mental health’ condition was very much not socially acceptable.

> *“People will make judgements, and we are very much in society where people go ohhh, you’ve got a therapist what’s wrong with you. Well actually there isn’t anything wrong with me”* (Anna)

Jane described the internalisation of feeling different due to having a diagnosis that was not heard of as much as other diagnoses (post-partum psychosis), which often led to her feeling uncomfortable in social situations.

> *“When I went to baby groups and things, I didn’t cope with the ones where people we’re just sitting and talking because I felt different”* (Jane)

These feelings were thought to be the result of a lack of social awareness about mental health in general.

> *“There is a lot of stuff in the media, and social media, isn’t there about talking about mental health…I feel like it’s talking about the ‘nice’ kind of mental health which means normally you are like everyone else you are an average person with a normal life and suddenly we’re a patch where you feel a bit depressed, or you are struggling with anxiety…but we still don’t talk about the ‘un-nice’ mental health problems as much - like people who are suicidal people who have schizophrenia people with bipolar. I feel that even though you are supposed to feel like you are part of things and part of the conversation because this is mental health, we are talking about, I still don’t fit into the type of mental health that we want to talk about on a general day to day level”* (Mary)

Mary’s use of quotation marks during the conversation when using the word ‘nice’ demonstrates her desire to be accepted by society. She refers to ‘normal’ and ‘average’ as fitting in, which may be reflective of the way in which mental health

services are commissioned. For example, services are commissioned based on need, and underpinned by epidemiological data about health conditions (Moreno-Agostino *et al.,* 2021). Depression, for example, is cited as the largest 'burden' of disease (Murray *et al.,* 2020). In relation to accessing mental health services, healthcare services create divisions whereby those condition that fit more easily into the way services are designed are viewed as typical of society (Johnstone, 2019). This structure leads to judgements, based on assessments/diagnoses, which were felt by all participants.

All patient-participants talked about the sense of feeling judged during interactions. John (below) shared two examples of two different clinical encounters. In both encounters he had felt judged, which exacerbated his already declining mental health, so much so that he was left feeling worthless and attempted to end his life immediately after the interaction.

> *"They (referring to GP) made a judgement on why I was there…erm, it was a bit of an emergency one where I was feeling extremely suicidal, and er, I just left work and went to the GP who basically just shouted at me. That was the opposite of compassion [laughs]. I know I am laughing about it, but it was horrible at the time"* (John)

> *"The first time I have seen that person…he didn't even talk to me about my experiences which were well documented obviously. I just felt absolutely, I felt like scum basically and that it was all my fault. I didn't feel like being on this earth anymore and so I took an overdose. I didn't go to accident and emergency with it, and I didn't even ring my GP because I felt like I wasn't even worth that"* (John)

Patient-participants described distinct outcomes which, when compassion was experienced, could facilitate recovery. The expression of compassion was extremely important and had enduring therapeutic effects for the healing process.

> *"My therapist who I now trust is holding that hope for me saying … she (therapist) is really upfront and frank… so there is that belief that change can happen…'I'm going to be empowering you'… It's more like her compassion is, is, to tell me that I deserve to be here and that I deserve to be heard"* (Sara)

> *"I absolutely lost all capacity to make decisions for myself. It was really scary … I can remember talking to them (the nurses) about how I shouldn't be here because I don't deserve it and they really kindly sat with me and went 'right, let's talk through all your worries and let's write down why it is okay to be here' and I found that piece of paper a few weeks ago and it really made me bawl. But it was somebody taking that time to sit with me and go 'let's try and get through this, let's push through that barrier that you do deserve care'"* (Jane)

Participants were clear that, without the experience of compassion, their mental health would be adversely affected, and they became detached from engaging with health services.

> *"If I was to go into the environment and feel like there wasn't any compassion it would feel very unsafe. It would probably add trauma rather than help. So, I guess that's the thing really, if you don't have compassion, it is probably added trauma…If I do go into crisis, I tend not to use crisis services and to withdraw"* (Lilly)

> *"I had been put in that position where I had literally put myself out there, very vulnerable and met with this hideous response which made me fell, wow I need to close down, close down"* (Anna)

In most examples, where a nurse was believed to have a judgemental attitude, this was damaging to mental wellbeing. These quotes clearly demonstrate the

perceived healing power of compassion in the context of mental health. They also reflect the significant, and life-affecting consequences for patients when compassion is absent. Hence, compassionate interactions function to aid recovery and healing. As such, patients had high expectations that compassion would be fundamental to the care they received.

Other participants described judgements which were felt to be a result of being viewed as a *problem* that needed to be fixed, and that a clinical approach was the best way to 'correct' them (the patient).

> *"There was pressure from the doctor to take antidepressants like that was just the answer, not to talk about what the problem was…. I felt like that was [pause] just dismissed what was actually the matter really - 'Just take a pill on it will all go away'"* (Sara)

> *"Often you are at the mercy of staff who know better than you because you are the patient. Especially in relation to medication, you know, you are the patient, and you must be told"* (Zoe)

> *"There seems to be amongst mental health nurses that I have come across, that the patient is a patient because there is something wrong with them"* (Anna)

These quotes imply that observed variance in compassion is dependent upon the school of thought underpinning a nurse's training, and subsequent practice. Historically psychiatry has established itself from within the discipline of medicine, where all mental 'illnesses' were believed to have a biological cause (Freeman, 2010). The feeling among patient-participants suggests that many nurses fail to utilise the recovery principles, which view the patient as the 'expert' in their own life and live experiences (Barker & Buchanan-Barker, 2004).

Mary referred to her mental health condition(s) as complex (eating disorder, autism, PTSD, anxiety), however, it had been her diagnosis of eating disorder that had led to previous hospital admission, and subsequent appointments with mental health nurses. Below, Mary describes the experience at one of those appointments.

> *"Someone (nurse) might say, 'Oh well you say you feel like that but that is not how you are presenting at this appointment'. Like, they (nurse) don't believe that you are saying, that you are making it up to get attention because that's not what they're getting off you. It's like, 'well that is what I'm telling you I feel like though'*
> (Mary)

> *"My key worker (nurse in the community) I always felt judged by her, she always made little comments about like [pause] me being unwell, or 'there is something wrong with your brain' just 'something not right with you', just making me feel like there was just something wrong with me....And an emphasis on symptoms. I think something I have, this thing around compassion, that I have always struggled with, because I have been labelled as someone who has symptoms of psychosis or depression or whatever, they (referring to psychiatrist or GP) look at that and offer me medication rather than saying what is going on underneath that"*
> (Chloe)

The assessment processes used by mental health professionals, and a focus on 'objectively' observed measurements rejects lived experiences. In effect nurses and other healthcare professionals appeared to be more concerned with seeking to understand the diagnostic tools rather than seeking to understand the person. Being mindful of patients' distress and responding with compassion was an important part of the interpersonal interaction, and obviously crucial in terms of recovery. As Mary explained further, distress comes in various guises, and the point of mental healthcare services is to understand and relieve that distress.

"There are different types of pain…sometimes you might be angry, sometimes you might be upset, sometimes you might be grief stricken, sometimes it might be trauma, or sometimes you might be in physical pain. But, it's pain, it feels painful living, the mental health services – the sort of help they are supposed to provide – is the mental wellness equivalent of pain relief. Erm, and it doesn't exist as far as I can say, and I don't think it has existed in [city blinded] for a good 8 or 9 years" (Mary)

"There was absolutely no indication of any compassion whatsoever in any of the mental health nurses… the patient was a number, and they were not treated with any compassion, they were disregarded, they were not valued, they were not empowered" (Anna)

"There is almost like this, you get the sense that, and I guess it's because they (mental health services) have got less money now, but they (mental health nurses) are a bit more pressed for time and they're a bit stressed" (Sara)

Individuals working in healthcare had variable degrees of compassion, and some were able to positively influence patient wellbeing. However, the limitations to funding and budget cuts had meant that many experienced a deterioration in mental health. The policy changes in terms of compassion have clearly not been effective in rendering compassion to 'real' patients.

7.3.1 (Re)Traumatisation

Participants expected that care would be person-centred and acknowledge that people who access services often have past trauma(s). A '*trauma-informed'* approach to care describes an approach where the patient is thought about in terms of *'what happened to you'* rather than *'what's wrong with you'* (Sweeney *et al.,* 2018, p. 323). This approach also required the nurse to be mindful of *how* certain things, such as implementing restrictive practices, were carried out. This

was very important if the patient needed to be detained under the Mental Health Act (2007/1983)[45] (sectioned) or physically restrained.

Other elements of the trauma-informed approach included co-creation of care, and the nurse seeking permission before action. Attempts by the nurse to get to know the person in the context of their life and to think about a patient's holistic needs – 'emotional, social, family, basic needs' – was an important facet of this approach. Nurses clearly needed to have an awareness of how a patient's past trauma could impact on their present mental state. The absence of a trauma-informed[46] approach to care was prominent in participants' accounts. Sarah felt that mental health nurses needed more training.

> *"To be compassionate actually probably needs to have a little bit of… knowledge as well. Well for me particularly around trauma and to think about what that looks like and how it might affect someone….I've been surprised at how I can find a trauma-informed policewoman [laughs] but in the NHS there are some very* ***not*** *trauma-informed mental health workers"*
> (Sara)

Mary also felt that there was a lack of recognition regarding how nurses' respond to trauma, and how the system often caused (re)traumatisation to individuals who access services.

> *"Trauma work is very different because you are not dealing with one or two incidences, you are dealing with 40 years' worth of multiple trauma upon trauma, upon trauma…So, you are going through quite a lot and it's really hard to go through. It's really hard work, obviously the ideal outcome is that it is positive*

[45] Please refer to the definition and descriptions outlined in Chapter 1 of this thesis.
[46] Researchers and policymakers increasingly recognise that adverse childhood events (ACE) cause trauma and impact adult mental health. The ACE framework provides a guide for early interventions to mitigate suffering in the future (Parliament UK, 2018).

> *because your life is better, you are either recovered or you are certainly better than you were. But it's so hard to go through and then to feel like it was a waste of time, like that has created more trauma for you really without a positive outcome"* (Mary)

A trauma-informed approach to care was believed to be a compassionate way of working with patients in this context. This was interconnected with seeking to understand the person in the context of their life. Patient-participants felt this involved getting to know the person and seeing the person as 'more than' their mental health difficulty or condition. Nurses were regarded as compassionate when they were perceived to be looking beyond a person's mental health difficulty, and to focus first and foremost on the person instead of their diagnosis.

> *"I think someone who has compassion recognises that you are more than, more than this little person having a complete breakdown"* (Sara)

> *"She (referring to a nurse) kind of helped to remind me that there wasn't anything wrong with me, and remind me of my strengths, and made may realise that I have been through a lot which I don't think I appreciated"* (Chloe)

Connecting with someone on a human level involved more than collecting a personal history but working 'with' that person to create a plan for care that works for them. For Zoe and Mary, absence of co-created care was perceived as a 'non-compassionate' approach to care.

> *"There should be some dialogue because when I went into that ward round, they had made all the decisions, they had sanctioned them all and it wouldn't have mattered what I was going to say…it would have been more compassionate if they'd included me rather than making all their decision without even speaking to me about it"* (Zoe)

> *"It's not compassionate not to discuss people's care with them, or to tell them what is going to happen, or spring stuff on them, or to suddenly have your worker leaving with no notice…It's quite inhumane really, that is the only way I can describe it. If compassion is pivotal to someone's wellbeing, which it is, I think in any aspect of life, but certainly if you are dealing with mental health and mental health services it is absolutely pivotal and nothing else will ever work without it"* (Mary)

Clearly, for patient-participants compassion was crucial and tied up with the relational aspects of caring, including the co-creation of care planning. A dialogue between the nurse and the person receiving care was considered the conveyance of compassion at the interpersonal level. Inviting the person to be involved in making decisions about their care was believed to be empowering for the patient, especially when there was the potential for restrictions to be placed on someone's life. Patient-participants wanted to experience the co-creation of care but explained that this experience was uncommon within mental health services (in the study area).

Many participants described how the negative attitudes of some individual nurses had cause (re)traumatisation and systemic stigma through the perpetuation of negative attitudes and associated negative language. Biomedical knowledge of psychiatric classifications and interpretations of mental health delegitimises peoples' lived experiences. Clearly, working with vulnerable people requires the nurse (or other healthcare professional) to have a particular attitude. The attitudes, behaviours, and negative language (which may touch on old traumas) used around

certain diagnoses caused distress to patients. Again, this was destructive and had implications for mental wellbeing.

> *"You are just adding more trauma aren't you if you classify people as PDs[47] and stuff like that. Or like 'oh they are all mental'. I just think well if you find it so difficult when you're in charge of vulnerable people then why don't you just get a different job? If you have to categorise people in such a way, then you probably shouldn't be working with vulnerable people. It's still their experience, and there are so many people that are traumatised on the wards"* (Lilly)

> *"I was medicated against my will – like held down by four people and injected for medication, and at the time I thought people were trying to gang rape me. Like it was just really traumatic…I was traumatised by the people who were supposed to be helping me"* (Chloe)

The damage to Chloe's mental state while being treated in mental health services was expressed throughout the interview. Biomedical dominance and a lack of trauma-informed care in Chloe's experience led to the experience of re-traumatisation. In the quote below, Sarah and Chloe clearly demonstrate how viewing them through the lens of the medical model of illness disregarded their voice and overlooked their lived experience. Instead, the focus was felt to be solely on their diagnoses and category of mental disorder, a trauma-informed (compassionate) response was believed to be absent.

> *"There was pressure from the doctor to take antidepressants like that was just the answer, not to talk about what the problem was…I felt like that was [pause] just dismissed what was actually the matter really - 'Just take a pill on it will all go away'"* (Sara)

> *"My key worker (nurse in the community) I always felt judged by her, she always made little comments about*

[47] PD is an abbreviation used to refer to people with a diagnosis of 'Personality Disorder'. Attitudes towards people with Personality Disorder (PD) have been shown to be generally negative (see McKenzie, Gregory & Hogg, 2022).

> *like [pause] me being unwell, or 'there is something wrong with your brain' just 'something not right with you', just making me feel like there was just something wrong with me…. And an emphasis on symptoms. I think something I have, this thing around compassion, that I have always struggled with, because I have been labelled as someone who has symptoms of psychosis or depression or whatever, they look at that and offer me medication rather than saying what is going on underneath that"* (Chloe)

This affirms the influence of a strict medical perspective on nurses' ability to continuously provide compassion within the care they deliver. While medication was felt to be useful, and vital for some people, relying solely on medication to treat mental health was not viewed as a compassionate response. Relying solely on the medical approach to mental health simply over-pathologises patients' lived experience.

7.3.2 Discursive Action: Desire to Experience Compassion (Felt-sense Response and Healing)

Participants discerned a compassionate nurse based on how they made them (patient) feel when interacting. This was described as an interpersonal connection or a relational space. Hence, the core component of compassion was underpinned by the nurse's virtues (of compassion) and conveyed at point of interpersonal connection, which, in effect, created a compassionate space. Participants described how a compassionate response (for the patient) was combined with seeking to understand them (patient) as a person.

> *"For me compassion is about how people make you feel, and kindness. Treating you as a real person and taking time to think what is right for this person, and*

knowing that that might change as things change, and as their conditions change and fluctuate" (Jane)

To meet the threshold of compassion, a nurse needed to make a conscious effort to relate to them (patient) as a human being. For patient-participants, compassion existed within a relational space and with the correct conditions present, which enabled compassion to be externalised by the nurse. This was achieved when the nurse used active listening as a way of getting to better understand them (patient) as a person.

The discursive construction of compassion was that it is fundamentally something inherent to (and enacted by) the 'individual' nurse – and that nursing and other healthcare professionals would embody the traits of compassion (as patient-participants described). This is understandable given that the NHS Constitution (a document which sets out patient's rights and the commitments of NHS staff to patients) claims that compassion is central to everything the values of the NHS and everything the NHS does (DOH, 2015).

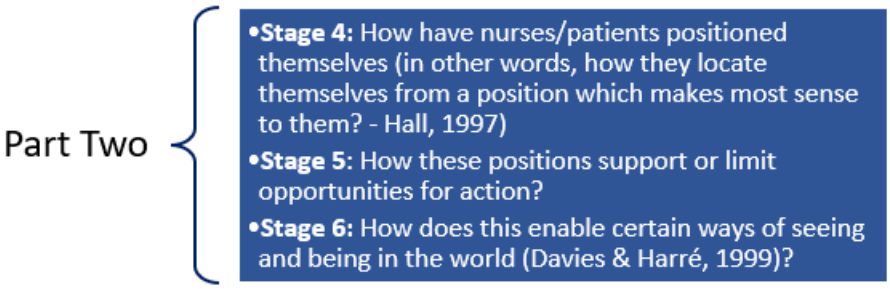
Patients' expectations for compassion can therefore be said to be facilitated by government ideology, as it (compassion) is presented in healthcare policy that 'caring work' involves prioritising patients first (Collins, 2014). Given the historical theorisation noted here regarding the essence of caring in nursing practice (Hoyt, 2010; Shattell, Starr, & Thomas, 2007; Straughair, 2012), and the supporting literature for understanding compassion (as 'part of the person – and the profession'), the governance of mental health nurses' conduct is easily established. Arguably, this is achieved through the art of caring, and nurses' desire

to attend to the needs of patients, create therapeutic relationships, and fulfil their sense of duty to both the patient and the organisations at which they are employed. This, therefore, situates nurses whereby they are held accountable to 'the State', the organisation, and 'patients' – otherwise referred to a 'service users' – for whom they are employed to deliver care. However, socio-normative discourses and organisational elements of the healthcare system were understood to constrain compassion due to the influences of these discourses on the attitudes of nurses.

Patient-participants' discourse clearly illustrates a desire for compassion, and when compassion was experienced, healing and recovery were felt to be made possible; or as Lilly put it: *"That's what everything comes down to…if someone is there and they are compassionate that can be just so healing you know".* Through their constructions of compassion and by outlining the importance of, and desire to receive compassion, this discourse acts to communicate the yearning for the enduring therapeutic effects of compassion to be felt more consistently, which may be achieved by creating societal and organisational changes.

Part Two

7.3 Positioning, Practice and Subjectivity



The specific focus for this next stage of the analysis is to consider how positionings might influence the actions that are possible (or not) for the subject (Willig, 2008a). The positioning of individuals in certain ways within a constructed version of the social world either enables or constrains what can be said, done or experienced. Given that certain practices or ideologies become legitimate within certain discourses (Foucault, 1982), here possibilities for actions and interactions (of patient-participants) are examined – considering patient-participants' own discourse, as well as the institutional and wider social discursive constructions of compassion.

7.3.1 Positioning of Mental Health Patients

Patient-participants identified themselves as *'patients',* effectively as consumers and/or recipients of mental health care. From this position there was an expectation that they would be able to access the service(s) they needed and would receive

care and treatment. The type of care that ‘all’ patient-participants’ expected to receive was ‘compassionate’ care. However, as discussed in part one of this chapter, many described scenarios where compassion was absent.

As noted in section 7.2, where an individual nurse was constructed as lacking compassion, this was related to their attitude (exposed through the language they used) or behaviours displayed toward patients. The felt-sense response (of the patient) in these examples was that of a lack of compassion. This felt-sense response extended to the system at large, which was experienced by some patient-participants as a compassionless system. For instance, patient-participants who reported having the following self-reported diagnoses, ‘trauma, trauma/psychosis, bipolar, alcoholism, and eating disorder/body dysmorphia’, described experiences where they had struggled to access services. From herein, I shall refer to these participants (as they referred to themselves) as ‘complex’.

‘Complex’ patient-participants described experiencing lengthy waiting periods before they could access the help they needed. They implied that this was a result of their specific diagnosis, which determined whether they would be able to access the care they needed. Complex patients talked about how they felt they needed to ‘fit’ into the system, and this could be done by meeting certain objectively based criteria. This confounded wellbeing, particularly for those who had been seeking help from services over long periods of time.

> *“I have always found access to mental health services to be difficult, and initially in my journey I went through the GP to try and access mental health support and I didn’t really get anywhere. So, I ended up, I was*

struggling for a long time with depression and anxiety, insomnia, that kind of thing - following multiple family bereavements and I had to experienced and abusive relationship as well erm [pause] and, I was just really struggling to access any support really" (Chloe)

"At that point I was just desperate to see somebody…the waiting lists are very very long, and because I had had to jump through so many hoops to access her (nurse), it was, I just felt like I had to settle with it. even though it wasn't helping, in fact it was far from helping. So, the system, of the hoop jumping but you have to do if you are needing to access any kind of therapy is phenomenal, and it is actually quite degrading in itself" (Anna)

"I feel like I have had to jump through a number of hoops. It's been like, 'try the DIY IAPT[48] approach' 'try the 6-weeks of CBT[49] approach', 'try the CBT through your employer approach', 'try the 20 weeks of IAPT plus', or whatever... And, at each stage I have had to start again with a little bit of a tentative history, erm, and then at each stage it has been 'oh well, that's not enough" (Sara)

The structure of services created significant challenges to accessing what might be the 'correct' service. When 'complex' patients did eventually manage to access services, their fundamental need for compassion was ignored because they had waited for so long; however, this was damaging to mental health. As Anna notes, she *'just had to settle with it, even though it wasn't helping'*. Also, as Sara's quote demonstrates, she gave '*a little bit' of a 'tentative' history* each time a service was needed to be accessed, thereby editing her story to preserve her own sense of wellbeing. To protect her wellbeing, the sharing of past experiences of trauma needed to be consciously managed.

[48] Improving Access to Psychological Therapies (IAPT) services exist to provide evidence-based psychological therapies (like CBT) to people with anxiety disorders and depression.
[49] Cognitive Behavioural Therapy (CBT) is an evidence-based talking therapy, most commonly used to treat anxiety and depression.

Most patient-participants had been seeking help from services for long periods of time. They described how the desire for help had led to the existence of negative terminology or attitudes toward them. Participants stated how negative terms had been used to refer to them, either spoken directly to them or written in their patient record, e.g. attention-seeking, non-compliant, awkward, nuisance. Generally, participants were made to feel they were a problem because they were asking for help. However, where patient-participants did not refer to themselves as complex (I shall refer to these participants as non-complex), their experiences were described in a much more straightforward way. There were no reports of any negative attitudes or behaviours from individual nurses (or other healthcare professionals) within the system and gaining access to services had not been an issue for them. This suggests that within mental health services, there is a division of conditions, caused by the consumption of discourses relating to the classification system being used, e.g. the International Classification of Diseases (ICD). The assessment tools used by individuals within that system are structured based upon these classifications, which appear to enable assess to care and treatment for non-complex patients, and limited access for complex patients.

7.3.2 Opportunities for Action

Whether they had positioned themselves as ‘complex’ or ‘non-complex’, patient-participants expected that mental health services would contribute to recovery. Yet the challenges and barriers noted to accessing ‘compassionate care’ were considerable. The general view was that the current mental health system is

denying people (particularly those who were positioned as complex) the essential (compassionate) care that they so desperately need.

Complex patients spoke about how their experiences of mental health care had often caused more harm than good (see section 7.3 of this chapter). The structure of services, objective measures used to assess patients, medical model of illness, and pharmaceutical approaches to treatment were all noted as challenges to accessing mental health care and caused iatrogenic harm. This included judging and criticising patients based on 'objective' assessment criteria, rather than seeking to understand the person's experience, which was reported as damaging to mental wellbeing.

> *"It's harmful just in general being someone with serious mental health problems and having an appointment with a mental health professional - the clue is in the title - to have them paying almost exclusively attention to what I look like. Because you won't ever see me looking like that because I have got body dysmorphic disorder and I'm obsessive compulsive and I've got an eating disorder and so you will never ever see me look like that"* (Mary)

> *"I was very set on following my suicide plan. And, but…I just felt like that they didn't believe me…and that felt like they didn't care…I think in my mind was on my own track and I didn't want them to interfere so I just thought 'I'm going to say as little as I can get away with saying' and because my objective was to get back out again"* (Sara)

In Mary's account, the assessment process being followed is based on the understanding that if a person looks 'unkempt' then this would indicate a decline in mental health. However, this assessment focusses on 'objectively' observed measurements, which (as Mary notes) outright rejects her lived (subjective) illness

experience. In this sense, the assessment process seems to be more about seeking to understand the diagnostic tool rather than seeking to understand the person.

In Sara's quote, she talks about how her mental health had worsened to the point of actively seeking to end her life. Despite having been in a vulnerable state, Sara was left feeling discredited by services, which led to the internal management of messages conveyed to nurses and to other healthcare professionals. Sarah's extract demonstrates the potential life-affecting consequences when nurses or other healthcare professionals discredit the patient's voice.

7.3.3 Systemic Marginalisation and Stigma

'Complex' patient-participants felt unheard, judged, and criticised within a system that, in their view, was set up primarily to accommodate people whose mental health difficulties were more acceptable to society. For example, depression and anxiety are visible in the social narrative of mental health. In some cases, a diagnosis was helpful as it enabled people to make sense of what was happening to them. However, for those with complex diagnosis, systemic marginalisation was felt deeply, and the feeling of stigma was exacerbated.

Some participants reported how the experience of being in hospital was damaging, to the point that, despite still needing care and treatment, they would do whatever they could to be discharged. Participants reported feeling afraid of the way staff might construe their actions and behaviours. For example, Zoe articulated feeling that *"once a patient had been viewed through a certain lens (whatever their mental*

health diagnosis was)", then a patient's behaviour would (more often than not) be interpreted through that lens. For Zoe, healthcare staff needed to take a step back and think whether *"there may be other reasons the patient is being 'awkward'"*.

> *"There are times when the staff say, 'come on, you can do this' and you feel like saying 'no I don't want to' but you feel like you have to, or it will go down as awkward patient in your notes…It's an atmosphere of people being drilled based on what they (nurse) think is best for the patient. Not being open to other things"* (Zoe)

> *"it's almost like human rights abuse. But I think to actually lock someone away and take all their rights away from them, restrain them, and potentially medicate them against their will, or like erm, keep them for as long as they want to keep them for. Because you can be kept for quite a long time in hospital if you don't seem, if you don't comply with what they're telling you to do"* (Chloe)

Anna reflected on an experience of a family friend who had been sectioned[50] under the Mental Health Act (2007/1983). The observation was that compassion had been absent from this person's experience, and so they had left hospital still desperately in need of support.

> *"A young person that who was in their early 20s who is very close to me was sectioned…it was absolutely horrific to see, and the impact that had on them at a time when they were extremely vulnerable and had experienced a breakdown, and when compassion is so much needed and should have been provided, there was absolutely no evidence of that at all. And, so all that person did then was to do whatever they could to comply, to get out. There was no 'well actually I would really benefit from accessing some therapy could I do that that would be really great' it wasn't offered because they were already coming at him when he was already feeling degraded - making him feel like he was the faulty goods (emphasis)"* (Anna)

[50] See www.mind.org.uk (2022) for information on sectioning.

Why is it that the experience Anna described here is one that is perceived to be lacking compassion? Compared to the accounts of the nurse-participants, they reported that, while restrictive practices caused them (nurses) moral distress, these practices were necessary to perform in the 'best interests' of the patient. Perhaps it is the case that the practices necessary to keep people safe were considered by the nurses Anna observed (at the time) as compassionate responses?

In this case, knowledge of the risks associated with human beings who are experiencing acute psychological distress forms the basis for nurses' individual and collective discursive and non-discursive action (Jäger & Maier, 2009). Having not been privy to or made aware of these factors, Anna has only her own perspective to draw upon. Hence, there is a disconnect between the basis of understanding in terms of the 'reality' from the perspective of the nurses delivering care, and those (Anna) with an outward observation of their actions.

7.3.3.1 System Management and Socialisation

The training and subsequent socialisation of mental health nurses is a potential contributing factor in the negative language associated with mental health patients within the system, and the negative experiences described here (systemic marginalisation and stigma). This was harmful and had implications for mental wellbeing (see Lilly's account in section 7.3). The effect of this was patient experiences that were the opposite of compassionate, as compassion was

identified and understood by patients. There was a clear acknowledgement, from 'complex' patient-participants, that opportunities for recovery are significantly limited by the way services are structured. This demonstrates that the expectations set out by government, following the Francis (2010, 2013) report(s), that compassion is a universal construct within the UK NHS, has not translated to the patient experience. In fact, as patient-participants described during the interviews, their experiences within the current healthcare system lacked compassion.

Although, the 'notion' of compassionate care was presented (in policy and through organisational discourses), compassion (as expected) was often felt to be a facet of healthcare services. Indeed, as the empirical data in this chapter have shown so far, compassion was infrequently experienced.

> *"It is one of those things that could be quite easily put into a mission statement, like for a company or something - when you go into to a reception, and you say 'oh that's a lovely piece of fiction you've got there' [laughs]. And then you think about the reality of how everything is run"* (John)

> *"IAPT are under so much pressure they are crisis management rather than being able to be compassionate…it is like spiral effect of not enough money pressure on the individuals working within the system, services, is immense and consequently the delivery is questionable"* (Anna)

A compassionate model of care may be subsumed within a person-centred model, and, in mental health, this meant delivering trauma-informed care. However, (as previously discussed) a trauma-informed approach was lacking, and services (in the study area) were perceived not to be responding to trauma effectively or acknowledging the long-term effects of trauma. Hence, the way the policy

discourse is assembled is not how things 'really' are for people who receive care. This is illustrated in the obvious lack of compassion in patient-participants' experiences of mental health care. Despite the previous rhetoric around compassion in policy, patients' experiences continue to be felt as 'compassionless'.

As Sarah's quote (above) indicates, there was an economic pressure felt from within the system which also limited patients' experiences of compassion. The effects of budget restrictions were clearly felt by patients, e.g. patients were de-humanised and valued only in terms of cost-effectiveness. Hence, the clinical appropriateness and potential positive impact of compassion may not be seen as important.

Nurses within the system were perceived as entering the system with the values of compassion, however participants felt that these values were eroded over time. The effects of socialisation for new nurses within the existing system was considered to contribute to negative attitudes towards patients.

> *"I'd say that most people that are going into these sorts of professions generally tend to be quite caring individuals, or at least they start out that way"* (John)

> *"People come through training school get qualified and are full of ideals from the training – get out here. They, sadly, get a better appraisal if they fit in"* (Zoe)

> *"They are not given time to care really. They don't have the time to care that much, and they have also got more paperwork to do now that they used to do"* (Mary)

> *"The higher you get up in the tower, you lose sight of reality, and no disrespect as such but the bureaucracy gets tighter and tighter"* (Kevin)

The above quotes suggest that difficulties in delivering compassion (as mental health nurses also indicated) are confounded by managerialism and bureaucracy within the NHS. The hierarchical structure of the NHS means that each person within the system has something to compare themselves against. It is possible then that, for compassion to become the correct way of doing things (and the standard culture within an organisation), nurse leaders, who are in a position to influence others, must demonstrate the values of compassion.

7.3.3.2 Economic Reality

Patient-participants shared concerns surrounding the withdrawal of specific types of community services, which had resulted in the feeling that there was a lack of parity of esteem[51] for mental health. These services were considered vital for mental wellbeing. Services that had been withdrawn were viewed as effective in reducing social isolation.

> *"I remember a few years ago we were talking about parity for mental health and physical health, and we are nowhere near to achieving that because it requires money. And I think it also requires joined-up thinking across departments so things like social prescribing - like why not have community sessions for people like gym sessions between the local authority and the healthcare systems? A lot of people's clubs are closed, and libraries are closed, or they're not as good as what they should be because you can't use them as a community space anymore and said that community infrastructure is crumbling. So, all these social interventions that we can get for people, to make connections like self-help groups, the backdrop is fading"* (John)

[51] Parity of esteem describes the need to value mental health equally to physical health (see chapter 1, section 1.1.). The Coalition Government proposed how to deliver 'parity of esteem' by 2020 (see NHS England, 2016).

Awareness of insufficient funding was an emotive topic. Participants spoke about how inadequate resourcing of mental health services had meant patients were not able to receive the follow-up care, or timely responses from services that were desperately needed; this unavoidably resulted in a deterioration of mental wellbeing.

> *"I am home and I'm still feeling really vulnerable, but they don't contact me until 7:30 pm the next day…. I felt so vulnerable, so vulnerable, And I would rather they just say that they (services) are not there and call the Samaritans than pretend that they are, because I was so at risk… even then, two days after being pulled off of a riverbank, I was then 2 days later going out to scope other locations"* (Sara)

As someone who had accessed services over two decades, Sara had observed how follow-up care had reduced over time.

> *"I would say that in my 30s when I first accessed crisis that it was better resourced. Just in the sense of that there was more follow-up"* (Sara)

For Anna, funding cuts were connected to the reorganisation of services, and the creation of new cost-efficient services. The introduction of Cognitive Behavioural Therapy (CBT) was not considered to be a compassionate approach to delivering mental health care.

> *"My first bout of therapy was when I was about 30,35 ish I think - and my experience then was to be part of a pilot scheme for doing CBT online. I found that extremely negative, depersonalised and not very compassion at all…and I felt really sad that this was going to be rolled out by the NHS…at the time, I felt it was a very generic approach and didn't meet the needs of the individual at all…CBT has absolutely no person-centred basis whatsoever, and I have actually*

been face to face with someone, a CBT practitioner…they just deliver CBT…you literally go through these stages and that is it" (Anna)

The restructuring of services over time was perceived as having made the system more difficult to access. A lack of funding and insufficient follow-ups for people leaving hospital transcended whatever the diagnosis was (or how participants referred to their mental health difficulty).

"When you are on the ward for only 2 weeks and then detoxing, there is no aftercare for that, no follow up and 2 weeks without a drink. I can remember the first one I did; I walked down to the pub at the bottom of the road and got drunk" (Kevin)

The reality, from the patient-participants' perspectives, the system simply needed more compassion. For instance, the example Kevin gave regarding detox relies on *human-to-human* interaction(s) and not 'online' or 'over the phone' therapy, e.g. CBT & IAPT.

7.3.4 Continual Suffering – Where's the Compassion?

Foucault's (1991/1978) concept of governmentality encourages exploration of the discourses that encourage neoliberal subjects to 'self-govern', in addition to the 'macrotechnologies' through which organisations facilitate neoliberal programmes (in this study, the compassion agenda) (Foucault, 1978 *in* Burchell, Gordon, & Miller, 1991; Rose, 1999). In the current study, patients-participants spoke openly about the difficulties in accessing mental health care; many reported having lengthy waiting periods to access the support they needed. If being compassionate

as an individual nurse (or other healthcare professional) is viewed as being responsive to another person's needs (NMC, 2015), at a systems level, this seems antithetical to this very basic and vital principle of compassion. It is almost as if patients are being triaged to receive compassion – and that their suffering has become commodified. I suggest this point, not to attempt to assert 'the truth', rather to explain how mental health services have been arranged under a neoliberal regime.

Services are essentially positioned to aid citizens' return to work, and thereby back to, once again, becoming a functioning, productive 'body' to the State economy. When a *'patient'* (my italics) presents to their GP surgery for example, the physician(s) and other healthcare professionals are implicated in the broader surveillance of health and the bureaucracy of healthcare services – under the guise of providing 'cost-effective' (evidence-based) treatments and services. Consequently, 'audit-based' ways of working become normalised in this climate to promote ways of thinking about mental health that are congruent with the demands of government, State spending, and the wider economy (see Owens, Singh & Cribb, 2019). Hence, human suffering is all too easily understood in economic terms – rationalised within a disease framework.

The accounts of patient-participants shown here support the above statement, for example, emphasis was placed on how assessment processes utilised by mental health professionals were focussed on 'objective' measurements. In addition, many were faced with having to meet a certain 'set' criterion before they felt they were eligible for any 'help'. Therefore, compassion (as defined in the literature, and

as socially constructed within these patient-participant accounts) as a response whereby the nurse seeks to ‘try’ to understand the ‘person’ becomes meaningless. Rather, mental health nurses are trained (according to whatever NHS protocol is being utilised within a service) to view the person through the diagnostic tool(s) being employed. These tools may be considered to aid decision making; decisions that (if foregrounded by compassion) ‘should’ seek to relieve suffering. However, this overlooks the nuances of power by which ‘decision making’ is prefaced under the guise of the ‘clinical decision‘ (see Karanikola *et al.,* 2018). This allows the nurse to rationalise their chosen course of action, which may not be viewed as ‘compassionate’ from the patients’ perspective.

7.3.4.1 Minimal Progress

The expectations and processes of government (such as mandating compassion, the de-commissioning of services, retrenchment, and austerity measures) have clearly had a negative influence on patients’ experiences of care. Mostly, patient participants felt as though they had to struggle to access to mental health services. When they had finally accessed services, many felt they gave up on receiving compassionate care and resigned themselves to the idea that compassion was a rare experience. Some accepted poor care experiences because they had been waiting such a long time to gain access. After having been able to access services, some patients had a continued need for support from services, which was also difficult to obtain.

The literature review in chapter 2 was focussed on how government had attempted to increase levels of compassion in healthcare by implementing a number of policy reforms, which had aimed to resolve the problem (that compassion was lacking in nursing). The lack of compassion experiences by the patient-participants in this study have demonstrated that the previous state-centric power struggles involving political attempts to attain social order (improve compassion in nursing) have not led to positive social change (increased compassion). Given the accounts of those receiving mental health care (participants in the current study) it is clear that very little progress has been made in terms of increasing the experience of compassion in the healthcare workforce. Political power, or in other words the discursive strategies used by government to improve patient satisfaction, through the experience of compassion (delivered by individual workers), has been unsuccessful. This is because these discursive strategies were a political ploy to place blame on individual workers rather than address any existing systemic, structural, organisational problems.

7.4 Summary of Key Findings

Patient-participants discursively constructed compassion as inherent to the individual nurse, and compassion could be felt by the patient through the nurse's virtues, attributes, and skills. Seeking to understand the person (patient) and the context of their distress was felt to be underpinned by compassion, and compassion was considered essential for the recovery process. However, many patient-participants described experiences where compassion was absent. Social

and institutional discourses were found to be influential in relation to the positioning of mental health patients as either ‘complex’ or ‘non-complex’. These influential discourses were embedded within the system as a whole and perpetuated by individuals employed within that system. Where negative attitudes were experienced, patients’ fundamental need for compassion was ignored due to the challenges they experienced accessing services. Moreover, the objective measures used to assess patients significantly limited the experience of compassionate care. As a result of the assessment criteria and classification of diagnoses (ICD criteria), patient-participants experienced systemic marginalisation, stigma, and continual suffering, which is counterintuitive to the notion of ‘care’.

An overview of the findings from this chapter are presented in Table 9 (below). In the next chapter, these findings will be discussed in relation to the literature presented in chapter 2, and the theory of governmentality (Foucault, 1978 *in* Burchell, Gordon, & Miller, 1991) outlined in chapter 3.

Table 9: Summary of findings – phase three

Stage of Willig’s (2008a) Analysis	Summary of Findings
1. Discursive Constructions	Compassionate virtues of the nurse Nurses used the skills associated with compassion, e.g. active listening, trauma-informed approach
2. Discourses	Socio-normative, medical, and political discourses evident in patient-participants’ accounts of clinical encounters with individual nurses who were perceived to lack compassion.
3. Action oriented	Speaking about their negative experiences of care, and associated language/behaviours that had caused these negative experiences, may be part of a strategy to bring

	about social change (have more compassionate experiences) or social justice (reduce negative experiences).
4. Positionings	Participants positioned themselves as 'patients' – divided into: - Complex - Non-complex
5. Practice	Opportunities for action are limited by: - Structure and/or governing of services & the socio-normative, medical, and political influences (section 7.3)
6. Subjectivity	- Continual suffering - Stigmatisation - Discredited voice - Marginalisation

Chapter 8: Discussion

8.1 Introduction

The broad aim of this thesis has been to explore the concept of compassion in the context of mental health care. From a theoretical perspective, this thesis has been concerned with how language has been used to shape and constitute the social world and the social sense of self (Davies & Harré, 1990; Miller & Rose, 1990; Rose & Miller, 1992; Willig, 2008a). The inquiry was underpinned by Foucault's (1975 and 1978 *in* Burchell, Gordon, & Miller, 1991) theory of governmentality and a critical discourse method was used to examine power relations and ideologies explicit and/or implicit in the use of language. The research objectives were to examine how compassion had been constructed in healthcare policy, to explore the discursive construction of compassion as understood by nurses working in the practical setting of mental health, and to explore the discursive construction of compassion from the perspective of people with lived experience of mental health care.

8.1.1 Statement of Major Findings

The document analysis made the assertion that discursive techniques and strategies had been used to influence the minds of individuals (nursing workforce) in the interests of those in power, i.e. government. Specific techniques were shown to have been used within political text(s) and talk, e.g. the two words 'care' and 'compassion' had been compounded, responsibility for the fate of local NHS organisations had been shifted to local Trusts, and it was indicated that financial

incentives had been made dependent upon ‘patient experience’ which was also interrelated with ‘quality’ care. The government’s conceptualisation of compassion had been disseminated from national level and integrated into local healthcare policy. It was asserted that these discursive strategies led to a (re)conceptualisation of compassion as a duty and responsibility of individuals within healthcare systems. However, the language used by government had placed a specific focus on shaping and regulating the conduct of nurses (Smith, 2013).

Phases two and three presented findings from interviews with mental health nurses (nurse-participants) and interviews with individuals who have lived experience of mental health care (patient-participants). Both nurse- and patient-participants constructed compassion as something that is inherent to the individual nurse and embedded within the nurse–patient therapeutic relational space.

Nurse-participants rejected the influence of compassion policy on their role and defended their position as compassionate practitioners from within the historical discourse related to the theory (and practice) of ethics in nursing – and existing definitions of compassion as a distinct emotion. Nurse-participants’ embodiment of compassion enabled them to position ‘the self’ as nurse-physician. It was suggested that, from this position, nurse-participants could promote patient recovery through the therapeutic use of ‘the self’, which enabled them to gain a sense of legitimate professional identity.

There was some evidence that the policy discourse had shaped the ideologies of some nurses, which were noted to have the potential to limit professional development and lead to unreliable value judgements, e.g. compassionate or not compassionate professional nurse(s). These value judgements were noted to have been used as part of an assessment for aspiring nurses and for established nurses looking to change roles or potentially as part of a promotion, i.e. Joanne's narrative in chapter 6, section 6.2.3. Compassion was significantly limited by the organisational structure and professional hierarchy in the NHS, for instance, there was a sense that nurses sometimes disagreed with the decisions made by psychiatrists which constrained compassion, or there was a feeling that nurses felt treatment decisions were wrong because they had not included the patient. The context in which the nurse-participants worked, e.g. community or in-patient service, also placed limitations on the nurses' ability to enact compassion, i.e. blanket rules and low levels of staff meant they often had insufficient time to spend with patients. These structural and organisational limitations caused nurse-participants to feel guilt, frustration, and a sense of having failed patients in the recovery process.

Patient-participants described the innate characteristics and specific skills of the nurse which had enabled them to 'feel' compassion. These were referred to as 'warmth, genuineness, active listening, and a non-judgemental approach'. Patient-participants' discourse reflected a distinct lack of compassion in their care experiences. This was associated with what were proposed to be negatively induced ideologies linked to nurses' overuse of 'objectively' defined assessments,

measures, and classifications of diagnoses. Patient-participants felt that these attitudes were antithetical to a compassionate approach (which was considered to aid healing) and discredited patients' voices. From a theoretical perspective, it was asserted that a dominant medical approach to mental health had marginalised discourses of compassion and humanism in the social world. This was believed to have caused inaccurate judgements to be made in relation to patient-participants' lived experiences, which caused stigma and the experience of (re)traumatisation or iatrogenic harm.

The following discussion will offer unique insights into the ways compassion was identified in the context of giving and receiving mental health care. It will explain how the data generated from this research have contributed to and expanded knowledge of compassion in relation to global viewpoints and existing explanations of compassion. It will consider theoretical debates regarding 'discourse as a social practice' and the power of discourses in constituting our social reality, specifically how types of knowledge can influence our views and experiences in the social world. I will draw from the theoretical constructs outlined in chapter 3 to make inferences in relation to the data that have been collected for this research.

8.2 Document-Level Data

At the beginning of this thesis, a review of the literature revealed that debates about compassion in healthcare had surfaced in the last decade. Scholars had stressed thinking about *how* compassion can be defined and *how* it can be effectively

demonstrated, specifically in relation to nursing work (Baránková, Halamová, & Kóróniová, 2019; Durkin *et al.,* 2019; Kim *et al.,* 2020). A notable turning point for this debate appeared to be marked by major care failures in the English NHS and previous implications of nurses 'apparently' lacking compassion (Berwick, 2013; Francis, 2013).

The picture that emerged from the document analysis (chapter 5) is one of work practices having been shaped within a discourse of individual responsibility for compassion. It was also evident from the document analysis that the political rhetoric on compassion has led to the word 'compassion' having become representative of both 'quality' care and 'safe' care (DOH, 2012). However, most striking was that nurses' professional conduct had not previously been regulated in relation to compassion, as compassion was absent from the standards and proficiencies for nurses prior to care failures in the UK NHS (Francis, 2013; Keogh, 2013; Parish, 2013). In response to the Francis reports (2010, 2013), the NMC (2015, 2017) made clear that to meet the professional standards for nursing, all nurses (and midwives) 'must' respond with compassion, which then made compassion an 'expected' professional standard and something to be continually evaluated in practice. The use of the word 'must' indicated that the writer (NMC) has power over nurses to regulate the conduct of nurses (and midwives). Of course, the core role of the NMC (2015, 2017) is to 'regulate' and promote high standards for the nursing and midwifery professions. Some studies have pointed out that the Francis (2010, 2013) report noted that it was not just nurses who were accused of poor de-humanising care practices, but healthcare workers at all levels

of seniority. Yet, the government's policy response appeared to have attacked nursing competencies. This demonstrates the narrow scope of the government's compassion policy, which fixated on nurses' behaviours to increase compassion in healthcare. It also illustrates an attempt by the government to shape the behaviour of nurses using disciplinary practices specific to nursing work (Miller & Rose, 1990).

As such, nurses have had to negotiate the foregrounding of compassion in their practice, while also confronting the challenges associated with the fragmentation of health and social care in the UK (Pownall, 2013), e.g. previous government reforms such as privatisation and the decommissioning of services (see deZulueta, 2016; Kerasidou, 2019). According to West, Bailey, & Williams (2020) these healthcare reforms have been implemented by a regime focussed on austerity (Tucker, Moffatt, & Timmons, 2020), which have caused prolonged and excessive workloads that have had significant negative consequences on the wellbeing of nurses, including limiting their ability to maintain compassionate care.

A change in the discourse on compassion in nursing (post Francis) is evident within the empirical research, which (at the time of writing) appears to continue to attempt to identify, define and measure the values and behaviours associated with compassion (Durkin *et al.,* 2019; Pryce-Miller & Vernel, 2014; Sinclair *et al.,* 2016b; Strauss *et al.,* 2016; Blomberg *et al.,* 2016; Papadopoulos *et al.,* 2020). It can be argued that this, in itself, exemplifies the productive power of the UK political rhetoric, and the direct impact of it, in terms of how the healthcare policy response has generated a shift in thinking about compassion in healthcare in the social world

(Foucault, 1979). However, the academic literature pertaining to compassion in healthcare has been characterised by decontextualised and reductive research outputs. For instance, as noted in the literature review (chapter 2, section 2.2.1), the available peer-reviewed publications were largely opinion pieces, discussion pieces, and theoretical papers. Researchers who have accounted for the context(s) in which groups or individuals' function, such as Sinclair *et al.* (2016a, 2016b, 2018), have concentrated on palliative care environments in the Canadian healthcare system. It is possible that the UK government's compassion rhetoric may not be met with the same responses if Canadian nurses. or those elsewhere outside of the UK, were asked the same questions that were asked to mental health nurses in the current study. I am not suggesting that healthcare systems outside of the UK are not multifaceted, complex, or as dynamic as the UK system, however; simply that the way in which they are governed and funded is not the same. Hence, these environments will be variable, and compassion may exist differently or bear different cultural meanings. Furthermore, the current state of the international literature on compassion in healthcare, and that which the current study has gone some way to addressing, is that there is a significant lack of understanding regarding how compassion is identified and what the function of compassion might be in context of mental health care. As noted within the literature review (chapter 1, section 1.4), this context has some unique features which make it different to many other care environments (Mercer, 2015).

In terms of quantitative research, Singer and Klimecki (2014) employed neuroscientific techniques to attempt to demonstrate the difference between

empathy and compassion. This illustrated an experimental effort to define compassion. However, this type of research is reductive in the sense that it reduces compassion to a set of images, and patterns of images, i.e. exposing areas of the brain that light up in response to certain pictures. This approach alone does not provide sufficient understanding of what people think or feel, how they behave in their natural surroundings, or what the mechanisms involved in those responses might be. If combined with qualitative studies, then together this would provide a more in-depth exploration of the concept of compassion as qualitative studies can ask the what? how? and why? questions to explore what people think and feel in certain situations and contexts.

8.3 Nurse-Level Data

The aim of phase two of this research was to explore mental health nurses' discursive constructions of compassion. Data were analysed according to Willig's (2008a) discourse analytical approach (chapter 4, section 4.5.3). This approach was useful for elucidating discursive accounts and experiences while also encouraging consideration of the relationship(s) between nurse-participants' individual discourses and the wider social discourses. Findings from the interviews with mental health nurses are discussed in relation to the existing literature and as theorised by Willig (2008a).

8.3.1 Personal and Professional Domains

Nurse-participants discursively constructed compassion as inherent to the individual and considered compassion to be a part of who they were as a person (and a professional). The identification of compassion as an innate human characteristic aligns with previous research which suggests that nurses embody compassion (Durkin *et al.,* 2019). Whilst a review of the literature did not find any previous studies to substantiate this claim in the context of mental health nursing, this finding infers strongly that compassion is understood as something that an individual possesses inherently. Therefore, the policy changes within nursing, e.g. compassion being added to the NMC Code of Conduct (2015, 2017), and values-based recruitment being introduced (HEE, 2014), are useless in terms of any attempts to evaluate nurses (in any areas of practice) unless it can be determined exactly 'what' is being evaluated. Some studies have shown that certain characteristics and personality traits are associated with compassion, for example, the nurse displays 'warmth' and 'gentleness' (Malenfant *et al.,* 2022). However, exactly what is meant by warmth and gentleness and how these traits are communicated in the act of caring may be equally contested. It is pertinent therefore to consider how compassion might be more robustly measured in the future.

Nurse-participants also reported compassion to be fundamental to why they had chosen to enter mental health nursing. Compassion was understood to be core to their practice and demonstratable by engaging with patients via the TR. This is reflected in nurse-participants' descriptions of compassion as inseparable from

themselves as a person and themselves as a professional. Taken together these results are in agreement with surveys and qualitative research, which have shown that aspiring nurses choose to enter the profession because they already consider themselves to be caring and compassionate (Traynor, 2014; Maben, 2014). However, throughout the interviews nurse-participants referred to the emotionally exhausting nature of working in mental health nursing and the complexities of the decisions and situations they were faced with on a day-to-day basis. It is possible therefore that personal (inherent) levels of compassion will fluctuate and be influenced by situational factors, for example, working in environments where staff are faced with challenging or aggressive patient behaviours such as inpatient environments (CQC, 2017). Indeed, whist writing this thesis research has indicated that a person's degree of compassion can ebb and flow over time (Sinclair *et al.,* 2021). This corroborates with the findings of Maben (2014) and West, Bailey, & Williams (2020), who have asserted that factors such as high caseloads, high turnover of patients, as well as financial pressures and poor management styles, all negatively impact individual levels of compassion. Given that nurse-participants constructed compassion as something that can be enacted via the nurse–patient relationship, this result would suggest that there is a definite need for mental health nurses to have protected therapeutic time with their patients in order to maintain compassion in practice, and, as stated within the NHS Constitution (2015), put patients first.

8.3.2 Defending Nursing as ‘A Compassionate Profession’

It was suggested in section 8.1 of this chapter that there has been a shift in the conceptualisation of compassion in terms of how it has been ‘politically’ configured as a duty and responsibility of individual nurses. For Foucault (1975), a concept (like compassion), a belief, social rule, or particular mode of behaviour is believed to become embedded through relations of power that are established by the socially constructed discourses of larger institutions and/or organisations (Wodak & Meyer, 2009; Foucault, 1995/1972) – these discourses both influence and are influenced by social practices. Hence, it could be argued that the way in which nurses have socially constructed themselves as the embodiment of compassion provides evidence of the institutionalisation of the discourse on compassion, which plays into the government’s conceptualisation of compassion as a professional duty. However, Chaney (2021) claims that there has been a long and convoluted history in nursing regarding the construct of compassion. In her study of compassion as an ‘emotion’ in nursing, she has demonstrated that during the interwar period (1918-1939) nurses were expected to demonstrate sympathy, whereas, since the Francis reports (2010, 2013) compassion has become ubiquitous in nursing work. However, nurse-participants’ constructions of compassion as part of the person (and profession) disclose some curious parallels with the historical discourse of nursing theory, for instance, Florence Nightingale’s concept of ethical knowing (Fawcett, 2006; Nelson & Rafferty, 2012) in relation to the nurse’s personal and professional conduct might indicate that compassion has become a contributory factor to the ‘ethics of care’.

At this point it is relevant to consider that, in the social world, individuals are exposed to a multitude of discourses, and the meanings we develop are heavily influenced by and defined within our early life experiences and upbringing (see Mezirow, 1991; also van Dijk, 2006). Reflection upon our lives is one of the key things that makes us decidedly ‘human’ and, therefore, those ‘frames of reference’ represent taken-for-granted ways of seeing ourselves in the world. Hence, the existing (politically defined) discourse on compassion may not be representative of ‘new nursing knowledge’, as claimed by Chaney (2021), rather this emergent discourse has simply added to nurses’ existing meaning perspectives of themselves as compassionate individuals and compassionate professionals with expectations that all nurses will follow a strong ethical code of practice (NMC, 2018). It is possible that existing perceptions of ‘the self’ as compassionate practitioner may simply be the way individual nurses have always considered themselves to be. As such, the way compassion has been *framed* in the discourse may provide a sense of ownership of compassion from within the nursing profession, thereby allowing nurses to symbolically manifest a new ‘compassionate’ model of care for contemporary nursing work. This may have enabled mental health nurses to realise the ‘professional self as compassionate self’, which has implications for the morale and confidence of individuals within the existing workforce. For instance, the internalisation of this discourse (considering the self as compassionate practitioner and justifying one’s actions within this personal perspective) positively shapes nurses’ collective sense of identity. This has implications for attracting new nurses to the profession and enabling existing

nurses to have a sense of pride relating to their professional status in society. In general, this fits with Larson and Larson's (1979) summary of the defining characteristics of a 'true' profession, i.e. *'professional association, cognitive base, institutionalised training, licensing, autonomy and control, and code of ethics'* (p. 221).

This inference can be understood within Foucault's oeuvre, which demonstrated a concern for understanding the development and organisation of the institutional practices that shape human subjectivities (see Beaulieu & Gabbard, 2006). For Foucault, the self participates in discourse from the inside because we are constituted by discourse (Willig, 2008a). Hence, the way in which each nurse-participant rejected the discourse may have provided them a sense of internal freedom from the political discourse and the influence of policy upon their role. According to a governmentality perspective, as conceptualised by Rose and Miller (2010), nurses may have rejected the policy discourse as having had an influence on their role, however, their professional autonomy is 'regulated autonomy', which is reflective of the power of political rationalities in that it places 'legitimate' limitations on civil liberties. However, the discourses we participate in are never fixed, hence they always leave open the prospect for us to constitute 'the self' in different ways thereby guaranteeing our human freedom (Allen, 2011). Individuals can choose to leave or change roles and/or professions, which means that there is a certain amount of choice in how 'the self' is constructed by the self.

The way in which participants in the current study talked about compassion in their clinical practice could be said to demonstrate resistance to the political rhetoric on

compassion by mental health nurses. The specific examples that can be illustrated here are those of Erin, Alison, and Megan as they talked about how they did not 'need' a policy to be compassionate or did not 'think of' any policy that has 'made' them act more compassionately. This finding is significant in light of the literature review, which noted that the notion of care in mental health has a longstanding connection to the inherently 'relational' aspects of nursing in this context. Mental health nurses' reflections of the professional self (as compassionate self) were synonymous with definitions found in the nursing literature where compassion is defined as having two distinct parts, 'emotion and action' (Gilbert, 2017; McCaffrey & McConnell, 2015). The professional self is therefore constituted as compassionate through the discourses and practices associated with the established knowledge found to underpin much of mental health nursing theory and practice. This suggests that nurse-participants' notions of compassion have been constructed through discourses associated with this specialist discipline of nursing (Haber, 2000; Foucault, 1979).

It is not surprising that nurse-participants considered the professional self to epitomise compassion, conveyed through the TR (Hartley *et al.,* 2020). Particularly, since this discourse has been central to the theory of the development of the nurse–client relationship within mental health nurse education since Peplau introduced the concept in 1952. However, as Fairclough (2015) explains, discourse is a social practice and *"Even a discourse in which participants apparently arrive at (virtually) the same interpretations of the situation and draw upon the same interpretative procedures and discourse types, can be seen as an effect of power*

relations and as a contribution to social struggle" (p. 173). This statement would suggest that it could be possible that nurses have needed to defend their position as compassionate practitioners in response to the political 'attack' on their professional conduct as 'lacking compassion' following the Francis reports (2010, 2013). The fact that nurse-participants' shared accounts of compassion as an inherently human concept highlighted their efforts to defend themselves as fundamentally compassionate.

8.3.3 Transformed Sense of Professional Self

This enquiry was grounded in poststructuralist discourse theory and the Foucauldian notion of discourse (1995/1972), which holds that through the production of categories of knowledge and assemblage of texts, knowledge and power are simultaneously reproduced. Discourse is powerful in that it governs subject framing and positioning, i.e. what it is possible to do, and who it is possible to be. Interviews with nurse-participants were analysed and interpreted using the theories of discourse, knowledge, power, and the subject, as proposed by Foucault (1975, 1982, 1995/1972). The document analysis, presented in phase one, suggested that the construction of compassion within policy was an attempt by government to control the behaviour of individual nurses, in the NHS, by manipulating the social practice of language. For example, following the Francis reports (2010, 2013) the UK government disseminated an ideology that caring is not caring without compassion. Guided by Willig (2008a), nurse-participants' discourse inferred that the policy discourse on compassion in healthcare represents a productive power. The positive function of the compassion discourse

in nursing has meant that mental health nurses have been able to (re)position themselves within this discourse as nurse-physician. They can be viewed as capable of providing both care and treatment using the self as a therapeutic tool to aid patients' recovery. This has potentially strengthened their sense of professional identity. From this perspective, compassion cannot be straightforwardly State regulated, as suggested within the document analysis.

Conversely, high expectations for the intra-professional practice of compassion were evident in nurse-participants' dialogue. This supports theoretical assertions about the power of discourse to induce attitudes (Van Langenhove & Harré, 1999; Willig, 2008a; 2008b) and has implications for those entering the profession, i.e. to attain the standards required by the NMC (2017) "*nurses are required to '*respond compassionately*'"* (p.7), despite the anticipated complexities of enacting compassion and structural barriers to delivering compassionate care. On the other hand, this could indicate that, through discursive constructions of themselves as 'the essence' of compassion, nurse-participants have reinforced the policy discourse that healthcare workers are individually responsible for enacting compassion. The latter illustrates the influence of the political discourse as an effective form of discipline (Foucault, 1975) by creating a course of conduct whereby much of the work of power is done internally, by ourselves and to ourselves. The feelings evoked by this powerful, internalised, discourse, i.e. that compassion is viewed as enhancing recovery using the therapeutic self, could potentially limit nurses' thinking about professional development. This has potential consequences for the recruitment of the future healthcare nursing workforce

generally, in terms of career advancement and job satisfaction for those within the existing workforce, which may have further implications on workforce retention.

8.3.4 Compassion 'Policy' Discourse as a Potentially Dividing Practice

Nurse-participants' viewed themselves as capable of improving patients' experiences of care through the expression of compassion via the TR. The idea that compassion was associated with personal characteristics (expressed within the nurse–patient relationship), and a part of nurses' professional conduct could mean that (from a theoretical perspective) the policy discourse on compassion has had potential to fuel divisions within nursing. This is because the policy discourse has presented an opportunity for individuals to subjectively appraise the ethical foundation(s) of each other's professional activities (Willig, 2008b; Van Langenhove & Harré, 1999). Nurse-participants' accounts indicated that internal value judgements were being made relative to their contemporaries, for example, some referred to 'the self' as being different and having more compassion than other colleagues. However, these subjective evaluations of one's actions and behaviours may be erroneous given that compassion cannot be measured or operationalised in a valid or reliable way (Skwara *et al.,* 2017). It has only been very recently that a valid measurement tool to measure patients' experiences of compassionate care has been developed (Sinclair *et al.,* 2021) (see Appendix 5). External judgements made by one nurse toward another may lead to disciplinary action if someone is judged to be 'uncompassionate', with punitive systems and processes in place to report any perceived lack of compassion (for example, the NMC and CQC). It is possible there may be psychological threat in terms of how

nurses' clinical practice might be evaluated and interpreted. This might explain the way in which nurse-participants contended they were essentially and fundamentally compassionate. Perhaps nurse-participants unconsciously protected themselves by investing in a certain type of discourse, e.g. they presented themselves and everything they do as 'compassionate'. This may be related to the characteristics of the researcher (mental health nurse) and nurse-participants' desire to be recognised and represented in this research in a positive way. This might also explain why nurse-participants spoke more freely when 'off record' (discussed in chapter 10, section 10.4).

As previously discussed, nurse-participants strongly rejected any influence of the compassion policy on their intentions to express compassion. Regardless, they had high expectations for other nurses to demonstrate 'a good measure of' and/or 'the right amount of' compassion. Furthermore, nurse-participants' discourse implied a culture where compassion is an expected standard that develops through the experience of delivering care. This could be indicative of ideological thinking that has been imposed by government, through the discourse presented in chapter 5, which appeared to be, for some, deeply ingrained in their thinking:

> *'What I do see now is that student nurses they want be ward managers within two years, you know and they want to be a director within three, and I think…well make some bloody beds first'* (Erin – SNP)

This quote implies a culture where student nurses are regarded to be obliged to spend time doing, what is perceived as the 'real' work before they could be considered ready, or able to, progress in their career. This echoes the government

discourse, in which compassion was espoused as being increased through getting *"the right people, with the right skills"* into nursing (DOH, 2013b, p. 4). In this policy document, focus was placed on compassion in practice. In the context of mental health *"the therapeutic relationship as a skilful interaction"* (p. 22) was cited as critical for compassion in practice. The idea of getting back to basics was a slogan used by government (and the national press) post-Francis (2013) which suggested that practical activities such as supporting patients to eat, wash, dress, and go to the toilet would foster compassion from within the profession. Clearly, given the narratives shared by mental health nurses in the current study show that the TR is core to mental health practice and improving patient outcomes. Yet, the explicit recycling of government rhetoric, i.e. *"make some bloody beds first"* supports theoretical assertions about the power of discourse to induce attitudes (Van Langenhove & Harré, 1999; Willig, 2008b) and has implications for new nurses who are entering nursing with established ways of thinking, which may be more (or less) conducive to what are perceived to be compassionate nursing behaviours.

Cavanagh *et al.* (2020) have noted that there is a longstanding body of empirical evidence which observes that the organisational cultures that nurses find themselves in can inhibit the expression of compassion. Moreover, team culture can directly impact healthcare standards, including worsening patient care and negatively impacting the psychological wellbeing of nurses (Ortega-Campos *et al.,* 2020; Alharbi *et al.,* 2019). Clearly government discourse on compassion has influenced the way some individual nurses think, which may limit professional

development for new nurses – until they are perceived to be adhering to this internalised notion of compassion that some nurse-participants appeared to hold.

However, nurse-participants' shared opinion was that *'caring for'* the person came down to the medical practitioners as well (comment by ward-based female nurse-participant). Yet, there was no mention of using the disciplinary processes to push back against this apparent lack of care from medical professionals. This could indicate the involvement of subliminal work on individual subjectivities (Rose, 1993), where nurses have been made to feel they are the ones who have overall responsibility for 'compassionate care'. Perhaps, reluctance to utilise the processes in situ for discipline at the inter-professional level of interaction might reflect a power relationship that has not been explored in this empirical work. Although, there has been some discussion, regarding a culture of fear and organisational silence within the NHS (*see* Pope, 2019), which indicates this might be an area for future research to consider.

8.3.5 Organisational Limitations to Compassion

Nurse-participants expressed a deep sense of guilt and feelings of frustration that they had little quality time with patients, which conflicted with their ideals for delivering compassion. They remarked on the stress caused by a high administrative burden and excessive workloads. Further problems were caused by unequal power-dynamics relating to the nurse–psychiatrist relationship and that psychiatrists (in the study area) often failed to include patients in decisions about care and treatment. Without speaking to psychiatrists and/or observing these

dynamics in real time, it is difficult to comment on the likely causes of psychiatrists' behaviours towards patients. Nevertheless, nurse-participants argued that these organisational factors significantly limited the expression of compassion. There are similarities between the organisational barriers to compassion expressed by participants in the current study and the findings of Crawford *et al.* (2014), in which mental health care environments were referred to as a *"factory-style, conveyor belt health service*" (p. 3594). Commentators like West *et al.* (2020) have also noted that nurses' workloads are excessive and staff shortages confound these pressures. The policy response to the Francis reports (2010, 2013) was supposed to be focussed on ensuring 'safe' staffing levels and developing a culture of compassion. Yet, at the time of writing this thesis, there are still large numbers of nurse and midwife vacancies. These observations reflect a significant lack of progress despite the government's response to care failures. Hence, it could be argued that the government rhetoric on compassion was a way of presenting an easy-to-mobilise solution to the problems that were identified at the time, but still these appear to have not yet been addressed at the organisational level.

All nurse-participants reflected on scenarios when they had worked within in-patient settings and had experienced a 'lack of time'. Lack of time, however, was a common discursive theme regarding the realities of implementing compassion. The pressure to provide a *compassionate* approach to care caused anxiety for mental health nurses, especially those who were working within acute services where they were faced with the need to manage (sometimes) aggressive patients in addition to other work pressures mentioned above. An evident sense of

responsibility for patients' experiences was expressed in nurse-participants' discourse which caused them to feel moral distress, anger, and frustration at external constraints placed upon them. Nurses ideally wanted to be physically present with the patient to demonstrate compassion. This aligns with the work of Barron, Deery, & Sloan (2017) and Durkin *et al.* (2019). However, lack of time to engage with patients therapeutically caused moral distress, affirming existing opinions regarding tensions with compassion and nurses' ethical frameworks (Mercer, 2015). Moral conflict was also marked by feelings of guilt that episodes of care could not be improved because of time constraints on nurses. This supports claims that nurses' ability to enact compassion has been continually impeded by an under-resourced and overly pressured healthcare system, as asserted by Chaney (2021) and West *et al.* (2020). Hence, it can be argued that the politically conceptualised version of compassion as a universal indicator of 'high-quality' *nursing* care is naïve and untenable.

8.4 Patient-Level Data

8.4.1 Compassion is Innate to the 'Individual' Mental Health Nurse

A review of the literature for the current study revealed a scarcity of empirical research regarding how compassion is identified from the first-person perspective of people with lived experience of a mental health condition(s) (patients). Patient-participants in the present study indicated that compassion has the power to facilitate healing. Healing was said to occur **'**within' the relational interaction between mental health nurse and patient – and when the nurse displayed the

virtues or characteristic traits that were perceived as external demonstrations of compassion. For instance, patients described a compassionate nurse as someone who conveyed a non-judgemental, calm, warm, and authentic demeanour.

This formulation, which was echoed throughout the transcripts, is largely reflective of the historical context of the ethics of 'caring' in mental health nursing which is aligned with the development of the TR. Interestingly, in a study of the TR from the perspectives of patients, Shattell, Starr, & Thomas, (2007) inquired, "*What is therapeutic about the therapeutic relationship?"* (p. 277). The following was observed:

> *"Participants reported that healthcare professionals related to them through their personal attributes, mutual investment, particular communication techniques, and self-disclosure. Personal attributes of the health-care professional included being non-judgmental, patient, soft spoken, open, genuine, calm, and stable." - p. 278*

This is consistent with the data obtained for the current research and suggests that the TR functions to generate 'feelings' of compassion from the nurse to the patient. The current study found that patients identified the disposition of the mental health nurse, i.e. someone who is warm, calm, attentive, actively listens, is trustworthy and genuine, to be reflective of compassion. These findings also align with the findings of a study by Baránková, Halamová, & Kóróniová (2019), who noted that the experience of compassion was embodied by the demeanour of the person providing care. It is important to bear in mind that relationships are central to mental

health nursing work, which could explain why patients' expectations for compassion were high.

Patients' identified compassion as innate and associated with the nurses' innate virtues as a prerequisite to compassion; virtues provided the foundation for an external response to a patient's suffering. When this virtuous response occurred within the relational space or TR, it was considered to be compassion – or compassionate engagement. This is similar to the research noted in a scoping review by Sinclair *et al.* (2016a) (see Malenfant *et al.,* 2022 for updated version), in which patients and their family members described 'inherent' qualities such as respect, care, and kindness when remarking on 'what makes a compassionate healthcare provider?' This suggests that compassion in healthcare is understood as being rooted in the human attributes and behaviours of individual nurses, regardless of the context or clinical setting. The main difference however is that mental health nursing is centred around the development of the TR, which is believed to be critical for patients' recovery (Lorien, Blunden, & Madsen, 2020). The observation that the nurses' demeanour is crucial to providing an external response to the patient's suffering indicates that the 'individual' enactment of compassion has important implications in terms of the positive benefit for patients – nurses can alleviate patients' distress and suffering. While compassion has previously been observed to have a positive effect on patient health and wellbeing (Kang, Go, & Bruera, 2018; Kirby, Tellengen, & Steindl, 2017), at the time of writing this thesis, this is the first study to acknowledge these similarities in the context of receiving physical (general) and mental health care.

8.4.2 No Time for 'Seeking to Understand'

Patient-participants reported that the skills of the nurse were essential for seeking to understand their holistic needs. From the patients' perspectives, the nurse needed to have developed the skill of active listening, which would help them (nurse) to understand the patient's suffering and how it affects someone, in the context of their (patients') life. According to Wagner and Whaite (2010), seeking to understand a patient holistically is fundamental to all nursing work. However, it is claimed (Bond, Stickley, & Stacey, 2022; Gabrielsson *et al.,* 2020; Shattell, Starr, & Thomas, 2007) that listening is a vital skill for mental health nurses that can be developed with practice. The is significant as the development of the nurse–patient relationship is believed essential for healing to occur (Gabrielsson *et al.,* 2020; Haber, 2000). However, a lack of time for nurses to engage with patients has been noted within the existing literature (Crawford *et al.,* 2013, 2014). This means that the experience of compassion cannot flow because the TR is difficult to establish amid time constraints, as experienced by the patient-participants in this study.

Given that listening is a vital aspect of mental health care and core to seeking to understand peoples' lived experiences, nurses must have sufficient time to build and maintain therapeutic relationships with their patients. As noted in chapter 5, the NHS Constitution states that "*We find time for patients, their families and carers…because we care"* (2015, Linked para.17). Yet, the findings reported here appear to support the assumption that patients experienced a lack of compassion because nurses simply do not have enough time. This may be linked to the way in which health and social care services have become fragmented over time,

because of government implementation of austerity measures (Tucker, Moffatt, & Timmons, 2020). Hence, compassionate engagements between nurses and patients cannot 'easily' exist because changes to the structure of the healthcare services over the last decade do not provide nurses with the space for therapeutic interactions to occur (Crawford *et al*., 2014).

8.4.3 Seeking to Understand or Seeking to Judge?

Patient-participants were clear that when nurses had time to listen, mental health could be positively or negatively affected, depending on the nurse's attitude. During the interpersonal connection of nurse and patient, patients wanted to feel that the nurse 'genuinely' cared for them. However, when the nurse was perceived to have used the information gained through listening to make a judgement on them (patient), then mental health was adversely affected. This finding would appear to fit with Nussbaum's (1996) account of compassion as a basic social emotion, and that our emotions (level of compassion) are shaped by our moral reasoning as well as the personal circumstances we find ourselves in. A possible explanation for the apparent varied personal differences in compassion may be due to the way in which different individuals (nurses) have been shaped by their individual social and historical circumstances. For instance, it is likely that an individual nurse's thinking about mental health and/or mental illness may have been influenced by a specific school of thought during their nurse education and training (Santos *et al.,* 2018).

According to Nussbaum (1996), nurses' compassion may be limited by a 'eudaimonistic judgment', which means that the patient's suffering is more likely to be responded to if the nurse has known the patient for a longer period. This suggests that a nurse is more likely to feel compassion (as an emotion) when they have become familiar with the person they are caring for, which is heavily dependent upon the nurse having sufficient time to develop the nurse–patient relationship.

8.4.4 Induced Attitudes

Patients used words like *self-centred, critical, inconsiderate, inhumane, painful, harmful, judgemental, abusive, degrading, traumatising, depersonalised, inappropriate, discrediting, being gaslit, devalued,* and *discriminating* in their constructions of individual nurses who lacked compassion.

Discourse theorists assert that our experiences in and of our social world are heavily shaped by language and social context (Davies & Harré, 1990; Gergen, 2007; Wodak & Meyer, 2009; van Dijk, 1995, 2006, 2009; Van Langenhove & Harré, 1999). From this perspective and considering that these descriptions of nurses are reflective of nurses with negative ideologies toward patients, it is pertinent to contemplate how a collective culture might be easily induced – whereby patients' behaviours, patterns of behaviours, and how they choose to present themselves in the social world are considered within a certain type of discourse.

In the results shown in chapter 7 (section 7.3.3), for example, Zoe articulated the feeling that once a patient had been viewed through a certain lens (whatever their mental health diagnosis was) then their behaviour would (more often than not) be interpreted through that lens. Zoe's experience is reminiscent of the 1973 experiment by Rosenhan, which concluded:

> *At its heart, the question of whether the sane can be distinguished from the insane (and whether degrees of insanity can be distinguished from each other) is a simple matter: do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them?*
>
> - Rosenhan 1973, p. 251

Zoe also spoke about having formal and informal conversations with mental health professionals in which she had been told that she was not 'presenting' as struggling, when she had communicated that she was in fact experiencing a decline in her mental health. When questioned, the nurse responded by stating "*that's how we are trained, to recognise and respond to the way you are presenting – 'objectively'"*. Because Zoe's version of suffering did not 'fit' with the nurse's diagnostic assessment, it had meant that Zoe did not receive the help she desperately needed at that time. This brings into question, as Rosenhan did in 1973, the validity and reliability of 'objective' measures used in the practice of psychiatry.

What do these 'objectively' defined mental health categories and labels seek to achieve, and for whom? In the case of a nurse's approach to a patient, this could

be perceived as though the nurse was ‘seeking to understand the diagnostic tool’ approach, rather than seeking to ‘understand the person’, which is potentially antithetical to both compassionate care and person-centred care (Collins, 2014; DOH, 2012a). Of course, as mental health nurse-participants noted, it is often difficult to navigate unhelpful divisions between mind and body, which can make caring for ‘emotional’ and/or ‘psychological’ distress challenging (see Power, Baker, & Jackson, 2022; *also* Zhang *et al.,* 2018). Interestingly, the contemporary context of caring in mental health is one of transformation and acceptance that distress is not exclusively rooted purely in biologically ascribed symptoms (Johnstone, 2019). However, the use of ‘objective’ measures, when applied by the nurse over and above a compassionate approach, was viewed as discrediting patients’ lived experiences.

8.4.5 A Humane Response to Suffering

As discussed in the literature review, the nursing literature has traditionally emphasised the importance of relationships in mental health practice (Bordin, 1979; Gilbert *et al.,* 2008; Rogers, 1961). Therefore, biologically defined categories may be practically unhelpful for mental health nurse education and practice, as they may obscure the connection between the social realities of emotional suffering. On the other hand, for patients, the ability to search and find descriptions of conditions (e.g. online, via the nhs.uk website, for example) may be useful in helping them to make sense of their feelings and what they might be experiencing.

According to Kinderman (2014), a humane response to suffering is to seek to understand the patients' world, their life, and their experiences. Regardless, it has been well documented (McKenzie *et al.,* 2022) that patients' experiences of care within NHS mental health services in the UK are fraught with negativity toward certain diagnoses, such as 'Personality Disorder'. Individuals with this diagnosis have been referred to as 'emotionally draining' in the literature (see Chartonas *et al.,* 2017, p. 16) as they often engage in self-harming and impulsive behaviours that are difficult to manage and to comprehend. While nurses' responses and attitudes to people labelled 'personality disordered' may be complex (Bodner *et al.,* 2015; Flynn *et al.,* 2019), commentators who have critiqued neoliberal discourse have asserted that the notion of responsibility for our health, and patients' capacity for responsibility for their own health, have led to these attitudes becoming normalised in mental health care environments. As discussed by Brown & Baker, (2013) this may explain why patient-participants experienced systemic stigma as commonplace in their interactions with nurses within the current healthcare system. The healthcare workforce is formed of individuals with various backgrounds, upbringing, education, and so forth. It is therefore reasonable to imply that within the healthcare system exists a multitude of ideologies (Bröckling, Krasmann, & Lemke, 2010a). When mental health nurses engage in the TR with their patients there will always be the potential for them to draw upon various forms of knowledge with which to formulate judgements (Nussbaum, 1996). It may be difficult to separate the medical, social, and psychological from any personal biases. Hence, there is always a tendency to make a judgement (perceived to be

wrong by the patient) in relation to someone's care and treatment, which can lead to further stigma (see Hui *et al.,* 2021).

The negative attitudes that patient-participants reported to have experienced from nurses in this study make it difficult to establish a TR built on trust, which is intended to mobilise hope, is core to recovery, and is considered a compassionate response (Bond, Stickley, & Stacey, 2022; Gilbert *et al.,* 2008). The building of trust was important in the patient population studied here, for example, Zoe (chapter 7, section 7.2.1) described feeling 'exceedingly suspicious' when she became unwell. Likewise, Sarah commented on the need to 'feel safe' when she was contemplating suicide, and honesty and trust were implicit in the perceived feeling of safety within the interactions Sara described with the policewoman. This in and of itself highlights the uniqueness of the mental health context, which relies significantly on building relationships. Comparatively, as Sinclair *et al.*'s (2016b) empirical model would suggest, in a cardiac unit, for example, compassion would more likely be experienced by a patient as an action (i.e. someone attending to the patient when they are having a heart attack). Hence, this result must serve as a reminder that compassion is about 'caring' for people when they are potentially in their worst state, and the associated patient experiences (in the mental health context, this may be suspicion/paranoia). Trust was believed to be fostered through a relational approach and is noted to be essential (Felton, Repper, & Avis, 2018) for working in mental health. It is therefore important that compassion takes precedence as this may be useful for improving occurrences of future mental health conditions (Murray *et al.,* 2020).

In the mental health context, nurses were regarded as compassionate when they were perceived to be attempting to look beyond a person's mental health difficulty, and to focus first and foremost on the person, not their diagnosis. However, if indeed compassion was foregrounded over 'objective' measures and protocols at the individual level, for example (hypothetically speaking) if a nurse ignored protocols, and instead of handing out a box of antidepressants or a six-week course of CBT, they prescribed a two-year course of psychological therapy which 'cost' significantly more to the public purse. Perhaps, this hypothetical nurse (or other healthcare professional) would risk being considered maverick by going against protocols and conventional diagnostic approaches (as discussed previously). For instance, protocols will fundamentally function to control 'clinical decisions' to ensure 'appropriate' healthcare spending (NICE Guidelines, 2022b) and the most affordable care in a service, rather than 'appropriate' care and treatment *per se*. The point I am making here, linked to the notion of governmentality, as conceptualised by Miller and Rose (1990), is that nurses are autonomous practitioners only so far as their professional lives are 'regulated'. However, this has a positive function in that regulatory and disciplinary bodies exist to safeguard vulnerable individuals who are placed in care.

8.4.6 Biological Sciences: Actors on a Social Stage

Given that the social discourse, emergent at the time of the Francis reports (2010, 2013), and the government's subsequent policy reforms that aimed to address the issues raised by Francis (increase compassion in healthcare), it is ironic that patient-participants referred to the mental health care system as 'compassionless'.

While the policy discourse might manifest punitive processes for nurses within new forms of domination (faced with potential discipline in the perceived absence of a compassionate response), patients' accounts indicated that there has been very little progress in terms of realising the experiences of compassionate care. As patient-participants' accounts showed, their desire to receive help had led them to experience stigma such as being labelled as 'attention-seeking'; implications that they were a 'problem' to be fixed; references to them as the 'awkward' patient in their clinical notes. The overreliance on the use of the medical model was suggested as a key factor which led to feelings that their voices were discrediting and lived experiences were undervalued and/or invalidated.

Patients were essentially (re)traumatised by their experiences within the current healthcare system. This was particularly noticeable for those patient-participants who referred to themselves as complex. These patient-participants had experienced numerous barriers to accessing services. Sarah gave an example of where she had been to see her GP and had felt pressured to simply take antidepressant medication, which she felt had dismissed her subjective lived experience as this response assumed her mental health condition would simply go away by 'taking a pill'. Zoe also mentioned how, as a patient, she had felt, particularly in terms of medication, i.e. "*Often you are at the mercy of staff who know better than you because you are the patient. Especially in relation to medication, you know, you are the patient, and you must be told"*. This implies that a power dynamic exists in terms of nurses' knowledge and use of medication. Furthermore, Ann noted that among mental health nurses, she felt there was a

distinct ideology that patients were flawed in terms of their biology and a ‘problem’ that needed to be ‘fixed’.

As noted in the literature review (chapter 1, section 1.1), over time there has been a growth in pharmaceutical approaches to mental health conditions, which is supported by a large body of epidemiological data relating to illness and disease (Moreno-Agostino *et al.,* 2021). Brown and Baker (2013) have acknowledged that a discourse of responsibility for health (and mental health) exists in conjunction with the fact that aspects of health and disease have begun to be considered more and more in pharmaceutical terms. Perhaps the most notable in this discourse, and arguably the most successful, has been the narrative surrounding global mental health and the numerical grounding of the ‘burden’ of disease – for example, depression is cited as a major contributor to the overall global disease burden (Murray *et al.,* 2020). Statistical evidence has shown that depression has become less prevalent in higher income countries over time (*for statistics on global trends in depression see* Moreno-Agostino *et al.,* 2021). This implies that the success of health services within higher-income countries like the UK might be the result of a ‘medical’ approach, for example, the use of antidepressant medications as a form of treatment. On the other hand, one might argue that access to ‘psychological’ therapies is not a medical approach *per se*, which would seem to contradict any argument about the framing of health and indeed ‘mental health’ in purely pharmaceutical terms. However, Rose and Miller (2010) hold the view that the administration processes within modern forms of government exist within a matrix of knowledge created from economic, spiritual, legal, medical, and technical

entities in order to form notions of what is conceived as *"good, healthy, normal, virtuous, efficient, and profitable"* (p. 273). These various forms of 'expert' knowledge are central to the activities of government, because as these fields of knowledge evolve, they can be utilised by government in terms of planning and governing the *"wealth, health, and happiness"* (Rose & Miller, 2010, p. 272) of the population. Consequently, the psychological lives of individuals and their experiences of healthcare are fundamentally shaped by government policies (Rose, 1999). From this perspective, it is also necessary to scrutinise research that focusses on mental health and wellbeing, which is potentially vulnerable to becoming thought about in terms of how it can contribute to reinforcing behaviours and patterns of observed behaviours that may be of value to 'the State' and the economy in the future. The latter statement might be considered a criticism of the current research. It therefore follows, that incentives for funding research techniques which can construct a particular view of the subject, for instance, seeking to understand objective symptoms and/or behaviours which might 'fit' a certain diagnosis could serve to reinforce governmentality, i.e. ways of thinking and acting upon the body (Foucault, 1979; Rose, 2006) in the social world. Having considered the experiences of the patient-participants in the current study, the use of 'objective' measures to determine notions of what (nurses and other healthcare professionals) was deemed to be 'healthy, or normal' caused feelings of having been judged. It could be that because of these perceived judgements, patient-participants are being inadvertently positioned within the healthcare system as 'deserving or undeserving of compassion'.

As revealed from the data, a judgemental approach had a negative impact on mental health. In a sense, the government's enthusiasm for services to be driven by scientific knowledge is fundamentally flawed in its logic as patient-participants described scenarios where they were continually unable to function in society – as a 'productive' citizen (Brown & Baker, 2013). On the other hand, as asserted by Rose (1999), mental ill-health, and conditions like depression, may have simply become the 'new normal' and expected outcome of today's society.

8.4.7 A Theory of Competing Discourses

Thinking about language and discourse as a social practice has been the central component of this thesis (Fairclough, 2013; Hall, 1992). Many scholars have made identity and discourse the object of their inquiry (see Wetherell, 2009), for example, Davies and Harré (1990) have conjectured that *to know anything is to know in terms of one or more discourses* (my italics), this might extend the questioning of the self, for example 'who am I?' or 'what am I?' (Rabinow & Rose, 2003; Hothersall, 2004). From this perspective, identity is therefore thought to be shaped within the social domain and the social practices that shape 'the self' (Elliott, 2020). As discussed in the literature review (chapter 3, section 3.7), from a theoretical perspective, a discourse is said to emerge from an institution (Wodak & Meyer, 2009) and can be about a particular topic. Hence, it is understood to be our relationship with discourse structures in the social world, and our interactions with others that enables us to (discursively) construct our social reality and social identity. Exploration of the compassion discourses in the social world and those

that emerged from the institution of politics and healthcare governance were explored in the analysis presented in chapter 5.

However, a wider system of discourses (such as socionormative and medical) were apparent in the patient-participants' interview data. It is possible that these discourses have been influential in the individual interactions between patients and nurses. Theoretically, this provides a broader picture in terms of the discourse on compassion and how other (institutional) discourses might be potentially limiting the uptake of the compassion discourse (see Figure 8, overleaf). At this point, Foucault's (1991/1978) understanding in terms of the question of *'How have I become?'* (my italics) allows us to consider how ways of thinking about the 'self' are dominated by discourse(s) available at any given time (Fullagar, 2017 *as cited in* Cohen, 2017). From this viewpoint, the symbols, imagery, and terminology of mental health and mental illness can be considered as being delivered via mental health nurse training and education. For example, a broad range of perspectives are presented to aspiring nurses regarding the *origins* of mental health conditions, e.g. Bio-Psycho-Social (Santangelo, Procter, & Fassett, 2018). It is possible that if mental health nurses adopt a biomedical model of 'illness', they will draw upon 'evidence-based' practice, and potentially seek to depend upon 'objective' knowledge – knowledge which views the causes of mental 'illness' as having a neurobiological cause (Rose, 1999, 2019).

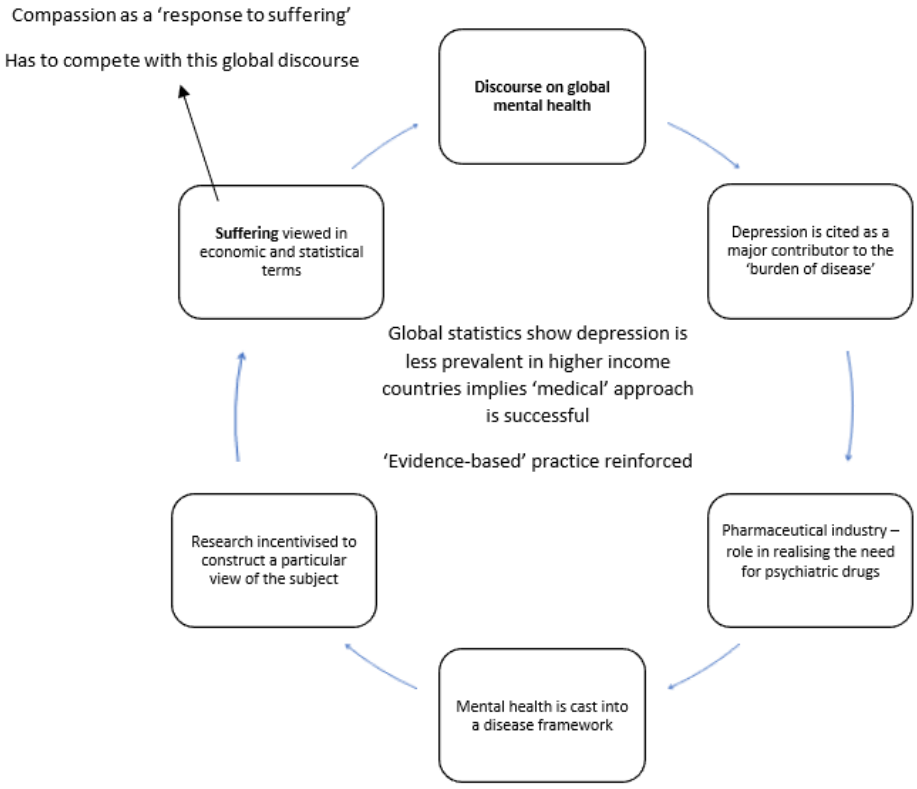


Figure 8: Discourses that are hypothetically competing with compassion

The problem with this is that a medicalised ideology reduces people with mental 'illnesses' to having a defective biology, in which they might be viewed as dependent, passive users of services. As a result, it may be more likely that emotional responses to difficult and challenging situations and/or life-events are easily disregarded, and emotional or behavioural responses to these events easily become over-pathologised.

Patient-participants' stories reflected the negative impact of the overuse of the biomedical model of illness, in terms of the limiting factors upon their experience of compassion. They described how they felt their voices were marginalised, and they did not feel their lived experiences were fully appreciated (see chapter 7, section 7.3). Statements made by some nurses were often felt as a judgement of the person. This was evident in patient-participants' stories of their experiences of mental health care at various levels, within primary and secondary healthcare services. Foucault (1995/1972) acknowledges that our understanding of mental 'disorders' is produced through a range of professional practices. These practices are supported by several interconnected discursive fields of knowledge, e.g. economic, medical, epidemiological, neuroscience, and pharmacology (Rose, 1999). This knowledge is legitimised as useful for informing the classification, distinguishing of, and organisation of human populations. In turn, these scientific techniques enable the surveillance of what is considered 'normal' or 'abnormal' in society. This has created what was felt by patient-participants in the current study as an 'us v them' power dynamic whereby patients were positioned as passive recipients of mental health professionals' legitimate 'expert' knowledge (Lawrence, 2006). Zoe's experience sums this up this neatly:

> *"Often you are at the mercy of staff who know better than you because you are the patient. Especially in relation to medication, you know, you are the patient, and you must be told… there is the power difference still there. Especially if you want to do other than they are suggesting they get a bit on their high horse – like I am the expert"* (Zoe)

This comment is a useful one for thinking about how marginalisation has become commonplace (Brown & Baker, 2013) and ingrained in the culture of mental health care services, through the process of (perhaps inadvertently) 'othering' people who access those services. This was evident in the accounts given by Chloe and Jane. Although Jane communicated having had mostly positive care episodes, she explicitly described the internalisation of the marginalisation she experienced in the social world generally. Jane referred to herself as 'different' and in her subsequent social interactions, she excluded herself (i.e. from the 'typical' mother and baby groups).

Accounts such as these reflect the broader structural issues in society, which permeate healthcare organisations, for example, ways of seeing the world (Van Langenhove & Harré, 1999) exist within the consciousnesses of the individuals who work in healthcare. For instance, as discussed previously, framing mental health as 'disease' places focus on the mind as having a personal deficit (Buntinx & Schalock, 2010). What is defined as healthy or unhealthy, sane or insane, is decided upon through 'credible' scientific discourses, which are then utilised politically and assembled via healthcare policy. In other words, what is judged to be 'normal' is defined by medicine (Lawrence, 2006). As such, our 'identities' can be understood to be shaped by the constructs available in society at any given time.

Consequently, discourses of compassion and attempts to (re)humanise healthcare then become marginalised in the social world, and negative attitudes toward people who experience mental health difficulties will continue to exist. However,

the environment of healthcare service where a nurse works might demand an objective or medical approach (Kane, 2015), for example, Jane described how when she had become unwell, she lost capacity to make decisions for herself. While compassion was considered important for patients in the current study, it may be that at times, when a person becomes acutely unwell and is a danger to themselves (or others), the medical lens is much more useful as it can enable clinical decisions to be made quickly. It can thus be suggested that the Bio-Psycho-Social (Santangelo, Procter, & Fassett, 2018) approaches to understanding and treating mental health conditions have a flexibility and can be used interdependently by the nurse depending upon the type of environment in which they work, e.g. hospital, community, or speciality services (such as psychological therapies, drug and alcohol services etc.). However, it was clear from the patient-participant interviews that compassion was important to the care they received. Therefore, I would argue that whatever approach a nurse adopts or whatever service they choose to work within, it is important to combine this with compassion (as defined by those who receive care) during all nurse–patient interactions.

Chapter 9: Conclusions

Compassion is a human construct, associated with the attitudes, behaviours, and clinical skills of healthcare workers. There is a social expectation that compassion will be evident in the care delivered to those who access healthcare services. In the context of mental health nursing, however, compassion is problematic due the practical and emotional constraints upon nurses' everyday practice. This thesis has set out to explore the influence of policy and/or political discourses on the experiences and subjectification of mental health nurses and people with lived experience of mental health care. A critical discourse analysis was conducted in three phases. Firstly, healthcare policy, political and professional texts and talk were analysed to determine 'how' a programme of compassion in healthcare had been assembled. This phase focussed specifically on the rationalities, techniques, and programmes of government and was guided by a governmentality framework provided by Miller and Rose (1990) and Rose and Miller (1992). Secondly, semi-structured interviews were used to explore mental health nurses' discursive constructions of compassion. Thirdly and finally, open interviews were conducted with patients who have lived experiences of mental health care to investigate what constitutes compassionate care from their perspectives, how they experienced mental health care, and the influences pertinent to those experiences. Phases two and three of this study were guided by Willig's (2008a) six-step Foucauldian-inspired framework for analysing discourse.

These areas of investigation are of particular interest given the scarcity of empirical research into the concept of compassion in the context of giving and receiving mental health care. A systematic review revealed that definitions of compassion in healthcare have begun to coalesce around the idea that compassion is a human concept, tied up in skills and behaviours that are perceived as moral or virtuous (Sinclair *et al.,* 2016b; *see also* Malenfant *et al.,* 2022). This understanding of compassion has progressed through considerable research efforts, which have focussed on developing an understanding of compassion from the perspectives both patients and other healthcare professionals (Durkin *et al.,* 2019; Ferraz, O'Connor, & Mazzucchelli, 2020; Ortega-Galán *et al.,* 2021; Sinclair *et al.,* 2018). However, the empirical research on the identification of compassion from the perspectives of nurses and patients has focussed largely on physical healthcare and palliative and physical (general) healthcare environments (Baránková, Halamová, & Kóróniová, 2019; Bramley & Matiti, 2014; Malenfant *et al.,* 2022). Comparisons between studies have been challenging due to the different research designs, methods, and contexts studied (Durkin *et al.,* 2019). For example, a consensus may have been reached regarding compassion as inherent to the demeanour of the individual nurse, yet nurses who work in the context of mental health have been understudied (Crawford *et al.,* 2013). Moreover, the first-person perspectives of patients with lived experience of mental health care have, hitherto, been overlooked and unexplored (Barron, Deery & Sloan, 2017; Rooney, 2020). In addition, while some authors have mentioned the potential influence of policy and governance on compassion within healthcare systems, an understanding of

'how' political (linguistic) technologies have been employed to mobilise knowledge regarding individualised conceptions of compassion is missing. This three-phase qualitative study has addressed these gaps in knowledge.

Findings from this study confirmed that compassion is identified as an innate 'human' characteristic. Nurse-participants spoke of themselves as the embodiment of compassion. They understood compassion to be at the core of their practice, and demonstratable through the TR, which they had been trained to develop with patients. In the context of providing mental health nursing care, compassion was important and, when embedded within the TR, was perceived to positively contribute to psychological healing and recovery. This supports the work of authors who have claimed compassion can improve health outcomes (Gilbert, 2010; Hammarström *et al.,* 2020; Trzeciak & Mazzarelli, 2019). Yet, nurse-participants' desire to engage in the TR was reported to be impeded by high-pressure working environments; low staffing levels; objectively focussed risk assessments. Moreover, nurse-participants deemed restrictive practices to conflict with their underlying ethical framework. These factors, noted to limit nurses' ability to engage in the TR, caused stress, frustration, and feelings of guilt when they did not have sufficient time to spend with patients. The emotions evoked by the implementation of restrictive practices have been shown to cause high levels of work-related stress for mental health nurses (Power, Baker, & Jackson, 2020). However, restrictive practices and risk assessments were considered necessary to ensure staff accountability and patient safety. Consequently, mental health nursing is viewed as particularly challenging in terms of demonstrating compassion. In this sense,

the policy discourse on compassion (as an individual responsibility) is idealistic and untenable, as previously argued by Tierney, Bivins, and Seers (2018) and Dashtipour *et al.* (2020).

Patient-participants identified compassion as inherent to nurses' virtues, which were described as precursors to bringing about the patients' felt-sense response (compassion). This also affirmed studies within the field of physical health care in which compassion has been defined as *"a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action"* (Sinclair *et al.,* 2016a, in Sinclair *et al.,* 2021, p. 1). When compassion was experienced, recovery was felt to be made possible. However, many participants were re-traumatised, and mental health conditions were exacerbated by interactions with nurses and other healthcare professionals (GPs and Psychiatrists) that lacked compassion. Moreover, compassion was constrained by the structure of services and lengthy waiting times to access mental health care.

Guided by Willig's (2008a) conceptual framework, the analysis and interpretation of the interview data from patient-participants suggested that negative experiences of care were influenced by socio-normative, medical, and political discourse. These discourses shape professional ideologies and healthcare cultures, such that the importance of compassion is overlooked. I contend, theoretically, that the negative attitudes of nurses are generally evident in terms of how 'mental health' is conceptualised and understood. This understanding, which percolates through the social world, is influenced by several discourses (for example objective evidence-based assessments, scientific measures, and diagnostic criteria). The

psychological absorption of these discourses by individuals and groups (nurses or other healthcare professionals) generates the negative ideologies reported by patient-participants in the current study. Findings of this study have shown that an overreliance on the use of the medical model can lead to stigmatisation, marginalisation, and the discrediting of patients' lived experiences. Furthermore, 'evidence-based' practices may reinforce social narratives that people with mental 'illnesses' are defective, dependent, problematic, *"passive users of services"* (Rapp & Goscha, 2006, p. 93). As a result, it is possible that emotional responses to difficult and challenging situations or life-events are disregarded and emotional and/or behavioural responses over-pathologised. This ideology serves to reinforce aspects of health and disease which are considered in pharmaceutical terms (Abraham, 2010), which places focus on mental health conditions that have become 'normalised' such as depression – backed up by epidemiological data. As I have contended within the discussion section of this thesis, discourses of compassion and humanism are important to the process of recovery. Yet, in the context of receiving mental health care, the value of compassion to policymakers has yet to be realised.

9.1 Significance & Contribution(s)

The findings of this research are significant as the identification of compassion from the first-person perspective of people with lived experience of mental health has, hitherto, been missing from the existing scholarship. The empirical findings presented in this thesis have addressed this gap. These findings have extended

the existing research on compassion by providing empirical evidence for what has only been previously known in theory. The identification of the individual characteristics and skills associated with compassion in the context of mental health care will provide researchers, who have studied compassion in general (physical) health and palliative care environments, with a better understanding of the transferability of their own research findings to more diverse healthcare contexts.

The findings of this thesis contribute to the sociological scholarship by demonstrating that the political discourse on compassion in healthcare represents a productive power, which has enabled mental health nurses to position themselves as providing both care and treatment. This was suggested to have strengthened mental health nurses' sense of professional identity. Objective measures and assessments were inferred to have implemented systemic stigma as they were theorised to have induced negative (judgemental) ideologies in mental health nurses. This critical, theoretical understanding of compassion has practical implications for the way in which mental health nurses are educated in the future. Importantly, these findings imply that nurse education must place equal emphasis on the relational aspects of caring that patients and nurses both identified, e.g. listening skills, and seeking to understand the person within the therapeutic space, which is where compassion was reported to have been evident (felt by patient). This has the potential to be impactful in the future if this knowledge can be effectively mobilised within the mental health nursing community and implemented at educational policy level, such as HEE.

Nurse-participants reported significant limitations to enacting compassion, such as low staffing levels and risk assessments impeding time for the TR. Indeed, many remarked on how this had caused moral injury and led to feelings of guilt and frustration. In a recent independent report to government (Messenger, 2021), it was noted that the context for change in the NHS is particularly challenging in terms of the external pressures, for example, *"performance metrics, stringent regulatory requirements, and short-term political demands"* particularly when *"combined with internal pressures such as staff shortages, budget issues, sectoral disparity and pandemic-induced backlogs have created a very difficult backdrop for compassionate leadership and collaborative, inclusive behaviour to thrive"* (Linked para. 3 of introduction). The findings of this research in terms of the challenges nurse-participants faced in delivering compassion, together with the findings of Messenger's (2021) report and that of West *et al.* (2021), denote the potential for these pressures to negatively impact the wellbeing of nurses. This suggests there is a need to focus on maintaining the wellbeing of the current nursing workforce moving forward.

9.2 Strengths & Limitations

There are strengths to this research, for example, CDA is an interdisciplinary methodological approach which has allowed for the consideration of a variety of perspectives in the analysis. The method itself has flexibility, which enables individual interpretations and explanations based upon insights derived from the position of the researcher. Due to its inherent flexibility, CDA can offer unique

insights into ongoing social debates about any topic, at any time. However, individual interpretations can be difficult to repeat and verify. This can attract criticism regarding personal bias in the analysis of textual and/or oral statements, which might be viewed as supporting the stance of the researcher. Thus, the analysis presented in this thesis cannot be viewed as having offered any definite explanations. Also, given the abductive nature of the method, the conclusions made are only probable. Some researchers choose a computer-aided discourse method, or corpus linguistic approach, which can help to reduce or avoid researcher bias. However, it could be argued that human interaction with either corpus-based or individual CDA approaches can be viewed as introducing bias into the analytical process (Piepenbrink & Gaur, 2017).

The document analysis has contributed to what is recognised as an emerging critical dialogue regarding the concept of compassion in healthcare. This has been notable in the last decade, whereby scholars have commented on the tactics employed by government in relation the contemporary conceptualisation of compassion, and the influence of the government rhetoric on compassion in shaping employee subjectivities. CDA offers a programme of research whereby socially relevant events and experiences can be explored. Critical implies that the researcher themselves are self-reflective, and seeks to describe beyond dichotomous views and perspectives to explain the complexities of the social world we live in. Moreover, the process of abduction (continually moving between theory and empirical data) involves a commitment on behalf of the researcher to take a stance on the subject topic under investigation. My position as insider (mental

health nurse) is therefore viewed as a strength of this study due to the researcher's tacit knowledge and lived experience of the topics that have been discussed in this thesis. Using CDA, and through the early publication of this research, this thesis has made the linguistic tactics of the elites in society transparent. This will enable those who have little or no access to individuals in positions of power – or those who are involved in healthcare policy decision-making – to have greater awareness of the tactics used by government to control conduct. Through these published outputs, this research helps to raise political awareness and astuteness among the nursing community.

This research has several limitations. First, the social world constitutes an open system and discourse is continually being produced and re-produced within the social world. Discourse is therefore viewed as unstable and continually changing, which means the data presented in this thesis are only representative of the social context at the time it was collected. Second, a small number of participants were interviewed at stages two and three. Critics may remark on how this limits the generalisability; however, the findings provide preliminary insight into the characteristics of compassion in mental health. The depth and richness of the data highlight the conditions that are required to enable therapeutic relationships (grounded in compassion) to flourish. There are notable parallels between the current research and how compassion has been identified previously in physical health environments. This work has also brought into focus the challenges to providing compassionate care in the context of mental health which can be used

to consider the complexity involved in implementing any of the recommendations form this work (chapter 10).

Third, nurse-participants (phase two) were predominantly female, which is synonymous with existing research on compassion. The sample of nurse-participants is comparable with workforce statistics which showed that at the end of 2021, *"88.6% of the 342,104 nurses and health visitors are women"* (NHS England, 2021b, Linked para. 4). It could be argued that this reduces generalisability of the findings. However, rather than attempting to make generalisations, the intention has been that this research adds to the existing scholarly conversation about the concept of compassion. In addition, this predominantly female sample is ecologically valid since it is representative of the real-world context of the individuals and the environments they are employed within the UK NHS. However, it is recommended that phase three of this research be repeated with a larger number of patient-participants, and with equal amounts of males and females. This will allow for further comparison to be made in relation to the findings presented here.

Fourth, all the participants (nurses and patients) were all White and from the UK, which privileges those voices who are potentially less likely to experience racial discrimination in healthcare. It is inappropriate to assume that nurses (healthcare staff) or patients from ethnic minority backgrounds will identify (or indeed experience) compassion in the same way, and in the same context, to that which was studied here. Hence, to maximise the transferability of the findings, accounts from an ethnically diverse population should be collected in the future. The

interview data have, however, revealed a wealth of in-depth information relating to compassion in the context of giving and receiving mental health care and treatment. The authenticity of the accounts presented in this thesis contributes to the perceived genuineness which allows for better understanding of participants' individual and collective lived experience of compassion in this practical setting. While it is possible to find previous research and scholarly commentary on the topic of compassion in the context of mental health, the contribution of the current research is that it presents the first study to identify compassion from the perspectives of people with lived experience of mental health care. This provides the basis for further study of compassion in this unique context. Furthermore, this research has accessed mental health patients who are noted to be notoriously difficult to obtain access to. Therefore, this work has provided a platform to shine a light on the voices of those who took part. Not only does this build the capacity for nurses to become involved in research, but it is of particular importance for those living with mental health conditions who frequently experience marginalisation and injustice because of structural inequalities in society (Hui *et al.,* 2021).

Finally, as previously mentioned, the findings are limited by the unstable nature of discourse and subjectivity in the social world. Subjectivity is constantly being reconstituted each time we engage with discourse. Therefore, data are representative only of the social 'reality' of participants at the time of collection. Moreover, data were collected from one location in the North of England, therefore any future research would benefit from analysing a larger corpus of language, from

a wider geographic area. Irrespective of the limitations noted here, findings offer preliminary insight into how compassion is identified in mental health care and the potential for compassion to have a positive influence on health outcomes in this context. The areas of exploration in the current study are significant and of particular interest given the dearth of empirical research in the practical setting of mental health.

9.3 Final Reflections

9.3.1 Was Talking about Compassion Censored?

Reflecting on the interviews with nurse-participants, I note how many were keen to continue to discuss the topic of compassion after the interview had concluded. Six out of the seven nurse-participants spoke at length after the interview to describe their individual perspectives and/or experiences and talk about where they felt compassion was absent. They claimed that many of their (nursing) colleagues had wanted to take part in this study but were fearful of doing so; stating that their colleagues did not feel comfortable speaking about experiences of compassion, or a perceived lack of compassion. There was a general feeling that compassion was 'just another thing to get told off about'.

Fear to speak freely is contrary to the political construction of citizens as 'free' and 'autonomous' (Young, 1981). Hence, it could be argued that this is reflective of both the hierarchical nature of the NHS and the unseen force of political power that is governmentality (Foucault,1978 *in* Burchell, Gordon, & Miller, 1991). This could explain why nurse-participants were tentative or hesitant to describe compassion at the beginning of the interview. The length of time that participants were keen to speak 'off record' suggests nurse-participants may have been guarded during the interview. Arguably, one might consider whether nurses felt able to speak about what they 'really' wanted to speak about during the interview. Is it possible this is an effect of governmentality in and of itself? Does this suggest then that

governmentality creates a sanitised version of truth because the participants did not feel able to expresses themselves freely?

9.3.2 Connection Through Stories

The stories patient-participants shared for the construction of this thesis have brought forth powerful accounts of their experiences of receiving mental health care and treatment. The notion of compassion in mental health care opened a complex web of feelings and emotions associated with both nurse-participants' everyday professional practices and patient-participants' personal experiences of care. Compassion was an emotive topic, and personally I found it deeply saddening that the services which exist (first and foremost) to support people with mental health conditions were, in many cases, not able to provide the compassion that was desperately needed.

When I stop to reflect on this research process, I am taken back to a clear recollection of patient-participants speaking, with such passion and determination, and telling me how grateful they were that I was conducting this research, and how important this topic was (and is) to them. The stories they shared with me will remain such powerful memories and will drive me forward to continue to do what I can to improve patient experiences in the future. I have felt so many points of connection with so many of those stories told by all the participants in this research. The act of being heard and validated stood out as something tangible that can be done to truly enable compassion to be felt. As per the ethical principles for the study, I followed up with each participant to check wellbeing. While doing so, I was

often left wondering how the re-telling of personal stories might have impacted on the people telling them. So, I reached out to ask patient-participants if they had any reflections, that they felt willing to share about the research experience. One person sent the following email:

> *"Thanks, Carmel,*
>
> *Good to hear from you. I found telling my story very helpful as it gave me another opportunity to make known some of the things, good and not so good, that we encounter as patients in mental health care."*

I felt that the way I conducted the interview process was with compassion in mind and the need to create space to allow people to be heard. It was great that so many participants were willing to share their experiences. However, the scope of the PhD in terms of time, and ethical approvals, meant that I was not able to continue with data collection (for phase three) for as long as I would have liked to. Potential participants were keen to be included but did not have the opportunity to do so. The email below shows how keen people were to share their lived experience of compassion.

> *"I couldn't believe the enthusiasm in the response for it – I share a fair few research studies of PhD students and rarely get that sort of response – there were loads more than I told you, but most were only able to do it if it was virtual because of distance!"*

It was a privilege to meet the participants, and while listened to their recordings, and read through the transcripts, it reminded me of how when we listen to other people's accounts it reminds us of our own experiences. Listening to participants'

experiences has also made me think about the use of voice, and how as researchers we can position these collective voices to influence broader social landscapes. Scholars use various methods, traditions, models, and frameworks to facilitate understanding. This has made me consider the way I have, as a researcher, represented the participants in this thesis, and how the experiences they shared with me have translated into the knowledge generated from this thesis. Have I accurately represented their voices and, if so, how might this work begin to have impact in the ‘real world’?

Chapter 10: Recommendations

It is anticipated that the knowledge generated from this thesis, and that which will follow, will have implications for the future of healthcare policy in terms of considering how to improve experiences of care in the context of mental health and how future practices such as protected therapeutic nurse–patient time might be implemented. A key finding of the current study is that, in the context of mental health, compassion was not just expected from patients, it was felt to offer a sense of healing and hope for recovery in the future. Sadly, however, many patient-participants spoke of instances where compassion was absent from healthcare interactions, and where their experiences within the mental health care system generally had a negative impact on psychological health and wellbeing. The conjecture that the existing policy discourse on compassion is in direct competition with medically focussed, numerically driven, evidence-based discourses demonstrate that, if patients' care experiences and health outcomes are to be improved, a different approach is required. Based upon the knowledge generated from this thesis, several recommendations are made for future research, policy, practice, and education.

10.1 For Research

While this research has broken ground in terms of generating new insights into the unique environment of mental health care and has used a methodological approach that is currently absent from the literature on compassion (CDA), further research is required to examine the experiences of compassion in mental health

environments at both a national and international level. For instance, future research may wish to consider whether compassion is identified in the same way in a larger group of patient-participants and explore how compassion is identified by people with lived experience of mental health care, who have further protected characteristics such as ethnicity, gender, and sexuality.

While based only on a single site, the current research has expanded the way compassion is understood by focusing on a population that has hitherto not been considered (mental health). Hence, it would be beneficial to expand this research to generate and build ‘qualitative’ accounts of compassion in this context. For example, how do the experiences discussed in this thesis differ across gender and cultures, and are patients’ experiences the same in different geographical locations?

More research needs to be undertaken to focus on developing a deeper understanding of compassion from the perspective of patients from the margins of healthcare, where, as this thesis has demonstrated, delivering compassionate care is more challenging and fraught with ethical dilemmas. This will enable a better understanding of what the function of compassion might be in terms of recovery. Developing patients’ narratives on a larger scale will enable further insight to be gained regarding how episodes of care in mental health services might be improved in the future. It is recommended that this be generated in collaboration with those who provide mental health care and individuals who use mental health services.

Most relevant to this thesis are the accounts of those who receive mental health care, and their view of compassion as a virtue, inherent to the individual nurse. Perhaps, more importantly, compassion was felt to be a necessity for mental health and wellbeing more broadly. Compassion, as discerned from both nurses and patients' individual and shared accounts, was felt to have healing power when perceived to be evident within interactions with nurses. Using the virtues and/or traits that were identified, it is possible to create a guide for all nurses (and others involved in caring role within mental health) regarding what constitutes compassion.

Sinclair *et al.* (2021) have developed the best-validated compassion rating scale – the Sinclair Compassion Questionnaire (see Appendix 5). This enables patients to rate a healthcare service based on the level of compassion they receive. Evaluations can be collected on a weekly or monthly basis and fed into the current system that the UK has for appraising services – the CQC. If this were to be applied in the UK system, it might allow services to demonstrate their ongoing commitment to delivering compassionate care.

10.2 For Education and Training

This thesis has argued that a contemporary version of compassion has been mobilised within the UK NHS and that this is a result of governmentality (Foucault, 1978 *in* Burchell, Gordon, & Miller, 1991). This discourse, albeit over a decade ago, has led to epistemic shifts among the global scholarly community in terms of the need to understand compassion. Not only has the rise in neoliberal ideology

limited nursing practice, but it has seeped into the collective consciousness, such that systemic stigma is insidious and embedded with the culture of healthcare services. *How can this be resolved? What can we do as a society to begin to address some of the issues raised in this thesis?*

Within the NHS workforce, the nurses' position is complex as nurses can be considered to exist within a liminal space between acting as government servant and providing the quality of care which patients expect to receive. Therefore, it is important to ensure student nurses acquire and develop an understanding of the political structures and the potential influence of this on their professional practice and development.

For nurses, resistance to the political discourse was in the form of notions of compassion that were constructed from the discipline of mental health nursing, and the understanding that compassion is an inherent characteristic trait, belonging to the person. The provided a sense of freedom from state control. However, the prevailing discourse on compassion also has repressive power as it enables professional nurses to make value judgements about each other's compassionate practices. Therefore, making distinction(s) between an individual as 'compassionate' or 'not compassionate' can be considered as a dividing practice within healthcare teams (Rabinow, 1984) which may lead to tension within teams and create poor team culture(s). The current research, the work of Sinclair and colleagues (2016a; 2016b, 2018; 2022), and the King's Fund (2021) have cast light on the knowledge required to underpin professional healthcare cultures based on compassion. An investment in leadership development with a focus on critical

reflection of ‘the self’ and the impact of ‘the self’ on others might help to drive improvements, positively impact on student experiences, as well as improve retention rate from within nursing (see Bond *et al.,* 2022a).

In exposing the beliefs of mental health nurses and patients, compassion is understood to be tied up with the attitudes, behaviours, and skills of nurses, and it may be possible to design training that is focussed on the concepts and domains (the specific attitudes, behaviours, clinical skills) known to improve compassion in practice.

Clearly, compassion is an incredibly important element to recovery for mental health patients, and there is potentially a chain of effects when a nurse is perceived to be treating a patient with compassion. The positive impact of compassion is practically important in this respect, as the positive effects impact not only the patient but the family and care givers and may prevent or reduce the potential length of hospitalisation. Therefore, the influence of the ‘experience’ of compassion may have consequences for wider society, such as improving healthcare cultures and health outcomes. Once the scholarly community has resolved compassion as a concept in terms of deriving a way in which it can be operationalised, tools can be developed to help nurses to feel more connected with the people they care for. This up-skilling of nurses may be a suitable option to improve healthcare interactions, particularly in mental health which relies on the development of the TR.

10.3 For Practice and Policymakers

Regardless of the critiques presented here, the mental health workforce has unparalleled opportunities to support people to address certain risk factors which are known to account for the gap in premature morbidity and mortality for people who have a mental health condition (see Plana-Ripoll *et al.,* 2019). For this to be achieved, however, organisational changes are required to ensure that nurses can deliver on the essential improvements that are required to improve health outcomes for people living with mental health conditions. As discussed previously, this would require a sustained investment to increase staff numbers, ensure the correct skill mix of clinical staff, and implement changes at the organisational level, e.g. putting processes and frameworks into effect to enable compassion to flow during interactions, and to enable nurses to have protected clinical reflection time.

Mental health care involves intrinsically being caught up in human relationships. It is at this relational level that compassion (as understood by mental health nurses) can be experienced. Yet, unseen forces may unconsciously limit the effect of compassion within such interactions. These forces may be social, economic, deeply psychological, or personal. The positive impact of reflection, made possible through regular clinical supervision, has been noted by various clinical academics internationally (see Berry & Robertson, 2019; Butterworth & Faugier, 2013; *also* Delgado *et al.,* 2020; Driscoll *et al.,* 2019; Oates, 2018). Given the complexities involved in mental health nursing practice, it is essential that this professional group has access to regular clinical supervision as this may help mental health nurses to build resilience and reduce burnout. Moreover, ensuring that nurses

have protected time to develop increased awareness of the varied parts of themselves (which they bring to the nurse–patient relationship) may ultimately support them to maintain a compassionate approach. This could be achieved by advocating for protected clinical supervision time to be made mandatory across the NHS and in private establishments.

Clinical supervision has been a longstanding quality indicator monitored by the Care Quality Commission in England (CQC, 2022). Given the difficulties the NHS has faced during the COVID-19 pandemic, it is understandable that the health of the NHS workforce has been referred to as "*in its most fragile state ever*" (Joint Statement by 15 arms-length bodies (Multiple authors, 2021). Nurses are recognised as 'safety critical' to the healthcare workforce; able to recognise and respond to the deteriorating condition(s) of patients for whom they care (Rafferty & Holloway, 2022). Therefore, protected time for nurses to reflect on practice, and help each other to work through any challenges they face is a major workforce strategy proposal that would require a system-wide commitment. This is supported by various third-party organisations who have focussed their activities on developing and offering this type of support for nurses – examples include Schwartz Rounds® (Maben *et al.,* 2018), Resilience Based Clinical Supervision (Stacey *et al.,* 2020), and Nightingale Frontline® (Bond *et al.,* 2022b). The latter has been successful in supporting nurses in the last two years during the Covid-19 pandemic. Clearly, for compassion to be realised as everyday practice, an ethical commitment to the wellbeing of the existing and future healthcare workforce must be considered. Perhaps then, there might be a better opportunity to consider

research with a focus on identifying ‘humanising’ practices and establishing ways to implement these into healthcare practices with the aim of assisting mental health recovery, personal growth, and wellbeing.

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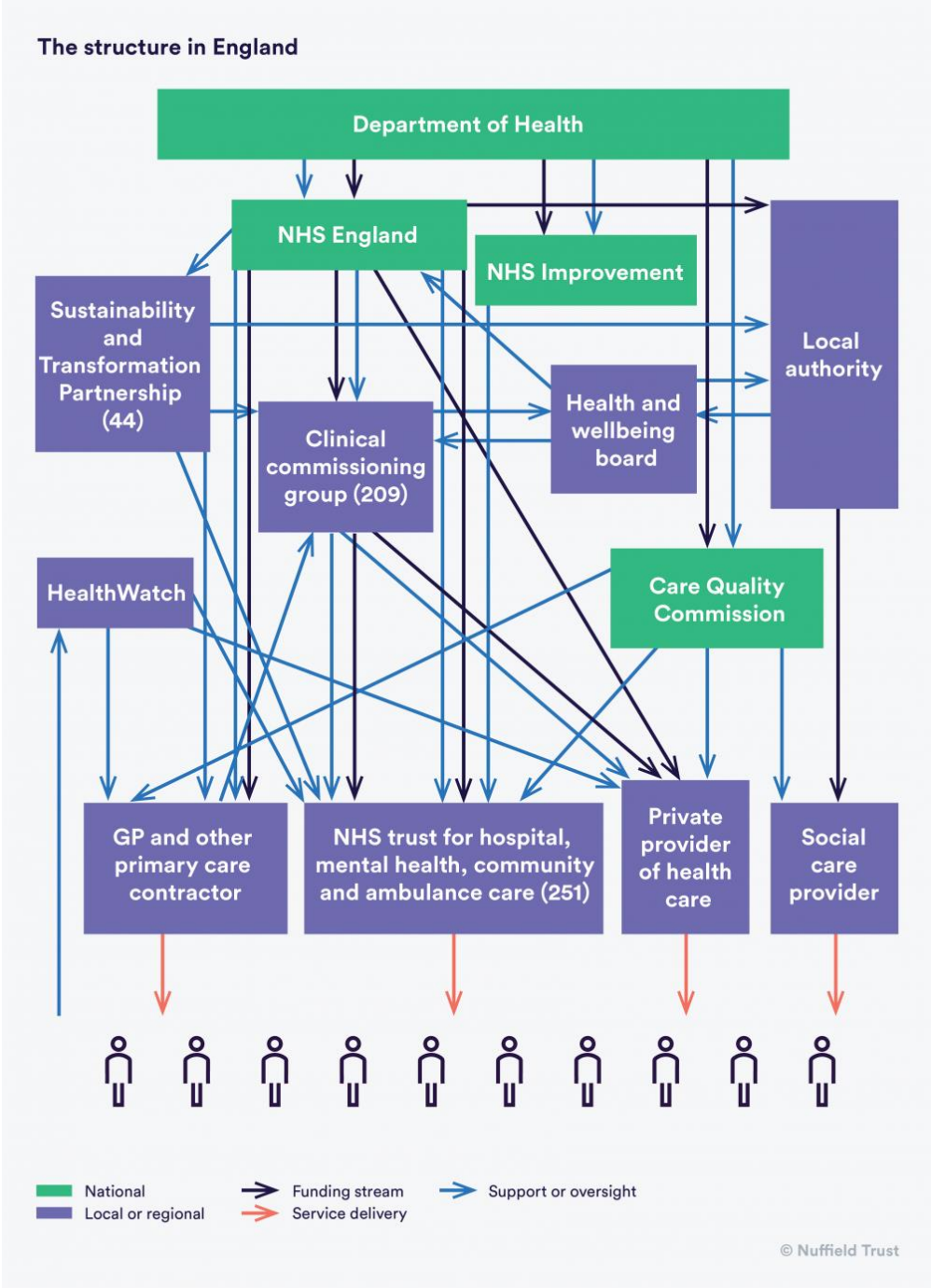
Appendix 1: Structure of the Health & Social Care System in England



Picture Ref: Nuffield Trust (2017)

Appendix 2: Health Research Authority & Research Ethics Committee Approvals

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Stephen Timmons
Professor of Health Services Management, Director,
Centre for Health Innovation, Leadership and Learning
University of Nottingham
Nottingham University Business School
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NG8 1BB

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24 June 2020

Dear Professor Timmons

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Compassion in Healthcare: A study exploring the influences of discourse on the subjectification of nurses and patient narratives in the context of mental health**
IRAS project ID:	**281630**
Protocol number:	**20030**
REC reference:	**20/WM/0139**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

Appendix 3: Study Documents

Consent Form

Title of Study: Exploring the concept of compassion in the context of mental health care

RDU Ref: 281630

Name of Researcher: Carmel Bond

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 3.0 dated 10/06/20 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Participant Information: Staff

Participant Information Sheet **STAFF**
(Final version 3.0: 10/06/20)

RDU Ref: 281630

Title of Study: Exploring the concept of compassion in the context of mental health care

Name of Chief Investigator: Professor Stephen Timmons
Local Researcher: Carmel Bond

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of this study is to examine national and local policy on compassion and explore how this can influence the professional identity of nurses (and nurse associates) working in mental health. It also aims to explore whether any tension exists in this environment between caring for a person and control of a person (since some patients may be detained under the mental health act).

Why have I been invited?

You are being invited to take part because you work in mental health care and are expected to deliver compassion as part of your role. We would like people who have experience of caring for people who have been detained to take part in our study.

We do not expect you to have read the NHS policy on compassion. However, you may be aware of the compassion in practice strategy or your trust's local policy on compassion.

We are inviting between 10 and 20 participants like you to take part as we would like to explore your experiences of delivering compassion in the context of mental health.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you take part, you will be asked to give your consent and read this information first. You will then be invited to an individual telephone interview with the researcher. This can be arranged at a time to suit you. It is expected that this will take between 30 minutes – 1 hour. However, if you feel you need more time this can be extended. With your consent, the researcher will record the interview – only your name and the date of the interview will be required. Your real name will be replaced by a code in order to maintain confidentiality.

The researcher will make a note of your gender, occupation, and how long you have been qualified. However, no other information about you will be required.

Where do I send my consent form?

If you wish to post your completed consent form, please send this to the Co-Investigator, Carmel Bond. The postal address can be found at the end of this document. You can ask for a stamped address envelope to be sent to you.

OR

You can provide an electronic copy of your consent form. This can be emailed to: Carmel.bond@nottingham.ac.uk

Redacted

Manager).

Once your signed consent form has been received, a suitable date and time for you to take part in the interview can be arranged.

Expenses and payments

You will not be paid to participate in the study. However, you will be provided with a certificate of participation which you can use for your professional development portfolio or revalidation file.

What are the possible disadvantages and risks of taking part?

It is not anticipated that there will be any harm will come to those who participate in this research. You will not be disadvantaged in any way if you take part in this research and this will not affect you in any way different to those who choose not to take part.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help explain more about how compassion is experienced and understood in mental health care in the future. It will help to understand how government policies and professional codes of conduct influence nurse's professional roles. The information we get from this study might help support improvements to policy, practice and education of mental healthcare professionals in the future.

What happens when the research study stops?

At the end of the study, your interview data will be transcribed by the researcher and analysed as part of a PhD thesis in mental health and wellbeing. The results may also be used in academic journal publications in the future. Any extracts of the interviews used in these publications will be made anonymous in order to keep your identity confidential. If you participate and would like to have the results of this research fed back to you, then you will need to provide the researcher with your consent to hold your contact details so that you can be co[Redacted]t in the[Redacted]t. It is [Redacted] and So[Redacted]

What should I do if I feel distressed?

If you feel distressed during the interview, please tell us, and we will offer to pause or conclude the process - you can stop the interview at any time. If you continue to feel distressed after leaving, you might wish to consult with your GP or with the following services which are available in Sheffield and nationally for confidential emotional support and information:

Rethink Mental Illness – Sheffield

Web: www.rethink.org/help-in-your-area/services/advice-and-helplines/sheffield-helpline/

Tel: 0808 801 0440 **OR** Sheffield 0114 258 2593

A [Redacted]y m[Redacted]alth &[Redacted] 2[Redacted]

Saneline

Web: www.sane.org.uk/what_we_do/support

Tel: 0300 304 7000. Available every day from 4.30 – 10.30pm (local rate number – included in inclusive/free minutes on mobiles).

Textcare: confidential text support sent at specific times, set up via an online form (see link above).

Support Forum: www.sane.org.uk/what_we_do/support/supportforum

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our information available from www.nottingham.ac.uk/utilities/privacy.aspx
- by asking one of the research team
- by sending an email to dpo@nottingham.ac.uk, or
- by calling us on 0115 748 7179

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Economic and Social Research Council [grant no. ES/P000711/1].

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by West Midlands – Coventry & Warwickshire Research Ethics Committee.

The design of the interviews (referred to in the "What will happen to me if I take part?" section) and the information presented in this participant information sheet has been informed by consultation with qualified mental health nurses who are known to the researcher but are independent of this research.

Further information and contact details

Co-Investigator:
Carmel Bond
Mental Health and Wellbeing PhD Student & RN (Mental Health)
Centre for Health Innovation, Leadership and Learning

Participant Information: Patient

Participant Information Sheet **PATIENT**
(Final version 3.0: 10/06/20)

IRAS Project ID: 281630

Title of Study: Exploring the concept of compassion in the context of mental health care

Name of Chief Investigator: Professor Stephen Timmons
Local Researcher(s): Carmel Bond

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of this study is to explore mental health service users' experiences of compassion.

Why have I been invited?

You are being invited to take part because you have experience of being cared for in mental health services. We are interested in understanding your experiences of receiving compassion in an environment where you are currently (or have previously been) detained under the mental health act. We are inviting between 10 and 20 participants like you to take part, in order to explore your personal experiences.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you decide to take part, you will be asked to give your consent first. You will then be invited to an individual interview with the researcher who is collecting the data for this study. It is expected that this will take approximately between 30 minutes and 1 hour. However, if you feel you need more time this can be extended. The interview will take place either on the ward where you are currently an in-patient or within the community mental health hub.

With your consent, the researcher will record the interview – this will be an audio recording only, the interview will not be visually recorded. Only your name and the date of the interview will be required. Your real name will be replaced by a code in order to maintain your confidentiality.

The researcher will make a note of your gender, however, no other information about you will be required.

If you agree to take part, you will be asked to describe your personal experiences of the care you have received in mental health services, while being detained. You will be asked about what your views of compassionate care are and what compassionate care means to you. You will only be required to meet once for the researcher to complete the interview.

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

It is not anticipated that any harm will come to you if you choose to participate in this research. You will not be disadvantaged in any way if you take part in this research, and this will not affect any of the care and treatment you receive in any way. You will not be treated differently to those who choose not to take part.

What are the possible benefits of taking part?

We cannot promise the study will help you directly but the information we get from this study may help explain more about how compassion is experienced and understood in mental health care in the future. The information we get from this study might help support improvements to policy, practice and education of mental healthcare professionals in the future.

What happens when the research study stops?

At the end of the study, your interview data will be transcribed by the researcher and analysed as part of a PhD thesis in mental health and wellbeing. The results may also be used in academic journal publications in the future. Any extracts of the interviews used in these publications will be made anonymous in order to keep your identity confidential. If you participate and would like to have the results of this research fed back to you, then you will need to provide the researcher with your consent to hold your contact details so that you can be contacted in the future. You may be in

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What should I do if I feel distressed?

If you feel distressed during the interview, please tell us, and we will offer to pause or stop the process - you can choose to stop the interview at any time. If you continue to feel distressed after leaving, you might wish to speak with your usual clinical care team to explore this further. You might wish to consult with the following services which are available in Sheffield and nationally for confidential emotional support and information:

Rethink Mental Illness – Sheffield

Web: www.rethink.org/help-in-your-area/services/advice-and-helplines/sheffield-helpline/

Tel: 0808 801 0440 **OR** Sheffield 0114 258 2593

A 24/7 Sheffield Helpline that offers emotional support and information to people affected by mental

Redacted

Saneline

Web: www.sane.org.uk/what_we_do/support

Tel: 0300 304 7000. Available every day from 4.30 – 10.30pm (local rate number – included in inclusive/free minutes on mobiles).

Textcare: confidential text support sent at specific times, set up via an online form (see link above).

Support Forum: www.sane.org.uk/what_we_do/support/supportforum

National mental health charity offering specialist emotional support and information to anyone affected by mental illness, including family, friends and carers, via an out-of-hours helpline and online support forum.

Samaritans

Web: www.samaritans.org

Tel: 116 123 (Free from any phone) **OR** Tel: 0330 094 5717 (local call charges apply)

Available Monday, Tuesday, Thursday, Friday, Saturday, and Sunday 10.00am – 20.00

272 Queens Rd, Lowfield, Sheffield S2 4DL

National confidential listening service offering a safe space to talk.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this

Redacted

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

How will we use information about you?

We will need to use information from you for this research project. This information will include your:

- Initials
- Name
- Gender

People will use this information to do the research and to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our information available from www.nottingham.ac.uk/utilities/privacy.aspx
- by asking one of the research team
- by sending an email to dpo@nottingham.ac.uk, or
- by calling us on 0115 748 7179

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Economic and Social Research Council [grant no. ES/P000711/1].

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by West Midlands – Coventry & Warwickshire Research Ethics Committee.

The design of the interviews (referred to in the "What will happen to me if I take part?" section) and the information presented in this participant information sheet has been informed by consultation people with lived experiences of mental health. These people are known to the researcher but are independent of this research.

Further information and contact details

Co-Investigator:
Carmel Bond
Mental Health and Wellbeing PhD Student
RN (Mental Health)
Centre for Health Innovation, Leadership and Learning

Interview Schedule: Staff

Exploring the concept of compassion in the context of mental health care

IRAS Project ID: 281630
Sponsor reference: 20030
Name of Chief Investigator: Professor. Stephen Timmons
Co-Investigator(s): Carmel Bond

Semi- Structured Interview Schedule _**STAFF**
(Final_V1.0: 06/05/20)

Can you please tell me generally about your role as a mental health nurse and describe the daily activities you undertake as part of this role?

What do you consider to be the most and least important aspects of your job?

How would you describe your identity as a mental health nurse?

How do you think others view you in your professional role?

Are you aware of the NHS or your local trust policy on compassion? If so, how important do you consider this policy to be in relation to your nursing role?

In your view, how much does the NHS or trust policy influence your role?

In what way do you think compassion is delivered in mental health, that might be different to physical health care.

What if anything might enable you to successfully deliver compassionate care in the environment you work?

Is there anything that you feel might limit your ability to deliver compassionate care?

What do you think has the biggest impact on mental health recovery for the people you care for?

Is there anything else that you would like to add?

Interview Prompts: Patient

Exploring the concept of compassion in the context of mental health care

IRAS Project ID: 281630
Sponsor reference: 20030
Name of Chief Investigator: Professor. Stephen Timmons
Co-Investigator(s): Carmel Bond

Interview Schedule **_PATIENT**

(Final V1.0: 06/05/20)

Can you please tell me about your experiences of care in mental health? Positive or negative.

Can you recall a time where you feel you have received care that was compassionate? What was this like?

How do you view the role of mental health nurses in relation to compassion?

Can you recall a nurse (or other healthcare professional) who showed compassion? Please describe.

Would you say compassion is important to the care you receive? If so, can you explain why?

What do you think makes compassionate care possible, or not possible, in mental health services?

Is there anything else that you would like to talk about, that you have not talked about today, that you feel is important to your care experience/s?

Distress Protocol: Staff

Distress Protocol _1.0_ STAFF_07/06/2020

Compassion in Mental Health

IRAS Project ID: 281630

Distress Protocol 1: Protocol for managing distress for staff participants being interviewed over the telephone, in the context of a research interview.

(Modified from: Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing*, *23*(5), 343-350).

Distress

- A participant indicates they are experiencing stress or emotional distress
  OR
- Exhibit behaviours/sounds suggestive that the discussion/interview is too stressful, such as breaking voice or crying

Stage 1 Response

- Pause the discussion/interview
- Researcher (who is trained mental health professional) will offer immediate support and assess mental status:
  Can you tell me what thoughts you are having?
  How are you feeling right now?
  Do you feel you are able to go on about your day?

Review

- If participant feels able to carry on:
  Resume interview
  OR
- If participant is unable to carry on
  Go to stage 2

Stage 2 Response

- Stop interview and encourage participant to seek additional support e.g., contact a supportive family member, friend, or colleague
  OR
- Offer, with participant consent, a member of the research team to provide a follow up call
  OR
- If participant discloses having been experiencing increased distress prior to the interview, encourage them to contact their

Signpost/ Follow up

- Refer participant to support services information provided in the PIS
  OR
- Email a copy of the debriefing sheet, with participant consent.
- Encourage participant to call their GP if they continue to experience increased distress in the hours/days following the interview
- Follow up with a courtesy call (If requested/consented)

Distress Protocol: Patient

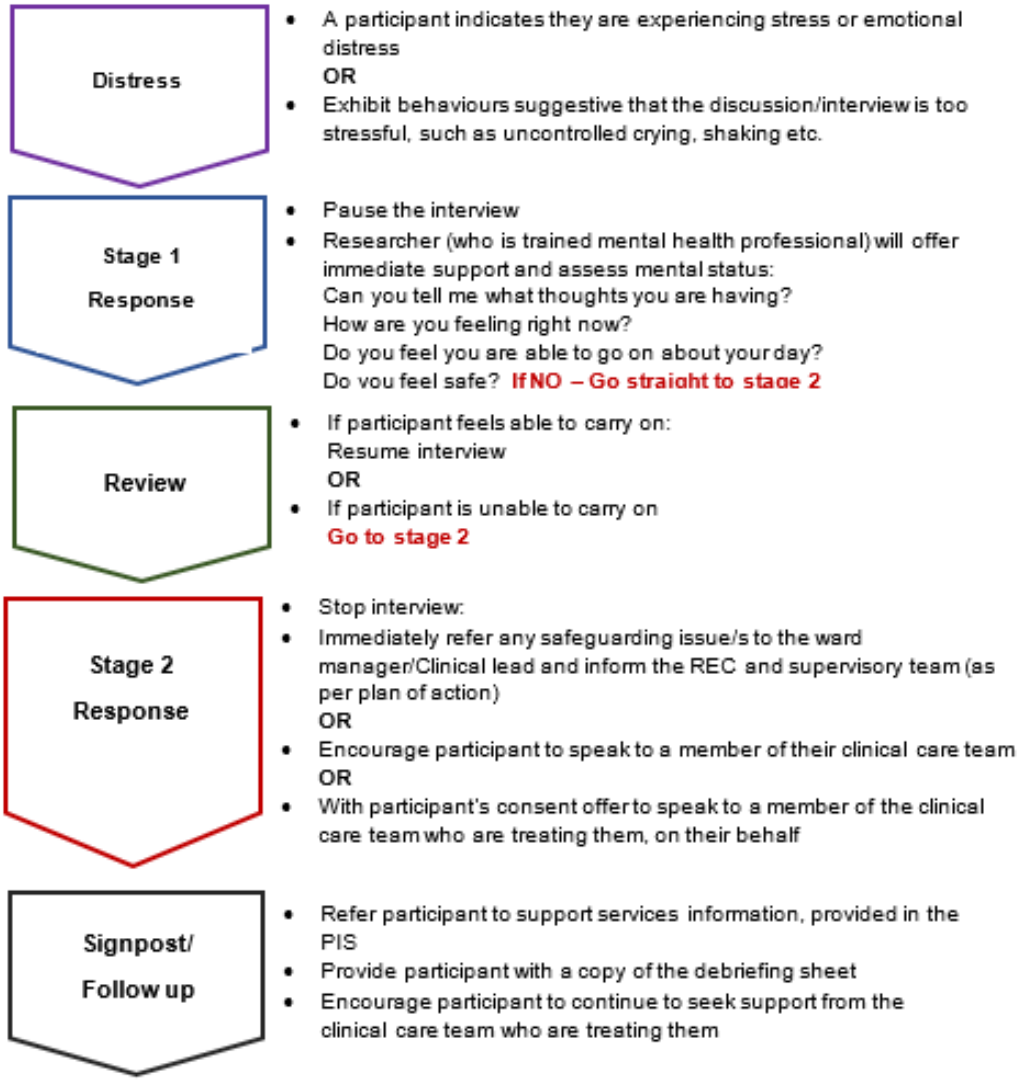
Distress Protocol_PATIENT_07/06/2020

Compassion in Mental Health

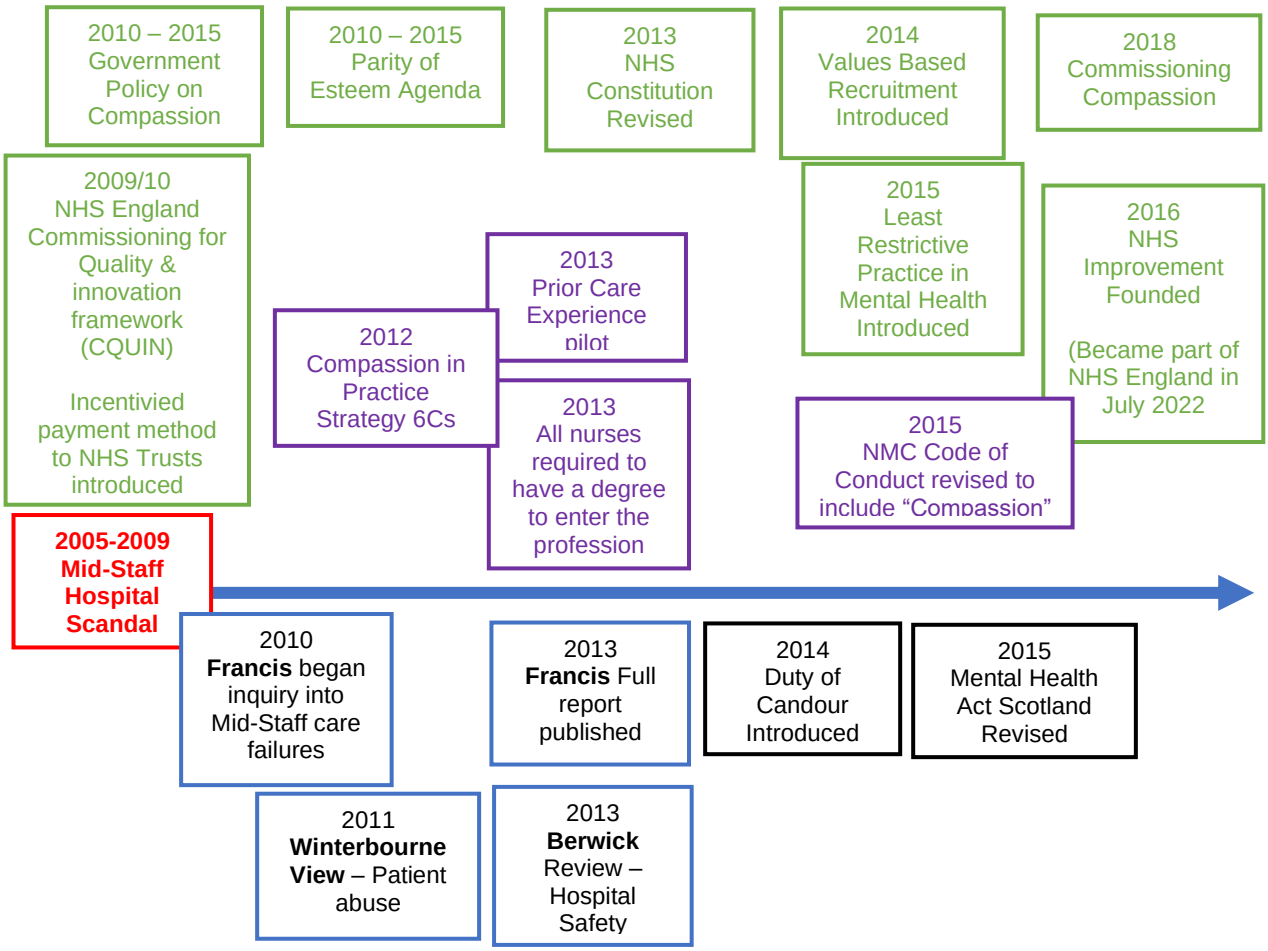
IRAS Project ID: 281630

Distress Protocol 2: Protocol for managing distress, in the context of a research interview. For service user participants being interviewed face-to-face.

(Modified from: Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing*, *23*(5), 343-350).



Appendix 4: Timeline of Events Following the Mid-Staffordshire Hospital Scandal



Green = Changes to policy/national guidelines
Blue = Public Inquiries
Purple = Changes specific to Nursing
Black = Changes to Legislation

Appendix 5: Sinclair Compassion Questionnaire – Short Form

The Sinclair Compassion Questionnaire-Short Form (SCQ-SF)

This questionnaire has been developed to ask you about your experience with the following aspects of compassionate care. Please carefully read each question and rate your level of agreement with it.

Instructions:
In thinking about your Healthcare Providers over the past 7 days, please rate the following:

1. I felt that my Healthcare Providers were attentive to me.

○Strongly disagree ○Disagree ○Neutral ○Agree ○Strongly agree

2. My Healthcare Providers were very supportive when they talked with me.

○Strongly disagree ○Disagree ○Neutral ○Agree ○Strongly agree

3. My Healthcare Providers provided care in a gentle manner.

○Strongly disagree ○Disagree ○Neutral ○Agree ○Strongly agree

4. My Healthcare Providers saw me as a person and not just as a patient.

○Strongly disagree ○Disagree ○Neutral ○Agree ○Strongly agree

5. My Healthcare Providers had a warm presence.

○Strongly disagree ○Disagree ○Neutral ○Agree ○Strongly agree